Minutes of ED Clinical Governance Meeting

29th MAY 2015 - 14:00 – 15:00

ED REGISTRARS’ ROOM

**Present:**

Steve Haig (Chair) Vikki Brown Will Chapman Annette Baskerville

**Minutes of Last Meeting:**

These have been circulated via the Intranet and there were no issues as a result.

**Lessons from Complaints:**

1. Complaint 358296 presented by VB: this was about a patient with a recurring rectal prolapse. Issues were around staff not listening to patient regarding pain relief.

Lessons: Staff are reminded to give timely pain relief and explanations.

1. Complaint 598596 presented by AB: 90 year old lady on a cardiac monitor with multiple ectopic beats.

Lessons: Staff are reminded to give explanations and to check for medical alerts.

1. Complaint 653996 and 560996 presented by AB: loss of property.

Lessons: Staff reminded to complete the forms.

1. Complaint:450696 presented by AB: lady was discharged in the early hours to a nursing home because of transport arriving at 0200. Staff at nursing home were happy to accept and so patient was transferred however this lady’s daughter was upset about the fact that she was transferred at this hour of the night. Unfortunately the patient died two days subsequent to this.

Lessons: Staff are reminded to transfer during daylight hours if at all possible and to chase Arriva.

1. Complaint Number 77906: lady presents to Minors with a toe laceration. Noted on CAS card that she was allergic to Penicillin. She was prescribed Augmentin by mistake.

Action: A Trust alert is going on Medway.

**Lessons from IR1s:**

1. 77797: Person became very aggressive after falling into a canal having drunk a lot of alcohol and taking novel psychoactive substances. He squared up to several staff and threatened to kill us all and also to vomit all over one of the nurses. Security and Police were called. The ED doctor decided that bloods and further investigations were needed. Security had to leave as they were busy elsewhere on site and Police also left.

Action: This has been reviewed extensively and further conflict resolution training has been put into place for the Emergency Department. Additionally I have looked into this from a medical perspective and I would like to remind all staff that either the nurse in charge or the ED Registrar should be phoning the on-call ED consultant should similar instances happen and there is a debate over whether or not investigations should be done.

1. 77633: Patient on the Observation Ward was given Parvolex following self-poisoning. An infusion pump was found running at 143 ml per hour instead of 66 ml per hour which the pump was set up at. It is believed that the patient had adjusted the pump whilst in the toilet. The infusion was stopped and then re-started at the correct rate.

Lessons: Staff are reminded to be vigilant around this.

1. 77502 reported by HSDU: blue bag was full of rubbish, single use instruments and sharps.

Action: Posters have gone up around the Emergency Department reminding staff of appropriate disposal of sharps and instruments.

1. 78069: Patient was admitted to Observation Unit for chest pain, panic attack and hearing voices telling him to harm himself and others. He was waiting to see the Mental Health nurses and the intentional round was being used. However at the next intentional round he was found not to be in the department. The security team was called and security cameras showed the patient leaving in a taxi. Police were contacted and they visited him at home but could not persuade him to come back. Eventually the GP was contacted and he arranged follow-up.

Lessons: Staff are reminded that intentional rounds need to happen but that we also need to be vigilant at all times.

1. 78013: A MET call was put out for a patient on the ward following a fall and some blood loss from the scalp. CT was requested by the MET team at 0332. The scan was not performed until 0445. The report was then not made available until 0700 the patient having been kept immobilised all this time.

Action: This has been looked into and staff are reminded that if there is a delay in getting a report from the RRO then the on-call Great Western Hospital Radiologist should be contacted to expedite this.

1. 77821: This one has been reported previously via the governance meeting and this is a follow-up. This was a patient with dehisced surgical scrotal wound which was repeatedly re-sutured in the Emergency Department.

Action: AB reported that she had met with the nurse who had re-sutured at one point and discussed the appropriateness of this.

1. 77741: This is a confused elderly patient who became more confused and was difficult to manage in the Observation Unit. This resulted in the patient being sedated with Haloperidol.

Lessons: Staff are reminded that confused elderly people can become quite aggressive particularly in unusual situations and that senior medical help should be requested.

1. 77944: The blue form that is used to send the patient from Minors to x-ray had the patient’s ID label stuck on top of the previous patient’s label. This is an Information Governance issue additionally the blue forms are at times used by the radiographers to write down the initial report of what they see on the x-ray.

Lessons: Staff are reminded to use new forms for each patient.

**Any Other Business**

The dates of future meetings are:-

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 14:00 and to take place in the Registrars’ room.

Dr Steve Haig