Health and Social Care Board

Public Health Agency

August 2020 – Edition 17

Learning Report

SERIOUS ADVERSE INCIDENTS

April 2019 - March 2020

This report is normally issued on a bi-annual basis, however, Edition 17 covering the period 1 April 2019 – 30 September 2019, due for issue in early March 2020, was postponed in light of the rapid development of Covid-19.

In order to avoid any delay for future editions, it was agreed to issue Edition 17 as an annual report for the period 1 April 2019 – 31 March 2020.

Future editions will continue to be reported on a bi-annual basis.

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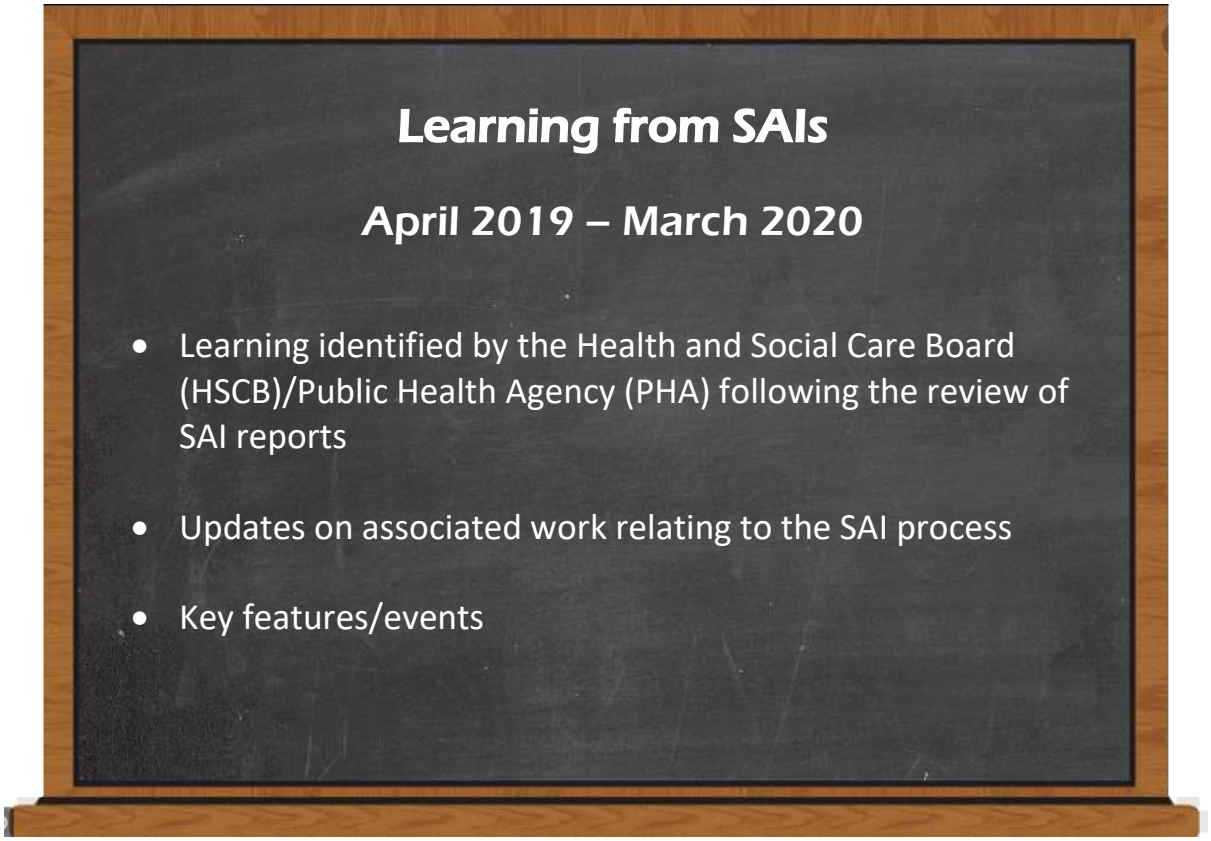
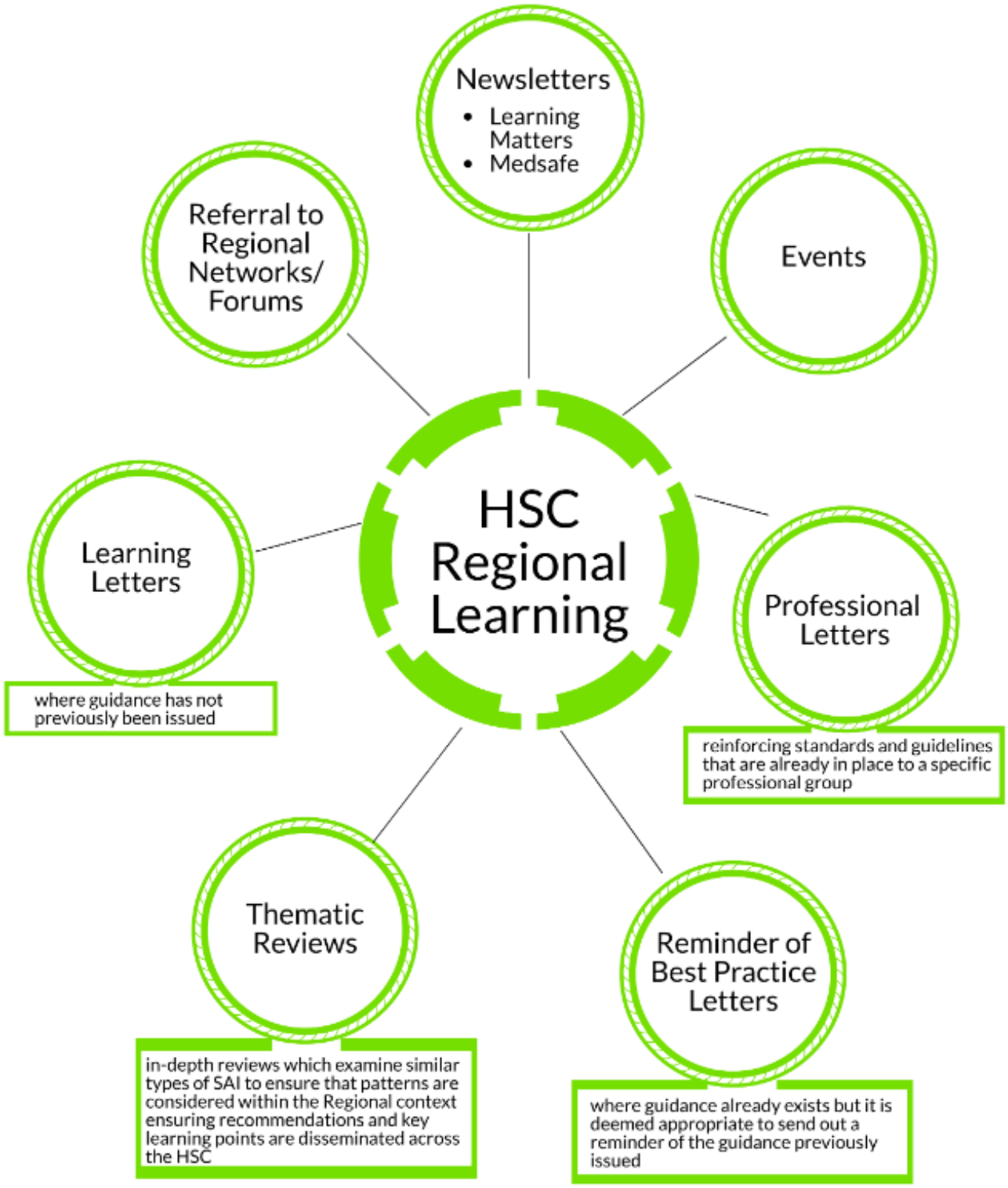
TYPES OF LEARNING



Various Methods of How we Disseminate Learning from SAIs



Overview of Learning from SAIs Disseminated Throughout the Reporting Period

2	Learning Letters
12	Reminder of Best Practice Guidance (SQR)
4	Professional Letters
2	Newsletters
26	SAIs referred to Other Forums/Networks

The HSCB, working closely with the PHA, is responsible for identifying and disseminating regional learning from its monitoring role in relation to SAIs.

Whilst learning from SAIs is a significant element to improving practice, the HSCB and PHA are cognisant that each and every SAI has a personal impact on individuals and families. Therefore for the purposes of this report patient identifiable information has been removed.

Learning Disseminated During the Reporting Period

Learning Letters

- Aortic Stenosis diagnosis and follow-up - LL/SAI/2020/035(AS)

- Care of women presenting with post-menopausal bleeding - LL/SAI/COMP/2020/036(AS)

The above learning letters can be accessed by HSC staff via the following link
http://insight.hscb.hscni.net/safety/safety-and-quality-learning-letters/

Aortic Stenosis diagnosis and follow-up

The learning related to patients with a diagnosis of aortic stenosis (AS) for whom there was a lack of clarity in communication with the patient and their GP, and arrangements for follow-up.

A Learning Letter was issued to HSC to draw hospital doctors' and GPs' attention to introduction of new NI guidance on follow-up of patients with AS and asking all non-cardiologists who diagnose or care for a patient with the condition to refer to cardiology at the time of diagnosis, if symptoms worsen or if it is unclear whether they are on active follow-up. Patients should also be given written information on their condition. Cardiology teams were asked to ensure there is a system for senior review of a selection of ECGs to maintain reporting quality, and that there is clear communication regarding clinical responsibility and follow up.

The letter was brought to the attention of all relevant medical, clinical physiology staff and service managers.

Reminder of Best Practice Guidance (SQR)

- Specific Cardiac Arrest Protocol for Patients fitted with left ventricular assist devices (LVAD) - SQR-SAI-2019-049 (AS)

- Difficult / Failed Intubations - SQR-SAI-2019-050 (AS)

- Delayed Diagnosis of Diabetic Ketoacidosis in a young adult - SQR-SAI-2019-051 (AS/PHC)

- Sore Throat Care Pathway for adults - SQR-CR-2019-052 (AS)

- WHO Surgical Checklist - SQR-SAI-2019-053(AS)

- Phenobarbital elixir contains a high level of alcohol. It is not recommended for use in children - SQR-SAI-2019-054 (AS/MCH/PHC)

- Timely recognition and treatment of sepsis - SQR-SAI-2019-055 (AS/MCH/OPS)

- Correct administration of medicines - SQR-SAI-2019-056 (All PoCs)

- Head Injury in Patients taking Oral Anticoagulants - SQR-SAI-2019-057 (AS)

- Delayed Diagnosis of Appendicitis - SQR-SAI-2019-058 (AS)

- Wrong connection of peripheral and regional anaesthetic infusions/block - SQR-SAI-2019-059 (AS)

- Risk of Death or Serious Harm by Falling from a Hoist - SQR-SL-2020-060 (All PoCs)

Difficult / Failed Intubations

Following a number of SAIs notified in which there were difficult or failed intubations the HSCB/PHA issued a reminder of best practice to the wider HSC. The contributory factors in the incidents were:

- There was an unplanned self-extubation in critical care, following which the patient developed acute airway obstruction from laryngeal oedema;

- A patient suffered non allergic anaphylaxis which resulted in a surgical tracheostomy. A leak was detected but during the tracheostomy tube exchange the airway became compromised;

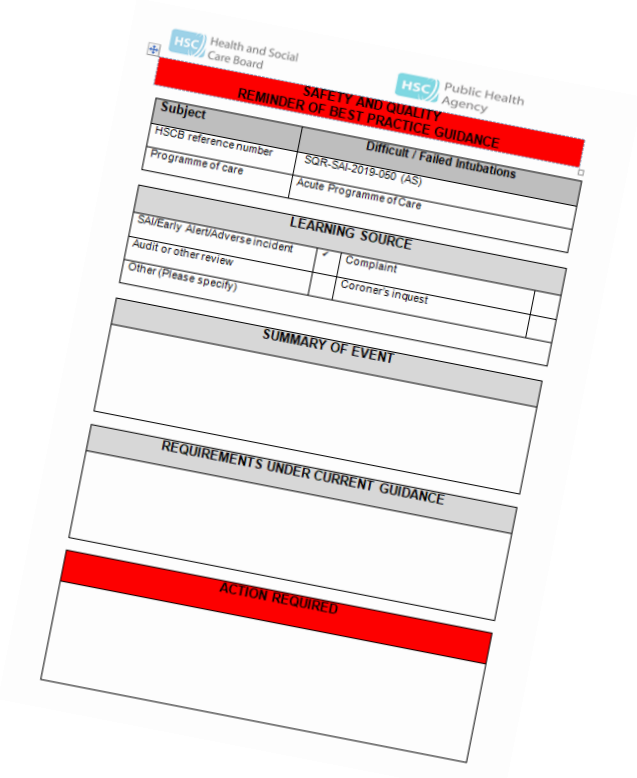
- A patient was extubated but developed respiratory failure. Initial attempts at re-intubation were unsuccessful and cricothyroidotomy was undertaken;

- Following elective surgery a patient's clinical condition deteriorated. During tracheal intubation, the patient aspirated gastric contents and resulted in a cardiac arrest.

The reminder of best practice guidance letter was issued in order to ensure that all staff involved in airway management including critical care areas, operating theatres and emergency departments read and adhere to local protocols in relation to difficult or failed intubations. The letter also advised all Managers of services who may be involved in airway management, including critical care areas, operating theatres and emergency departments to ensure they have local protocols that reflect the DAS and NAP4 guidelines on difficult intubations and to have systems in place to remind staff of the protocols on a regular basis.

The above reminder of best practice guidance can be accessed by HSC staff via the following link:

http://insight.hscb.hscni.net/safety/safety-and-quality-best-practice-reminder-letters/



Professional Letters

Four professional letters were issued during the reporting period

- Immediate learning re restricted areas for patients/ public - PL/2019/038

- Sharing Learning - Protocol for the Repatriation of Patients from Abroad - PL/SAI/2019/039

- Guidelines for the Administration of Methylthioninium Chloride for the Treatment of Ifosfamide Induced Encephalopathy in Adult Oncology and Haematology Patients - PL/SL/2019/040

- Immediate learning re Identifying an Acutely Unwell Child - PL/SAI/2019/041 (AS)

Professional Letter example

A patient was referred to an orthopaedic unit following brain and cervical spine injury, which had been managed conservatively. The patient's condition deteriorated and the patient required a CT and high doses of sedatives before transfer. On arrival at NI, the crew transporting the patient contacted the hospital to raise concerns that the patient may not be suitable for ward level care and the patient was re-directed to ED for initial assessment. On arrival it was noted the patient had a tracheostomy in situ, which had not been communicated prior to transfer. The patient was admitted to a ward but 3 beds in the unit had to be closed to allow safe supervision of a patient with a tracheostomy, head injury and to allow isolation due to infection control risk.

Following this incident, a patient protocol for fracture patients repatriated from overseas was developed for use within the Fracture Trauma Unit. The protocol was shared with the wider HSC requesting Trusts to ensure there are local protocols for repatriation of patients from abroad similar to the fracture that ensures appropriate ward selection, infection control procedures on arrival, documentation of all injuries and illnesses before repatriation and a named liaison person in the Trust who oversees repatriation from abroad protocols

Newsletters

Learning Matters provides a method of sharing learning relating to SAIs, complaints, reviews and patient experience across Northern Ireland.

Two newsletters were issued during the reporting period - Edition 9 was issued in July 2019 and a special 'mental health' Edition (Edition 10) was issued in January 2020.

Edition 11 and Edition 12 (Maternity Edition) have been issued and feature the following topics, all of which relate to learning of SAIs.

Edition 11


Learning Matters

QUALITY 2020

Issue 9: July 2019

Interaction of Selective Serotonin Re-Uptake inhibitors (SSRIs) with Monoamine-oxidase Inhibitors (MAOIs)

Introduction

Welcome to the ninth issue of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in it's 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.

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- Contact the haematology doctor on call at the Belfast City Hospital (BCH) if a patient, with congenital bleeding disorders under the care of the NI Haemophilia Comprehensive Care Centre BCH, presents acutely out of hours – 7
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Selective Serotonin Re-Uptake inhibitors (SSRIs) are contraindicated with concomitant use of monoamine-oxidase inhibitors (MAOIs). Their coadministration can lead to increased serotonin levels, which could cause serotonin syndrome – a rare but dangerous clinical condition.

A recent SAI reported the admission of an elderly patient to ICU due to serotonin syndrome, triggered by a simultaneous prescription of a MAOI and SSRI. The patient was on a MAOI prior to and during hospital admission. During admission the depressive state of the patient was reviewed, and SSRI was prescribed and administered for two days. The combination of these two medicines caused serotonin syndrome and the admission of the patient to ICU.

Serotonin syndrome presents with a spectrum of clinical findings ranging from benign to lethal that arise from an excess of serotonin in the Central Nervous System (CNS). The diagnosis of this syndrome is clinical and classically involves a group of symptoms including mental changes, agitation, confusion, myoclonus, hyperreflexia, rigidity, tremor, sweating, diarrhoea with abdominal cramping, malignant hyperthermia, hypotension, coma and even death.

MAOIs are used much less frequently than tricyclic and related antidepressants because of the dangers of dietary and drug interactions. They can interact with a number of common substances including decongestant cough medications and some foods such as mature cheese, salami, Oxo and Marmite. Therefore, care must be taken when these antidepressants are prescribed to counsel patients appropriately.

Since the effects of both MAOIs and SSRIs may persist for some time after their discontinuation, a wash out period will be required if switching from SSRI to MAOI or vice versa is considered. It should be noted

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- Checking patient details on images and other investigations
- Focus on News2
  News2 Training
  Focus on NEWS2 continued
- Sterile water should not be used for bladder irrigation
- Importance of appropriate communication and follow up of diagnostic testing
- Communication in Primary Care
- Communication between secondary care and district nursing
- Advice for patients waiting for elective surgery
- Communicating and acting on urgent lab results
- Double check: Is it micrograms or milligrams?

Edition 12

- Invasive Placentation – increase in SAIs reported
- Pregnant women presenting at Emergency Departments (ED)
- Group B Streptococcal Disease, Early-onset- Green top guideline 36
- Use of syntocinon for induction of labour
- Importance of all staff documenting care in the Maternity Hand Held Record
- Undertaking and Documenting Important Discussions on Mode of Delivery and Interventions
- Cold Chain Failures Affecting Antenatal Anti-D Immunoglobulin
- The SAI Process; a Partnership between Regional Bodies and Trusts

Edition 13 is currently being produced.

All editions of Learning Matters newsletters can be accessed at: https://www.publichealth.hscni.net/publications/learning-matters-newsletters

Thematic Reviews

Thematic Reviews are in-depth reviews which examine similar types of SAIs to ensure that patterns and themes are considered within the regional context ensuring recommendations and key learning points are disseminated across the HSC. A Thematic Review of Insulin Prescribing Incidents has been undertaken and was issued in December 2019.

Referral to Other Forums/Networks

HSCB/PHA may request other networks/forums to consider learning that has been identified following the review of a SAI. During the reporting period 26 cases were referred. These Networks/Forums included: -

- CCaNNI
- Cervical Screening Programme Laboratory QA Group
- Dysphagia Group
- Estates Task and Finish Group
- Gynae Cancer Network
- Interface Pharmacists Specialist Medicines Group
- Maternity Collaborative Group
- MRCN
- Neonatal Network and the Paediatric Network Forum
- NICAN
- Northern Ireland Transfusion Committee
- Providing Community Care Group
- Regional Falls Group
- Regional OOH Provider Operational Task Group
- Regional Pressure Ulcer Prevention Group
- Regional Sepsis Collaboration in HSCQI
- Special Services Commissioning Team
- Trauma Network
- Unscheduled Care Group

Events

Annual Regional Serious Adverse Incident and Complaints Learning Workshop

The 5th Annual Regional Serious Adverse Incidents and Complaints Learning Workshop was held on 29 May 2019, hosted by HSCQI on behalf on PHA and HSCB. 176 delegates attended from a range of organisations including HSC Trusts, PHA, HSCB, Patient Client Council (PCC) Department of Health (DoH) and Regulation and Quality Improvement Authority (RQIA).

The event was aimed at frontline clinical staff, those who manage clinical services and staff involved in complaints investigation and or SAI review processes. The workshop programme, developed in partnership with Trust governance leads, drew together the learning from a number of SAI and complaints case studies. The voice of a service user was provided by a father, who shared his story of how a Trust managed a complaint involving his son who has a complex condition. Dr Dawn Benson, Acting Head of Investigation Education, Learning and Development and Dr Kevin Stewart, Executive Medical Director and Deputy Chief Investigator from the Healthcare Safety Investigation Branch (HSIB) delivered a session on sense-making, human factors, ergonomics and lessons learnt.

The aim of the workshop was to use collaborative learning to;

i. Improve how we collectively learn from the review of SAIs and investigation of complaints across the system
ii. Improve how we translate learning into actions and change.

The event was a huge success and was positively evaluated by delegates.

Selected comments from the evaluation:

'It prompted me to reflect on how we engage with families in the event of an SAI'

'Hearing the views of families and service users and how their view and opinions matter'

'The case studies were invaluable in illustrating the process and systems to be used'

'Learning from SAI cases and seeing what could be brought back to own working environment'

It was planned to hold the 6th Annual Regional Serious Adverse Incidents and Complaints Learning Workshop in June 2020, however due to the COVID-19 crisis, this was cancelled. It is hoped that this event will be rescheduled at a later date within this financial year.

Conclusion

The Health and Social Care system is constantly striving to provide safe and effective care for all the people in Northern Ireland. As part of this we endeavour to always learn when things go wrong including through the Serious Adverse Incident process.

The role of the HSCB and PHA in this is to ensure the learning is shared across the system as appropriate at all times being aware that the key aims of the SAI process is to;

- Improve safety by sharing learning in a meaningful way
- Reduce the risk of recurrence
- Provide a consistent approach

We have recognised that timely dissemination of learning is important to all those involved in the process and as a result have improved the process regarding reviewing reports.

Family engagement is an essential element of the SAI process and this was highlighted by the Chief Executive of the HSCB, who issued advice to the HSC system to ensure family engagement is central in the event of a SAI.

Towards the end of this reporting period the rapid development of Covid-19 has required the full focus of HSC staff. Whilst the SAI Procedure remains the extant guidance relating to the roles and responsibilities of HSC Trusts in respect of SAIs, certain requirements within the current procedure were relaxed to allow HSC organisations to focus their efforts where they are most needed. SAIs did however continue to be notified during this period and where relevant immediate action undertaken. At the same time the HSCB and PHA have worked closely with HSC Trusts and put in place some interim arrangements which have enabled regional learning from SAIs to continue to be identified and disseminated in a timely manner.

Throughout this crisis and beyond, we will continue to work with our colleagues across the system to ensure learning is identified and disseminated from SAIs and other processes as appropriate in order to ensure all patients and their families receive safe, high quality, person-centred care.