Minutes from ED Clinical Governance Meeting 01 MAY 2015 - 13:30 – 15:00

**Present:**

Steve Haig (Chair) Nagaraj Kumar Beatrice Bertoli

Annette Baskerville Ben Aslam Vikki Brown

Sally Bowyer Patricia Monteiro Jono Howell

Atif Latif Sathish Kumar

**Minutes of Last Meeting:** These have been circulated via the Intranet and there were no issues as a result.

**Introduction and Apologies**

**Presentation on Femoral Nerve Block Poster/Service Evaluation/Sticker**

A presentation was given by Holly Baker, Rebecca Butler and Weiken Tan, 3rd year MDEMO medical students from the University of Bristol. The poster is based on a retrospective study and uses the visual/analogue scale. In evaluating the service certain problems were highlighted concerning poor record-keeping. Uncontrolled pain post femoral nerve block means a corresponding increased requirement for analgesia. Use of the proforma sticker may encourage the physician to return to the patient more regularly to check the analgesia levels and requirement.

This is an important step in the NOF procedure which will be implemented in the Emergency Department within the next two weeks.

BA suggested we could put the dosage on the sticker. Or use standard dosage?

SH said one dose not suitable for everyone.

Action:

Production of stickers to be organised by ED secretaries.

**Lessons from Complaints/IR1s:**

1. Complaint 758996: 21 month old child, unwell with a temperature of >39 and RR of 40. Seen by SHO who prescribed analgesia. After discussion with ED Registrar the patient was sent home even though temperature was still 38.8 after anti-pyretics. Parents were advised to bring the child back if unwell. The child was brought back threedays later with a diagnosis of pneumonia and the child went on to have a partial lobectomy in Bristol.

Lessons:

This patient was not properly assessed and advised.

If advised to re-attend if unwell it should be on a specific date at a specific time to see a specific clinician.

An appropriate advice leaflet can be given.

1. Incident Number 75553: Doctor from Resus in ED phoned porters to request 6 units of O negative blood to be brought to the clinical area. The porter supervisor advised this was not the process to ask for blood urgently but the doctor had put the phone down before an alternative was agreed. A porter went to the pathology issue fridge and took 6 units of O negative blood from the fridge and took it to ED. The bio-medical scientist on duty saw what was happening and contacted the ED to discuss. Agreed that all 6 units would not be needed in the half hour so 4 units were returned and safely put back into stock. One unit of blood was used and the remaining one unused but it was returned too late to put back into stock. Unit wasted at a cost of £121.85.

Learning:

SAB said protocol states give 6 but caution is advised.

1. Incident Number 78201: 17 year old DSP. Management plan to move to Observation Ward which patient reluctant to do because doors are locked. Security had to restrain patient as she got off the trolley whilst in transit and was on the floor.

Action:

MDT meeting of all interested parties.

1. Incident Number 708013: Delay in acceptance of CT scan request by Out of Hours Radiology Service. Delay in scanning and further delay in reporting. The patient was kept immobilised all the time.

Learning:

VB advised that the reporting turnaround for Radiology should not be > 1 hour

Action: for Radiology to investigate

1. Incident Number 77969: ED nurse not trained to cannulate and take blood samples from a paediatric patient was verbally “attacked” by Orthopaedic Registrar for not knowing how to do this.

Action:

The matter has been referred to Mr Sunny Deo/Danny Little

1. Incident Number 77944: The blue x-ray form which the patient brings back from x-ray to Minors had the patient’s identification label stuck on top of the previous patient’s identification label. This could be peeled off to reveal the previous patient’s personal details.

Learning:

This is a serious Information Governance issue.

Action:

Without fail use one form for each patient.

1. Incident Number 77465: Lack of notification to mortuary staff that body bag in use and no note of explanation as to why it was in use.

Learning:

A patient can be placed in a body bag if there is an excessive amount of discharge from the body; in this case the patient had a significant GI bleed.

Action:

Neither the Charge Nurse nor the Staff Nurse was aware of the need to notify the mortuary but both have been informed that use of a body bag must be documented.

1. Patient with scrotal wound following surgery at Manchester Royal Infirmary. The surgical SHO closed the dehisced wound on two attendances over an infection and without antibiotic cover. The surgical SHO asked a staff nurse (who had never sutured a scrotum) to close the wound. The surgical SHO did not seek a more senior surgical opinion after failure of the initial closure on the first attendance of the patient. On the patients third attendance the surgical SHO refused to see the patient.

Action:

Referral to Mr Iacovou

1. Incident Number 77797: Patient came into Resus following a fall into the canal after drinking excessively and taking legal highs. Patient woke up and became aggressive both verbally and physically. One security guard and one ambulance person were hit. Police stayed only a short while as doctor needed to take bloods and carry out further investigations. Security left as they were busy.

Learning:

Discussion about tolerance of aggressive patients and boundaries led to thinking that a more senior doctor or a consultant might have told the patient to go.

AB stated this was a very serious incident. The patient put his fist to the nurse’s face and said he would kill people.

Action:

BA encouraged awareness of staff working in isolated areas for example Resus, the Plaster Room and Theatre and the wearing of a security bleep.

SH stated that more senior discussion was needed on this point.

AB advised that work is being done to address the above issues. There are plans to introduce conflict resolution courses run by ex-Military Police and the option of providing a security guard to stay with the ED night shift is being looked at currently.

1. Incident Number 77444: Patient admitted to Resus for manipulation of wrist following fracture. The nurse drew up Lignocaine 1% 300 mg instead of Prilocaine and was unaware of the error but it was picked up by an ED senior registrar who then observed the patient for any adverse reaction. Manipulation completed but Bier’s cuff left in place.

Actions:

AB stated that the drawing up of all anaesthetic drugs should be checked by the senior staff.

ED Staff Nurse on duty at the time has met with her line manager to discuss potential factors which contributed to the error.

1. Incident Number 77819: Majority of PCs in ED were not allowing log on and only one computer was available for requesting investigations.

Learning:

SH understood that one possible cause was that the same servers had been used for the installation of electronic prescribing and therefore the system had become overloaded.

Action:

BA will email Constantin Jabarin regarding an additional white board.

1. Incident Number 76856: Patient found to be wearing nasal specs which had been plugged into the **air valve instead of the oxygen valve**.

Action:

Trust Equipment inspected all ED oxygen outlets to ensure gas outlet labelling was correct.

1. Incident Number 77205: In Resus the patient’s **oxygen tubing** was attached to an air flow meter rather than oxygen. Situation rectified quickly.
2. Incident Number 77533: Delay in administering of a chest drain because of confusion about which team was to take over the care and subsequent inappropriate delay in transfer of patient.

Learning:

If the patient needs a chest drain this should be done without delay.

1. Incident Number 76923: Patient admitted to ED with swollen erythematous elbow and was pyrexial, tachycardic and tachypnoeic. Delay in screening for sepsis via the Sepsis 6 Pathway. Failure to recognise that measurement of lactate at 5.3 is a trigger to complete a Sepsis 6 Pathway. Antibiotics delayed on the advice of the orthopaedic SHO despite clinical evidence of severe sepsis.

Learning:

In terms of administration of antibiotics the evidence of severe sepsis outweighs the intention to aspirate a joint – antibiotics should not have been withheld.

Action:

For consultant investigation.

1. Incident Number 75831: Staff member who examined a paediatric patient with respiratory/chest problems was unable to examine patient’s chest as did not have a stethoscope. Unable to verify identity of this member of staff as no printed name/bleep number.

Learning:

BA/SH reiterated that name/grade/speciality must be documented at all times as this is basic record-keeping.

1. Incident Number 76603: Patient admitted to Observation Ward with drug-induced psychosis and started to engage in activities which put his life and potentially the lives of others in danger. Nursing staff requested mental health support as they felt that the situation was unsafe due to level of care denied to the other patients on the ward as a result of this patient’s behaviour. ED registrar stated that because the patient was suicidal but not trying to abscond no further support would be available from RMN and patient could not be sectioned.

Learning:

It was inappropriate to request Mental Health support. The real need was for a member of the security staff/Band 2 nurse who could attend and spend time with the patient on a 1:1 basis.

It is outside the spirit of the Mental Health Act to section people when there is no bona fide mental health issue.

1. Incident Number 76434: On receiving a patient in Resus it was noticed that 1 litre of saline with kcl was infusing without a pump. 350 mls had infused within 2.5 hours instead of over the normal 8 hours.

Actions:

This is an agency nurse and Nurse Bank has been instructed that the nurse is no longer to be booked for ED.

All ED staff have been reminded that potassium additives to IV fluids must be administered via a pump.

1. Incident Number 75420: Second presentation of fall and head injury in the space of one month of an elderly patient who was admitted overnight to the Observation Ward. No formal neurological examination documented in the notes. Discrepancies regarding observations in nursing handover notes. Subsequent CT scan revealed a large acute on chronic subdural with mid-line shift.

Learning:

Elderly patients who lose their balance and fall backwards are not “mechanical falls”

All elderly patients admitted to the Observation Unit should have the minimum of blood tests, urinalysis and observations done.

Elderly patients presenting after two falls and head injuries who are falling more should have CT scan.

1. Incident Number 76400: Due to staff shortages a decision was made to carry out a brief cardiovascular, respiratory and abdominal examination without a chaperone. On completion of the examination the doctor was alerted by the patient’s step-father to the fact that on several occasions the patient had made false allegations about male staff inappropriately touching her.

Action:

AB/IN to put appropriate alert on Medway patient record.

1. Incident Number 76292: On **checking CDs** established that 3 Diamorphine were missing. Missing drugs were later found ? under CD books.

Learning:

AB reported that three similar incidents have happened over the last twelve months. In two cases the drugs were found. In the other case it seemed that the drugs had not been signed out by the anaesthetist.

Action:

AB stated that if this happens again the situation will be closely monitored.

1. Incident Number 76291: Doctor went in to record observations on a patient at 0400 and noticed a tourniquet around the left upper arm. Patient’s arm was dark in colour and cold to touch and capillary refill of around five seconds. Blood sticker time was 2256.

Action:

Nurse in area and nurse in charge informed. Discussion with EDA and medical doctor.

? use a self-releasing tourniquet

1. Incident Number 76211: HSDU staff found disposable syringe with needle without sheath in **blue bag** collected from the Emergency Department.

Action:

All staff reminded to dispose of sharps correctly in sharps bins.

1. Incident Number 75800: Child with viral wheeze not triaged within target time. Tannoy went out in Minors waiting room informing patients that there was a five hour wait. Parents decided to leave and the child did not have an initial assessment. Returned to ED in the evening acutely unwell with severe exacerbation of viral wheeze and required iv treatment in Resus

Learning:

Had the child been triaged appropriately and the parents not encouraged to leave on initial presentation the need for treatment in Resus potentially could have been avoided.

Action:

AB stated if there is more than a three hour wait the Paediatric team is to be called for help.

1. Incident Number 75915: Doctor prescribed “overoxyban 50 mg” which does not exist in the BNF. Patient was on Rivaroxaban 15 mg. Patient was also prescribed Dalteparin as doctor had not realised that the wrongly prescribed drug was an anti-coagulant.

Action:

Review by medical consultants and Pharmacy.

1. Incident Number 76114: Patient with a fracture of C2 spinous process was without collar and blocks and not immobilised.

Learning: If any form of fracture is being investigated with trauma as the mechanism the patient should be collar and blocked until the neck has been cleared.

1. Incident Number 73499: Patient admitted to ED with unknown D & V. Septic pathway started. Fan therapy and stripped down. Swelling and redness to right arm noted. IV antibiotics prescribed. Care taken over. Medical registrar informed and ? necrotising fasciitis. Patient died.

Learning: Delay in treatment and procedure.

1. Indident Number 74724: Patient with chest pain given Fondaparinux when already on Dabigatran.

Learning:

Contra-indication of drugs..

1. Concern regarding policy: Motorcyclist involved in an RTC. Despite morphine requirement and ongoing pain staff were assured at handover that there were no concerns about him. He was subsequently seen by a SpR in ED and found to have severe back and abdominal pain and CT scan showed an open pelvic fracture requiring transfer to Southmead. It transpired that although he was travelling at 10 mph at the point of impact the other vehicle was going a lot faster and he was dragged along the road for some distance by the other vehicle.

Action:

All patients who present with motor cycle injuries are to be assessed initially in Resus.

**Complaints – Nursing Issues**

Attitude

12794: BP/TIA – nurse did not listen to patient. Staff reminder to give patients their full attention.

12413: SEQOL front of queue issue. Ensure that patients returning from SEQOL go to the front of the queue.

12802: Fireman with a shaved head asked to complete an alcohol questionnaire. Check appropriateness of questionnaire.

13098: Patient felt “bullied to go to SEQOL”. Ensure effective communication as to rationale regarding streaming to UCC.

261166: Patient sent home with UTI and came back. Ensure full checking of all investigations prior to discharge.

12781: Patient sent to UCC with inadequate analgesia. Ensure pain score completed and adequate analgesia given prior to streaming.

755996: Attitude of nurse regarding admission. Patient did not feel taken seriously. Raised at all staff meetings in order to ensure that staff remain non-judgemental.

Clinical Reasoning of Nurses

627696: Baby observation discrepancy. Nursing staff must ensure that concerns are highlighted to senior doctors.

13037: Alert not checked. Staff reminded to ensure alerts are checked.

579596: Clumsy male agency nurse. Wife of patient not happy about the way he leaned across the patient. Remind staff to be aware of ergonomics when working in ED.

Property

653996: Property check list to be completed on all patients who are admitted.

471096: Property check list to be completed on all patients who are admitted.

68635: HI CT scan re-attend. No discharge advice. Discharges must be safety-netted. Patient had been in several times with alcohol and there had been difficulty in assessing.

**Any Other Business**

Trauma call for wards does not require an ED response and presence. It is directed at the orthopaedic registrars.

Dates of next meetings:

Friday 29th May 2015

Friday 3rd July 2015

Friday 14th August 2015

Friday 4th September 2015

Friday 2nd October 2015

Friday 6th November 2015

Friday 4th December 2015

All meetings to start at the new time of 14:00.

Dr Steve Haig