Belfast Health and Social Care Trust

Safety Matters

May 2015
Issue 6

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Reporting Patient Falls Incidents

Do you ensure that Patient Falls Risk Assessment and Bed Rails Documentation are fully completed and regularly reviewed, particularly after a patient falls and following a change in the patient's condition?

The Belfast Trust has a responsibility to report patient fall incidents, resulting in a major injury or being taken to hospital, to the Health and Safety Executive (HSENI) under the **Reporting of Injuries and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR),** if the fall has arisen out of or in connection with a work activity.

This includes where equipment or the work environment (including how or where work is carried out, organised or supervised) are involved. Such incidents are reported to HSENI by the Belfast Trust Health and Safety Team. Evidence of documented, implemented and reviewed Patient Falls Risk Assessments are key requirements for HSENI.

Examples of RIDDOR reportable patient falls incidents include:

- A Service User falls and fractures their leg. There is a previous history of falls incidents, but reasonably practicable measures to reduce the risk have not been put in place
- A Service User (who is capable of understanding and following advice) falls off the toilet, having previously been advised not to get up, is injured and taken to hospital. They have been left alone for dignity reasons. Their care plan identified that the individual should have assistance or supervision
- A member of staff left a patient out of earshot and without a call bell they could use, or had not responded promptly when they did call, as adequate supervision had not been provided
- A Service User falls out of bed, is injured and taken to hospital. The assessment identified the need for bedrails but they, or other preventative measures, were not provided.

RIDDOR reportable patient falls are commonly reported due to:

- Incomplete Patient Falls Risk Assessment or Bed Rails documentation
- No evidence of documentation review following a change in the patient's condition after a previous fall incident, or
- Identified controls not implemented at the time of the incident.

If you require any further information please contact your partnered Health and Safety Manager.

Management of Carcinogens within Service Areas

A new campaign "No time to Lose" was launched in November 2014. This campaign focuses on causes of Occupational Cancer and encourages Managers and COSHH (Controls of Substances Hazardous to Health) Assessors to take action and ensure appropriate processes and controls are in place.

This renewed focus on working with carcinogens should reinforce the requirement to ensure Service Areas have robust processes and controls in place. These substances may be known carcinogens for example cytotoxic medications or contained within substances identified through hazard statements and risk phrases (on Safety Data sheets) for example **H350, H351, R45** or **R49.**

Belfast Trust COSHH Assessors should ensure that a COSHH Risk Assessment is completed for each activity where there is potential exposure to a carcinogen. The primary goal of this Risk Assessment should be to eliminate or substitute the substance containing the carcinogen. In the event the carcinogenic substance cannot be eliminated or substituted they must control exposure to as low a level as is reasonably practicable.

A sample COSHH Risk Assessment based on a cytotoxic medication (Cyclophosphamide) can be downloaded from the Belfast Trust HUB via clicking on this **link.** **Your partnered Health and Safety Manager, Pharmacy Department or Occupational Health Services should be contacted for further advice and guidance.**

The following methods of control should be considered:

- Use totally enclosed systems
- Where this cannot be achieved plant should be used for example, local exhaust ventilation systems
- Document and communicate safe systems of work
- Keep carcinogenic substances to the minimum needed
- Clearly label carcinogenic substances
- Clearly identify the areas in which exposure to carcinogens may occur
- Do not eat, drink or smoke in the areas concerned
- Provide adequate washing facilities
- Provide appropriate personal/ respiratory protective equipment as per risk assessment.

NEW General Risk Assessment and COSHH Risk Assessor Refresher Workshops

The Belfast Trust Health and Safety Team have developed NEW General Risk Assessment and COSHH Risk Assessor Refresher workshops. These 2 hour workshops are intended to have a practical focus, building on existing knowledge and experience gained by current Belfast Trust Risk Assessors, during their initial 4 hour course. **Staff who have completed a General or COSHH Risk Assessment course (4 hours) within the last 3 years can now attend a 2 hour refresher workshop.**

New Course Titles	Course Duration	Frequency	What Course to attend?
COSHH Risk Assessment Refresher	2 hours	Every **3** years	Initially attend the 4 hour course and then the 2 hour refresher course
General Health and Safety Risk Assessment Refresher	2 hours	Every **5** years	Initially attend the 4 hour course and then the 2 hour refresher course

Staff can book onto the training courses through HRPTS. Please contact your partnered Health and Safety Manager for further information

Learning from SAIs: Use of the Hyperkalaemia Kit and the Treatment of Hyperkalaemia in Adults

A patient was admitted with hyperkalaemia. Although treated using a hyperkalaemia kit, 50 units of soluble insulin in glucose 50% was administered instead of 10 units.
The member of staff involved often made up 50 units in 50ml to treat Diabetic Ketoacidosis (DKA) and felt familiarity with this dose had contributed to the incident. They were also unfamiliar with the hyperkalaemia kit and did not recall hearing about it at induction. On this occasion, one nurse obtained the insulin from the pharmaceutical refrigerator and another provided a second check. The second check was of the quantity of insulin but not the appropriateness of the dose for the condition being treated.
During blood glucose monitoring post insulin-glucose infusion, as the patient's blood glucose decreased, the member of staff who had administered the insulin realised they had given 50units of insulin, instead of 10units. Appropriate treatment was instigated and the patient made a full recovery.

LEARNING

The insulin should be obtained from the pharmaceutical refrigerator and second checked by the senior nurse on duty. They must be aware of the condition being treated and must document on the Kardex/ Emergency Department Flimsy that they have carried out the second check.

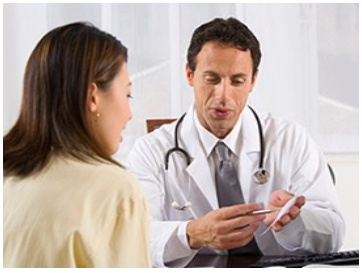
In this incident, appropriate blood glucose monitoring meant staff quickly realised too much insulin was administered. Blood glucose should be monitored 15 and 30 minutes after administration of insulin/ glucose and then hourly up to 6 hours after completion of administration as delayed hypoglycaemia is commonly reported when less than 30g of glucose is administered with insulin. Urea and electrolytes should also be monitored at 1, 2, 4, 6 and 24 hours after last administration of insulin/ glucose.

Please click on this **link** to download the recently updated GAIN guidance on the 'Emergency Management of Hyperkalaemia in Adults' guidelines in line with Renal Association guidance, particularly to reflect these changes in monitoring requirements when treating hyperkalaemia. The Belfast Trust **Policy for the Treatment of Hyperkalaemia in Adults can be download from the Belfast Trust HUB via clicking on this link.**

The updated GAIN guidance also includes changes made following this incident to emphasise on the 'How to make up 10 units of Actrapid® (soluble) insulin in 50 ml glucose 50% vial using the hyperkalaemia kit' the dose of insulin to treat hyperkalaemia is 10 units. **Use of the hyperkalaemia kit and the Belfast Trust Policy for the treatment of hyperkalaemia in adults should be included in Medical, Nurse and Pharmacy staff induction.**

Guidance On Service User / Family / Carer Engagement In SAIs

Guidance from HSCB on Service User / Family / Carer engagement in SAIs is now available and can be downloaded from the Belfast Trust HUB via clicking on this **link**. This valuable aid to staff includes the following:



- The principles of being open with Service Users / Families / Carers
- Details the various stages of engagement from recognition that a SAI has occurred to the conclusion of the process
- Provides clear step by step advice on the procedures to be followed when staff are communicating with Service Users / Families / Carers
- In addition, a leaflet (Appendix 2 of the guidance) will assist Service Users / Families / Carers who are involved in the SAI process.

We would ask that you arrange for this guidance to be disseminated to all staff in your areas who have the potential to communicate with Service Users / Families / Carers following an incident. The HSCB have said that guidance will be reviewed after one year, taking account of feedback on its use, to ensure it remains fit for purpose.

Revised Belfast Trust HUB Page for Standards Quality and Audit Department

The Belfast Trust Standards, Quality and Audit Department provide advice, support and assistance to colleagues throughout the Belfast Trust in improving the standard of care provided through:

- Supporting Health and Social care Audits and Quality Improvement Audits. This includes co-ordination of national and regional audits and providing advice and support for locally initiated projects
- Development of Belfast Trust Standards, Guidelines, Care Pathways and Policies
- Co-ordinating participation in RQIA inspections
- Dissemination, implementation, monitoring and assurance of guidance from external sources to the Belfast Trust for example NICE, DHSSPSNI, NPSA, PHA.

More information regarding these services can be downloaded via clicking on this link to the revised Belfast Trust HUB Page for the Standards Quality and Audit Department.

Revised Belfast Trust Quality and Audit Proposal Form / Policy

Staff carrying out an Audit, a Service Evaluation or a Continuous Quality Improvement Project should register their project with the Belfast Trust Standards Quality and Audit Department using the New **Project Proposal Form** which can be downloaded from the Belfast Trust HUB via clicking on this **link**.

The Proposal Form can be submitted by post to the Standards Quality and Audit Department, 4th Floor, Bostock House, Royal Hospitals, Grosvenor Road, Belfast, BT12 6BA or by sending a request to the following email address:

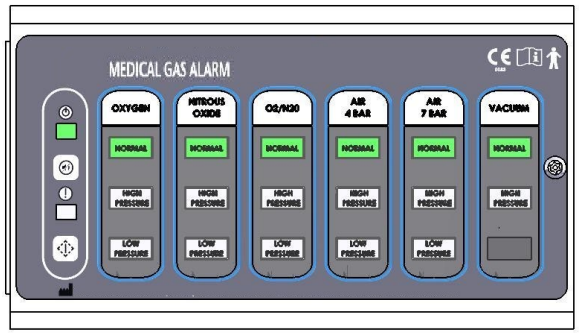
quality&audit@belfasttrust.hscni.net

Audit activity within the Belfast Trust is reported on every six months to the various Directorates as appropriate. Therefore **it is essential all projects are registered with the Standards Quality and Audit Department.** Completing a Project Proposal Form also gives staff the opportunity to request support (if required).

The Standards Quality and Audit Department can assist with every facet of the Audit / Quality Improvement process from planning and project management through to the presentation. The Department also provide formal Clinical Audit training sessions which can be booked through HRPTS.

Further information relating to Audit and Quality Improvement can be found in the recently updated Belfast Trust Quality Improvement and Audit Policy which can be download from the Belfast Trust HUB via clicking on this **link**.

PROCEDURE FOR DEALING WITH MEDICAL GAS PIPELINE EMERGENCIES including FIRES



Medical Gas Alarms

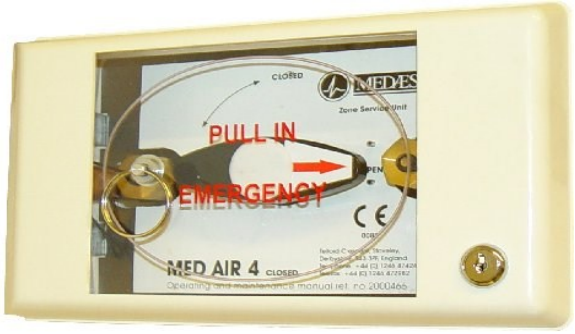
- If Alarm sounds phone Switchboard (0) and tell them the location of the alarm and what the message on the panel says (High Pressure, Low Pressure)
- Switchboard will then contact Estates who will address the cause of the alarm
- Contact the Patient Flow Manager (bleep 2288) if necessary and advise them of the alarm.
- Alarm sound can be muted after contacting Switchboard/Estates but if the alarm condition is not rectified it will alarm again after 15 minutes

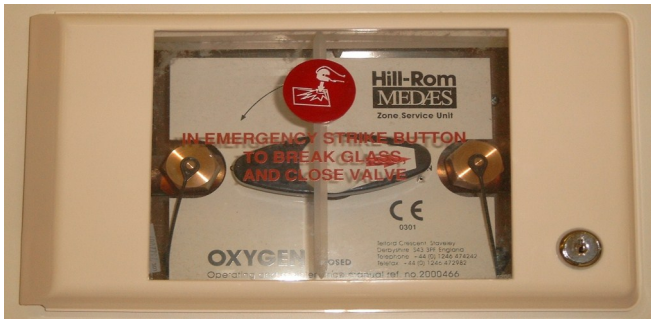
NB During the routine daily fire check ensure that there is a **NORMAL** light on the **ALARM** panel, no light also means a failure or fault.

Pipeline Supply Emergency including Fire

In the event of a fire that cannot be dealt with locally or a pipeline supply emergency (e.g. damage to a medical gas outlet such as a flowmeter or pendant hose) the gas supply may need to be isolated

- Identify the correct valve unit for the appropriate gas (Oxygen, Medical Air, Nitrous Oxide)
- Be aware of what areas each valve supplies and inform other wards/ departments of the shutdown if necessary
- Break the glass panel as indicated on the valve unit and turn the valve lever one quarter turn to OFF
- Notify Estates via switchboard as to the nature of the problem, as detailed above.

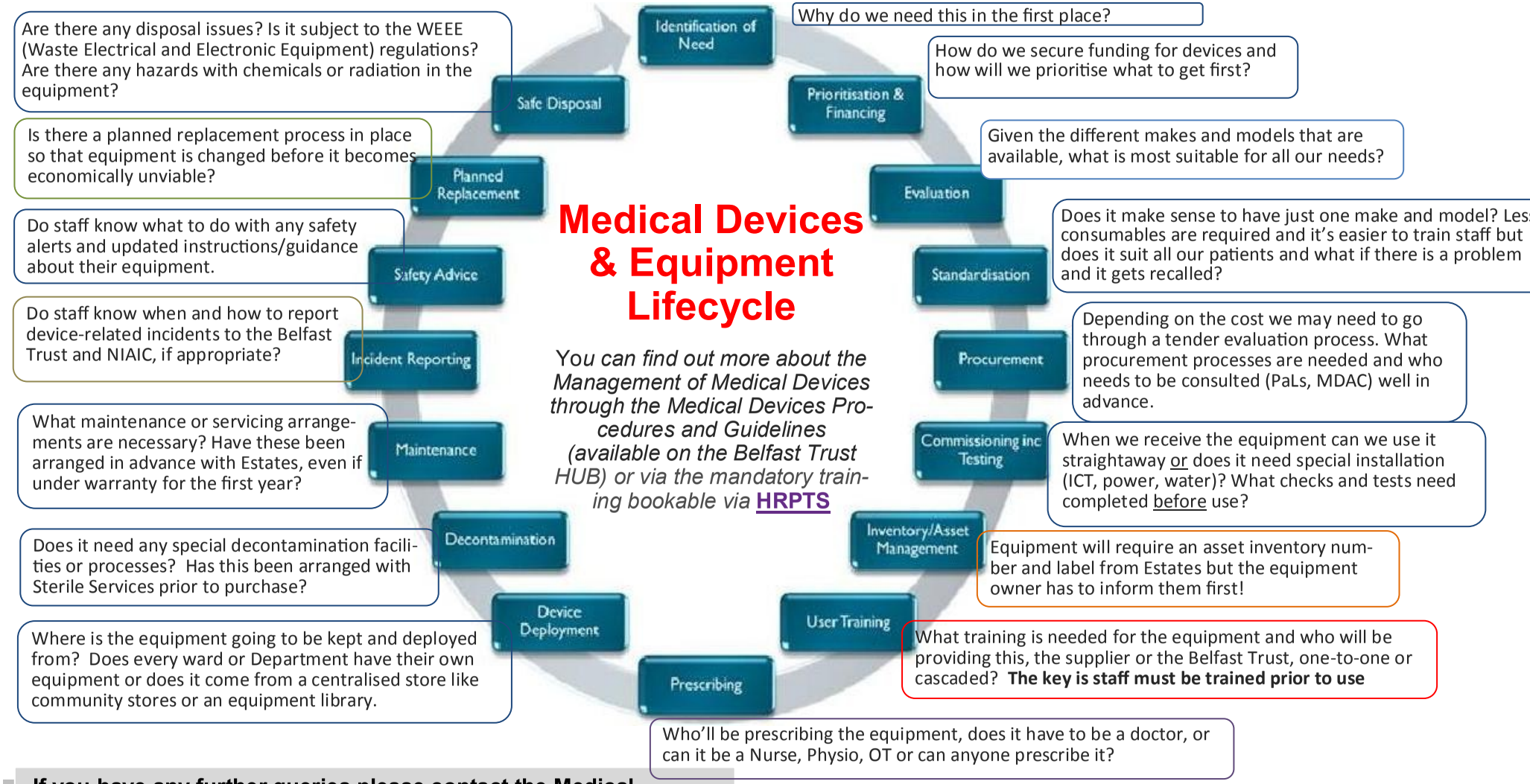




INQ

What Do We Need to do Next? The Lifecycle of a Medical Device

It's important to think about **all** aspects of its lifecycle from evaluation through to final disposal. Although this is usually primarily the concern of a manager or DEC (Department Equipment Controller), it is useful that all staff should have an awareness of the path, as illustrated in this diagram.



If you have any further queries please contact the Medical Devices Team within the Risk and Governance Department

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Good Record Keeping - A Simple Guide (download poster here)

Good record keeping remains a key requirement from SAI reviews and is a key issue for our Trust. By keeping to this simple guide you can improve clinical standards; protecting not only patients, but also yourself in the face of an incident / complaint investigation, inquest or clinical negligence claim.
Source: Hill Dickinson