Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 67 of 2022

Date of Notice: 5 August 2022 **Witness Statement of: Aidan Dawson, Chief Executive, Public Health Agency**

I Aidan Dawson will say as follows:

1. This is my second written statement to the Urology Services Inquiry. I make this statement as a supplement to my substantive statement of 24 October 2022. I am grateful to the Inquiry for this opportunity to elaborate on my previous evidence and do so in order to offer clarity on the PHA's role in the Serious Adverse Incident process and the ongoing review thereinto.

2. The procedure for the reporting and follow up of Serious Adverse Incidents (2016) outlines the purpose of this process as;

- To provide a mechanism to effectively share learning in a meaningful way with a focus on safety and quality ultimately leading to service improvement for service users, and;
- To ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident.

3. The SAI procedure (when incidents are notified and when reports are received by SPPG/PHA) is anonymised and therefore is not a mechanism for identifying staff involved in incidents. The SAI procedure is not replacement for, or an alternative version of, disciplinary processes which may arise separately in relation to such incidents.

4. The Department of Health is currently leading on a review of the SAI process following the RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland (June 2022). The PHA is represented on this review by the Director of Nursing and the Director of Public Health on the oversight board. The Assistant Director and Nurse Consultant for Safety, Quality and Innovation are also closely involved in this work. The intention is to move way from the use of "Serious Adverse Incidents" and to identify "Patient Safety Events (PSE)" for Learning and Improvement. This work is ongoing and is expected to be completed in 2024, but agreed changes are being introduced incrementally throughout the process, to manage the transition and to expedite changes where possible.

5. It is the intention that the new process will allow for a more flexible, system-focused approach to learning and improvement framed within a culture which prioritises safety, openness and compassion for all those involved in a Patient Safety Event.

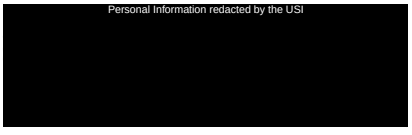
6. Identification of learning from SAIs is ongoing throughout the process. Once a SAI is notified it is reviewed by the Safety and Quality team for any immediate actions, then is reviewed by the incident review group again to identify if there is any immediate learning. Once the report is received it is listed for the appropriate professional group where it will be reviewed in a collective multidisciplinary group to identify if any regional learning should be issued. The PHA are constantly reviewing the methods of learning we utilise in order to disseminate regional learning and are about to start a second ECHO programme for learning from SAIs which engages our service colleagues in the learning. The first programme was very well evaluated. We can on occasion issue letters but going forward these will largely be issued for urgent learning where prompt assurances of compliance are required. The method of learning that the PHA is responsible for issuing is Learning Matters/ Learning From newsletters. These are reminders based on learning from SAIs. I take leave to exhibit sample Learning Matters publications to this statement.

7. PHA hosted a series of Regional SAI Learning Events. These were co-ordinated by what was the Safety Forum (now HSCQI) and brought together speakers from all of the Trusts to present on some of their incidents in order to learn together. They usually had keynote speakers in both morning and afternoon and then a variety of breakout rooms where attendees could go to learn from areas pertinent to their practice. These events took place up until 2019 but were stood down due to the Covid-19 pandemic. I refer to a sample of the programmes for these Learning Events for the Inquiry's information.

8. These Learning Events have not recommenced since emergence from Covid-19 and, although restarting them has not been ruled out, they have to some extent been superseded by the ECHO (Extension of Community Healthcare Outcomes) programme which allows more people to take part in regional learning. This programme commenced in 2022/23 and has been well-received among HSC colleagues. I exhibit an evaluation document on an ECHO on learning from Serious Adverse Incidents and, specifically, the deteriorating patient.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: 

Aidan Dawson, HMFPH

PHA Chief Executive

Dated 30 January 2024

HSC Public Health Agency
Safety Forum

Regional Serious Adverse Incident (SAI) Learning Workshop Mossley Mill, Newtownabbey, BT36 5QA.

Tuesday 14th April 2015

Time	Activity	Lead
9.30	Registration - Tea and coffee	
10.00	Opening	**Mrs Mary Hinds** Director Nursing, Safety, Quality and Patient/Client Experience Public Health Agency
10.10 10.30	PLENARY SESSION SAI presentation Patient's Perspective on SAI	Combined Presentation from HSCB Patient representative and Belfast Trust
11.00	Streamed SAIs - Session 1 • Mental Health (Room1) • Maternity (Room2) • Integrated Care (Room3)	Work Stream Chair(s) (2-3 SAIs per room)
12.30	Lunch	
13.30	Streamed SAIs - Session 2 • Social Care (Room1) • Maternity/Acute Care (Room2) • Acute Care (Room3)	Work Stream Chair(s) (2-3 SAIs per room)
15:00	Tea and coffee	
15.15	PLENARY SESSION Work Stream – Debrief How can we improve the learning from SAIs?	**Dr Gavin Lavery** Clinical Director HSC Safety Forum
16:00	Close	**Dr Carolyn Harper** Medical Director/ Director of Public Health Public Health Agency

HSC Public Health Agency
Safety Forum

Regional Serious Adverse Incident (SAI) Learning Workshop
Mossley Mill, Newtownabbey
Friday, 11 March 2016
PROGRAMME

Time	TITLE	Speaker
09:30 – 10:00	Registration - Tea and coffee	
PLENARY SESSION		
10:00 – 10:10	Opening Remarks	Lynne Charlton (PHA)
10:10 – 10:30	When things go wrong; The voice of patients	Dr Tom Frawley (NI Ombudsman)
10:30 – 10:50	When things go wrong; Staff involved in an SAI	Dr Gavin Lavery
10:50 – 11:20	Tea, coffee and networking	
11:20 – 12:50	Parallel SAIs x 3 Themes - Session 1 • Acute Care • Mental Health/Learning Disability • Integrated Care/Social Work/Community Care	Work Stream Chair(s) (3SAIs per room)
12:50 – 13:50	LUNCH	
13:50 – 15:20	Parallel SAIs x 3 Themes - Session 2 • Acute Care • Maternity/Paediatrics • Integrated Care/Social Work/Community Care	Work Stream Chair(s) (3SAIs per room)
PLENARY SESSION		
15:20 – 15:40	SAIs, Human Factors & Simulation What is the link?	Dr Michael Morrow (Regional Lead, NIMDTA)
15:40 – 16:15	Summary of day & discussion Promoting ALISS	Dr Gavin Lavery
16:15 – 16:30	Closing Remarks	Dr Gavin Lavery

HSC Public Health Agency
Safety Forum

HSC Health and Social Care Board

Regional Serious Adverse Incident (SAI) Learning Workshop
Mossley Mill, Newtownabbey
Tuesday, 23 May 2017

Time	TITLE	Speaker
09:30 – 10:00	Registration – Tea/coffee/scones	
PLENARY SESSION		
10:00 – 10:10	Opening Remarks	Mrs Valerie Watts
10:10 – 10:40	The voice of the service user	Mrs Maria Somerville
10:40 – 11:10	2nd victim	Dr Rachel Doherty
11:10 – 11:40	Tea, coffee and networking	
11:40 – 13:10	Parallel SAIs x 3 1. Acute 2. Maternity 3. Mental Health/Social Care	Work Stream Chair(s)
13:10 – 13:50	LUNCH	
13:50 – 15:20	Parallel SAIs x 3 1. Acute 2. Primary care/community 3. Acute	Work Stream Chair(s)
15:20 – 15:40	Choking thematic review	Mrs Mary McElroy/Ms Mary Emerson
15:40 – 16:00	Foundation Doctors' experience of incident reporting	Dr Sara Lawson
16:00 – 16:15	Reflections and close	Mr Brendan Whittle

HSC Public Health Agency
Safety Forum

HSC Care Board

Regional Serious Adverse Incident (SAI) Learning Workshop
Craigavon Civic Centre
Thursday, 07 June 2018

Time	TITLE	Speaker
09:30 – 10:00	Registration – Tea/coffee/scones	
PLENARY SESSION –Chair Dr Tony Stevens		
10:00-10:15	Welcome and Opening Remarks	Prof Charlotte McArdle
10:15-10:25	Ice-breaker	Dr Mark Roberts
10:25-10:45	SAI case study 1 – Importance of Safe prescribing and continuity of care	Dr Gary Benson, BHSCT
10:45-11:05	SAI case study 2 – Hip Replacement component mismatch	Mr Kieran Lappin, WHSCT
11:05-11:20	An emerging picture – themes from the last 12 months	Dr Jackie McCall
11:20-11:50	Tea, coffee and networking	
11:50-12:35	Broader lessons for Improving Safety – lessons from the Hyponatraemia Inquiry	Dr Anne Kilgallen
12:35-13:15	Enhancing Human Factors and Ergonomics understanding to improve our response to adverse incidents	Dr Shelly Jeffcott
13:15-14:00	LUNCH	

Parallel Sessions – Learning from SAI case studies			
14:00-15:00	Breakout 1	Breakout 2	Breakout 3
	Family Involvement	Maternity	Sepsis
15:00 - 15:30	Strengthening our response to adverse incidents Dr Jeff Brown	Never Events and National Safety Standards for Invasive Procedures Dr Mark Roberts/Mrs Grainne Cushley	Human Factors Dr Shelly Jeffcott

PLENARY SESSION		
15:30-16:00	Interactive Session – Improving how we collectively learn from adverse incidents	Mrs Mary Hinds/Dr Mark Roberts
16:00	Reflections and close	Mrs Mary Hinds

Public Health Agency

HSCQI Inspire • Connect • Improve

HSC Health and Social Care Board

Regional Serious Adverse Incident (SAI) and Complaints Learning Workshop
A just culture – How we learn
Craigavon Civic Centre
Wednesday 29 May 2019

TIME	TITLE		SPEAKER
09:30 – 10:00	Registration – Tea/coffee/scones		
PLENARY SESSION – Chair: Dr Maria O'Kane			
10:00-10:15	Welcome and Opening Remarks		Mary Hinds
10:15-10:30	Ice-breaker		Levette Lamb
10:30-10:50	Jaimie's Story – Managing a patient with a complex condition – the family's perspective		Jim, Jaimie's father
10:50-11:30	Lessons from the Healthcare Safety Investigation Branch		Dr Kevin Stewart
11:30-12:00	Tea, coffee and networking		
12:00-12:20	Improving medication safety in Northern Ireland – responding to the WHO Challenge 'Medication Without Harm'		Cathy Harrison
12:20-13:00	Sense-making, patients and their families		Dr Dawn Benson
13:00-13:50	LUNCH		
PARALLEL SESSIONS – Learning from SAI case studies			
	Human Factors and Simulation – Dr Ann Hamilton & Dr Jackie McCall	Dealing with Complexity – Mary McElroy & Briege Quinn	Never Events / Other – Liz Fitzpatrick & Anne Kane
13:50-15:00	Case studies and Q&A	Case studies and Q&A	Case studies and Q&A
PLENARY SESSION			
15:00-15:30	Interactive Session – Improving how we learn		Shane Devlin
15:30	Reflections and close		Shane Devlin

The 'Regional Serious Adverse Incident and Complaints Learning Event ' has been approved by the Federation of the Royal Colleges of Physicians of the United Kingdom for 5 category 1 (external) CPD credits.

LEARNING MATTERS

ISSUE 14
DECEMBER 2020

IN THIS EDITION

Link below to previous learning:
www.publichealth.hscni.net/publications
https://hsctrust.hscni.net/safety/

Welcome to issue 14 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

QUALITY 2020

Airway Management

An older patient with dementia attended the emergency department following a fall at home. They had a number of comorbidities including Atrial Fibrillation, for which they were taking Rivaroxaban. They were triaged as category 2 'to be seen within 10 minutes', due to their level of pain. On initial assessment their clinical observations were within normal limits.

A Computerised Tomography (CT) scan identified a mediastinal and retropharyngeal haematoma. The patient deteriorated rapidly in the department and had a respiratory arrest. There was a delay in securing the patients airway which was felt to be below the standard expected. The patient was transferred to a regional unit but sadly passed away. There were multiple factors contributing to suboptimal airway management which included:

1) Difficult airway due to Retropharyngeal Haematoma
2) Staff being unaware of location of oropharyngeal airways
3) Lack of Laryngoscope blades; these had been used earlier in the day, and the trolley had not yet been restocked
4) Staff unfamiliar with equipment; Gum-Elastic Bougie (GEB) was handed to the doctor upside down and the Endotracheal (ET) tube was applied to the Bougie upside down

Although airway management was deemed substandard, the reviewing team felt it was unlikely to have contributed to this patient's outcome.

KEY LEARNING

- Local protocols which address difficult intubations should be adhered to
- Resus trolleys and difficult airway trolleys should have a documented check on a **daily basis,** and it should have subsequent **restocking** and a further documented check after each use
- All ED nursing staff should be trained in the use of intubation equipment so they can be of assistance when an anaesthetic assistant is not immediately available
- A dedicated anaesthetic assistant should be available, as per 2018 Association of Anaesthetists guidelines *'The Anaesthesia Team',* available at the link below:

https://anaesthetists.org/Portals/0/PDFs/Guidelines%20PDFs/Guideline_The%20Anaesthesia%20Team_2018.pdf?ver=2019-01-08-163915-087&timestamp=1546967138246&ver=2019-01-08-163915-087&timestamp=1546967138246

LEARNING MATTERS

ISSUE 14
DECEMBER 2020

IN THIS EDITION

Link below to previous learning:
www.publichealth.hscni.net/publications
https://nidirect.hscni.net/library/

Cauda Equina Syndrome

A patient attended the Emergency Department (ED) with acute on chronic back pain. They had a 1 year history of chronic back pain and no other co-morbidities of note. On the day of presentation they experienced a sudden onset atraumatic exacerbation of their back pain, experiencing 10/10 pain, which radiated down the left leg to the knee, with associated paraesthesia over the left leg.

The patient was assessed with the left knee being the focus of the pain, therefore a knee X-ray was undertaken to exclude a bony injury. Documentation from this assessment describes sudden onset left knee pain with paraesthesia. Power and reflexes normal. There was no documentation of bowel or urinary symptoms, and no digital rectal examination was performed.

The patient was handed over to another clinician and following discussion with the Emergency Medicine Consultant, they were informed there was no injury to the knee, and explained it may be a 'bulging disc' in their lower back, so was referred for a Magnetic Resonance Imaging (MRI). The patient was discharged pending an outpatient MRI. No clear safety net or discharge advice was provided.

Four days later and still experiencing severe pain, the patient sought medical advice in the private sector. An MRI was subsequently performed which indicated cauda equine compression at the height of L5/S1. The patient was urgently transferred to the regional spinal unit for surgery, following a diagnosis of Cauda Equina Syndrome. Ten months post discharge the patient continues to experience ongoing pain, left leg weakness, bladder dysfunction and impaired sexual function.

KEY LEARNING:

Cauda Equina Syndrome (CES) is a relatively rare, but very disabling condition and can be a source of significant morbidity as well as litigation.

The British Association of Spine Surgeons and the Society of British Neurological Surgeons joint 'Standards of Care for Suspected and Confirmed Compressive Cauda Equina Syndrome (Dec 2018) is available at the link below:

https://www.spinesurgeons.ac.uk/resources/Documents/News/Cauda_Equina_Syndrome_Standards_SBNS_BASS%20-%20Dec%202018.pdf

- A patient presenting with acute, or exacerbation of back pain or leg pain, with a suggestion of a disturbance of bowel/bladder function OR saddle sensory disturbance should be suspected as having CES
- Suspected cases of CES should be urgently investigated; if imaging is not requested the reason should be clearly documented
- MRI scanning should be available on an emergency basis for cases of suspected CES and should not be delayed unless there is a clinical reason
- Normal bladder function does NOT rule out CES
- Normal anal tone does NOT rule out CES

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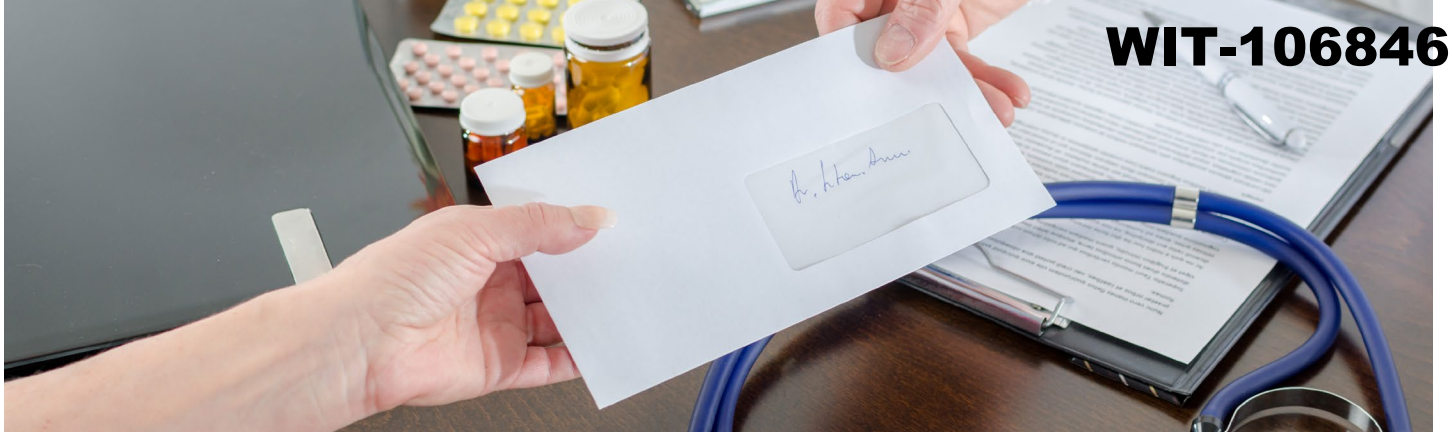
Link below to previous learning:
www.publichealth.hscni.net/publications
http://nsic.hscni.net/safety/



Management of referrals from more than one source

A patient with diabetes attended the Eye Casualty complaining of visual disturbance over recent months, blurred vision in the right eye and photophobia. On clinical examination proliferative diabetic retinopathy was noted in the right eye and severe non-proliferative diabetic retinopathy in the left eye. Urgent pan retinal photocoagulation (PRP) laser therapy was carried out to treat the proliferative diabetic retinopathy and the patient's details were added to the waiting list for further PRP laser treatment.

The patient re-presented to Eye Casualty 12 weeks later complaining of further blurred vision and a stinging sensation to the right eye. The patient's eye condition had deteriorated further. A second referral for PRP was completed, at which time it was discovered they were already on the waiting list, following the initial presentation. 4 weeks after the second presentation they underwent a second PRP treatment; this was 16 weeks after the first presentation to Eye Casualty. Theoretically, if PRP laser therapy had been provided within 4 weeks of the patient first presenting to Eye Casualty, this treatment may have inhibited the disease progression in this patient's right eye.

At the time of presentation there were two separate pathways for referring patients for PRP laser therapy. These were 'day case with procedure' and 'outpatient with treatment'.

These pathways have since been combined and have resulted in decreased waiting times for urgent treatments. A single waiting list has allowed for more effective triaging and waiting time management by the waiting list office and clinical team.

KEY LEARNING

- Care should be taken by the receiving speciality when referrals are taken from more than one source to ensure that patients are triaged appropriately.

LEARNING MATTERS

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Never Event: Incorrect prosthesis implanted during total knee replacement

A patient underwent an elective left sided total knee replacement using the LCS® complete knee system. The procedure was carried by the orthopaedic registrar under the supervision of their consultant. The procedure was carried out without incident, however on closing the surgical site a theatre nurse noted that the implant traceability stickers indicated a right sided prosthesis had been implanted, rather than a left sided prosthesis. On discovery of the error the incorrect right sided prosthesis was removed, and a left sided one was placed.

This incident is classified as a **Never Event** ***'wrong implant/prosthesis'*** as per HSC Revised Never Events List, accessible at the link below:

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-36-18.pdf

In this case the WHO Surgical Safety Checklist was not fully adhered to and the laminate on 'wrong implant/prothesis' which was implemented to prevent such never events, was not used. A review into the incident did not find any other contributory factors to this incident instead staff reflected that they did not follow the correct procedure.

IN THIS EDITION

Link below to previous learning:
www.publichealth.hscni.net/publications
https://hsci.hscni.net/library/

KEY LEARNING

- Use of the wrong implant or prosthesis is a 'Surgical never event'
- Human Factors are a key contributor to Adverse Incidents
- The risk of these can be reduced by following validated checklists and standard operating procedures
- The WHO Surgical Checklist 'Time out' includes 'Anticipated Critical Events' which asks 'Are there any specific equipment requirements?'. While the exact size of prosthesis may not be known prior to surgery, the laterality could be indicated at this stage.
- An 'implant pause' should be observed in all relevant cases in which scrub nurse and operating surgeon step away from the operating field to verify correct implants have been acquired, and in cases of more than one implant, that they are compatible. The implant type, size and expiry date should be read aloud

The HSCB/PHA has previously issued learning in relation to 'Mismatched/Incompatible components in elective orthopaedic joint replacement surgery' which is accessible at the link below:

SQR-SAI-2019-046 (AS) Mismatched Incompatible components in elective orthopaedic joint replacement surgery (hscni.net)

The Healthcare Safety Investigation Branch (HSIB) also published a report on wrong site surgery titled: *'Investigation into the implantation of wrong prostheses during joint replacement surgery'* (June, 2018) which provides details of their findings of a national investigation carried out on similar incidents. Both the final report and summary are accessible at the link below:

https://www.hsib.org.uk/investigations-cases/implantation-wrong-prostheses-during-joint-replacement-surgery/final-report/

LEARNING MATTERS

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IN THIS EDITION

Link below to previous learning:
www.publichealth.hscni.net/publications
http://nsic.hscni.net/urology/

Safer bowel care in patients with spinal cord injury or neurologic conditions

Patients with spinal cord injury, especially those with spinal cord injury above T6, are particularly susceptible to the potentially life-threatening condition autonomic dysreflexia, which is characterised by a rapid rise in blood pressure, risking cerebral haemorrhage and death.

Patients with spinal cord injury or neurological conditions may have neurogenic bowel dysfunction, which often means they depend on routine interventional bowel care, including the digital (manual) removal of faeces (DRF). Lack of adherence to DRF can increase the risk of autonomic dysreflexia.

A search of the National Reporting and Learning System (NRLS) over a four-and-a half-year period identified 61 reports of significant delays in providing DRF or an appropriate alternative, including three cases of autonomic dysreflexia.

Key issues identified were:

- Lack of staff with the training and experience to perform DRF or an inability to identify staff with the appropriate training
- Unclear local policies stating who could perform DRF
- Lack of knowledge of relevant clinical guidance
- Uncertainty over requirement for and provision of training
- Uncertainty over using alternative methods of bowel management
- A mistaken belief that this type of care constitutes assault

KEY LEARNING:

Autonomic dysreflexia is a medical emergency seen most commonly in patients with spinal cord injury. It is the result of an uninhibited sympathetic nervous system response (commonly known as fight or flight response). The cause of this response is due to a noxious stimuli below the level of spinal cord injury, most commonly bladder or bowel distension.

Signs and symptoms include: hypertension, tachycardia, and headache. Note that on examination, signs may vary above and below the height of injury. Signs seen in areas above the level of injury include flushing and sweating; signs seen below the level of spinal cord injury include pallor and skin cool to the touch.

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Link below to previous learning:
www.publichealth.hscni.net/publications
http://insight.hscb.hscni.net/safety/

Safer bowel care in patients with spinal cord injury or neurologic conditions *(continued)*

Management:

- Sit the patient up
- Loosen or remove tight clothing (tight clothing is a potential cause)
- Regular, frequent blood pressure monitoring
- Check for signs of constipation or haemorrhoids
- Check urinary catheter for blockage or full catheter bag, or consider inserting catheter if patient is not catheterised
- If systolic blood pressure >150mmHg start pharmacological management

Other patient groups susceptible to autonomic dysreflexia include severe stroke, severe Parkinson's disease, multiple sclerosis, cerebral palsy or spina bifida.

References/resources:

1. NHS Improvement Patient Safety Alert (July, 2018): Resources to support safer bowel care for patients at risk of autonomic dysreflexia
Patient Safety Alert - safer care for patients at risk of AD.pdf (england.nhs.uk)
2. NHS Improvement: Resources to support safer bowel care for patients at risk of autonomic dysreflexia | NHS Improvement
3. Tracy's story - YouTube Tracy shares her personal story of the fear she experienced when hospital staff didn't listen to her advice regarding her symptoms of autonomic dysreflexia

- Autonomic dysreflexia: Royal National Orthopaedic Hospital

https://www.rnoh.nhs.uk/services/spinal-cord-injury-centre/medical-management-advice/autonomic-dysreflexia

If you have any comments or questions on the articles in the newsletter please get in contact by email at learningmatters@hscni.net
Learning Matters is available on:
www.publichealth.hscni.net/publications
http://insight.hscb.hscni.net/safety/

LEARNING MATTERS

ISSUE 18
OCTOBER 2021

IN THIS EDITION

Link below to previous Learning Matters:
Learning Matters Newsletters | HSC Public Health Agency (hscni.net)

Welcome to this Special Edition (issue 18) of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

QUALITY 2020

Special Edition Learning Matters: Risk of serious harm or death from choking on foods

Background

Welcome to this Special Edition Learning Matters Newsletter on risk of serious harm or death from choking on foods. This edition will focus on the serious patient safety issue of choking, which unfortunately remains a prevalent public health concern for the Northern Ireland adult population. From 2016 to the present day, there have been **23** choking related Serious Adverse Incidents (SAIs) reported across Health and Social Care (HSC) and the private and independent sector. Of these 23 SAI's, 21 have tragically resulted in death due to choking. Five of these SAIs have occured since February 2021.

In addition, there have been approximately **1383** choking related Adverse incidents (AI's) reported across Northern Ireland HSC Trusts (2016-Feb 2021).

LEARNING MATTERS

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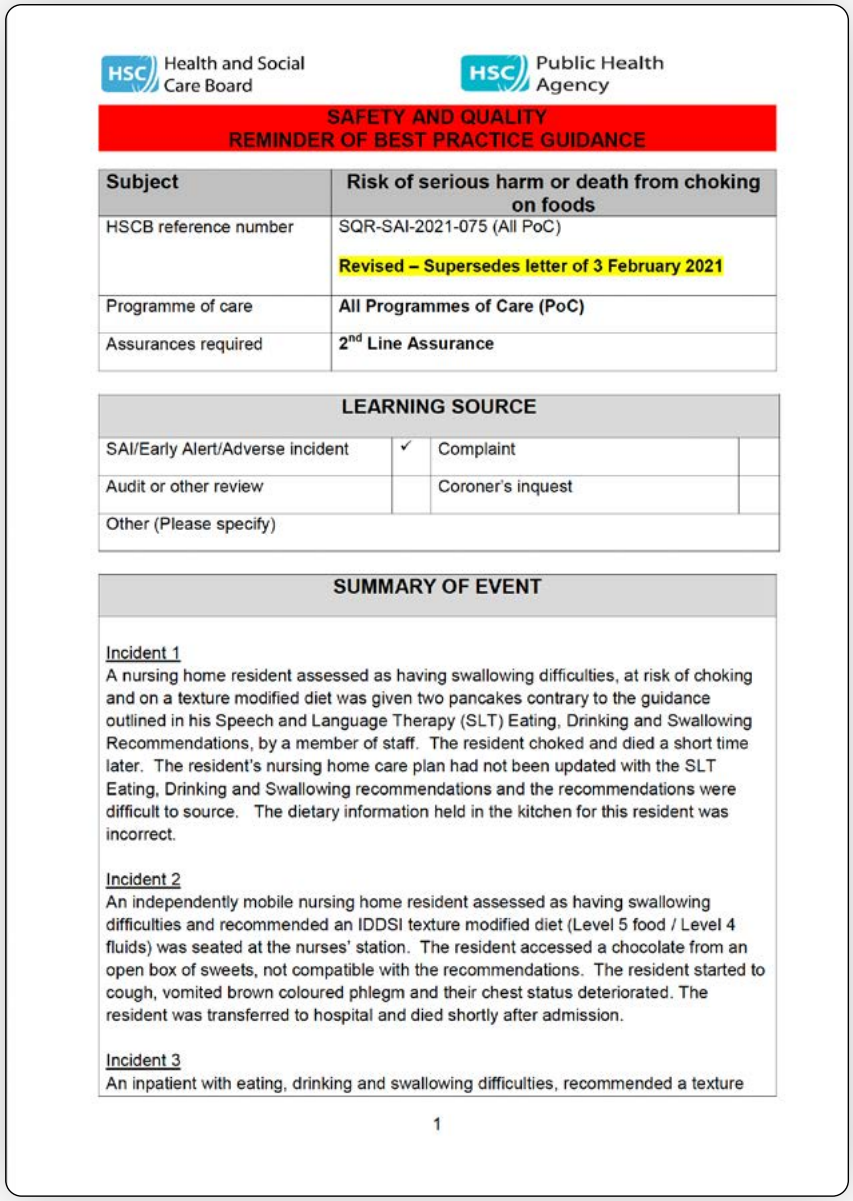
Recent regional learning issued in relation to harm from Choking

On 3rd February 2021, the HSCB / PHA issued a Safety and Quality Reminder of Best Practice Guidance Letter – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)[1]

The letter outlined five choking serious adverse incidents attributed to a failure to recognise and support the needs of people with eating, drinking and swallowing difficulties and at risk of choking. **Six key learning points/recommendations** for all health and social care staff involved with supporting the care of adults and children who present at risk of eating, drinking and swallowing (EDS) difficulties were highlighted. This letter was reissued in June 2021 to include all Programmes of Care.

Whilst much regional work has been undertaken to maximise the safety of people with EDS difficulties, the ongoing deaths as a result of choking remain unacceptably high. In response to the Safety and Quality Reminder of Best Practice Guidance letter, the Chief Medical Officer (CMO) wrote to the HSCB and PHA outlining extreme concern at the preventable deaths which continue, despite previous interventions and guidance issued.

This Special Edition Learning Matters is part of this work and aims to keep the spotlight on this serious patient safety concern. Health and Social Care staff must be aware of the **6 recommendations** for all staff involved with supporting the care of adults and children who present at risk of choking.



HSC Health and Social Care Board | HSC Public Health Agency

SAFETY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE

Subject	Risk of serious harm or death from choking on foods
HSCB reference number	SQR-SAI-2021-075 (All PoC) **Revised – Supersedes letter of 3 February 2021**
Programme of care	**All Programmes of Care (PoC)**
Assurances required	**2nd Line Assurance**

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	✓	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

Incident 1
A nursing home resident assessed as having swallowing difficulties, at risk of choking and on a texture modified diet was given two pancakes contrary to the guidance outlined in his Speech and Language Therapy (SLT) Eating, Drinking and Swallowing Recommendations, by a member of staff. The resident choked and died a short time later. The resident's nursing home care plan had not been updated with the SLT Eating, Drinking and Swallowing recommendations and the recommendations were difficult to source. The dietary information held in the kitchen for this resident was incorrect.

Incident 2
An independently mobile nursing home resident assessed as having swallowing difficulties and recommended an IDDSI texture modified diet (Level 5 food / Level 4 fluids) was seated at the nurses' station. The resident accessed a chocolate from an open box of sweets, not compatible with the recommendations. The resident started to cough, vomited brown coloured phlegm and their chest status deteriorated. The resident was transferred to hospital and died shortly after admission.

Incident 3
An inpatient with eating, drinking and swallowing difficulties, recommended a texture

1

1 Safety and Quality Reminder of Best Practice Guidance – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)

LEARNING MATTERS

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Link below to previous Learning Matters:
Learning Matters Newsletters | HSC Public Health Agency (hscni.net)

SAFEY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE LETTER: RISK OF SERIOUS HARM OR DEATH FROM CHOKING ON FOODS - KEY LEARNING

The reasons why people choke are complex and often have numerous contributory factors. Recognition of patients' difficulties, implementation of Speech and Language Therapy Eating, Drinking and Swallowing Recommendations into a care plan, alongside coordinated multidisciplinary team efforts, reduces the risk of serious harm or death.

- SAFETY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE Letter 'Risk of serious harm or death from choking on foods' (SQR-SAI-2021-075) outlines **six recommendations** for all staff involved with supporting the care of adults and children who present at risk of eating, drinking and swallowing difficulties. They are:

1. When a person has identified eating, drinking and swallowing difficulties this should be centered on an **up to date** Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet, within individual care plans.
2. Clear mechanisms for the **communication** of swallowing recommendations to those who are providing food or caring directly for individuals with swallowing difficulties should be in situ within the care setting, including when transferring between locations, include all staff (domestic and catering staff) and where appropriate families and visitors. Nil By Mouth signs should be clearly visible to all staff.
3. The needs of individuals with swallowing difficulties should be **communicated at pivotal times**; handover, meal and snack times, if people move facilities, attend day centres or go out in the care of others.
4. The development of a process for a **safety pause** before any meals and snacks should be considered e.g. "what patient safety issues for meal and snack times do we need to be aware of today?"
5. Ensure foods or fluids that pose a risk to individuals with eating, drinking and swallowing difficulties are stored securely.
6. The **training** and **development** needs of staff providing care for individuals with eating, drinking and swallowing difficulties should be identified and arrangements put in place to meet them.

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Serious Adverse Incidents reported since February 2021

Since issuing the Safety and Quality Reminder of Best Practice Guidance Letter in February 2021, six further SAIs have been reported to the HSCB/PHA. An overview of those with regional learning are provided below:

- A resident in a Private Nursing Home was passing a tea trolley in the corridor which had a plate of buns on it. The resident ate one of the buns. Five minutes later they were found choking by a member of staff in the corridor. An ambulance was called and the resident was transferred to hospital. The resident had a Speech and Language Therapy (SALT) care plan which recommended their food as IDDSI Level 6 (soft, "Food should be cut into small pieces (no bigger than 1.5cm)". The resident required supervision at meal times as they were identified as being at risk of choking. The resident's capacity regarding their dietary needs had not been assessed. Sadly the resident was pronounced dead a short time later.

- A hospital inpatient was not provided IDDSI Level 1 (Slightly Thick Fluids) from admission and 5 days later they experienced a choking episode. They were commenced on antibiotics for pneumonia/aspiration. The patient's family advised that they should have been on IDDSI Level 1 from the outset. The patient deteriorated and sadly passed away.

- A patient with a history of aspiration and diagnosis of dysphagia was transferred between sites within a hospital. Nursing handover noted a requirement for modified diet and fluids. Speech and Language Therapy Eating Drinking and Swallowing Recommendations could not be located. The patient aspirated on food which did not meet the Speech and Language Therapy recommendations. The patient's condition deteriorated and they were transferred for medical management.

- An inpatient in an acute mental health care setting was discovered unresponsive and sitting on the bed in a lent over position by nursing staff. Food was observed on the person's shoulder. CPR was commenced and the patient was transferred to the Intensive Care Unit. The patient died eight days later and the cause of death was recorded as cerebral hypoxia secondary to cardiac arrest which resulted following choking on food. The patient had been recommended an IDDSI Level 7 diet at the time of the incident and food intake was to be supervised.

In summary, these SAIs relate to adults with eating, drinking and swallowing difficulties and the failure to recognise and support their needs. On each occasion, there was a failure to confirm the eating, drinking and swallowing needs of the person, and a failure to communicate their needs to the wider team and ensure safe communication and meal time processes were in place.

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Current Guidance

Current guidance relevant to these Serious Adverse Incidents which all Health and Social Care workers must be aware of is:

1. International Dysphagia Diet Standardization Initiative
2. In 2018 NHS Improvement issued Patient Safety Alert NHS/PSA/RE/2018/004 "Resources to support safer modification of food and drink" detailed at
   HSC (SQSD) 16 18 - Resources to support safer modification of food and drink (hscni.net)

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Fundamentals of Care – Identifying and supporting the needs of people with Eating Drinking and Swallowing (EDS) difficulties

The following measures will support identification of EDS difficulties and the complex needs of people at risk of choking. In adult inpatient care settings all registered nursing staff must ensure that every patient has a robust Person-centred Nursing Assessment and Plan of Care completed on admission. The section on Eating and Drinking (see below) must be accurately completed to ensure early identification of any eating, drinking and swallowing difficulties, support referral to Speech and Language Therapy for further assessment and /or support identification of any existing SLT recommendations.

Eating and drinking

Person – All About Me	Assessment
Able to eat and drink: ☐ Independently ☐ Help required ☐ Full assistance	Nil by mouth ☐ Yes ☐ No
Difficulty swallowing: ☐ Yes ☐ No	Last ate: _____
Appetite: ☐ Good ☐ Fair ☐ Poor	Last drank: _____
Appetite change: ☐ Yes ☐ No	Enteral feeding: ☐ Yes ☐ No
Dietary Requirements/Modifications including preferences:	Type of feed:
	Regime:
Food intolerances:	Route/ Device type:
	Size:
Do you wear dentures: ☐ Yes ☐ No	Frequency of change:
Top present: ☐ Yes ☐ No	Date next change due:
Bottom present: ☐ Yes ☐ No	Are you taking oral steroids: ☐ Yes ☐ No
Secure fitting: ☐ Yes ☐ No	Do you wish to be involved in your insulin administration: ☐ Yes ☐ No ☐ NA
Diabetes: ☐ Type1 ☐ Type 2 ☐ None	If Yes, Person able and agrees to administer insulin under supervision: ☐ Yes
Controlled by: ☐ Diet ☐ Tablet ☐ Hormone ☐ Insulin	
Other: _____	

Figure one: Person-centred Nursing Assessment and Plan of Care

All other healthcare settings

For all other health care settings that do not use the inpatient Person-centred Nursing Assessment and Plan of Care document, such as nursing and residential settings, the same principles must apply and the regional Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet (REDS) must be central to safe management of the person's needs.

Interface between primary and secondary care

All relevant healthcare staff must ensure effective communication between the primary and secondary care interface, regarding any patients/clients who have identified eating, drinking and swallowing difficulties. An up to date Speech and Language Therapy Eating, Drinking and Swallowing Care Plan specific to their needs, must be in place.

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The Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet

FOR ALL STAFF: When a person has identified eating, drinking and swallowing difficulties this MUST be centred on an up to date Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet. This document is central to supporting the needs of people with dysphagia. Robust communication and meal time systems must be in place to support its implementation and communicated widely with all staff.

For adults, the Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet (REDS) was launched in October 2021, to help maximize the safety of people with EDS difficulties.

This document must be kept in its **original format** and **not translated or modified!**

Speech and Language Therapy
Eating, drinking and swallowing recommendations

Swallow Aware

HSC Health and Social Care

Patient name:	Health and Care number:	Date of plan:

Important information to help when eating, drinking and swallowing

Food	
Drinks	
Bread	
Supervision	
Additional considerations	

Contact your Speech and Language Therapist if you experience:

- Coughing and or choking when eating and drinking.
- Frequent chest infections (always contact your GP if chesty).
- Difficulty managing the food or liquid consistencies you have been advised to follow.
- Your voice sounds gurgly after meals or drinks.

Ask your doctor or pharmacist about prescribed medications or supplements.

Supplementary information given:			
Speech and Language Therapist	Signature	Print name	Contact no.
Discussed with:			

Figure two: Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet

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Staff roles and responsibilities in supporting people with EDS difficulties.

Dysphagia NI has developed guidance on the roles and responsibilities of Health and Social Care staff in supporting the safety of people with eating, drinking and swallowing difficulties. The regional document can be accessed at the following link: 'Are you caring for someone with Eating, Drinking and Swallowing difficulties?'

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Other Key Patient Safety Alerts

1. Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder

In 2015, NHS England issued a Patient Safety Alert on Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder (health-ni.gov.uk). This alert was issued following an incident where a care home resident died following the **accidental ingestion** of the thickening powder that had been left within their reach. Thickening powder formed a solid mass which caused fatal airway obstruction.

Whilst it is important that thickening products remain accessible, all relevant staff must be aware of **potential risks to patient safety**. **Appropriate storage and administration** of thickening powder needs to be embedded within the wider context of protocols, bedside documentation, training programmes and access to expert advice required to safely manage all aspects of the care of individuals with dysphagia.

2. Polyethylene glycol (PEG) laxatives and starch-based thickeners: potential interactive effect when mixed, leading to an increased risk of aspiration

In April 2021 the Medicines and Healthcare Products Regulatory Agency (MHRA) issued their Drug Safety Update volume 14, issue 9: April 2021: 1. Of note:

- There have been reports of a possible **potential harmful interaction** between **polyethylene glycol (PEG) laxatives and starch-based thickeners** when they are mixed together.
- Combining the two compounds can counteract the thickening action and result in a thin watery liquid — patients with swallowing difficulties (dysphagia) are potentially at **greater risk of aspiration** of the thinner liquid.
- **Avoid directly mixing together PEG laxatives and starch-based thickeners**, especially in patients with dysphagia who are considered at risk of aspiration, such as elderly people and people with disabilities that affect swallowing.
- Report suspected adverse drug reactions (ADRs) to the Yellow Card Scheme

3. Risk to patient safety: prescribing and dispensing thickeners and thickened oral nutrition supplements

HSCB has received reports of adverse incidents where people with dysphagia received thickeners or thickened oral nutritional supplements that were not suitable for them. Reasons for this include:

1. Parallel imported products were dispensed from community pharmacies that could cause confusion and increased risk to patient safety; these include thickening products that are not IDDSI compliant and thickened oral nutritional supplements in packs using older “Stage” terminology rather than the new “Level” description.

2. GPs prescribe these products on the recommendation of a SLT or dietitian. Non-specific product descriptions e.g. “Thickening product” may result in an inappropriate product being prescribed. Product details should be clearly described in letters of recommendation to avoid any confusion.

People with dysphagia must receive IDDSI compliant food and fluid consistencies and IDDSI compliant products to reduce the risk of complications such as choking and aspiration. See letter issued from HSCB ‘Risk to patient safety: Parallel imports of thickeners and thickened oral nutritional supplements’

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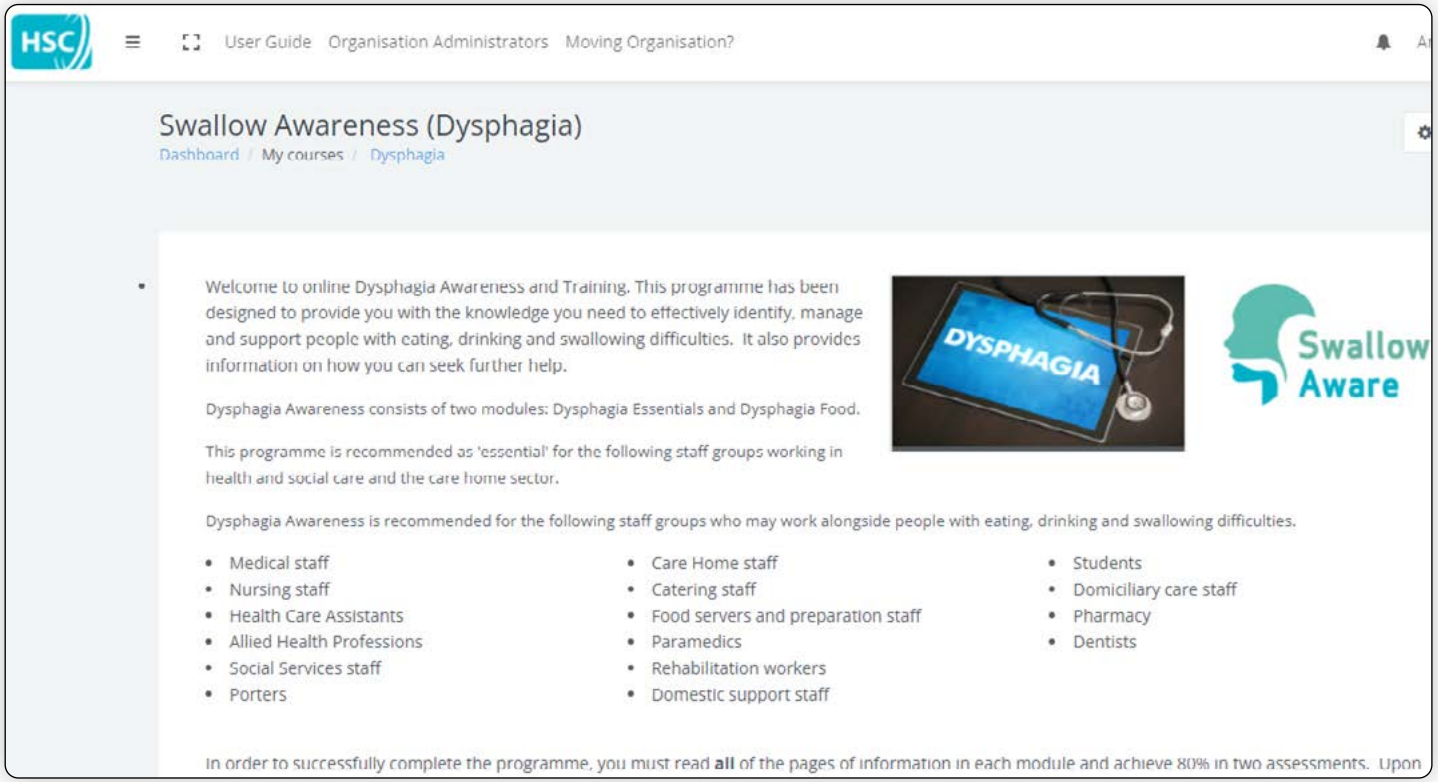
REGIONALLY ENDORSED E-DYSPHAGIA AWARENESS TRAINING TO SUPPORT STAFF:

One of the 6 recommendations of the Safety and Quality Reminder of Best Practice Guidance letter is to ensure the training and development needs of staff providing care for individuals with eating, drinking and swallowing difficulties are identified and arrangements put in place to meet them. To support this recommendation, it is advised that staff access regionally endorsed e-Dysphagia Awareness training via the HSC Learning Centre. This training has been designed to help all staff identify, support and manage the needs of people at risk of choking and / or eating, drinking and swallowing difficulties. This e-learning programme is available at: Dysphagia (hsclearning.com)



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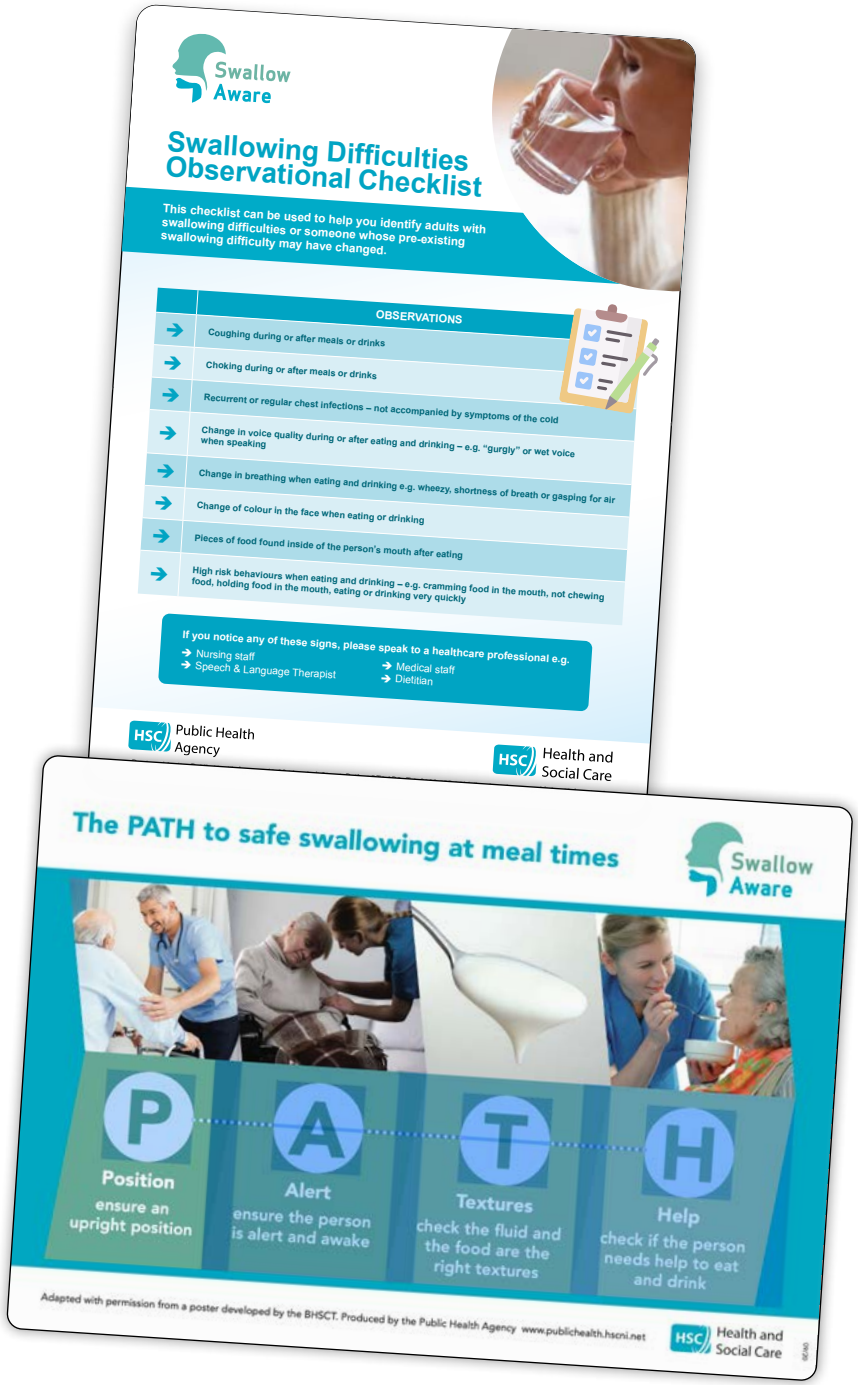
Practical resources to support staff:

- International Dysphagia Diet Standardization Initiative IDDSI - Home
- Resuscitation Council UK (2021), Choking Guidance; available at: Adult Choking Algorithm 2021.pdf (resus.org.uk)
- Resuscitation Council UK (2021), Paediatric Choking Guidance; available at: Paediatric Choking Algorithm 2021.pdf (resus.org.uk)
- Dysphagia Northern Ireland, Public Health Agency, practical resources to support staff available here: Dysphagia | HSC Public Health Agency (hscni.net)
- Staff Roles and Responsibilities supporting people with EDS
- **Swallowing Difficulties Observational Checklist** – a checklist to help staff identify adults with swallowing difficulties or someone whose pre-existing swallowing difficulty may have changed
- **PATH Resource** – Position, Alert, Textures, Help – feeding support for carers and staff to support safe swallowing at mealtimes



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Practical resources to support staff:

- How to Help People with Swallowing Difficulties Keep Their Mouths Clean – guidance for carers and staff to support oral hygiene for people with swallowing difficulties
- Dysphagia Adverse Incident Trigger List – Information for staff on reporting swallowing related incidents or "near misses" using local risk management systems
- NI Formulary Website Poster – Medication information for adults with swallowing difficulties – everything at just one click for healthcare professionals, patients and carers

If you have any comments or questions related to this Special Edition of Learning Matters please get in contact by email at learningmatters@hscni.net

All previous editions of the Learning Matters Newsletter can be accessed here:
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EDITION 24
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Welcome to edition 24 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

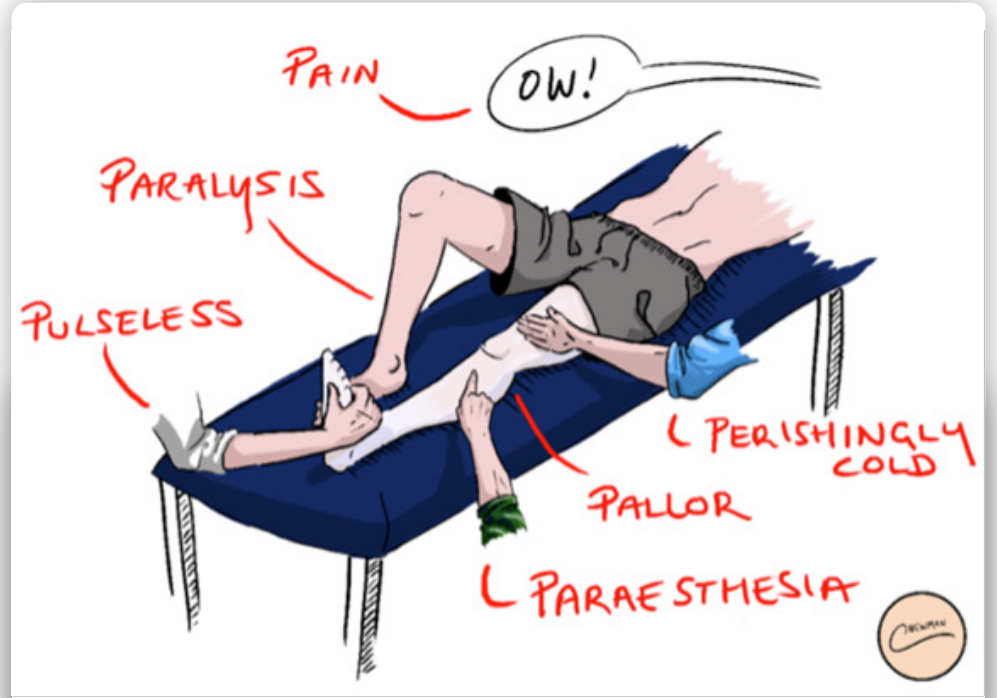
QUALITY 2020

Acute Limb Ischaemia

Summary of Serious Adverse Incident (SAI)

A patient attended the Emergency Department (ED) complaining of pins and needles at the top of their leg, with grey discolouration and toes cold to touch. The patient had a history of disc prolapse and previous sciatica like symptoms. On examination by the ED doctor, a diagnosis of sciatica was made and the patient was discharged with analgesia and request for the General Practitioner (GP) to refer for neurological review.

Five days later the patient reattended the ED with an obvious cold white limb. They were referred urgently to the vascular service and had surgery for clot removal, however two days later they experienced a heavy bleed and further surgery was required for above knee amputation.



The 6 P's of Neurovascular Assessment

The findings from the Serious Adverse Incident (SAI) review confirmed the initial examining doctor recorded a thorough examination, however the previous history of disc prolapse influenced the differential diagnosis of referred pain and the possibility of a vascular cause of the symptoms was not explored.

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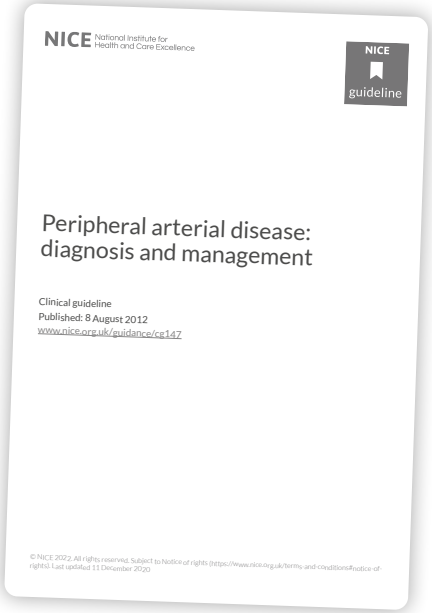
KEY LEARNING

Key learning related to this SAI is provided by the Royal College of Emergency Medicine; Acute Limb Ischaemia Guidelines (2022) available at: Acute Limb Ischaemia - RCEMLearning.

- Acute limb ischaemia carries a high morbidity and mortality (level 4 evidence).
- Classical signs (6 P's) of acute limb ischaemia may be attenuated in a patient with pre-existing peripheral arterial disease and collaterals.
- Few patients present with simple embolus without underlying peripheral arterial disease (level 4 evidence).
- All patients with suspected acute limb ischaemia should have arterial Doppler examination performed (level 5 evidence).
- All patients with acute limb ischaemia should receive analgesia, heparin and oxygen (level 5 evidence).
- Assessment of sensorimotor deficit helps determine the urgency of intervention (level 4 evidence).
- Patients with no or mild sensory loss should proceed to formal imaging (usually angiography) prior to intervention (level 5 evidence).
- Patients with motor deficit may proceed to theatre for intervention with on-table imaging (level 5 evidence).
- Patients with fixed skin mottling and complete paralysis have signs of an unsalvageable limb: in these patients revascularisation is dangerous and the choice is between amputation and palliation (level 4 evidence).
- There is no evidence to support the use of thrombolysis over surgery in the management of the acutely ischaemic limb (level 1a evidence).
- Beware the patient with a popliteal aneurysm and a history of acute limb ischaemia: a thrombosed popliteal aneurysm carries a 50% risk of amputation (level 4 evidence).[1]



1 NICE guideline for peripheral article disease: diagnosis and management. Clinical guideline [CG147] 2012 (updated: 11 December 2020) - https://www.nice.org.uk/Guidance/CG147

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Management of Headache Presentation; Subarachnoid Haemorrhage

Case Studies

Three Serious Adverse Incidents (SAIs) were reported related to patient presentation of severe headache, where a subarachnoid haemorrhage (SAH) diagnosis was either not considered or delayed. A summary of the SAIs is provided below, for the purpose of sharing the current Guidance and key learning related to this important and often life-threatening clinical presentation.

PATIENT A was brought in by ambulance complaining of sudden onset headache, having vomited once, neck pain and heaviness in their legs. A locum middle grade doctor assessed the patient as FAST (Face, Arms, Speech, Time) negative, no photophobia and feeling very weak overall. The patient was alert and orientated, pupils equal and reacting to light, power 5/5, normal gait/coordination and no focal neurology. The doctor discharged the patient with safety net advice; advising GP review and to return if worsening headache, FAST positive or any further/new concerns.

The next day the patient attended by ambulance having been found unresponsive in bed. The patient was intubated and ventilated in ED and a CT scan was undertaken which showed a **subarachnoid haemorrhage** resulting from a 5mm anterior communicating artery (ACA) aneurysm.

The patient underwent emergency surgery and was managed post-operatively in intensive care and then transferred to a rehabilitation unit.

PATIENT B attended the ED by ambulance following referral by the GP out of hours, complaining of sudden onset of headache and vomiting, from the previous day. Following clinical assessment, investigations (including CT brain) and treatment by the emergency medicine, general medicine and acute medicine teams, the patient was discharged home the following day with a diagnosis of migraine.

The patient re-attended the ED two weeks later having had a seizure in the context of a persistent headache. Following clinical assessment, investigations and treatment by the emergency medicine and critical care teams, the patient was transferred to the regional neurosurgical team with a diagnosis of an **extensive sub arachnoid haemorrhage with hydrocephalus** and underwent coiling of a left posterior communicating artery aneurysm.

PATIENT C presented to the ED following a collapse episode at home, loss of consciousness, seizure activity, incontinence of urine and faeces, persistent vomiting and headache. The patient was hypertensive in ED with no significant findings on examination. Given Patient C's history, a CT Brain, CT Spine and bloods were performed and reported as normal. The case was discussed with the ED consultant and given the history; a diagnosis was made of first seizure. The patient was discharged home with the GP to refer to neurology.

Eight days later Patient C re-attended the ED via ambulance following a collapse episode at home. A CT brain was performed which showed a **large volume sub arachnoid haemorrhage** and CT angiogram showed an **intracranial aneurysm**. Anaesthetics were present and Patient C was transferred to the regional ICU for neurosurgical opinion. No intervention was offered based on the radiological findings and clinical severity. Sadly, brain stem tests confirmed brain stem death.

On subsequent review of the initial CT scans for patient B and C, there were subtle signs of subarachnoid haemorrhage.

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Current Guidance Related to these Case Studies

- The Royal College of Emergency Medicine (RCEM) **Guideline for the Management of Lone Acute Severe Headache**[2] (2009) is applicable to all three case studies. The RCEM also provide a very useful learning article on **Primary Headache**[3] (2022). The Primary Headache guideline highlights red flags and outlines that 90% of headaches presenting to ED are primary. If there are any significant findings in history or examination, further investigation is required. A table of Red Flag Symptoms is provided by the RCEM:

Red Flag Symptoms

Certain features of the presentation may be regarded as 'red flags'. These significantly increase the risk that there is a secondary cause for the headache and therefore, further investigation is warranted.

These are:

- Headache in someone >50 years
- Thunderclap headache **(headache reaching maximum intensity within 60 seconds of onset)**
- Headaches increasing in severity and frequency
- Headache with fever, neck stiffness, or reduced level of consciousness
- Focal neurological symptons or signs
- Papilloedema
- Headache after trauma
- Loss of vision/amaurosis fugax
- Immunonocompromised, Malignancy

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The presence of any 'red flag' feature mandates further investigation of a patient presenting with headache.

- The clinical history of sudden or abrupt onset severe headache in these case studies warrants further investigation to exclude serious underlying pathology. It should also be noted that a normal CT **does not** rule out SAH, so if clinically suspected a lumbar puncture should also be undertaken **Guideline for the Management of Lone Acute Severe Headache** (RCEM, 2009).

- The National Institute for Health and Care Excellence (NICE) provide guidance on **Headaches in over 12s: diagnosis and management [CG150]**[4] (2021). Sections on assessment i.e. 1.1.1 and 1.1.2 and management 1.3.2, are all of relevance to these case studies in the management of headache.

The National Institute for Health and Care Excellence (NICE) provide guidance on **Subarachnoid haemorrhage caused by a ruptured aneurysm: diagnosis and management [NG228]**[5] (2022). Section 1.1 assessment and diagnosis are relevant to all of these case studies and in particular sections 1.1.10 – 1.1.13 below: *It is worth noting that the study used in the NICE guidance regarding CT scan in 6 hours used neuroradiologist reporting the CT Scan. In current practice across the HSC, an out of hours Consultant Neuroradiology report is often not available as it is usual practice for the out of hours CT scan being reported on by a radiology registrar. A consultant review is then required and for that reason a lumber puncture is often required, even if the CT is normal.*

2 https://rcem.ac.uk/wp-content/uploads/2021/10/Lone_Acute_Severe_Headache_Flowchart_Dec2009.pdf
3 https://www.rcemlearning.co.uk/reference/primary-headache/#1643120419710-75c762da-adbc
4 https://www.nice.org.uk/guidance/cg150/resources/headaches-in-over-12s-diagnosis-and-management-pdf-35109624582853
5 https://www.nice.org.uk/guidance/ng228/resources/subarachnoid-haemorrhage-caused-by-a-ruptured-aneurysm-diagnosis-and-management-pdf-66143842385605

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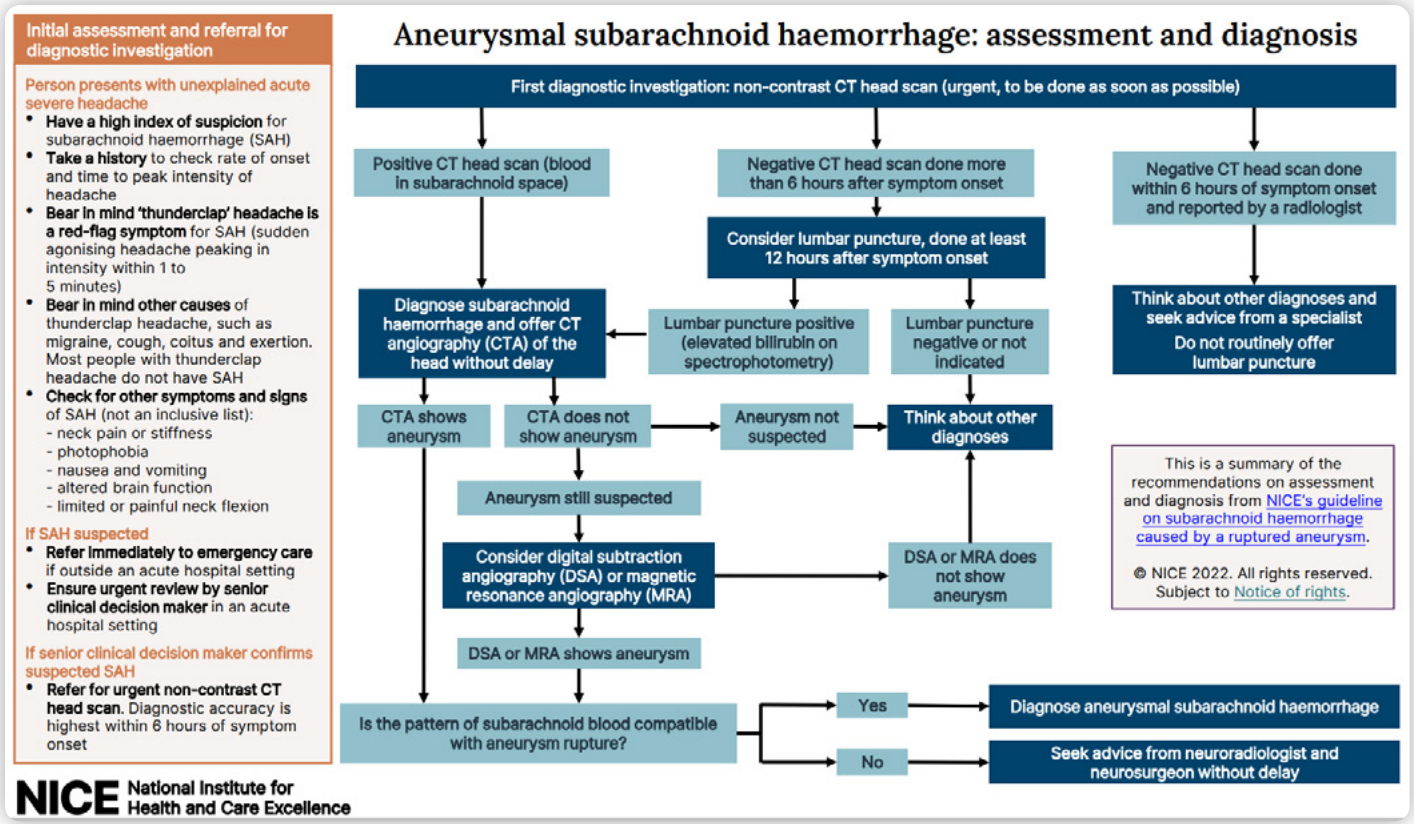
Diagnosing a subarachnoid haemorrhage

- Diagnose a subarachnoid haemorrhage if the non-contrast CT head scan shows blood in the subarachnoid space.
- Allow at least 12 hours after symptom onset before doing a lumbar puncture to diagnose a subarachnoid haemorrhage.
- If a CT head scan done more than 6 hours after symptom onset shows no evidence of a subarachnoid haemorrhage, consider a lumbar puncture.
- If a CT head scan done within 6 hours of symptom onset and reported and documented by a radiologist shows no evidence of a subarachnoid haemorrhage:
  - do not routinely offer a lumbar puncture
  - think about alternative diagnoses and seek advice from a specialist.

NICE NG228 provides this useful summary of the recommendations on assessment and diagnosis of SAH caused by a ruptured aneurysm



Also available here: https://www.nice.org.uk/guidance/ng228/resources/visual-summary-on-the-assessment-and-diagnosis-of-aneurysmal-subarachnoid-haemorrhage-pdf-11262251629

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In addition to the NICE Guidance the SNOOPP10 list of red and orange flags for secondary headaches in clinical practice is used[6] in neurology, which are similar to the NICE [NG228] Guidance.

Table 1: SNNOOP10 List of Red and Orange Flags

2	Neoplasm in history	Neoplasms of the brain; metastasis	Red
4	Onset of headache is sudden or abrupt	Subarachnoid hemorrhage and other headaches attributed to cranial or cervical vascular disorders	Red
		Giant cell arteritis and other headache attributed to cranial or cervical vascular disorders; neoplasms and other nonvascular intracranial disorders	
6	Pattern change or recent onset of headache	Neoplasms, headaches attributed to vascular, nonvascular intracranial disorders	Red
8	Precipitated by sneezing, coughing, or exercise	Posterior fossa malformations; Chiari malformation	Red
10	Progressive headache and atypical presentations	Neoplasms and other nonvascular intracranial disorders	Red
		Headaches attributed to cranial or cervical vascular disorders; postdural puncture headache; hypertension-related disorders (e.g., preeclampsia); cerebral sinus thrombosis; hypothyroidism; anemia; diabetes	Red
12	Painful eye with autonomic features	Pathology in posterior fossa, pituitary region, or cavernous sinus; Tolosa-Hunt syndrome; ophthalmic causes	Red
13	Posttraumatic onset of headache	Acute and chronic posttraumatic headache; subdural hematoma and other headache attributed to vascular disorders	Red
14	Pathology of the immune system such as HIV	Opportunistic infections	Red
15	Painkiller overuse or new drug at onset of headache	Medication overuse headache; drug incompatibility	Red

Abbreviation: ICHD-3b = International Classification of Headache Disorders 3b.
An overview of signs and symptoms, their related secondary headache, and distribution in red and orange flags.

6 Do, T.P., Remmers, A., Schytz, H.W., Schankin, C., Nelson, S.E., Obermann, M., Hansen, J.M., Sinclair, A.J., Gantenbein, A.R. and Schoonman, G.G. (2018). Red and orange flags for secondary headaches in clinical practice. Neurology, [online] 92(3), pp.134–144. doi:https://doi.org/10.1212/wnl.0000000000006697.

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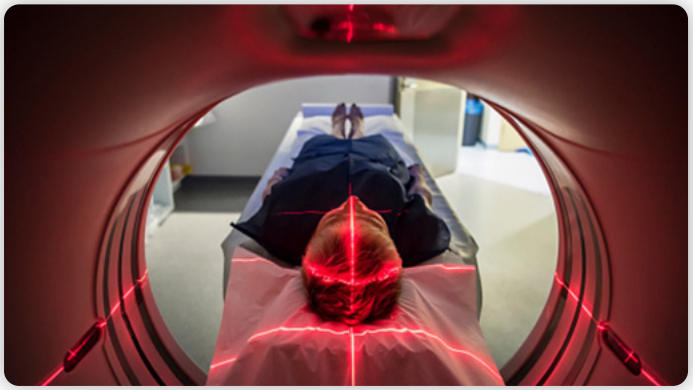
Low Threshold for CT Scanning in Ongoing Headaches



A patient attended the Direct Assessment Unit (DAU) with a 2-week history of vomiting, diarrhoea and feeling feverish, with a headache, after returning from a foreign holiday. Following assessment, a diagnosis was made of travel related vomiting and diarrhoea, and the patient was treated and discharged with medication and advised to increase oral intake. The patient was treated and discharged with medication and advised to increase oral intake.

A plan was put in place to consider CT brain if the headache was non-resolving and there was ongoing vomiting. The patient subsequently attended the ED 3 days later with ongoing headache. The patient was given pain relief. Medical staff assessed the patient as having no features suggestive of raised intracranial pressure and therefore no requirement for an emergency CT brain scan. The patient was discharged into the care of the GP for follow up if required.

This patient had previously been treated for **left renal cell carcinoma** approximately 9 months prior to both these presentations. The patient sadly passed away 2 days after being discharged.

The Autopsy Report identified cause of death as:

- Cerebral Oedema associated with cerebral metastasis of a renal cell carcinoma. Given the presence of a metastatic tumour within the left temporal lobe and cerebral oedema, it is obvious that this was the cause of the patient's headache and vomiting.

Current Guidance Related to this Case

As per NICE CG150 Headaches in over 12s: diagnosis and management:

1.1.1 Evaluate people who present with headache and any of the following features, and consider the need for further investigations and/or referral:

- worsening headache with fever
- sudden-onset headache reaching maximum intensity within 5 minutes
- new-onset neurological deficit
- new-onset cognitive dysfunction
- change in personality
- impaired level of consciousness
- recent (typically within the past 3 months) head trauma
- headache triggered by cough, valsalva (trying to breathe out with nose and mouth blocked) or sneeze
- headache triggered by exercise
- orthostatic headache (headache that changes with posture)
- symptoms suggestive of giant cell arteritis

1.1.2 Consider further investigations and/or referral for people who present with new-onset headache and any of the following:

- compromised immunity, caused, for example, by HIV or immunosuppressive drugs
- age under 20 years and a history of malignancy
- a history of malignancy known to metastasise to the brain
- vomiting without other obvious cause [2012]

KEY LEARNING

- Medical staff should have a **low threshold for CT scanning** ongoing headaches.
- Red flag symptoms of headache for those over 12 years of age are defined in NICE CG150 **Headaches in over 12s: diagnosis and management** and if present consideration should be given for further investigations.

LEARNING MATTERS

EDITION 24
JANUARY 2024

IN THIS EDITION

Differential Causes of Elevated Troponin T: Unconscious Bias in Healthcare

Summary of Event

A patient with a history of non-valvular atrial fibrillation presented to the ED following a fall at home. The patient was assessed and a Computed Tomography (CT) brain scan was performed as well as a chest and hip x-ray. All were reported as nothing abnormal detected.

A 6 hour troponin T level showed an increased troponin which was diagnosed and treated as an acute coronary syndrome (ACS). The patient was transferred to the cardiology ward.

The patient was later found to be non-responsive. An urgent CT Brain was performed which showed **a left sided subdural haematoma**. After discussion with the cardiology consultant and neurosurgeons the patient was diagnosed with a non-survivable subdural haematoma.

A Do Not Attempt Resuscitation (DNAR) order was discussed and agreed with the family. End of life care was initiated until the patient sadly passed away. The death certificate recorded cause of death as a subdural haematoma and fall.

KEY LEARNING:

- **Clinical decision making:** In this case the clinician made the diagnosis of Acute Coronary Syndrome (ACS) in a patient who presented to the ED following and fall and associated head injury despite there being no cardiac history. The elevated Troponin T was misinterpreted as ACS; importantly no other causes of an elevated Troponin T were considered and no other indicators of ACS were present.
- **Unconscious Bias:** Unconscious (or implicit) bias can have a life-or-death impact in a healthcare environment. Learning how to identify and overcome bias is essential to improving the delivery of healthcare to diverse populations. Your brain is able to process situations quickly because it relies on what it already knows - or *thinks* it knows. Your memories help your brain categorize and sort information so it can be quickly analyzed without your awareness. All of your experiences and impressions inform your current actions, and help your brain make automatic conclusions.

Unconscious bias can lead to false assumptions and negative outcomes.

LEARNING MATTERS

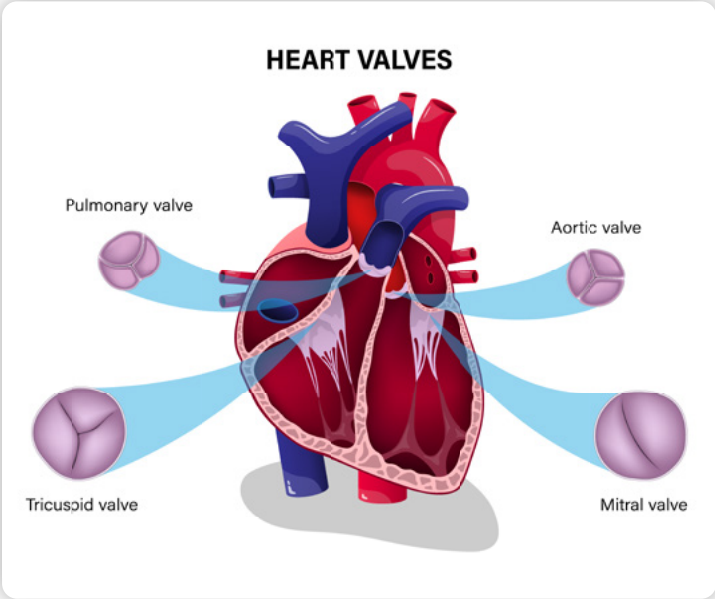
EDITION 24
JANUARY 2024

IN THIS EDITION

Loss of Audible Click in Mechanical Heart Valve

A patient who had previous aortic (single tilting disc) and mitral (bileaflet) mechanical valve replacement surgery 13 years previously, attended the Emergency Department (ED) complaining of chest pain, dyspnoea and not hearing their valve click. The patient was admitted and investigations including transoesophageal echocardiogram (TOE) and fluoroscopy showed both valves to be functioning normally. There was no obvious abnormal or reduced leaflet movement, but the aortic valve gradient was significantly elevated. The patient was discharged with a plan for a follow-up echocardiogram in 1 year.

The patient re-presented at ED three weeks post discharge with significant pulmonary oedema due to mechanical aortic valve obstruction. They were transferred for emergency cardiac surgery the following day, however died prior to surgery being undertaken.



KEY LEARNING

1. Have a high index of suspicion of mechanical valve dysfunction in patients complaining of symptoms and **loss of audible click**, especially in single tilting disc valves.
2. Transoesophageal echocardiographic (TOE) and fluoroscopy (for at least 10mins to detect intermittent valve leaflet dysfunction) in addition to transthoracic echocardiography (TTE) should be performed early if a diagnosis of mechanical valve dysfunction is being considered.
3. Refer early to a heart team if a diagnosis of prosthetic mechanical valve dysfunction is being considered.
4. Early surgery (as urgent or emergency) should be performed if a diagnosis of mechanical valve leaflet dysfunction is confirmed, as delay results in poor outcomes.

LEARNING MATTERS

EDITION 24
JANUARY 2024

IN THIS EDITION

The Importance of Maintaining up to date Patient Demographic Information

A Serious Adverse Incident (SAI) was reviewed which involved the stillbirth of a baby due to fetal sepsis.

The patient had a history of recurrent urinary tract infections, which were not documented by the Trust antenatal services at booking. Her original booking questionnaire completed at the time of GP attendance was completed using her maiden name. On the day of the hospital booking appointment a further questionnaire was completed and this recorded her married name with the maiden name in brackets. However, booking bloods and patient labels were completed under her maiden name as the HCN used matched the maiden name on the hospital system. Around one month after booking the patient requested her name be changed to her married name at the GP practice. At this point her hospital records were not updated.

During the antenatal course approximately nine urine samples were submitted by GP and maternity services. There were four episodes of infection with positive MSSU results and of these three were treated empirically.

She was prescribed antibiotics at 37+1 weeks gestation, the following day the patient attended the Admissions department Maternity Hospital with a history of uterine tightenings and reduced fetal movements. On auscultation, no fetal heart was heard and Obstetric staff confirmed intra-uterine death. The baby was delivered stillborn. The cause of death was noted as fetal sepsis.

The patient changed their surname following their antenatal booking. The GP Practice changed their patient records with the patient's new surname aligned to their Health and Social Care Number. However, the Trust's PAS system was not updated with the patient's new surname. Therefore, a contributory factor in this SAI was the fact that urine samples were sent from the GP Practice with labels with new surname and H&C number whereas the Trust sent urine samples with patient's old surname and H&C number; this led to delays in urine results being processed by the lab.

KEY LEARNING

- The Northern Ireland Management of Infection Guidelines for Primary Care provides guidance for treating Lower UTI in Pregnancy-Asymptomatic Bacteriuria and Lower UTI in Pregnancy-Symptomatic UTI
- NICE CKS guidance Scenario: UTI in pregnancy no visible haematuria | Management | Urinary tract infection (lower) - women | CKS | NICE states seek urgent specialist advice on further management of pregnant women with recurrent lower UTI.
- All healthcare staff must check with antenatal patients if there are any changes to names or addresses and update their clinical systems appropriately.
- Patient test samples must always include the patient's H&C number.
- It must be emphasised to all antenatal patients at their time of booking that they need to carry their maternity hand-held record (MHHR) to all appointments with health professionals and ask that a summary of their visit is included their maternity hand-held record. Completion of the MHHR is the most effective way to keep all health professionals involved in the care of antenatal patients up to date.
- The maternity hand-held record (MHHR) needs to include the GP referral letter if available as CCG will include the most important facts of the patients past medical history from the computerised GP clinical record.

LEARNING MATTERS

EDITION 24
JANUARY 2024

IN THIS EDITION

De-activation of Swipe Cards

In a recent Serious Adverse Incident, a former member of staff was observed accessing locked office premises without permission, the day after their employment ceased. The individual was able to access the premises as they had a number of swipe cards allocated to them. It was thought that previous cards had been lost over time; and as a result, replacement cards had been issued without the old cards being deactivated.

KEY LEARNING

- Staff must only have one active swipe access card assigned to them at any given time.
- When a member of staff requests a new swipe access card, their previous card must be immediately deactivated.
- A robust record keeping and governance process must be place to ensure only the appropriate staff have active swipe access cards.

If you have any comments or questions related to this Edition of Learning Matters please get in contact by email at learningmatters@hscni.net

All previous editions of the Learning Matters Newsletter can be accessed here:
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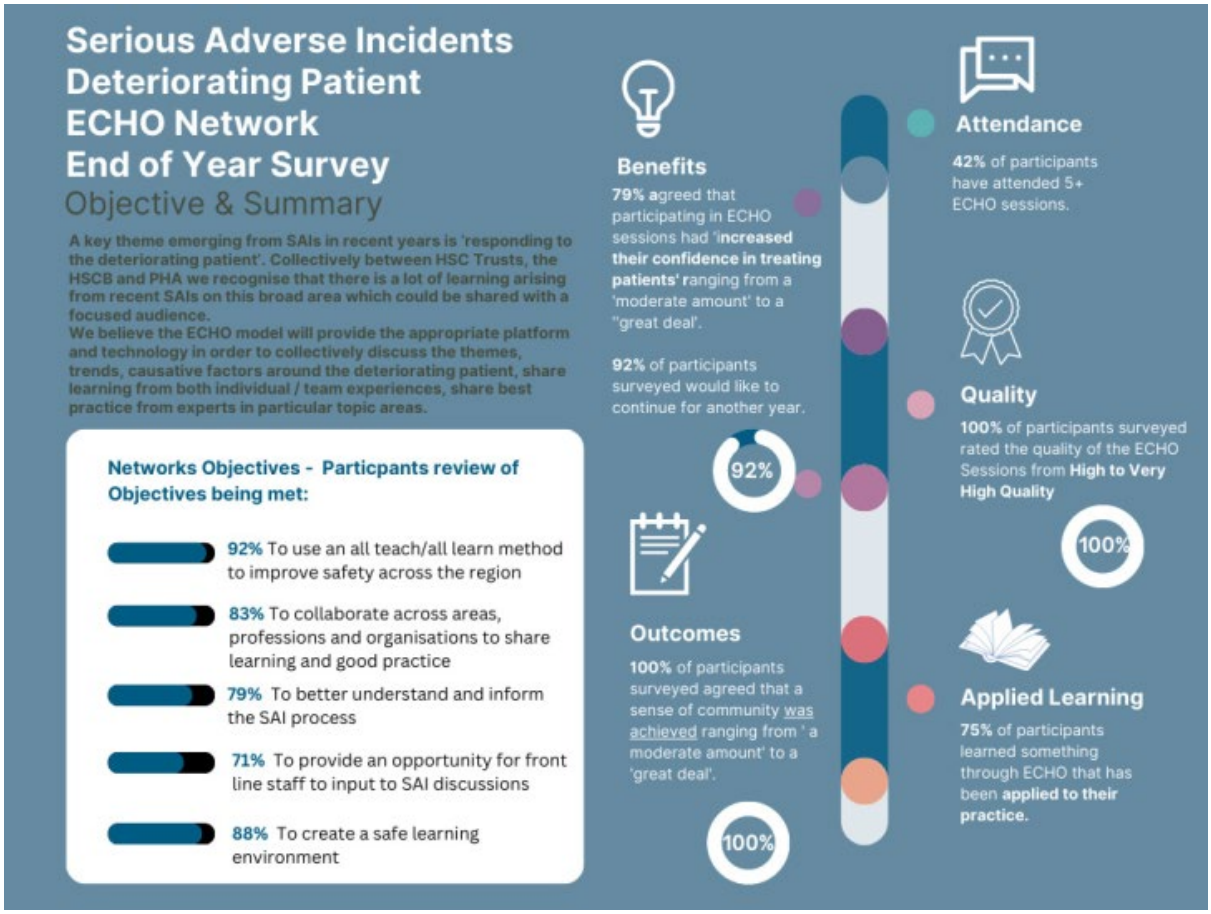
Serious Adverse Incidents
Deteriorating Patient
ECHO Network
End of Year Survey
Objective & Summary
A key theme emerging from SAIs in recent years is 'responding to the deteriorating patient'. Collectively between HSC Trusts, the HSCB and PHA we recognise that there is a lot of learning arising from recent SAIs on this broad area which could be shared with a focused audience.
We believe the ECHO model will provide the appropriate platform and technology in order to collectively discuss the themes, trends, causative factors around the deteriorating patient, share learning from both individual / team experiences, share best practice from experts in particular topic areas.
Networks Objectives - Particpants review of Objectives being met:
92% To use an all teach/all learn method to improve safety across the region
83% To collaborate across areas, professions and organisations to share learning and good practice
79% To better understand and inform the SAI process
71% To provide an opportunity for front line staff to input to SAI discussions
88% To create a safe learning environment
Benefits
79% agreed that participating in ECHO sessions had 'increased their confidence in treating patients' ranging from a 'moderate amount' to a "great deal'.
92% of participants surveyed would like to continue for another year.
92%
Outcomes
100% of participants surveyed agreed that a sense of community was achieved ranging from ' a moderate amount' to a 'great deal'.
100%
Attendance
42% of participants have attended 5+ ECHO sessions.
Quality
100% of participants surveyed rated the quality of the ECHO Sessions from High to Very High Quality
100%
Applied Learning
75% of participants learned something through ECHO that has been applied to their practice.

Strengthening the Workforce