LM Learning Matters

QUALITY 2020

Issue 2: June 2014

Act FAST when Stroke suspected

A residential home contacted the GP out of hours service about one of their residents who had developed arm weakness and slurred speech but who appeared to be getting better. The GP advised the home to wait an hour and if the symptoms persisted to contact the patient's GP.

In this case, the residential home should have dialled 999 and the patient should have gone directly to hospital, or the GP out of hours should have advised the home to dial 999 and send the patient to hospital.

The importance of early recognition of stroke is that it allows patients to be assessed quickly for thrombolysis. Thrombolysis can be given up to 4.5 hours after the onset of an ischaemic stroke which has been confirmed by CT scan. The earlier it is given to suitable patients the better the outcomes (i.e. less disability) for stroke survivors. Currently the thrombolysis rate for ischaemic stroke in Northern Ireland is 12%, but expert opinion used by National Institute for Health and Care Excellence (NICE) suggests that this could be as high as 20% in the next 5 to 10 years.

Key Learning

The **FAST** campaign describes the common signs of stroke

Facial weakness – can the person smile? Has their mouth or eye dropped?

Arm weakness – can the person raise both arms

Speech problems – can the person speak clearly and understand what you say

Time to call 999 if you see any one of these signs

Introduction

Welcome to the second issue of Learning Matters Newsletter.

Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care and we recognise that we need to use a variety of ways to share learning such as learning letters, alerts and reports. The purpose of our newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

Contents

Removal of Central Lines

Central Venous Catheter (CVC) more commonly known as 'central lines' provide direct access into the blood stream. Specific conditions may require placement of these lines and they can remain in place for long-term use. It is important that care is taken with the removal of central lines in order to decrease the incidence of complications such as air embolism.

Recently a Serious Adverse Incident (SAI) was submitted in which a patient suddenly deteriorated following the removal of a central line and during the investigation it was identified that correct procedure for removal of the central line had not been followed. Although central line removal is a fairly straightforward procedure, complications can occur, especially when recommended procedures are not followed. On this occasion the catheter was removed while the patient was sitting up and the technique used and the position of the patient contributed to the patient suffering an air embolus. Following immediate intervention the patient made a successful recovery.

Key Learning

- Proper positioning of the patient is essential to preventing an air embolism when removing the central line. It's imperative to place the patient in the Trendelenburg position when possible. If not possible, the supine position is sufficient when removing a central line, due to the pressure gradient of the blood vessels.
- Trusts have developed policies for the removal of central lines which covers both primary and secondary care.
- Central lines should be removed by a qualified Health Care professional. Any problems observed should be reported to a physician immediately.

Over infusion of IV fluids

Following a Serious Adverse Incident it was noted that an accidental over infusion of a drug occurred when the drip was disconnected from the administration pump but not from the patient. This resulted in free flow of the fluid/ drug into the patient which resulted in significant harm at the time. The patient has subsequently recovered.

There is a risk of the accidental over infusion of intravenous fluids and medicines associated with not disconnecting the infusion from the patient when removing it from the pump, or overriding of safety mechanisms on infusion pumps.

This risk has the potential to result in death or injury regardless of the fluid being administered.

Key Learning

- All intravenous fluids or medicines should be disconnected from the patient before removal of the pump.
- All clamps on intravenous administration sets must be closed before removing the administration set from the infusion pump, or switching the pump off. This is required regardless of whether the administration set has an anti-free flow device.

Ensuring the Safer Use of Bed Rails

A recent incident occurred in which an elderly patient who had died from natural causes, was found trapped between the bed rails and the bed. Further investigation identified that:

- Bed rails had been used even though the risk assessment indicated they should not have been.
- The gap between the bed rails and the mattress was more than the recommended in the Medicines and Healthcare Products Regulatory Agency (MHRA) Device Bulletin Safe Use of Bed Rails (MHRA 2013).
- An air flow mattress was used without an underlay mattress which contributed to the patient sliding between the bed and the rail.

Whilst bedrails can successfully prevent falls, incorrect use can result in a serious risk to the person and entrapment can lead to asphyxiation.

Risk assessment is key to the safe use of bedrails and the assessment should include the bed occupant, proposed equipment, bed and mattress.

Further information on the safe use of bed rails can be found at:-

- National Patient Safety Agency (NPSA) guidance 'Safer Practice Notice 17' (NPSA 2007)
- MHRA Device Bulletin Safe Use of Bed Rails (MHRA 2013)

Key Learning

- Always conduct a bed rails risk assessment before use. Review and record any significant change in the bed occupant's condition, according to local policy.
- If you consider bedrails a risk to the person, do not use them and explain to the person and their family why they are not recommended.
- On-going training should be available for all personnel involved in the use, purchase, storage, attachment, maintenance and care of bed rails.

Development of a key Cardiotocography (CTG) Evaluation Tool

Cardiotocography (CTG) is a continuous recording of the fetal heart rate and uterine activities by electronic means. Following a number of Serious Adverse Incidents (SAIs) where interpretation of the CTG in the antenatal period was found to be an issue or contributory factor to the incident, the HSC Safety Forum Maternity Quality Improvement Group was asked to develop a Regional Antenatal CTG evaluation tool.

The purpose of the tool is to assist staff in the interpretation of antenatal CTGs as part of overall risk assessment of the women and her baby. A CTG evaluation sticker has also been developed to guide staff actions.

Key Learning

- The tool will assist staff in the interpretation of antenatal CTGs as part of overall risk assessment of the women and her baby.
- The tool is a guide and should not override professional opinion.
- CTG is not appropriate for routine use in pregnancies under 28 weeks gestation unless requested by a consultant.

The assessment tool is ready for ordering by the Trusts as a 12 month pilot in all the maternity units in Northern Ireland.

The Yellow Card Scheme: Patients can contribute to medicines safety by reporting side effects

In a recent local incident, a patient experienced an adverse reaction to a prescribed medicine. The adverse reaction was not commonly known and a series of investigations to diagnose and treat the symptoms was undertaken before the link to the medicine was identified and subsequently the Medicines and Healthcare Products Regulatory Agency (MHRA) notified.

The patient thought that the medicine may be a possible cause of the symptoms but was unaware that, in addition to consulting with their doctor or pharmacist, they could also report the suspected side effect directly to the MHRA.

Information about adverse reactions and side effects to medicines is gathered by the MHRA through their Yellow Card Scheme. Reporting to the scheme enables us to learn about side effects and problems that may not have been known about before. The MHRA can then update the warnings that are given to people taking or using the medicine, and to healthcare professionals so that the medicine use can be made safer for everyone. Healthcare professionals commonly report adverse reactions; however patients should also be encouraged to do this.

Information reported by patients and the public in this way is a highly valued and important contribution to medicines safety in the UK.

Key Learning

There are 3 ways in which members of the public can report side effects using the Yellow Card Scheme.

- Use the online Yellow Card form; this is the easiest way to report if you have access to the internet at www.mhra.gov.uk/yellowcard
- Ask your pharmacist for a Yellow Card form which you can complete and post free of charge
- Call the yellow card hotline on 0808 100 3352

For further information see www.mhra.gov.uk/yellowcard

Contact us

HSC Health and Social Care

If you have any comments or questions on the articles in the newsletter please get in contact by email at learningmatters@hscni.net or by telephone on **0300 555 0114**.

Learning Matters is available on:
www.publichealth.hscni.net/publications
www.hscboard.hscni.net/publications/index.html