

**ED CLINICAL GOVERNANCE MEETING**

**04 SEPTEMBER 2015 IN ED REGISTRARS’ ROOM**

**Present:**

**Steve Haig (Chair) Sarah James Andy Memory Sharon Westmore**

**Annette Baskerville Amanda Vittles Lucy Williams Laura Harrington**

**Ben Aslam Daren Hiller Atif Latif**

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| **No** | **Subject** |
| **1.** | **MINUTES OF LAST MEETING:**  The meeting on 14th August 2015 was unattended. |
| **2.** | **IR1s**  **Incident 81173:** Glucose not administered alongside the insulin infusion when BM below 15.  Learning: missed medication – medicines governance.  **Incident 81134:** Problems with rescue of deteriorating patient. Nurse advised by Orthopaedic Registrar that pressure bandaging and move to Resus not required. Patient went on to suffer stroke probably as a result of profuse bleeding and physiological stress.  Learning: use clinical knowledge and if concerns speak to the orthopaedic on call consultant. This incident has been referred to Mr Sunny Deo.  **Incident 81261:** Patient on Entonox did not wish to be without the Entonox. Threw the Entonox filter at the nurse when she tried to remove it.  Learning: awareness that Entonox can have neurological consequences and current debate about its effects.  **Incident 81101:** Attempted cannulation of patient failed leading to needle stick injury.  Learning: always wear gloves as this has the effect of wiping the needle if skin punctured.  **Incident 81080:** Verbal abuse, mental health nurse on ED nurse.  Learning: all of us need to be mindful of treating people appropriately. Investigation by AWP. The person dishing out the abuse has now left the Trust.  **Incident 81042:** breach of one hour target for sepsis treatment.  Medical error missed medication. This was a day when we had 32 ambulances in a 2 hour period. It should have been possible for SAU staff to deal with the sepsis treatment. News score of 5+ must be attended to.  Action: SH to ask Dr Constantin Jabarin, Chief Clinical Information Officer, if it is possible to put the News scores on the whiteboard.  **Incident 81233:** Patient’s grandmother told by GP that he would be referring her grand-daughter as an emergency and that she would not need to wait but would be seen straight away. The grandmother was verbally abusive to reception staff when it was clear that this would not be the case.  Learning: it is difficult when a patient is given the wrong expectation by other health professionals however this has to be managed.  **Incident 81219:** Under mattress, under bed head and in bottom of trolley was evidence of a large amount of dried yellow liquid which appeared to be urine.  Learning: awareness of contamination.  **Incident 80958:** Patient did not receive an appropriate review by Mental Health team for over 20 hours following attempted suicide by strangulation. This is one example of a number of similar referrals.  Action: incident referred to AWP. Reminder when engaging the help of the on-call services to get the name of the person on the end of the line and note time of call made and telephone number to call back on if there is a lack of suitably skilled staff at the time.  **Incident 80952:** Patient alternately vacant and then aggressive following alleged assault. Whilst in resus patient grabbed a syringe and needle which had been prepared by the anaesthetist with sedation drug Propfol and during a period of aggression used unsheathed needle to scratch a police officer. Sharps procedure was followed  Learning: Sedation by the senior ED registrar would have been a better course of action in this case. Medication must be drawn up by the nursing team. The medication should not be left lying with the needle on.  **Incident 81201:** Patient had a chest and abdominal x-ray conducted 4 days prior to reporting of a blood pregnancy test. A signed pregnancy form had been scanned into CRIS.  Learning: always check even if it is appropriate to x-ray.  **Incident 80449:** Patient arrived in SAU from ED with tourniquet still in situ.  Learning: Carry out adequate observations at all times.  **Incident 76114:** Patient presented to X-Ray accompanied by a nurse and a monitor but was not strapped down and had no collar and blocks.  Learning: if any form of c-spine fracture is being investigated with trauma as the mechanism the patient must be collar and blocked until the neck has been cleared. SH has notified Dr Pegden asking her to investigate what went on with on call medical team on this occasion and to feedback about the importance of neck immobilisation.  **Incident 80682:** Insufficient information transferred from secondary to primary care via the health visitor and school nurse information sharing form.  Action: further action required to improve future liaison and information sharing between secondary and primary care.  **Incident 81027:** Two full boxes of morphine sulphate and two full boxes of Diamorphine found on the side in the treatment room. It seemed no-one had been made aware that the medication had arrived and needed to be signed into the controlled drugs book.  **Incident 80609:** Patient fell from a height from bed in resus. He was behind screens and the nurse was with another patient when she heard the noise of the patient falling.  Learning: take care with DSP patients who may be over-energetic due to medications or ETOH.  **Incident 80993:** Samples from Teal Ward found in ED. The tops of the blood bottles had popped off and the contents of the bottles had filled the clear attached bag.  Learning: awareness of risk of infection.  **Incident 80537:** Miscommunication between ED and Delivery Suite regarding severity of the condition of a patient with a postpartum haemorrhage. Delay also with iv access whilst in ED.  Learning: patient should have been cannulated whilst in ED.  **Incident 80436:** Verbal abuse 17 year old minor under CAMHS on staff. Patient was unhappy that he was deemed to be fit for discharge from Observation Ward. Later arrested by Police.  Learning: any agreement on management of 17 year old should be done consultant to consultant. Looking after a difficult adolescent in the Observation Ward is an inappropriate default.  **Incident 80321:** Verbal abuse patient on staff.  Action: security reviewed and concluded that this individual should be issued with a UBL (Unacceptable Behaviour Letter).  **Incident 80279:** Patient with cerebral palsy who is wheelchair-bound and who has carers four times a day sent home from ED at 04:32. The patient had no follow-up appointment with Fracture Clinic.  Learning: reminder to take care about appropriateness of sending individuals home at this time of day and also to give an appropriate advice leaflet, in this case post-sedation.  **Incident 80174:** Inadequate handover of care from ED staff to LAMU co-ordinator resulting in cardiac monitor being unavailable to a patient who needed one.  Learning: ensure accuracy of handover information.  **Incident 79691:** Inadequate handover of care from ED staff to orthopaedic on-call. Grade I open fracture not documented as being an open fracture and orthopaedic admitting team unaware as patient was already in POP at time of arrival.  Learning: be clear about the standard of documentation. Make it clear in the notes whether a fracture is open or closed.  **Incident 81766:** Drop from recorded GCS of 13/15 to 3/15 in thrombolysed stroke patient on arrival in LAMU. This does not appear to be an incident but a recognised complication of therapy. It is always possible that patients deteriorate on transfer to wards and the state of the patient may be different on arrival to the ward compared to when they left the ED.  **Incident 81916:** Confidential paperwork found in Majors waiting area on the floor by the children’s tables. It seemed that this patient’s Mental Health Matrix had been mixed up with the children’s colouring materials.  Learning: care to be taken to avoid breaches of confidentiality.  **Incident 80836:** A CT head scan was requested on a patient but the radiographer felt it was unsafe to proceed with the scan due to confusion and agitation of patient. The requesting doctor was informed but did not know the patient and had not requested the scan despite it having been requested using his ICE login.  Learning: it is unclear which ED doctor requested this. All staff will be reminded of the need to ensure they are logged in correctly prior to requesting investigations or inputting data.  **COMPLAINTS**  **Complaint 598596:** Complainant concerned that ED staff have no idea how to manage bedside manner in relation to patients with mental health issues and/or assume that they are attention seekers.  Action: mental health training to be offered to staff and staff to be clear about the management of their patients.  **Complaint 450696:** Complainant unhappy about transfer of her mother back to nursing home at 02:00 on a cold December night. The patient was being discharged back to her nursing home, a place of safety, not an empty house, and they were happy to accept her.  **Complaint 779096:** Complainant was prescribed a medication which contains Penicillin even though the ED doctor noted on the outpatient prescription form that she was allergic to Penicillin.  Action: all staff reminded to check allergy.  **Complaint 889296:** Complainant contacted PALS regarding her neighbour who arrived back home with a cannula in situ following attendance in the Emergency Department.  Action: staff reminded to ensure full discharge checklist is completed.  **Complaint 970096:** Complainant is a chemotherapy patient who had to wait in the main waiting area of the Emergency Department and found the experience stressful when feeling ill and having been advised to avoid crowds due to increased risk of infection.  Action: staff to be reminded that patients undergoing chemotherapy are to be treated in a more isolated environment and to be mindful of the concerns regarding crowded areas.  **Complaint 736096:** Complainant is daughter-in-law of 80 year old gentleman and the complaint is threefold around change of timing of transfer to new care home, discharge to new care home late at night against the family’s wishes and concern regarding the way in which a member of staff from the Emergency Department spoke to her.  Action: ensure EDD to be undertaken in hours when possible.  **Complaint 999996:** Due to lack of a cubicle and lack of a drip stand complainant was treated in a public area and attached to Hickman line via a porter’s chair. The complainant was concerned that paramedical staff were washing their hands in the sink between him and the drip and that the Hickman line could have been accidentally ripped out. Patient felt unsafe.  Action: all staff reminded to ensure this does not happen again. Choose suitable area and use drip stand.  **Complaint 1017296:** complainant concerned that the correct blood extraction procedure had been followed as a repeat sample had to be taken.  AB has explained to the complainant why the laboratory can ask for a sample to be re-taken and that this might be due to “underfill” or haemolysis of the blood sample. AB apologised that the reason for blood test needing to be retaken was incorrectly verbalised to the complainant.  **Complaint 1015696:** The family of an 89 year old DNAR lady who died in the department in May felt that she died in pain.  This is clearly unacceptable and will be flagged to senior doctors. |
| **3.** | **RESEARCH**  Very good response in GWH. Trials up and running. Need to recruit another Research Nurse. |
| **4.** | **MANDATORY TRAINING**  Ongoing requirement for everyone. (ENPs to be appraised additionally by Consultants.) |
| **5.** | **ELECTRONIC NOTES**  Ongoing transitional phase. |
| **6.** | **RAT** |
| **7.** | **AOB**  NEWS sheet – need to ensure that everything is filled in. |

**Date of Next Meeting: Friday 02 September 2015 in ED Registrars’ Office.**