LEARNING MATTERS

EDITION 26
JANUARY 2026

IN THIS EDITION

Welcome to edition 26 of the Learning Matters Newsletter produced by the System Learning, Transformation and Governance Team, PHA. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise the need to utilise a variety of methods to share learning, therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

QUALITY 2020

Retention of catheter following accidental patient removal

Summary of Event

Two Serious Adverse Incidents (SAIs) were reported related to retention of part of a plastic tube from a urinary self-retaining catheter (SRC).

Patient A was admitted following a fall at home. They were diagnosed with an acute kidney injury (AKI) for which an SRC was inserted as part of the management plan. Patient A became agitated and began pulling on their catheter, resulting in them accidentally pulling it out. The catheter was not fully inspected by staff at the time of its removal. A complaint was later received from Patient A's family stating that Patient A had deteriorated at home after discharge, complaining of pain coupled with reduced mobility. Patient A then passed a piece of plastic when going to the toilet which appeared to be part of a catheter.

Patient B was admitted after being knocked down by a car. Due to the nature of the injuries plus immobility, a self-retaining catheter (SRC) was inserted. Patient B was transferred to Ward X and over the course of the next 10 days became very agitated, secondary to head injury and acute delirium. They required 1:1 supervision to maintain safety with deprivation of liberty (DOL) safeguards in place, and they required pharmacological management of their agitation.

Patient B's urinary catheter was removed following a rehabilitation review, as this was felt to be contributing to agitation as a source of annoyance.

Later that day, a catheter was reinserted, as Patient B had not passed urine and remained agitated. It was anticipated at the time of re-insertion that the urinary catheter would remain in place until it was clinically appropriate to remove. A few days later Patient B pulled their urinary catheter out. At the time, the catheter was disposed of and not fully inspected by any of the staff on duty. Over the course of Patient B's inpatient stay, they intermittently reported dysuria, urinary frequency and microscopic haematuria. Patient was treated with antibiotics for a urinary tract infection; these were discontinued three days later following a negative Mid-Stream Sample of Urine (MSSU). Following discharge, Patient B contacted the ward to advise that they had passed a clear plastic tube when attempting to pass urine. A post incident review of inpatient imaging was then undertaken. An x-ray of the lumbar and sacral spine showed a foreign body, consistent with the shape of a urinary catheter measuring approximately 11 centimetres, visualised in the urinary bladder. The foreign body did not track down the urethra. This was not present on a whole-body CT scan carried out on admission.

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KEY LEARNING

- Indwelling catheters should only be used when there is a clear indication and after all alternatives have been considered.
- Catheterisation of patients who are agitated and/or cognitively impaired should be carefully considered and risk assessed, due to the possibility of deliberate self-removal of the catheter leading to tissue trauma.
- There should be constant review of the need for continued catheter usage; in acute areas this should be a daily review. Catheters should be removed as soon as clinically able.
- Staff must carry out a full inspection of the self-retaining catheter following both routine and accidental removals to ensure that it is fully intact and record the fully intact finding in the notes. The following questions should be included in the removal notes:
  - Was the length of time the catheter was in-situ appropriate for the type being used?
  - Was the type of catheter, drainage system and support garments/straps being removed appropriate?
  - Were the catheter tip and balloon intact upon removal?
  - Note if encrustation was present, and to what degree.
  - Note if the section of the catheter retained within the bladder was clean or dirty or if debris was evident.
- Medical staff should adopt a logical process for reviewing all images where no formal radiology report is available – "A-E approach to X-Ray interpretation" as per Advanced Trauma Life Support (ATLS) guidelines.
- Traumatic, unintended catheter extractions, whether patient-initiated or accidental, can cause permanent urologic complications, affect hospital length of stay, decrease patient satisfaction grades, and increase catheter-associated urinary tract infections.

References

- Catheter Care - RCN Guidance for Health Care Professionals
- Indwelling catheterisation in adults – Urethral and suprapubic - INTRODUCTION
- https://nurses.uroweb.org/guidelines/indwelling-catheterisation-in-adults-urethral-and-suprapubic

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Managing Suspected Cardiac Chest Pain in Emergency Departments

Summary of Event

A patient attended their General Practitioner (GP) complaining of new, sudden-onset, central chest pain, which was accompanied by chest tightness and sweating. Initial observations were performed by the GP and an Electrocardiogram (ECG) undertaken, the findings of which were interpreted as consistent with hypertension. Aspirin, as well as repeated Glyceryl Trinitrate (GTN) sprays at appropriate intervals, were administered, achieving intermittent relief of chest pain. The patient was referred by their GP to the local Emergency Department (ED) for assessment at around 3pm and transferred from their GP practice to the ED by ambulance. Triage occurred in the ED at 4.30pm, following which blood tests and an ECG, which indicated a potential abnormality, were performed. The ECG was emailed to the Primary Percutaneous Coronary Intervention (pPCI) co-ordinator but did not meet the criteria for pPCI. Following medical assessment utilising the local Chest Pain Pathway, the patient had serial troponins and a repeat ECG undertaken. Troponin levels were found to be raised but static and the repeat ECG showed no dynamic changes. The patient was monitored and further reviewed by nursing and medical staff in the ED over the course of the evening, during which no further chest pain was experienced. Just before midnight, the patient was discharged home with a diagnosis of stable angina and provided with safety-netting advice to seek further urgent medical attention as required. A plan for referral to the Rapid Angina Assessment Clinic (RAAC) for follow-up was made. Unfortunately, the patient passed away six days after attendance at the ED, with the preliminary post-mortem findings noted as; ‘Haemopericardium, Myocardial Infarction due to Coronary Artery Disease’.

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KEY LEARNING

- Patients presenting to EDs with cardiac-sounding chest pain who have elevated, but static, troponins with no obvious alternative cause for these raised troponins, should be reviewed by the Cardiology Team prior to potential discharge. This action should be highlighted within local Chest Pain Pathways.
- Although the local Chest Pain Pathway was followed during the management of this patient in the ED, no documented pathway was completed. Local Chest Pain Pathways should be completed and clearly documented in the clinical record for all patients presenting with suspected cardiac chest pain.
- Although the initial ECG was appropriately sent for triage to the pPCI co-ordinator and assessed correctly as not meeting the criteria for pPCI intervention, the interpretation of the ECG was not documented on the pPCI pro-forma. pPCI co-ordinators should document the interpretation of any ECGs triaged on the pPCI pro-forma and should communicate the findings to the referring clinician.
- Patients with suspected stable angina who are being discharged from EDs and referred for outpatient review at the RAAC should have medications commenced in the interim, provided there are no contraindications. These medications should include Aspirin, GTN and Beta-blocker, as per the Regional RAAC Pathway.
- Following the patient's death, it was noted that, despite planned referral to the RAAC, this had not been completed following discharge. Although this did not affect the patient's outcome in this case, safe and reliable referral processes with adequate governance should be in place to ensure that all referrals from EDs are acted upon as required.
- The key points to consider when managing suspected cardiac chest pain in EDs can be memorised through the acronym HEART; History, ECG, Abnormal troponins, Refer to cardiology and Treatment.

H History	Comprehensive history, using interpreters (preferably face-to-face) if language barriers exist.
E ECG	Serial ECGs, with interpretation documented on each ECG.
A Abnormal Troponin	Caution in the case of raised troponins, even if static, in patients with cardiac-sounding chest pain, especially if no alternative cause identified.
R Refer to Cardiology	Review by Cardiology Team for patients with raised Troponins, even if static, if no alternative cause identified.
T Treatment	Discharge observations, discharge red flag advice (verbal and written) and discharge medications (Aspirin, GTN and Beta-blocker), while awaiting RAAC referral.

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Administration of eye drops

A SAI was reported in which a patient was treated as an inpatient for a severe Herpes Zoster Ophthalmicus infection affecting hairline, forehead and eye. This was managed with oral antivirals and steroid eye drops. The patient had an expected medical complication which resulted in admission to ICU. During inpatient stay the steroid eye drops were administered inconsistently. The patient developed an extensive corneal melt condition requiring surgical removal of their eye. Whilst the direct cause was the severity of the viral infection the course of the infection may have been influenced by failure to prescribe and administer the eye drops as instructed by the eye clinic and delay in ophthalmology review.

Review of adverse incidents and complaints has shown other examples of eye drops not being prescribed and administered as instructed including eye drops being administered at the wrong time resulting in delay in a procedure, or patients who were on more than one type of eye drop, for examples for glaucoma, not receiving the correct treatment.

KEY LEARNING

- Medicines reconciliation should include topical treatments including eye drops
- Eye drops should be prescribed and administered as instructed by ophthalmology. There should be clear instructions on duration of treatment and any reducing dose schedule.
- Consider support from orthoptist for inpatients where there is not on-site ophthalmology.

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Silver Trauma: Not to be missed

A number of adverse incidents have been reported related to “Silver Trauma”. Trauma in older patients with polymorbidities can be missed as they are poor historians with conflicting collateral histories and atypical presentations. The “Silver trauma” emphasises early diagnostics, intervention and outcome including rehabilitation, decreasing mortality and morbidity. (1) The most common trauma is a fall of less than two metres from standing. (2) They should be searched for more than one injury (2) in this case, suprapubic tenderness. They can have atypical observations compared to younger people sustaining trauma. (1) Example, a higher baseline blood pressure due to significant aortic disease. Similarly, tachycardia can be masked by medications such as beta blockers.

They should be investigated for polytrauma following an unwitnessed fall with a low threshold for a full CT trauma series.

Furthermore, early reversal of anticoagulation should be implemented with adequate pain relief hydration to prevent delirium. (2) Knowing local pathways for referral to specialist services, and considering of patient’s and relatives’ previous wishes are key for early mobilisation and discharge. (1)

References

British Geriatrics Society. (2023). Silver Trauma: Not to be missed | British Geriatrics Society. [online]

Available at: https://www.bgs.org.uk/silver-trauma-not-to-be-missed.

Royal college of emergency medicine (2019). Major Trauma in Older People (ISS > 15) Click Here for Other RCEM Issued Safety Alerts and Safety Newsflashes Silver Trauma Safety Alert. [online]

Available at: https://rcem.ac.uk/wp-content/uploads/2021/10/RCEM_safety_alert_Silver_Trauma_Sept_2019.pdf.

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Raising awareness of PICA

Summary of Event:

A resident within a Care Home choked on a non-food substance and died. The resident had a diagnosis of cognitive impairment and exhibited PICA behaviours. Pica is an eating disorder in which a person eats things not usually considered food.

- To raise awareness of Pica across Trusts and with Care Homes and Domiciliary Care agencies
- Care home staff, in partnership with the resident's family / nominated person, should complete comprehensive risk assessments and care plans. Outcomes of which should generate referral to the most appropriate service
- When a service user is exhibiting Pica behaviours, a comprehensive person centred Multidisciplinary Team approach should be implemented
- The residents G.P. should be advised to ensure any appropriate onward referrals are processed i.e.: Psychiatry of Old Age, Psychology

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Prostate Specific Antigen (PSA) measurement and monitoring in patients taking 5-Alpha Reductase Inhibitors

Summary of Event:

- In 2014 a patient with lower urinary tract symptoms (LUTS) and a raised PSA was diagnosed with benign prostate enlargement following a negative biopsy. Five years later in 2019, the patient was diagnosed with ureteric stones and chronic LUTS, and therefore commenced on tamsulosin and finasteride (a 5-alpha reductase inhibitor).
- *As the patient was on finasteride his PSA should have been checked at 6 months and a new baseline PSA should have been established at this point; accounting for a compensatory adjustment of PSA by two after 6 months treatment.*
- The patient's PSA result in 2019 was 12.00 ng/ml, and following 11 months of treatment with the 5-alpha reductase inhibitor, the PSA was just below 9 ng/ml. Yearly PSA tests were completed and in 2022 it was >9ng/ml. *These PSA results should have prompted further investigation.*
- In 2024, the patient was referred for a Magnetic Resonance Imaging (MRI) scan of his Pelvis for persistent right hip pain, which showed a large right proximal femoral lytic / destructive lesion of the femur that was felt most likely to be a metastasis. This was confirmed on further imaging. The patient's PSA level on at this time was >120 ng/ml but had not been checked since 2022. In addition, *the review team concluded an MRI scan should have been requested in 2022.*
- A Transurethral Resection of the Prostate (TURP) biopsy confirmed adenocarcinoma of the prostate gland and the patient was referred for palliative treatment.

KEY LEARNING

- NICE CKS guidance **5-alpha reductase inhibitors | Prescribing information | LUTS in men | CKS | NICE** states that men being treated with finasteride or dutasteride should have a new baseline PSA after 6 months of treatment; a compensatory adjustment of PSA concentration to multiply the PSA value by two after 6 months (as it can cause a decrease in PSA by approximately 50% in this time); and the recommendation for subsequent PSA surveillance for men started on 5-alpha reductase inhibitors.
- Any confirmed increase from lowest PSA level while on a 5-alpha reductase inhibitor may signal the presence of prostate cancer or noncompliance to treatment and should be carefully evaluated, even if those values are still within the normal range for people not taking a 5-alpha reductase inhibitor.
- In the interpretation of a PSA value for a man taking a 5-alpha reductase inhibitor, previous PSA values should be sought for comparison.

For further guidance please go to:

1. 5-alpha reductase inhibitors | Prescribing information | LUTS in men | CKS | NICE
2. Lower urinary tract symptoms in men: management
3. Finasteride 5 mg film-coated tablets - Summary of Product Characteristics (SmPC) - (emc) | 13543

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Preparing Milk Formula

KEY SAFETY MESSAGES:

- **Already opened bottles of water (sterile or otherwise) should not be used to prepare milk formula or any other food or beverage.**
- **Chloricide Plus (2 in 1 Chlorine Disinfectant Cleaner Tablets – similar to Actichlor Plus) should always be prepared, used, stored and disposed of in line with Trust polices and procedure, regulations and the manufacturer's instructions.**

Summary of Event

An infant was admitted to hospital from the Emergency Department (ED) for ongoing treatment and a number of days later was transferred to another ward. On arrival to the ward the infant vomited and the family expressed concern that the vomit smelt of bleach. On investigation it was established that a member of staff had added **Chloricide Plus** to a 500ml bottle of sterile water with the intention of cleaning the kitchen area. The bottle of sterile water had been dated as opened and left unattended in the kitchen.

A second member of staff used the bottle of opened / dated sterile water to make up the baby formula milk and as this staff member was wearing personal protection equipment (PPE) they failed to smell the bleach from the water. The baby milk was fed to the infant through a nasogastric (NG) tube. The infant attended theatre for an emergency oesophageal gastro duodenoscopy (OGD) which indicated small superficial erosions. There was also mild inflammation which may have been related to either trauma from the NG tube or from the ingestion of the contaminated milk.

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KEY LEARNING

- Milk formula or any other drinks or food should never be made up from open bottles of water (sterile or otherwise). Milk formula should be reconstituted with approved commercially available products or locally agreed proprietary equivalents.
- Chloricide Plus or any other cleaning product should always be prepared, used, stored and disposed of in line with Trust policy and procedure, regulations and manufacturer's instructions.
- Chloricide Plus or any other cleaning products should never be prepared for use in an area where food or drink is prepared, served or stored.
- Chloricide Plus or any other cleaning product COSHH Risk Assessments should be in place and verbally communicated to all staff and kept under regular review.
- Staff working with Chloricide Plus or any other cleaning product should attend mandatory COSHH Awareness training (every three years). Staff should receive training on the use and correct dilution of Chloricide Plus or any other cleaning product (Standard Operating Procedure (SOP)/ dilution chart) on induction and refresher training.
- Cleaning products should not be decanted into unlabelled containers.
- Cleaning products should not be left unattended and securely stored when not in use.

If you have any comments or questions related to this Edition of Learning Matters please get in contact by email at learningmatters@hscni.net

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