CQM

NHS
East of England Ambulance Service
NHS Trust

ClinicalQuality**Matters**

Serious Incidents special

Winter 2020

#WeAreEEAST

Safe decisions, safe patients

Many incidents are reported every day by Trust staff and this helps us to identify when things don't quite go to plan. Importantly, it helps us learn from incidents to try to prevent them from happening again.

Thank you for continuing to report – it helps keep our patients and staff safer.

The Trust's patient safety specialists review all incidents on a daily basis. They flag some of them which they would like to take a further look at to see whether they may meet the criteria for a serious incident (SI). When the incident is flagged, the patient safety specialists call it a potential serious incident i.e. further information needs to be gathered to confirm one way or the other.

As you can imagine, just as much learning can be achieved from a potential SI as can be from a confirmed SI.
You may be invited to attend a roundtable review event with members of the clinical team. This is a completely blame-free environment where you are supported to identify what happened and attempt to work out why it happened. We aim to learn lessons and support you through any anxiety you have.

The patient safety team reviewed 90 potential SIs recently as part of ongoing work to ensure we maximise learning. Themes of incidents were identified and this special edition of Clinical Quality Matters is written to inform everyone of the considerations and the lessons that can be learned from such incidents.

Paul Gates
Deputy Clinical Director – Clinical/Consultant Paramedic

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Contents

Unrecognised fractures: almost exclusively lower limbs

By Rob Riches: Clinical Lead - Trauma and Critical Care & Anthony Brett - Patient Safety Lead

We all want to do the best for our patients and therefore it is essential that we ensure our musculoskeletal (MSK) assessment is thorough and identifies any injuries sustained. The impact of not identifying injuries is that delayed recognition of a fracture can result in malunion, embolic *complications, loss of function and infection. It is vital that we take a systematic approach to MSK assessment*, informing the patient of our findings and suggested treatment plan. Patients who are not conveyed to the Emergency Department (ED) should receive clear worsening advice which should also be clearly documented in the patient care record.

In the absence of any life-threatening injuries, we rightly often give priority to ensuring that the patient is comfortable. In the case of attending a faller, this may be partly achieved by assisting them from the floor. However, moving our patients should not be done before, or at the expense of, completing a full secondary survey and functional enquiry. This is an important way to ensure that any less obvious injuries are detected or ruled out (acknowledging that clinical examination will not detect every injury) before moving the patient and potentially exacerbating any injury.

A physical examination of the patient's limbs must also be completed prior to moving them from the floor. Important factors to specifically assess include:

- A visual inspection of the limb(s) to identify any bruising, swelling or haematomas or deformity. Palpate for any localised pain starting away from any areas of pain described by the patient.
- Assess sensation and circulation in each limb, paying particular attention to presence/absence distal to any pain or injury.
- Assess the active/passive range of movement and mobility of any affected limbs.
  This may include the mobilisation of joints to test their normal limits. Ligamentous and/or tendon injury should be considered, and joint laxity may be assessed if trained to do so.
  Muscle power can also be assessed 0-5 in each limb independently.
- Feel for any increased heat and palpate any areas of pain for obvious abnormalities.

Any deficit in these assessment criteria which are new for the patient post-fall, should result in further investigation, which may require admission to the ED.

After undertaking a thorough physical examination and history, it may be considered appropriate to mobilise the patient (should no abnormalities be detected in either of the above phases of the assessment which may be exacerbated by weight bearing).

Analgesia is essential to a good patient experience and should be considered and approached in a stepwise manner once an adequate level of information has been established. In a recent annual unexpected outcome review, a significant number of the cases reviewed did not have a pain score recorded, or were in the reviewer's opinion, not adequately analgised. 34 cases reviewed (where injuries were identified) specifically highlighted one of three areas of learning relating to pain management, which were; omission of any pain score, analgesia not adequate or analgesia omitted entirely.

Often intravenous paracetamol was the sole analgesic agent for orthopaedic injuries, even in the case of severe pain reported by the patient. This is not likely to have impacted patient outcome, however, will have a significant impact on the patient's pre-hospital experience.

It is essential that we assess and record pain scores and then administer appropriate analgesia with consent from the patient, especially in children and elderly patients.

Recent example of incident

A 93-year-old female patient fell from standing, causing pain in her leg. She was attended by a crew who did not follow a best-practice approach to undertaking a full secondary survey or mobility assessment.

The patient was discharged at her residential home where the carers subsequently struggled to mobilise the lady.

A second attendance one day later found her to have signs indicative of a fractured neck of femur despite the patient having not mobilised or fallen since the first attendance.

The patient was later confirmed to have suffered a fracture.

If injuries have been sustained through falling, a full history of the fall should be taken so that the mechanism of injury and any forces involved are understood, considering the patient's individual physiological reserve. Traumatic mechanisms in an elderly or frail patient require much less force to cause significant injury. Thus, full, and relevant history-taking forms a large part of individualised risk stratification when assessing any patient, including the reason for the fall occurring in the first place. We should all approach MSK examinations in elderly patients with a healthy level of assumption that injuries have been sustained. General questions about the fall could be asked, such as:

- What happened before the fall?
- Where and when did you fall?
- Why do you think you fell?
- How many falls have you suffered recently?

If the patient is in pain, questions should focus on the type, location, and severity of the pain, as well as if the pain is new, existing, or exacerbated post-fall.

Mobility is another key area of assessment. Knowledge of the patient's normal mobility is essential to give you a baseline from which to work when they are eventually mobilised. One pitfall observed

through incident investigations relates to the assessment of those who have pre-existing mobility issues. If the normal condition of the patient is not fully understood through thorough history taking, new mobility issues may be missed by assuming that they are pre-existing. Clinical curiosity will generally differentiate new from pre-existing issues, make sure you document this assessment and the information you have gathered to make this judgement. To assess the patient's mobility, they should be asked to walk a few steps, turn, and walk back (using a mobility aid if this is normal for them). If the patient's mobility or ability to bear weight is worse than normal, further assessment at an appropriate facility (likely to be ED) is required.

If the patient does have a painful injury, do not forget that this can mask other injuries. We should be particularly mindful of this when assessing elderly fallers with limb injuries.

The following case is an example where distracting injuries can result in missed injuries. A 74-year-old female who had fallen from standing at home. The patient had a fractured wrist identified by the attending crew, which was placed in a sling. The attending clinicians had assessed the patient and concluded there was no new spinal pain, but that the patient had new hip pain without shortening or rotation noted. The patient was moved to the DSA on a carry chair with their arm in a sling, the patient's own analgesia was administered (co-codamol). Following CT imaging the patient had the following injuries identified: Lumbar vertebral body fracture NFS; Pelvic ring fracture, isolated not destroying integrity of pelvic ring; Radius shaft complex fracture; Ulna distal Fracture.
The lesson here is to look beyond the obvious injury, to avoid suboptimal management of unidentified injuries. It is also key to ascertain the patient's previous medical history; diagnoses such as osteoporosis or previous limb surgery may increase the chances of an injury being sustained in a fall. Periprosthetic fractures may be caused by very little trauma.

Further reading:

Ottawa knee and ankle rules
https://jrcalc-web.netlify.app/#/tab/dash/guideline/G0580

NICE—sprains and strains
https://cks.nice.org.uk/topics/sprains-strains/diagnosis/assessment/

NICE—Fractures (complex): assessment and management
https://www.nice.org.uk/guidance/ng37/resources/fractures-complex-assessment-and-management-pdf-1837397402053

Emergency Medical Journal — Assessmemt and care of musculoskeletal problems
https://emj.bmj.com/content/emermed/22/1/68.full.pdf
https://emj.bmj.com/content/emermed/22/1/68.full.pdf

Safe conveyance of mental health patients

By Duncan Moore — Clinical Lead (mental health)

Conveying patients presenting with mental health need or distress can at times seem quite daunting. Our natural responses as ambulance clinicians are at times challenged, as concern regarding any behavioural patterns or actions that may place your patient or others at risk come to the forefront of our minds.

Historic stigma exists, and we may consider that there is elevated risk with this patient group.

The evidence, though, does somewhat refute this https://jech.bmj.com/content/70/3/223.

Such stigma may present as an unconscious bias at times which impacts on our care delivery within the softer skills element of our practice. The fear, real or unfounded around the aggression in this patient group can be managed on our part by adopting an open approach around the distressed person.

Recent example of incident

A crew attended an acute hospital to undertake a mental health transfer to a specialist unit.
Few details were given to the crew and no further history was asked for from the acute hospital staff.
The journey started uneventfully and the patient appeared calm and non-communicative.
During the journey, the patient suddenly removed his seatbelt and attempted to leave the ambulance via the side door.

Fortunately, the driver was aware of the situation and managed to bring the ambulance to a near stop before the patient jumped from the door.
An off duty police officer witnessed the events, was able to detain the patient, and the journey continued as planned.

Adopting an empathic rather than a sympathetic approach https://www.youtube.com/watch/KZBTYViDPlQ is a good start point, reflecting on one's own non-verbal body language will also assist; remember the value of appropriate eye contact and gestures that emit a calming message to a distressed patient. Patience and adopting active listening will support the development of a rapport to reduce and defuse a potentially volatile situation. Matching your verbal communication to this methodology will further enhance the patient contact and lessen any potential escalation in behaviour.

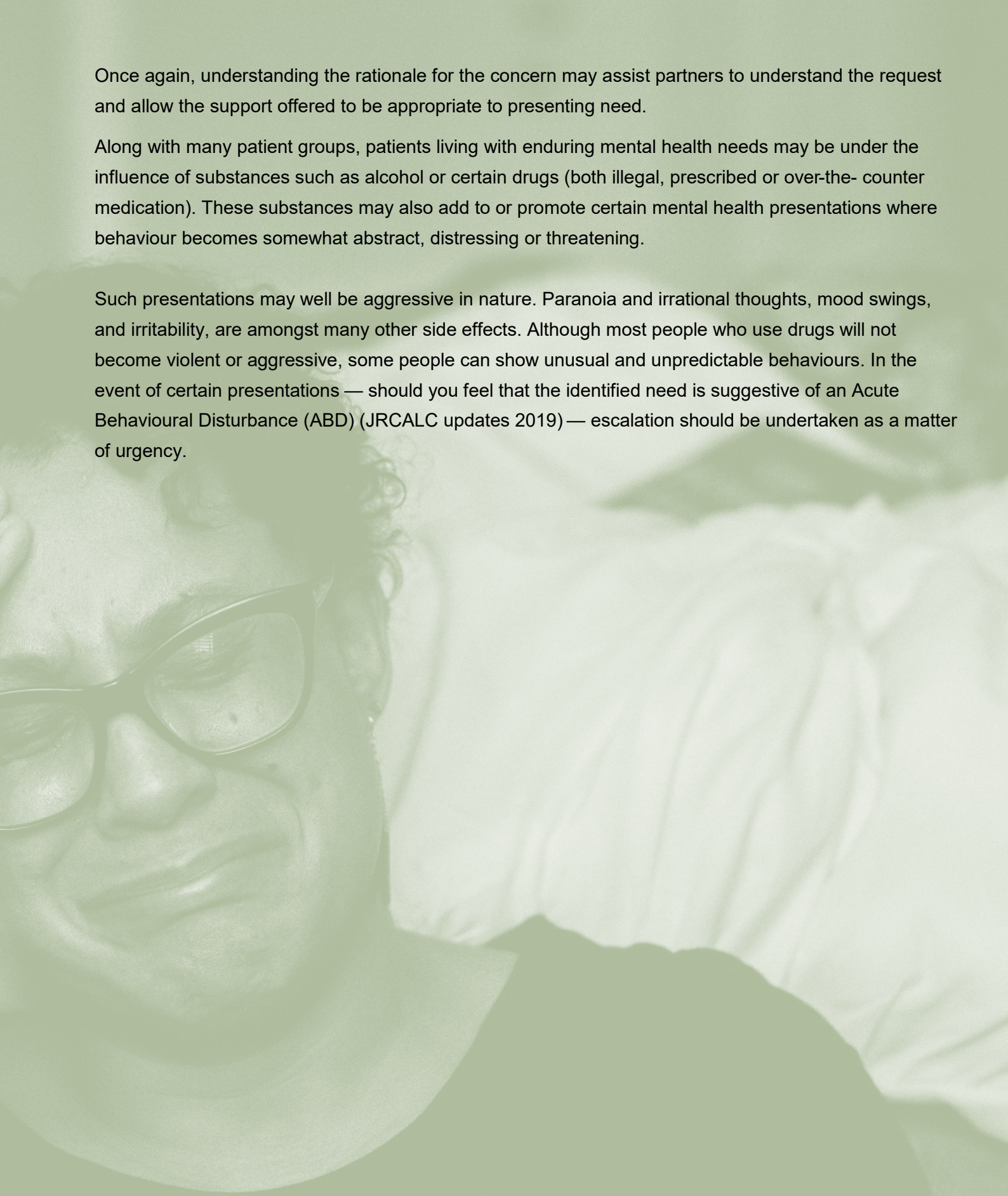
In respect to the practicalities around the conveyance, consideration should be made to the needs of the patient presenting. If associated physical health needs are present, these, where possible, should be addressed as required. If the patient's need is specific to mental health, then considerations around patient involvement and engagement should be offered as it would be with a physical health presentation. Offering such parity may support the points highlighted earlier and allow ownership to be passed to the patient. Reducing anxiety and distress by this action may also further support safe conveyance as the patient may feel they have regained a degree of control over the situation.

In a small group of patients where the presenting risk *does* require additional support and resourcing, a discussion should be undertaken with relevant parties prior to conveyance.

Once again, understanding the rationale for the concern may assist partners to understand the request and allow the support offered to be appropriate to presenting need.

Along with many patient groups, patients living with enduring mental health needs may be under the influence of substances such as alcohol or certain drugs (both illegal, prescribed or over-the- counter medication). These substances may also add to or promote certain mental health presentations where behaviour becomes somewhat abstract, distressing or threatening.

Such presentations may well be aggressive in nature. Paranoia and irrational thoughts, mood swings, and irritability, are amongst many other side effects. Although most people who use drugs will not become violent or aggressive, some people can show unusual and unpredictable behaviours. In the event of certain presentations — should you feel that the identified need is suggestive of an Acute Behavioural Disturbance (ABD) (JRCALC updates 2019) — escalation should be undertaken as a matter of urgency.



Management of patients with abdominal pain

By Daimon Wheddon – Clinical Lead

Abdominal pain is a common complaint in pre-hospital medicine. It affects nearly every person at least once in their lifetime independent of age, gender and social background and it is often not possible to reach a definitive pre-hospital diagnosis without further tests and diagnostics. Various factors can obscure the presentation, delaying or preventing the correct diagnosis, with subsequent adverse patient outcomes. It is estimated that approximately 25% of patients contacting the ambulance service with abdominal pain will have serious underlying conditions.

Clinicians must consider multiple diagnoses, especially those life-threatening conditions that require timely intervention to limit morbidity and mortality. It is therefore essential that we understand the red flags which require urgent attention and should share decision-making with a senior clinician when considering discharging patients with this challenging symptom.

Symptoms may be acute (an 'acute abdomen'), or chronic. There are many possible causes and often it is not possible to reach a diagnosis in pre-hospital care. The clinician should try to obtain as complete a history as possible as this is generally the cornerstone of a working diagnosis. The history should include a complete description of the patient's pain and associated symptoms. Medical, surgical, and social history should also be sought as this may provide important information.

Whilst the list is not exhaustive, it highlights some of the common examples for further information on the characteristics and associated symptoms

Acute Conditions (examples)	Chronic Condition (examples)
Appendicitis	Inflammatory Bowel Syndromes
Abdominal Aortic Aneurysm	Irritable Bowel Syndromes (IBS)
Intestinal Obstruction	Intra-Abdominal Malignancy
Diverticulitis Disease	Gastric and Duodenal Ulcers
Pancreatitis	Crohn's Disease/Ulcerative Colitis
Gynaecological Disorders	Hepatitis
Peptic Ulcer	Indigestion
Gastroenteritis	Constipation
Cholecystitis	Coeliac Disease
Ureteric Colic	Menopause
Abdominal Migraine	
Ischemic Bowel	
Infective Diarrhoea	
Peritonitis	
Torsion of the Testes	
UTI	

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please see JRCALC Clinical Guidelines 2019- page 151: https://jrcalc-web.netlify.app/#/tab/dash/guideline/G0190

Several recent Serious Incidents (SIs) and opportunities from Learning from Incidents (LFIs) have highlighted the importance of establishing the nature, location and pattern of pain when completing your assessment, together with associated symptoms that may indicate possible cause.
Whilst many causes of abdominal pain can be self-limiting, it is important that we recognise the risks associated with abdominal pain, the conditions that require further input and those that need more urgent lifesaving interventions.

It is worth highlighting that some patient groups may present with atypical symptoms for example alcohol dependence, immunosuppressed patients, and the elderly. In patients >65 years there is a 6-8 times higher mortality rate due to atypical presentations and presence of co-morbidities therefore a risk based management approach should be always adopted.

Red flag symptoms for abdominal pain may include the following

- Sudden onset abdominal pain
- Haematemesis
- Unexplained weight loss
- Change in bowel habit for > 3 weeks
- Unexplained PV bleeding
- Post-coital bleeding
- Shortness of breath
- Dysphagia
- Increased vaginal discharge
- Bloodstained vaginal discharge
- Pre-syncopal symptoms
- Haematuria
- Fever
- New onset dyspepsia
- Persistent unexplained vomiting
- Amenorrhoea
- Testicular pain
- Pain that awakens patient
- Blood in stool or urine
- Jaundice
- Oedema
- Abdominal mass or organomegaly

Potentially life-threatening diagnoses

- AMI
- Perforated viscus
- Ruptured abdominal aortic aneurysm
- Ectopic pregnancy
- Acute pancreatitis
- Acute cholecystitis
- IBD
- Renal stone
- Bowel obstruction
- Diabetic ketoacidosis
- PID
- Incarcerated inguinal hernia
- Pyelonephritis
- Ischaemic colitis
- Acute hepatic failure
- Appendicitis
- Diverticulitis

Cont.

Assessment and management should include:

- Assessment of <C>ABCD
- Examination
- History
- Known congenital or pre-existing conditions
- Associated symptoms
- Differential diagnosis
- If female of childbearing age consideration of other causes
- Base Line Observations
- NEWS2 score
- Adequate assessment of the patient's pain and adequate pain relief
- Shared decision-making if leaving patient in community
- Transfer to further care
- Documentation

Recent example of incident

A 49-year-old patient with learning disabilities was attended and recorded to be suffering with 10/10 abdominal pain.

The patient was also tachycardic and the patient's carers had voiced concerns that the patient was behaving abnormally for her.
The patient did not have mental capacity to make decisions about her own healthcare.

The patient was discharged with advice to see the GP and no analgesia was given.

The carers reported that they felt coerced into remaining at home. The patient was reattended four days later after a GP had visited the patient.

The patient was conveyed to hospital where she was found to have a bowel obstruction.

For the further management and assessment of abdominal pain please see JRCALC Clinical Guidelines 2019- pages 152-158 https://jrcalc-web.netlify.app/#/tab/dash/guideline/G0190

For all patients with abdominal pain being left in the community clinicians **must** adopt shared decision -making and discuss with another healthcare professional such as GP or OOH GP due to the complex nature of the presentation and potential for implications for missed diagnosis.
If you are unable to directly discuss with an HCP, please contact Clinical Advice on 01234779203.

Key points:

- Ensure that you have undertaken a thorough and full patient assessment and document your findings
- Pre-hospital diagnosis of the cause of abdominal pain is challenging and often not possible without access to investigations and tests in hospital or via primary care
- The important diagnoses to consider are those that are life-threatening - either as a result of internal haemorrhage, perforation of a viscus or sepsis
- For patients with upper abdominal pain, older patients and patients with a cardiac risk - always obtain a 12-lead ECG
- An assessment of a patient's pain should be conducted and documented: If a patient is in pain, adequate analgesia should be given
- Adopt a shared decision making model when considering leaving patients in the community
- Ensure adequate safety-netting, red flags symptoms and worsening conditions are discussed with the patient and documented if leaving patients in the community.

References and further reading

https://academic.oup.com/fampra/article/31/5/517/537129

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3468117/

https://patient.info/doctor/abdominal-pain-pro

www.gponline.com/red-flag-symptoms-abdominal-pain/gi-tract/gi-tract/article/1098647

https://jrcalc-web.netlify.app/#/tab/dash/guideline/G0190

https://jrcalc-web.netlify.app/#/tab/dash/guideline-cmgl/-102733

https://pubmed.ncbi.nlm.nih.gov/24449533/

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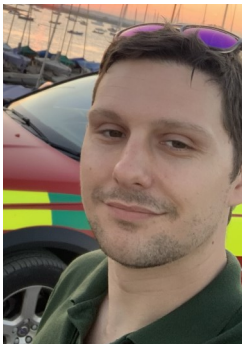
Drug administration

By Dan Phillips – Clinical Lead & Amy Godfrey – Senior Pharmacy Technician Manager



When preparing to give a patient any drug, the following process is best practice.
A SOP has been created to cover all aspects of Drug Medication administration.

Identify the correct drug and dosage by looking in the Clinical Practice Guidelines (JRCALC).

- Find the appropriate drug in the drugs bag.
- Check to ensure the packaging is intact and the drug is in date.
- Check that there are no other obvious defects with the drug presentation
- Check with your crew mate:
  - ⇒ Drug name
  - ⇒ Expiry date
  - ⇒ Intended dose
- Ensure your crew mate reads back to you what the drug is rather than you tell them – this reduces the risk of confirmation bias. For example, you can ask the person checking the drug to tell you what it is, and when it expires.
- Prepare drug for administration, double checking the route that it should be given.

This procedure must be used to check a drug prior to administration. There are no acceptable exceptions.
In circumstances where it is *physically not possible* to check the drug with someone, additional vigilance should be taken prior to administration.

We all know that errors can occur and often there are multiple factors that lead to the error occurring.
However, errors occurring due to basic safety checks not being carried out are not acceptable.
These can easily be avoided by following the training we have all had and following the processes that have been standard practice in health care for many years.

Please also see the Medicine Management SOPs

Recent examples of Serious Incidents

IM drug given IV.
Since January 2020 there has been three incidents recorded where adrenaline 1:1000 has been given IV instead of IM.
These are from across the Trust with no two locations the same. All three had different patient groups and presented with different clinical issues. All three had lessons learnt: one with a CVP identifying that gross error checking and the stress and emergency nature of the presentation led to a loss of situational awareness and the error occurring.

Diazepam given instead of ondansetron
A patient required an antiemetic, due to nausea and vomiting. A staff member was asked to draw up antiemetic but unfortunately did so without carrying out the proper checks discussed here.
Diazepam Solution was drawn up instead. The expiry date was then checked with a colleague but unfortunately not the drug name. The diazepam (full dose) was given to patient who deteriorated and lost consciousness.
This was treated accordingly by the crew but they were unaware of a cause of the reduced consciousness as they were still unaware of error. The error was identified when recording administration in the drug book and totals did not match. Unfortunately, no record of lessons being learnt have been documented in the Datix and the Datix was closed.
The medicines management team therefore had to follow up to ensure correct processes were followed.

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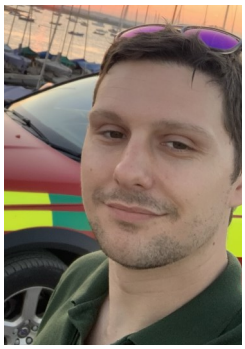
Discharging/non-conveyance of patients on-scene



By Daniel Phillips - Clinical Lead

The discharging/non conveyance of patients at scene is one of the highest-risk activities pre-hospital clinicians undertake. While it is true most decisions to discharge patients are safe and effective and the appropriate course of action for the patient. Discharging/non-conveyance is also a consistent theme of complaints, incidents, and serious incidents.

As the population ages, the number of complex co-morbid patients increases along with expectations that their complex chronic long-term conditions will be managed in the community, rather than secondary care. Patient expectations change and some patients do not wish to go to hospital.

In some cases specialist input is required. This may not be the local hospital; they may be required to transfer to a specialist unit and a hospital further away.

There are some principals that, if followed and, importantly, are always given consideration in these situations that can help reduce the risks associated with discharging/ non-conveyance.

It is sometimes inferred that the patient refused to go to hospital, but further investigation indicates that the patient had not been able to make a fully informed decision. This is not because they lacked capacity but because they had not been fully informed of the risks of *not* going to hospital. For consent to be valid the person must have all the information as to why something may be done or why it may not be, they must be able to repeat that in a way that indicates understanding and their questions have been answered.

Additionally, the following points must all be considered when discharging a patient from our care (clinician-led decision):

- Full and detailed history of the patient's chief complaint must be systematically gathered using appropriate open and closed questioning techniques. Alongside this, establishing the patient's previous medical history, drug history and allergies, social and family history is crucial.
  During this process all potential red flags should be identified, considered, and ruled out.
  Targeted questions should be used to investigate these. All information gathered must then be contextualised with the chief complaint and reasons for the call. This must be documented in detail on the patient care record.
- All relevant clinical examinations must be undertaken, considered in the context of the history taken, and documented.
- Observations should be recorded and analysed for trends of improvement or deterioration during the care episode.
- Risk stratification tools should be used (NEWS2, Well's score, non-conveyance check list).
- Differential diagnosis must be considered and "worst ruled out first". Do not diagnose or form a clinical impression when a more serious pathology cannot be ruled out i.e. chest pain is always cardiac or PE before it is muscular, you must be sure!

- Safety netting must be put in place and clearly documented on the patient care record and any documentation left with the patient.
- Relevant, detailed, and specific worsening advice must be given and documented.
- Newly qualified paramedics and other staff groups as required, must adhere to discharge of care protocols relevant to their roles.
- Decisions should be shared and referrals made to another healthcare professional, including the use of the clinical advice line.

Where a patient refuses treatment and transport (patient led decision), the above bullet points remain relevant; in addition:

- A mental capacity assessment must be completed and fully documented.
- Clinicians must fully inform the patient of all risks associated with the condition they are presenting with and their decision not to follow medical advice for transport to hospital.
- If a patient is reluctant to attend further healthcare, you must differentiate this from a refusal. A patient expressing a wish not to go to hospital is not the same as refusing and going against medical advice. Patient choice is important, but does not override clinical need.
- Decisions must be shared with another healthcare professional, including the use of the clinical advice line.

Further reading:

https://ntk.eastamb.nhs.uk/Documents/Downloads/Clinical%20update%20-%20newly%20qualified%20paramedic%20clinical%20support%20guidelines%20-%2001.04.17-1.pdf

https://ntk.eastamb.nhs.uk/CQM%20Autumn%202020%20-%20Non-Conveyance%20FINAL.pdf

https://patient.info/doctor/consent-to-treatment-mental-capacity-and-mental-health-legislation

http://east24/Policies%20and%20Trust%20Instructions/Clinical/Safe%20Non-Conveyance%20and%20Discharge%20Policy.pdf

COVID Note:
At the present time, no changes have been made to affect clinical decision making due to the global pandemic. Please refer to the COVID-19 clinical decision-making tool for further information

Further recent examples of incidents, reports along with lessons learned can be found on station in SI folders or via your AGM if you wish to read further:

- The discharge of a patient having suffered neurological symptoms and being assessed as having suffered a transient ischaemic attack. Later attended the same patient following a deterioration in GCS. No referral of care to another healthcare professional.
- Discharge of a patient with ECG changes. Patient was not fully informed of the danger of not being further assessed. The patient was conveyed the following day after deteriorating but sadly died at the hospital shortly after arrival.

Both above examples could have been avoided had the above suggested steps been followed.

Attending calls to children

By Lynda Steele - Deputy Clinical Director

Things to consider when attending calls to children:
Be professionally curious; get the whole picture…

- Ask when the child was last seen by a healthcare professional (e.g. GP, Midwife, Hospital Consultant).
- What was that visit for?
- Ask if they have been seen by any other professional (Social worker, nursery nurse).
- Ask how the child has been in recent days, how have they been today … what is their normal demeanour?

Chatting with the child and the parents, asking these key questions, whilst undertaking routine assessments can be the key to identifying something that raises a flag, even where observations are within normal range.

It is good practice to call another clinical professional, for instance CAL or GP, if you are intending to leave the child at home. A second person checking you have asked all the right questions will assist in developing the most appropriate care plan for the child's presenting condition and circumstances.

Following your discussion with others if the clinical decision is to leave a child at home.
Make sure the family understand that they can call 999 if the child's condition changes and that they can take the child to hospital if they remain concerned.

These are some guidelines that Ipswich Hospital have suggested to help us share information and make appropriate decisions. Other hospitals may have a slightly different approach:

- An infant under the age of 3 months (pre vaccination), with a temperature will require a septic screen in ED
- A paediatric patient that is administered salbutamol by EEAST needs to be monitored for four hours in ED
- A paediatric patient that has been given oxygen at any point, will be admitted to Paediatrics as soon as possible
- A baby under 28 days, will automatically be seen by the paediatric team.

Recent example of Serious Incident
A crew attended a non-mobile baby.
The patient was reported to be 'not with it, in a daze and gasping'.
Following a clinical assessment, which did not indicate any red flags, the patient was left at home with a recorded diagnosis of colic, matching the diagnosis given following his recent visit to hospital with the same symptoms.

The following day, the patient re-presented to the Trust following a seizure and was taken to hospital.
It was found that the child had bilateral subdural haematomas. It was found that, had shared decision making been deployed, it was more likely the child protection plan would have been identified and the child conveyed on the first occasion.

Here are a few points that have been raised based on recent experiences and are suggestions, *not* instructions:

- A child that is given salbutamol by EEAST
- A child that has had low Sp02 at any point
- A child with significant tachycardia eg. 180bpm+
- All significant tachypnoea or chest recession

Would benefit from *being brought in by an ambulance* (not in their parent's car).
If local to Ipswich Hospital, the paediatrics team are happy for you to call if advice is required.

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Active listening and history-taking

By Tim Hickey: Clinical Lead - Primary and Urgent Care

Many Serious Incidents (SIs) can potentially be avoided by listening actively to patients and the concerns which they bring to the conversation and consultation. Cases reviewed by the Patient Safety Team often see patient's concerns not being taken seriously — with avoidable harm resulting.

Recent examples include chest pain and difficulty in breathing being diagnosed as anxiety despite a reduction in SPo2, and the clinical significance of patients with increased joint or limb pain following trauma being missed. Such cases can lead to poor patient experience, deterioration, and long-term complications.

It is vital to holistically consider all elements of the care episode, such as history taking, clinical assessment, observations, investigations (such as ECG and blood glucose), and patterns of injury and illness, to make a sound clinical decision. Using a structured model of consultation can assist with this.

There are many different models of patient consultation in existence. Examples include the Phases of Consultation Model (Byrne and Long, 1976), the Disease-Illness Model (McWhinney, 1986), the Health Belief Model (Becker *et al*, 1974), the Seven Task Patient-Centred Model (Pendleton *et al*, 1984) and the Calgary-Cambridge Model (Kurtz and Silverman, 1996). Most have the aims of promoting patient-centred, efficient, healthy, two-way communication and information sharing between patient and clinician and establishing a list of relevant differential diagnoses before arriving at a mutually agreeable endpoint with a resultant clinical management plan (Denness, 2013) (Mehay *et al*, 2012).

The Calgary-Cambridge model is widely taught across medical education programmes and employed by clinicians across varying disciplines as it is practical and easy to follow, provides structure to clinician-patient interactions and helps build relationships.

Stage two of the Calgary-Cambridge model focusses on information and history gathering, including the biomedical reasons for the patient calling for help and their perceptions and ideas of the problem at hand (Munson *et al*, 2013). It is important during this stage of the consultation for the clinician to actively listen, allowing the patient to explain their story in their own words, thereby enabling a full and clear picture of the complaint to be formed (Munson *et al*, 2013).

Interruptions by those conducting the consultation may cause relevant or crucial information to be side-tracked or potentially even lost (Beckman *et al*, 1984). Be sure to use open questions and positive non-verbal communication techniques such as maintaining good eye contact, empathetic facial expression, and an engaged posture, nodding, and offering verbal agreeance where appropriate. This demonstrates that you are attentive, and that you are taking your patient seriously, helping to build and foster rapport and trust. The work of Byrne and Heath also supports the theory that eye contact, and good posture are influential in determining what the patient reveals during the consultation (Byrne *et al*, 1980).

The concerns of the patient and their family must be taken at face value. As such, ambulance clinicians should risk-assess the presenting condition and act appropriately. Serious injury or illness must be excluded – if this cannot be done the patient must be transported to an appropriate receiving facility for further clinical assessment.

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Support with complex clinical decisions is available via the Clinical Advice Line (CAL) if necessary.

Thorough history taking through a structured model of consultation, active listening, a good

understanding of signs and symptoms, the formulation of a list of differential diagnoses, and shared clinical decision making all assist in providing consistent, safe, and effective care for every patient.

Further reading:

https://patient.info/doctor/history-taking https://patient.info/doctor/paediatric-history

www.nursingtimes.net/clinical-archive/assessment-skills/communication-5-effective-listening-and-observation-skills-12-03-2018/

www.ems1.com/ems-education/videos/how-to-make-a-differential-diagnosis-PWHVMzPTcQlSB0JQ/
https://flippedemclassroom.wordpress.com/

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Byrne, P.S., Heath, C.C, (1980). *Practitioners' Use of Non-Verbal Behaviour in Real Consultations.* The Journal of the Royal College of General Practitioners. 1980;30(215):327–331

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Munson, E., Wilcox, A (2013). *Applying the Calgary-Cambridge Model* [Online].
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Thank you for reading CQM

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The next edition of CQM will be out in Spring 2021!

If you have an idea for an article,

please email communications@eastamb.nhs.uk

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