LM Learning Matters

QUALITY 2020

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Avoiding computer confusion: Log In, Check and Log Out

A Serious Adverse Incident (SAI) was notified following a prescribing error. This occurred when a doctor, who was using the Electronic Care Record (ECR) to complete Patient A's prescription chart, failed to log out when called away for a short time. In the interim another doctor opened a different patient's (Patient B) record on ECR and again did not log out.

Key Learning

When using any computer / software:

1. Always use only your own personal log in.

2. Always log out when leaving the computer even for a moment.

3. Always double check the patient's name and Health & Care number before prescribing medication.

When the first doctor returned to the computer, he/she did not verify the patient's details and assumed it was Patient A's record. The prescription chart was completed using Patient B's medications. This led to Patient A receiving the wrong medication on two occasions however the patient did not come to any harm.

Introduction

Welcome to the third issue of the Learning Matters Newsletter.

Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care and we recognise that we need to use a variety of ways to share learning. The purpose of our newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

Contents

National Patient Safety Alerts

http://www.england.nhs.uk/ourwork/patientsafety/psa/national-psa-system/

Patient Safety Alerts (PSAs) are used to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. From late 2013 there have been 17 PSAs issued by NHS England which are outlined below. Further information on PSA is available at: http://www.england.nhs.uk/ourwork/patientsafety/psa/

Ref No	Subject
NHS/PSA/W/2014/016	Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid or opiate treatment
NHS/PSA/2014/015	Resources to support the prompt recognition of sepsis and the rapid initiation of treatment
NHS/PSA/2014/014	Risks arising from breakdown & failure to act on communication during handover at the time of discharge from secondary care
NHS/PSA/W/2014/013	Risk of inadvertently cutting in-line (or closed) suction catheters
NHS/PSA/W/2014/012	Interpretation and Action on PCR Results
NHS/PSA/2014/011	Legionella and heating birthing pools filled in advance of labour in home settings
NHS/PSA/D/2014/010	Patient safety alert on standardising the early identification of Acute Kidney Injury
NHS/PSA/W/2014/009	Patient safety alert on risk of using vacuum and suction drains when not clinically indicated
NHS/PSA/W/2014/008	Patient safety alert on residual anaesthetic drugs in cannulae and intravenous lines
NHS/PSA/W/2014/007	Patient safety alert on minimising risks of omitted and delayed medicines for patients receiving homecare services
NHS/PSA/D/2014/006	Patient safety alert to improve reporting and learning of medical devices incidents
NHS/PSA/D/2014/005	Patient safety alert to improve reporting and learning of medication incidents
NHS/PSA/Re/2014/004	Patient safety alert on addressing rising trends and outbreaks in carbapenemase-producing Enterobacteriaceae
NHS/PSA/W/2014/003	Patient safety alert on risk of associating ECG records with wrong patients
NHS/PSA/D/2014/002	Patient safety alert on non-Luer spinal (intrathecal) devices for chemotherapy
NHS/PSA/W/2014/001	Patient safety alert on risk of hypothermia for patients on continuous renal replacement therapy
NHS/PSA/W/2013/001	Patient safety alert on placement devices for nasogastric tube insertion

Masking Challenging Behaviours

It is not unusual for patients presenting with a head injury to also have taken alcohol. This complicates history-taking and clinical assessment. Patients may be unable or unwilling to cooperate with staff and changes in their level of consciousness can be attributed to alcohol or drugs when in fact the patient is deteriorating due to their underlying head injury. Two SAIs were reported following deaths in patients who presented to ED following a head injury complicated by alcohol consumption. National Institute for Health and Care Excellence (NICE) 2007 guidelines on the management of head injury were not followed and changes in National Early Warning Scores (NEWS) scores were not acted upon, in part because changes in patient responsiveness were attributed to alcohol. A learning letter has been issued regarding the management of head injury complicated by alcohol ingestion (LL/SAI/2013/014 (AS) (January 2013)

Key Learning

- Know and apply your Trust's policy on assessment and treatment of head injury, including frequency of observations, indications for CT scanning and medical review.
- Adhere to scheduled observation times and record NEWS scores accurately in patients who have taken alcohol and/or drugs.
- Ensure that nursing staff new to the patient are made fully aware of the patient's observations and responsiveness up until that point.
- Always take action on a deteriorating NEWS score in line with Trust policy, even if this will sometimes turn out to be a false alarm in a patient who is under the influence of alcohol or drugs.

Share to Learn: Lesson of the Week

'Share to Learn' is the Western Health and Social Care Trust (WHSCT) in-house publication aimed at raising awareness and sharing learning from adverse incidents, complaints and near misses. It augments the learning letters, Learning Matters, and communications via governance and from the Medical Director's office. Recognising that there is a limit to the immediacy of written communication and to the volume of content, recently the WHSCT began to publish a 'Share to Learn' Lesson of the week. This sits on the Trust Intranet server and opens as the default on all desktop computers within the Trust. Each morning all staff who switch on a computer will be greeted by a quality and safety lesson derived from the risk and governance processes. A brightly coloured headline derived from the Share to Learn publication is intended to be read within seconds. The subject is chosen at the weekly Quality & Safety Steering Group chaired by the Head of Quality & Safety. Recent lessons of the week have included:

- the importance of insulin prescription and dispensing
- avoiding medication incidents
- consent processes
- good communication in avoiding misunderstanding

Where appropriate a hyperlink to Trust policy or background information is included. A repository of 'lessons of the week' is maintained as a reference, and is linked to the Share to Learn news-sheet. Maintaining the title and graphics of 'Share to Learn' provides a common theme and underlines the identity and importance of the messages.

Key Learning

- Trusts should consider adopting a similar approach to learning within their organisations as this has been identified by WHSCT as a good methodology to share learning.

Wrong Site / Wrong Procedure

Two SAIs have been reported recently relating to the wrong site or the wrong procedure being undertaken. In one, the correct site was identified but the wrong operation commenced. This was realised and the operation was stopped before completing the correct surgery. In the second incident the correct procedure was carried out but on the wrong site.

Both of these incidents highlight the benefit from complying with a surgical checklist, such as the World Health Organisation (WHO) surgical safety checklist before any procedure is undertaken http://www.who.int/patientsafety/safesurgery/checklist/en/

The WHO surgical safety checklist identifies a core set of surgical safety standards which can be applied in any healthcare setting. It is divided into 3 areas for completion:

- before induction of anaesthesia
- before skin incision
- before patient leaves the operating theatre.

Key Learning

- **USE** the WHO surgical safety checklist and **ASK**:
- **ASK** the patient to state their name and date of birth before any intervention, treatment, medication or transfer.
- **SEE** that the answer matches the name band and/or all documentation.
- **KEEP** the patient safe from intervention or treatment until you are sure.

Contact us

HSC Health and Social Care

If you have any comments or questions on the articles in the newsletter please get in contact by email at learningmatters@hscni.net or by telephone on **0300 555 0114 ext: 3446**

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