

NEWS on the National Early Warning Score

In late 2013, the National Early Warning Score (NEWS), an evidence-based tool to improve recognition and response to the deteriorating patient, was implemented across all in-patient adult general wards in all HSC Trusts.

Replacing the traditional observation chart, early warning scores (EWS) both “track” the patient’s vital signs and “trigger” intervention at predefined scores. The ongoing challenge is to ensure an abnormal NEWS score always prompts the right intervention at the right time.

All EWS give a score (between 0-3) to each of a number of vital signs or measures of “physiological health” - the more abnormal the observation the higher the score. Different EWS include a variable number of parameters – NEWS uses 6 and attributes an additional score

when patients require oxygen. The total NEWS (sum of these scores) indicates whether there is need for senior nursing/medical assessment and intervention and also the required frequency of NEWS scoring.

Trusts have completed their second NEWS utilisation audit. Informal feedback has suggested difficulties in scoring patients with long-term conditions (eg respiratory or neurological disease). In such patients, there may be an increased “baseline” NEWS score, thus an increased likelihood in reaching a “trigger score” with minimal change in their acute condition. The HSC Safety Forum is facilitating a regional approach to this issue to ensure the adjustment needed in such situations is appropriate and uniform across all Trusts.

Key Learning

- NEWS quantifies a patient’s degree of acute illness using vital signs and other information.
- NEWS is a tool to aid patient safety but does not replace/overrule professional judgement.
- A key outcome of increased NEWS score is ACTION (based on an agreed escalation plan) to prevent avoidable patient deterioration.

Introduction

Welcome to the fourth issue of the 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. 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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The process for escalating clinical concerns – when time is important, speak directly by phone – do not text.

The treatment of an acutely ill patient in a hospital setting was delayed due to the use of text messaging as a means of communication between professional colleagues. Such practice creates significant risks to patient safety as there is no confirmation that information has been received, read or understood in a timely manner.

The General Medical Council 'Leadership and Management for all Doctors' Guidance 2012 outlines the responsibilities of doctors in respect of communication, and highlights the responsibility to communicate relevant information clearly to colleagues.

Key Learning

- Communicating clinical information relating to an acutely ill patient requires an appropriate discussion between the relevant hospital staff either in person or by telephone. Only direct verbal communication can ensure all relevant information has been received, understood and considered in decision-making.
- Communication should be clear and concise and consideration should be given by both parties as to the level of urgency and action required. This may be helped by using structured communication such as SBAR

Getting to know the new oral anticoagulant medicines

In recent years the UK has seen the launch of four oral anticoagulant medicines apixaban (Eliquis®), dabigatran (Pradaxa®), edoxaban (Lixiana®) and rivaroxaban (Xarelto®).

These medicines are prescribed in some patients as an alternative to warfarin for the prevention and treatment of blood clots. Incidents have been reported involving these medicines resulting in:

- Increased bleeding risk
 - New oral anticoagulants prescribed in combination with other contraindicated medicines e.g. heparin
 - Loading doses continued as maintenance doses
- Treatment failure
 - Patients did not request repeat prescriptions for continued treatment

Analysis of the incidents highlighted a lack of awareness and about these medicines by both health professionals and patients as one of the main contributory factors.

Key Learning

Healthcare professionals should ensure that:

- They are familiar with the new oral anticoagulants e.g. indications, dosing, patient monitoring, contraindications, interactions.
- Patients are counselled at the start and periodically during their treatment with oral anticoagulants to ensure they understand their medicine fully e.g. the importance of taking the prescribed dose, signs of bleeding, when to seek medical attention.

For further prescribing and patient information visit www.medicines.org.uk/emc/

Volvulus in people with a Learning Disability

Two recent incidents have occurred in which the diagnosis of volvulus of the bowel was missed with fatal consequences. In both instances the patient had been referred by their GP and had significant communication difficulties.

The clinical signs and symptoms in these cases were hard to interpret by junior staff. In each case X-rays were taken and junior surgical advice was sought which did not clarify the diagnosis. The presence of on-going bowel activity further confused the clinical picture. The patients were discharged back to the community with a diagnosis of chronic constipation and provided with treatment for this condition. Death from infarction of the bowel occurred within 24 hours in both patients.

Key Learning

- Volvulus is a life threatening condition which occurs more frequently among people who have learning disabilities.
- Where communication difficulties make diagnosis more problematic, an extended period of observation should be considered to facilitate consultations and fully assess investigation reports.
- Junior staff should seek advice from senior medical ED staff, surgeons and radiologists prior to discharge back to the community.
- Consideration should be given to transfer to a more specialist centre if there is uncertainty over the diagnosis.

Informed Consent

From time to time complaints are received about the extent of the consent process for various 'elective procedures'.

This generally arises after the procedure and relates to potential procedural related adverse outcome not being specified in the written documentation. Frequently this will have been addressed either verbally or by way of an explanatory leaflet.

In each speciality area the extent of the consent process will depend on a wide range of factors.

These include what might be regarded as standard custom and practice for that procedure, the frequency of the outcome, any long term consequences which may impact on future life-style or expectations.

Key Learning

1. For consent to be valid it needs to be fully informed.
2. Staff are asked within speciality areas to consider their current consent documentation to ensure that it is fit for purpose.
3. In the case of 'elective procedures' staff should consider if they have covered all reasonably foreseeable adverse outcomes by way of a supplementary check-list, leaflet or some other recorded means of verification.

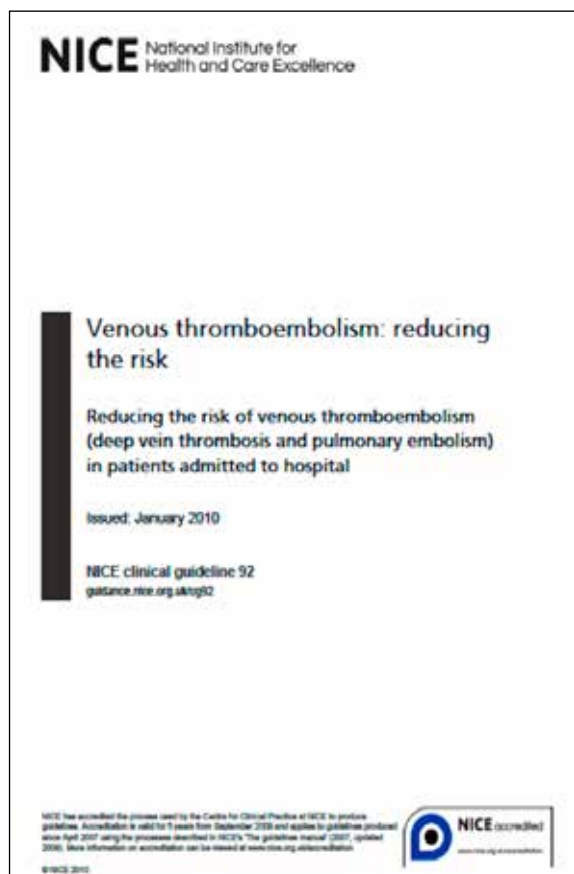
Reassessment of patient on Venous Thrombo Embolism (VTE) Prophylaxis

VTE is an important cause of death in hospitalised patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with a considerable cost to the health service. The risk of developing VTE depends on the condition and/or procedure for which the patient is admitted and on any predisposing risk factors (such as age, obesity and concomitant conditions).

A recent Serious Adverse Incident (SAI) reported the death of a patient due to VTE after 24 hours of admission despite being on an appropriate method of prophylaxis at time of admission. Low dose heparin can reduce the risk of VTE significantly; however, a small proportion of patients would still be at risk of developing VTE despite being on prophylactic treatment. It is therefore critical that all patients on VTE prophylaxis are re-assessed for their risk of developing thrombosis on a regular basis.

Key Learning

- **Trusts should** ensure that all patients on VTE prophylaxis with a length of stay greater than 24 hours are re-assessed within 24 hours of admission for risk of VTE and bleeding.
- **Healthcare professionals** should re-assess patients on VTE prophylaxis within 24 hours of admission for risk of VTE and bleeding.
- **Patients** on VTE prophylaxis should expect to have their risk of VTE and bleeding re-assessed within 24 hours of admission.



Current clinical guidelines recommend that patients on VTE prophylaxis should be re-assessed individually, considering both existing risk factors for VTE and bleeding. For patients with increased risk, the balance of risk versus benefits of treatment should be re-assessed at regular intervals.

The NICE CG 92 recommends that patients at risk of VTE should be reassessed within 24 hours of admission and whenever the clinical situation changes, to:

- ensure that the methods of VTE prophylaxis being used are suitable
- ensure that VTE prophylaxis is being used correctly
- identify adverse events resulting from VTE prophylaxis.



<http://www.england.nhs.uk/ourwork/patientsafety/psa/national-psa-system/>

Patient Safety Alerts (PSAs) are used to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. From late 2013 there have been 17 PSAs issued by NHS England which are outlined below.

Further information on PSA is available at: <http://www.england.nhs.uk/ourwork/patientsafety/psa/>

NHS England Ref No	Title of Alert	Stage	Link to NPSA on NHS England Website	DHSSPS Issued
NHS/PSA/W/2015/006	Harm from delayed updates to ambulance dispatch and satellite navigation systems	1	http://www.england.nhs.uk/wp-content/uploads/2015/07/ps-alert-amb-sat-nav.pdf	07/08/2015
NHS/PSA/W/2015/005	Risk of death or severe harm due to inadvertent injection of skin preparation solution	1	http://www.england.nhs.uk/wp-content/uploads/2015/05/psa-skin-prep-solutions-may15.pdf	08/06/2015
NHS/PSA/W/2015/004	Managing risks during the transition period to new ISO connectors for medical devices	1	http://www.england.nhs.uk/wp-content/uploads/2015/04/psa-managing-risk-during-transition-iso-connectors.pdf	03/07/2015
NHS/PSA/W/2015/003	Risk of severe harm and death from unintentional interruption of non-invasive ventilation	1	http://www.england.nhs.uk/wp-content/uploads/2015/02/psa-niv.pdf	03/03/2015
NHS/PSA/W/2015/002	Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder	1	http://www.england.nhs.uk/wp-content/uploads/2015/02/psa-thickening-agents.pdf	24/02/2015
NHS/PSA/W/2015/001	Harm from using Low Molecular Weight Heparins when contraindicated	1	http://www.england.nhs.uk/wp-content/uploads/2015/01/psa-lmwhs.pdf	26/01/2015

Drug administration using prefilled glass syringes.

Can you make the connection?

A Serious Adverse Incident occurred in which the condition of a general ward patient became dangerously unstable when clinical staff were delayed in administering emergency treatment to the patient.

The luer tip of the prefilled (glass) syringe which contained the emergency drug would not connect with a needle-free connector which was part of the intravenous cannula. The drug was subsequently administered using alternative venous access.

Similar examples of incompatibility between some combinations of prefilled glass syringes and needle-free connectors have been reported by other clinical teams.

There is a known incompatibility between some pre-filled glass syringes and some (but not all) needle-free connectors. This can be overcome by using specific adaptors which sit between the needle-free port and luer tip of the pre-filled syringe.

These adaptors should be removed after drug administration as, if left in-situ, there is a risk of air embolism or infection.

Key Learning

- Ward staff should know the prefilled syringes and needle-free connectors used in their clinical area.
- If adaptors are needed to overcome an incompatibility, they should be connected just before administration of a drug from the prefilled syringe and removed immediately afterwards.

Contact us



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 ext: 3446**

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