



Clinical Times

August 2011

FOCUS ON ASSESSMENT AND DOCUMENTATION



If you have any comments or would like to submit any articles to Clinical Times please contact Matt Brown, Governance Co-ordinator via email matthew.brown@wmas.nhs.uk or phone 01384 246436

Foreword

I am delighted to be able to present the fourth edition of the Clinical Times.

Well, I have been here for six weeks and I can honestly say that it's like moving to a new country. The language is different (not just the accent), the culture is different and there is a brand new set of customs to contend with. All that said I have been made to feel very welcome and I am really looking forward to the challenges that lay ahead.

I have arrived at a very exciting time, both managerially and clinically, with us advancing towards Foundation Trust and ensuring we are a well governed organisation. It is fundamental that the care delivered to patients is of the highest standard and frontline staff are supported in achieving this aim. At the top of my agenda, is my commitment, along with the Medical Director, to lead on, and ensure, patient safety remains a priority throughout the organisation.

The Clinical Times is designed to keep practitioners informed regarding changes in practice, share excellence and provide a glimpse into the future from a clinical perspective. I would welcome all clinical staff to give us feedback on the content, update us on your practice or highlight aspects of care you would like included.



Sandy Brown
Director of Nursing and Quality

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It's your ClinicalTimes how would you like it to develop?

If you would like to provide feedback on content, update us on your practice or highlight aspects of care you would like included please contact Matt Brown, Governance Co-ordinator via email

matthew.brown@wmas.nhs.uk

or phone **01384 246 436** in order for this to be passed onto the editors.

To register to receive both the Clinical Times and Weekly Briefing to your personal e-mail address please contact pressoffice@wmas.nhs.uk providing your name, base station and email address.

An Introduction to 'The Medical Model' of Patient Assessment

Christine Curtis – Regional Head of Clinical Practice

The Trust aims to implement a patient assessment tool for clinicians to use, which will enhance their ability to gain information and assess patients to a high standard. This in turn will support providing the depth of documentation of patient records required.

The system that is planning to be introduced is known as "The Medical Model"

The Medical Model has three parts:

1. History taking
2. Review of systems
3. Examination skills of systems

It is intended that the 2012-13 mandatory training plan will include training and assessment in the Medical Model.

This edition of the Clinical Times will introduce you to part one - "History taking", which principally relates to gathering information using:

- Subjective data (E.g. what the patient tells you)
- Objective data (E.g. What you detect during the history taking and information from your clinical observations and examination)

The next edition of the Clinical Times will introduce you to part two - "Review of systems" which is the questioning around the systems (E.g. Neurological, cardiovascular, respiratory etc.)

Training on part Three - "Examination of skills" will be developed with the Education and Training Department to support practical training in the future.

There is a DVD on clinical examination and patient assessment for your clinical professional development on the Virtual Learning Environment (VLE) on the intranet site.

Taking a comprehensive history, reviewing systems and conducting the relevant examination techniques will lead and guide the clinician in what to document, including pertinent negatives.

The Medical Model of Patient Assessment

Systematic Approach to History Taking

A detailed history is the foundation of obtaining information and has many advantages for us to deliver a high standard of clinical patient care. On documentation of a patient history, negatives as well as positives are beneficial within this process and should be documented. Adapting a systematic approach to gain a comprehensive medical history will enable a better view of the patient's condition and best treatment options available.

Identifying Data
& Source of
History

Age, Gender, Occupation, Marital Status. Do they live alone?
Hand domination (for upper limb injuries)

This history is usually provided by the patient but can be given by a friend, family member, a letter of referral or medical documentation.

Reliability of this information can be dependent on memory, trust, mood and overall situation.

Chief Complaint & Presenting Condition

There is often more than one symptom, or concern, which results in a patient seeking our advice:

- Quote the history of complaint or condition in the patient's own words i.e. "My stomach hurts and I feel ill"
- Time and date of onset of symptoms
- Onset – Gradual or of sudden (onset of symptoms or pain)
- Location
- Quality e.g. pain appears – e.g. full, sharp, stabbing or ache
- Severity - e.g. pain score
- Duration and Frequency - e.g. constant, comes and goes, on movement
- Aggravating and Relieving Factors - e.g. movement or breathing
- Associated symptoms
- Patient's thoughts and feelings should also be documented if they state any
- **Medication/Drugs to include** – PMO's, over the counter medication, herbal or illicit (e.g. other people's PMO's), recreational drugs (e.g. Heroin or weed)
Obtain dosage, route & frequency and when last taken.
- **Allergies** including reactions
- **Foreign travel** to include date and country

Past Medical History

Any childhood illness or adult illnesses with dates (e.g. Mumps 1999)

Split these into four sections:

- **Medical** – Diabetes, hypertension, asthma etc.
- **Surgical** – Operations, indications and history of specific trauma
- **Obstetric / Gynecologic** - Obstetric history, menstrual history, birth control
- **Psychiatric** – Diagnosis, hospitalisations and treatments
- **Immunisations** - Childhood, tetanus, Hep B.

Remember to log Dates.

Family History

Obtain information, including grand-parents, parents, siblings, children and grand children. Record any significant illnesses within the family such as:

Cardiac diseases, cancer, cholesterol, stroke & diabetes etc.
e.g. "Are there any illnesses within your family?" – "Yes my father and grandfather have suffered heart attacks in the past."

If parents are deceased what they died from and when? e.g. Mother died in 2010 from heart disease.

Social & Personal History

This information should include:

- Occupation, religious & spiritual beliefs
- Lifestyle habits – e.g. smoking – how many per day?
- Alcohol – units per week?
- Activities and daily living such as exercise and diet.

References: Bickley, L, S (2009) *Bates Pocket Guide to Clinical Examination and History Taking 6th Edition: China, Lipincott, Williams & Wilson.*

CQC Standards		
Regulation	Outcome	Outcome title
21	12	Requirements relating to workers
23	14	Supporting workers
20	21	Records

NHSLA Risk Management Standards for Ambulance Trusts 2011-12			
Standard	Standard title	Criterion	Criterion title
4	Clinical care	2	Health record keeping standards

Assessment and Documentation of Stroke – Achieving Clinical Performance Indicators (CPI's)

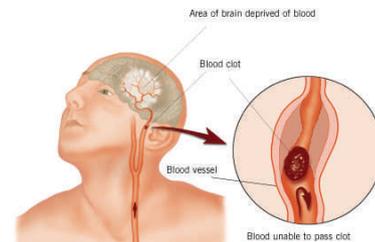
Matt Ward – Clinical Governance and Practice Manager

What are clinical indicators?

Clinical indicators have been developed in order to identify the adherence to current assessment and management guidelines for patients with specific conditions.

What clinical indicators are required for Stroke?

1. FAST assessment
2. Blood Glucose
3. Blood Pressure
4. Onset of Symptoms Time



These are core areas for all Stroke patients therefore we should be reporting at 100% in all cases.

Documentation on the Clinical Record

If any of the indicators are not met and there is a clinically justifiable reason why the indicator cannot be met, just record it on your clinical record.

For example:

- You may be unable to perform a FAST test due to the patient having suffered a previous neurological deficit
- The patient may not understand what you are asking them to do or they may be unconscious?
- The patient may refuse to have a blood glucose test

Clinically, by documenting these reasons it ensures that the hospital staff have a clearer picture of the patients condition prior to arrival in A&E and are able to plan further care required on this information. From a CPI reporting point of view, this ensures that the clinical audit team are able to record the correct results i.e. if the patient refuses (so long as they have mental capacity) to have their blood glucose measured this will be recorded as an exception and will not adversely affect the results.

Onset of Symptoms Time

Clinically, the onset of symptom time must be taken into account, where known, to enable you to determine if the patient is eligible for hyperacute assessment and thrombolysis.

If this is not documented (even though you may have considered the onset time in your plan of care) this will be recorded within the CPI's as though it has not been assessed, thus adversely affecting the results.

If the patient or persons present are unable to communicate accurate time of onset then:

- Onset of times will be when the symptoms were first noticed
- If the patient wakes up FAST +ve then the time of onset is when they went to bed
- If the patient is found FAST +ve then the time they were last seen is the recorded time

What should we be achieving?

Pre-alerting patients for Hyperacute Stroke Assessment.

All patients where FAST positive is found must be transported to an appropriate centre within 60 minutes.

FAST TEST

Facial weakness:

- Can the person smile?
- Has their mouth or eye drooped?



Arm weakness:

- Can the person raise both arms and hold them for ten seconds without any significant unilateral loss in power?

Speech problems:

- Can the person speak clearly and understand what you say?

Test all three:

If deficit in any one of the following tests and patient meets the criteria.

The following must be present:

- Onset of symptoms within 5 hours ***
- Positive FAST test.
- Conscious or easily rousable.
- No seizures/fits.
- Blood sugar ≥ 3 mmol/l

“BRING A WITNESS IF POSSIBLE”
Pre-alert Emergency Department saying

‘FAST POSITIVE STROKE PATIENT ONSET AT ---- HRS’

References:

- National Clinical Performance Indicators
- WMAS Clinical Guidelines for the Management of Stroke

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NHSLA Risk Management Standards for Ambulance Trusts 2011-12

Standard	Standard title	Criterion	Criterion title
4	Clinical care	2	Health record keeping standards
4	Clinical care	9	Stroke care
5	Learning from experience	1	Clinical audit

Documenting and Managing Stemi – Achieving Clinical Performance Indicators (CPI's)

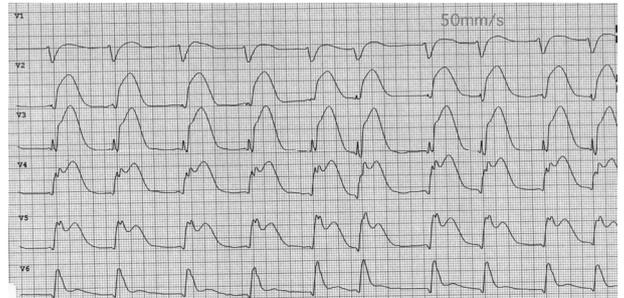
Matt Ward – Clinical Governance and Practice Manager

What are clinical indicators?

Clinical indicators have been developed in order to identify the adherence to current assessment and management guidelines for patients with specific conditions.

What clinical indicators are required for STEMI?

1. Aspirin administered
2. GTN administered
3. Two pain scores recorded
4. Morphine administered
5. Analgesia administered
6. SPO2 documented



What can I do to improve these?

Documentation on clinical record

Remember to record any pertinent negatives on the clinical record for example:

- Record any contraindication to drugs
- Reason why you have been unable to record two pain scores - including why the patient has refused to provide you with a pain score, or perhaps where the patient has been unable to provide you a patient score as they are unconscious or don't understand.

What should we be achieving?

PPCI – call to balloon in <150 minutes

Thrombolysis – call to needle in <60 minutes

PPCI 'v' Thrombolytic Therapy

Primary percutaneous coronary intervention (p-PCI) has become the treatment of choice for patients presenting with ST-segment elevation myocardial infarction (STEMI) when it can be performed expeditiously by an experienced team.

Within the West Midlands patients that can reach a PPCI centre within 90 minutes should receive the catheterisation within 30 minutes of their arrival.

This strategy has been found to be superior to thrombolytic therapy in improving morbidity and mortality. An important piece of information gained at the time of angiography and p-PCI is information not only about the culprit lesion but also about the extent and severity of the underlying coronary artery disease.

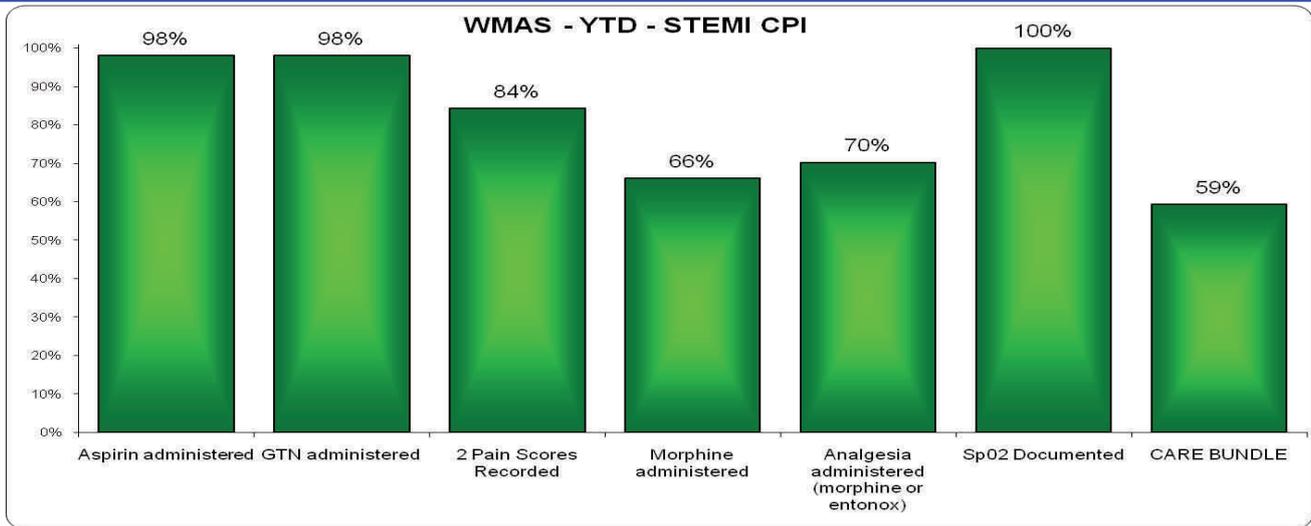
What's happening to pain scoring in the future?

Following a number of pain assessment workshops it was identified that it would be appropriate to introduce a pain scorer tool with a number of visual and descriptive aides to help identify the level of discomfort. A tool was developed and following approval will be introduced into the Trust.

Management of pain in Myocardial Infarction

The appropriate management of pain in Myocardial Infarction using Morphine helps the patient by:

- Reducing the pain experienced
- Reducing the stress experienced
- Reducing cardiac workload
- Reducing arterial spasm



References:

- Van de Werf, F, 2008. Management of acute myocardial infarction. *European Heart Journal*, 29, 2909-2945
- WMAS, Clinical Performance Indicators, May 2011

CQC Standards

Regulation	Outcome	Outcome title
12	21	Requirements relating to workers
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Clinical Team Mentors and Documentation Audits

Matt Ward – Clinical Governance and Practice Manager

The Clinical Team Mentors (CTMs) will be continuing to review patient records as part of the Clinical Performance and Documentation Audits.

Jenny Lumley-Holmes, Clinical Audit Manager has developed a database that allows the electronic recording of the audit. Supporting guidance is provided with reasons for the failure to document specific indicators such as:

- Clinical Performance Indicators
- Mental capacity assessment
- Medicines administration
- Non transportation information

CTMs will continue to provide feedback to staff and support the introduction of the medical model of assessment as it is introduced over the next 18 months.

References:

Clinical Records Policy

CQC Standards

Regulation	Outcome	Outcome title
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Emergency Services Dementia Guide Launched

Rob Cole – Regional Head of Clinical Practice

Walsall Primary Care Trust (PCT), West Midlands Ambulance Service and other partners have developed an Emergency Services Dementia Guide with input from mental health clinicians, learning disabilities clinicians and emergency services mental health leads. The guide has been developed to give front line emergency service personnel a better awareness and understanding of Dementia. The guide will be distributed to the police, fire and ambulance personnel through their respective services.

A copy will also be available for download via NHS Walsall's Dementia web pages and WMAS' intranet – Mental Health page: http://treble9.ad.wmas.nhs.uk/nursing_qual_prim_care/clinical_standards/mental_health.aspx.

Although it was originally designed for the Walsall area, it has since been modified for the West Midlands.

The Emergency Services Dementia Guide was developed as part of Walsall's implementation of Living Well With Dementia: A National Dementia Strategy. Its purpose is to raise awareness of dementia in emergency services and to offer personnel tips and strategies in caring for people with dementia whilst in their care, together with information about the Mental Capacity Act. In some parts of the West Midlands, two thirds of those people believed to have dementia have yet to be diagnosed. This guide lists the early signs of Dementia, and will be followed up by training in Dementia for ambulance service personnel.

More information on dementia can be found on the Alzheimer's Society website: www.alzheimers.org.uk

Dementia Facts

- Dementia describes different brain disorders that trigger a loss of brain function. These conditions are all usually progressive and eventually severe
- Alzheimer's disease is the most common type of dementia, affecting 62 % of those diagnosed
- There are currently 650,000 people with dementia in England
- 25 million people in the UK know a family member, close friend, or someone else with dementia
- Dementia costs the UK over £17 billion each year in care costs and hospital admissions
- Unpaid carers supporting someone with dementia save the economy £6 billion a year
- There are over 16,000 people under 65 with dementia in the UK
- Although dementia is a terminal condition, people can live with it for 7–12 years after diagnosis
- By 2025 there will be over one million people in the UK living with dementia

Early Diagnosis Facts

- In England, fewer than 40% of people with dementia have received a diagnosis
- *Early diagnosis enables people to:
 - Access advice, information, support and treatment (emotional, practical and financial) from social services, voluntary agencies and support groups
 - Plan and make arrangements for the future
 - Improve access to correct medication**
- In one survey, 30% of carers and 24% of the general population did not believe that effective treatments are available for dementia, and other studies have indicated that people believe there are restrictions on the use of medication.
- In another survey, one in three people (35%) believed nothing can be done to relieve the symptoms of dementia.

Dementia Signs and Symptoms

Dementia is not a single illness but a group of symptoms; which include loss of memory, mood changes and confusion.

Ten signs to be aware of:

1. Struggles to remember recent events, although they can easily recall things that happened in the past
2. Finds it hard to follow conversations or programmes on TV
3. Forgets the names of friends or everyday objects
4. Has difficulty recalling things that they have heard, seen or read
5. Repeats themselves or loses the thread of what they are saying
6. Has problems with thinking and reasoning
7. Feels anxious, depressed or angry about memory loss
8. Finds that other people start to comment on their memory loss
9. Feels confused even when in a familiar environment
10. Experiences changes in personality and mood

References:

- National Dementia Strategy – Department of Health
- Emergency Services Dementia Guide – Walsall Primary Care Trust
- * The Alzheimer’s Society website – www.alzheimers.org.uk
- ** Public awareness of dementia: What every commissioner needs to know, Alzheimer’s Society

CQC Standards

Regulation	Outcome	Outcome title
9	4	Care and welfare of people who use services
18	2	Consent to care and treatment
24	6	Cooperating with other providers

CQC Standards

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Paramedics - Driving ‘v’ Attending – What’s the View of the HPC?

Darren Davies – Risk Manager

The Health Professions Council (HPC) have written to all UK Ambulance Services providing its view on HPC Registered Paramedics and their responsibilities in relation to driving ‘v’ attending. The entire content of the letter reads as follows:



“I am writing to you about the long-standing practice for ambulance crews to share driving duties.

The HPC is receiving fitness to practise allegations against paramedics which arise from or involve a decision by the paramedic in question to drive the ambulance and leave a patient in the care of a less qualified ambulance clinician.

We recognise that it is a long-standing practice for ambulance crews to share driving duties, but that practice began at a time when both crew members would have had similar levels of clinical competence. Today, paramedics have clinical skills which exceed those of other ambulance clinicians by a significant margin. Consequently, paramedics need to consider carefully, on a case by case basis, whether they drive or attend patients.

The HPC is not suggesting that paramedics should cease to share driving duties with their colleagues, nor that less qualified ambulance personnel should cease treating patients. However, paramedics have a professional obligation to act in the best interests of patients and, where they are the senior ambulance clinician on scene, must use sound clinical reasoning to ensure that patients receive care from the most appropriate and available ambulance clinician.

The issue is encapsulated in Standard 1 of the HPC's Standards of Conduct, Performance and Ethics, which apply to all paramedics:

‘1 You must act in the best interests of service users.

You are personally responsible for making sure that you promote and protect the best interests of your service users ... You must not do anything, or allow someone else to do anything, that you have good reason to believe will put the health or safety of a service user in danger. This includes both your own actions and those of other people ... You are responsible for your professional conduct, any care or advice you provide, and any failure to act. You are responsible for the appropriateness of your decision to delegate a task. You must be able to justify your decisions if asked to ... ”

In practice, complaints to the HPC about this issue arise from two scenarios:

- where the paramedic is driving en route to a call and the attending, less qualified ambulance clinician, is the first person to reach the patient; and
- where, in conveying a patient to hospital, the paramedic drives the ambulance and leaves the patient in the care of a less qualified colleague.

In relation to the first scenario, if there is, or is likely to be, any delay in the paramedic reaching the patient - for example, because of the need to retrieve additional equipment from the ambulance or to manoeuvre the vehicle so that it is ready for rapid departure from scene - the paramedic must consider whether he or she should perform the task or leave the other crew member to do so, thereby ensuring that the paramedic reaches the patient first.

We recognise that the patient's presentation on scene will often not correspond with that described to the 999 call taker, but where the overall nature of a call suggests that it is life-threatening or otherwise serious, paramedics should consider whether they need to be the first on scene and if so, to leave tasks which may delay their arrival to less qualified colleagues.

In respect of the second scenario - deciding who attends the patient during conveyance - we equally recognise that, in many cases, a non-paramedic ambulance clinician will be more than capable of caring for the patient. However, it is important that paramedics give proper consideration to the care that the patient may need en route, particularly if it is care which only a paramedic can provide.

That consideration needs to include any potential deterioration in the patient's condition and take account of the fact that a less qualified ambulance clinician will only be able to call for assistance if he or she is aware of the need for such assistance. Paramedics should ensure that they do not endanger patients by putting their colleagues in situations where they may not be able to recognise or respond to subtle but significant changes in the patient's condition.

We recognise that the composition of ambulance crews may vary considerably from service to service and have no doubt that much of what we suggest here is already being done by many paramedics. Nonetheless, I would be grateful if you will bring the points raised in this letter to the attention of the paramedics who work for your service, in an effort to avoid unnecessary allegations being made against them."

<p>References:</p> <ul style="list-style-type: none"> • Letter to Chief Executives and Chief Officers – UK NHS Ambulance Services • Operational Notice ON/077 – 04 August 2011 • Health Professions Council – Code of Conduct • http://www.hpc-uk.org/assets/documents/10002367FINALcopyofSCPEJuly2008.pdf

CQC Standards		
Regulation	Outcome	Outcome title
9	4	Care and welfare of people who use services
21	12	Requirements relating to workers

NHSLA Risk Management Standards for Ambulance Trusts 2011-12			
Standard	Standard title	Criterion	Criterion title
5	Learning from experience	3	Concerns / complaints
5	Learning from experience	7	Improvement

Assessment of Patients Who Have Had Previous Medical Contacts – Lessons Learnt from Previous Incidents

Matt Ward – Clinical Governance and Practice Manager

It has been identified following a root cause analysis of a Serious Untoward Case that the details of previous medical contacts are not always being assessed and fully documented within the patient report form. During the assessment of the Presenting Medical Complaint (PMC) identification of previous medical contacts should be considered.

Although the following list is not exhaustive it provides examples of questions that may be used:

- Has the patient's condition improved or deteriorated following the prior medical contact?
- What was the treatment plan? - Is the patient adhering to the treatment plan and if not why not?
- What did the clinician diagnose the condition as?
- Was a safety net put in place and if so were/are any of the indicators to call for help present?
- Did the clinician indicate what treatment would be required if the condition deteriorated?
- Were any written records left and what do they indicate?

If the patient's condition permits and you have contact details for the clinician who previously attended, consider discussing the patient's condition with them to identify what course of action they recommended?

Remember to comprehensively record the answers to the questions posed above on your patient report form including details of any clinicians you subsequently contacted.

References:
• Root Cause Analysis (Confidential)

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20	21	Records

NHSLA Risk Management Standards for Ambulance Trusts 2011-12			
Standard	Standard title	Criterion	Criterion title
4	Clinical care	2	Health record keeping standards
5	Learning from experience	5	Investigations
5	Learning from experience	7	Improvement

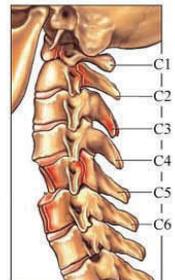
Learning Points from a Recent Case Involving Traumatic Injury

Shane Roberts – Regional Head of Clinical Practice – Trauma Management

A case attended by an NHS Ambulance Service involved a young woman who had consumed a significant amount of alcohol and was assessed and transported to hospital.

Falls were reported before the original 999 call, inside the hospital and following discharge from hospital.

On re attendance at hospital the following day it was found that she had developed paralysis and a dislocation of the cervical spine. In this particular case it was impossible to establish when the neck injury actually occurred – had they occurred before the original 999 call or after? The PRF from the case did not provide adequate information to indicate that significant injury was not a concern. Had a comprehensive assessment including history positive findings and pertinent negatives been documented it may have been possible to exclude the pre-hospital phase as being the time when the injury occurred and helped to narrow down the time frame in which this life changing event happened. This case raises issues from which learning must be disseminated.



Clinical Documentation

The PRF in this case contained insufficient detail to adequately support the crew's assessment of this patient.

- The PRF did not include the findings of the top to toe survey or the mobility of the patient given that she could stand (albeit with the support of one of the ambulance crew and a friend)
- There was inadequate detail with very little information, few pertinent positives and no pertinent negatives
- The recording of the Glasgow Coma Score was inaccurate
- There was no assessment of mental capacity. Given that the patient was described as being heavily intoxicated patient care would have been provided in the best interests of the patient. However there is no evidence that could support this decision.
- There was no record of the name of the receiving clinician recorded on the PRF which would have provided evidence of continuity of care

Findings and Recommendations from Clinical Case Review:

1. **Introduce a Medical Model of Assessment and Documentation to all Trust Clinicians**
2. **Provide additional guidance on documentation standards** – see guidance for the completion of patient records section below: **A Guide to Assessment and Documentation produced by Mike Smyth can also be accessed by following this link;**
http://treble9.ad.wmas.nhs.uk/nursing_qual_prim_care/clinical_standards/trauma.aspx

3. **Provide additional guidance on Glasgow Coma Scale assessment** – Guidance on correctly scoring patients using the Glasgow Coma Scale can be found by following this link:
http://treble9.ad.wmas.nhs.uk/nursing_qual_prim_care/clinical_standards/trauma.aspx

The case review found the GCS recorded by the paramedic was inaccurate (E2 V1 M5). The clinician later stated that the patient initially had her eyes open, was making incomprehensible sounds and was able to stand with support making the total GCS score 12. The combined GCS score recorded on the PRF was 8. On reflection the clinician believed that the patient GCS was higher than recorded.

4. **Increase levels of awareness of mental capacity**

The case review found there was no record of the patient's mental capacity. Given that the patient was been described as being heavily intoxicated the care of the patient would have been provided in the best interests of the patient. However there is no evidence that could support this decision.

Patient Assessment

It has been identified by the National Health Service Litigation Authority, together with the evaluation of complaints received by the West Midlands Ambulance Service, that one of the largest threats to patient care is inappropriate or incomplete patient assessment. The evidence indicates that if the patient assessment is not complete, or is inappropriately carried out, any subsequent treatment provided to the patient will be inappropriate due to the failed patient assessment.

Previous cases that have come to light include:

- Failure to carry out an ECG on a collapsed case where it was later discovered that the patient was in ventricular tachycardia.
- Failing to assess the cervical region in a patient who had suffered a significant fall, whereby it was later found that the patient had two displaced cervical vertebrae.
- Failure to carry out a blood glucose reading on a patient who had collapsed of unknown origin, where it was subsequently found out that the patient was DK acidotic (DKA).

Therefore, it is imperative that every patient receives an appropriate and comprehensive assessment to ensure that the patient's clinical parameters are within the scope of normality. It is also important that the assessment is documented on the Patient Report Form with positives being recorded, as well as negatives. For instance: patient's leg assessed: no bony injury, full range of movement, no tenderness, crepitus etc. present.

Alcohol and Spinal Cord Injury

Alcohol has been shown in studies to be a risk factor in spinal cord injury and to increase injury severity in spinal cord injury.

WMAS clinicians should maintain a high level of suspicion for C spine injury in a trauma patient who has consumed alcohol, particularly if there is any trauma above the clavicles.

GUIDANCE FOR THE COMPLETION OF PATIENT RECORDS (With thanks to Mike Smyth)

What are Patient Records?

Patient records include any information made by, or on behalf of, a health professional in connection with the care of a patient. They can therefore cover a wide range of material:

- Patient Report Forms
- Cardiac Patient Report Form
- Any correspondence between health professionals (GPs, Intermediate care team, District nurses etc)
- Print-outs from monitoring equipment (including ECGs)
- Computerised records
- Photographs, videos and telephone / radio recordings
- Reports or statements
- Any patient-identifiable information i.e. home address. (Kirke A, et al 2006)

Why Keep Patient Records?

Good patient records are needed for good clinical practice. Healthcare is now a multi-disciplinary, team process. To ensure that patients are treated efficiently and effectively, it is important that you, and other health professionals, have easy access to high quality patient records.

Good Medical Practice (GMC 2001)

This document specifies that healthcare professionals should 'keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'.

It also says that you should 'keep colleagues well informed when sharing the care of patients'.

To do this requires good medical records. In addition, the NHS is moving towards electronic records so that NHS professionals 'have reliable and rapid access, 24 hours a day, to the relevant personal information necessary to support their care'. This will require the production of high quality, up-to-date records.

Complaints and Claims

Good patient records are essential in responding to complaints and claims. They provide an objective record of the assessment and treatment of a patient. If you face a claim for negligence, good patient records are an essential part of your defense of that claim. Your assessment and care of the patient will be judged by the quality of your record-keeping. Many clinical negligence claims are indefensible because there are problems with the patient records, whether they are inaccurate, illegible, inadequate or simply missing.

You may have done nothing wrong, but unless the patient record substantiates this, it can be difficult to defend a claim. Courts have a tendency to believe the memory of a patient, for whom it was a once-in-a-lifetime experience, rather than the memory of a healthcare professional, recalling many years later one of many similar procedures.

"If it is not recorded, it did not happen, you have not done it!"

Peter Fulkes Q.C.
Suffolk Coroners Court
Crown vs. Henshaw 1997

- In court (s) the key document that relates to clinical care and or medicines administered is the PRF
- If it is not written down it did not happen (Barry v LAS)
- If is written down it happened as documented (Pemberton v Hampshire)
- In a court of law the best defense for any Health Care Professional is accurate concise and properly recorded patient notes.
- In the event that the court establishes that the note keeping is poor, this will invariably be held as a reflection on the level of treatment and care provided by the health carer. This also includes the administration of medicines.

Clinical Auditing and Governance

As well as enabling high quality care for individual patients, good patient records are increasingly valuable in improving standards of patient care. Auditing patient records is an important part of the clinical governance process, and the Trust records are designed around standard templates to facilitate this.

Writing Good Patient Records

Patient records should allow another healthcare professional to reconstruct your dealings with the patient.

While they should not be written for a lay reader, bear in mind that it is likely that the patient, their relatives or representative will read the notes in the future. In addition, the Data Protection Act 1998 requires you to give an explanation of any information that 'is not intelligible without explanation'.

Good Practice when Completing Patient Records

Patient records need to be written so they are:

- **Clear** - Write legibly in black ink. Do not score through boxes, if you are not required to fill them in just leave them blank as any marks in the box fields that are not recognised letters/numbers prevents the form from being scanned and this means it has to be manually entered. Do not use abbreviations such as +/- > < in the boxed fields as they are not recognised by the computer scanner although they may be used in the free text fields. Please ensure all text boxes are completed from the left hand side of the box. i.e.:

5	8	2		
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You should ensure the carbon copy of the PRF is legible prior to handing over to the hospital or in the case of non-conveyance, to the patient or appropriate relative or carer.

- **Abbreviations** - Using abbreviations saves time, but can lead to problems. It is important that abbreviations are unambiguous and universally understandable – do not rely on the context to give the meaning. For example, the abbreviation STI can mean Soft Tissue Injury or Sexually Transmitted Infection! Certain abbreviations are unacceptable, such as coded expressions of sarcasm. Attempts at humour or sarcasm have no place in modern patient records.
- **Objective** – opinions should be based on the facts you have recorded. Remember that patients or their relatives are likely to read the notes you write.
- **Contemporary** – write notes up as soon as possible after an event.
- **First-hand** – if information has been given to you by anyone but the patient, record that person's name and position. For example, it may be a relative, friend, translator, doctor or the police.

Whether information is obtained from the patient, or any of the above, please ensure that they understand the importance of providing accurate information and verify as necessary. This will help to ensure that appropriate care is delivered to the correct patient and that resources can be managed appropriately.

- **Tamper-proof** – any attempt to amend records should be immediately apparent. This should be done by a single line through the original entry and signed, and the time the amendment was made.

If any changes to the PRF are made which may affect ongoing care. Control should be informed to pass the information on.

- **Confidential** – Patient records should be kept in a secure environment. That means restricting access to authorised personnel and ensuring that records are kept physically safe. You must ensure records are kept in a confidential manner (in the provided folder when in the vehicle or handed directly to a member of staff). Patient records should not be photocopied.

Health Professions Council (HPC) Requirements

State Registered Paramedics have the following guidelines from the HPC surrounding record keeping.

Registrant Paramedics must:

2b.5. be able to maintain records appropriately:

- Be able to keep accurate, legible records and recognise the need to handle these records and all other clinical information in accordance with applicable legislation, protocols and guidelines.
- Understand the need to use only acceptable terminology (which includes abbreviations) in making clinical records.

You must keep accurate patient, client and user records.

Making and keeping records is an essential part of care and you must keep records for everyone you treat, or who asks for professional advice or services. All records must be completed and legible, and you should write, sign and date all entries.

If you are supervising students, you should also sign any student's entries in the notes. Whenever you review the records, you should update them and include a record of any arrangements you have made for the continuing care of the patient, client or user.

You must protect information in records against loss, damage or use by anyone who is not authorised.

You can use computer-based systems for keeping records but only if they are protected against anyone tampering with them (including other health professionals). If you update a record, you must not erase information that was previously there, or make that information difficult to read. Instead, you must mark it in some way (for example, by drawing a line through the old information).

Note: The above requirements have been adopted by WMAS, and technicians and ECAs must adhere to these requirements.

Nursing and Midwifery Council (NMC) Requirements

As a registered nurse or midwife, you must co-operate with others in the team:

4.4 Health care records are a tool of communication within the team. You must ensure that the health care record for the patient or client is an accurate account of treatment, care planning and delivery. It should be consecutive, written with the involvement of the patient or client wherever practicable and completed as soon as possible after an event has occurred. It should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

Management/Plan

This should clearly specify the outcome for the patient whether discharged, admission to acute hospital, or referral.

Referral to other health care professionals e.g. GP, district nurse, intermediate care, duty social worker (record the name, time and status)

Recording name, time and instructions of any health professionals spoken to for advice in relation to a patient e.g. GP or A/E Trust grade.

References:

- Meredith W, Rutledge R, Fakhry SM, et al. (1998) The conundrum of the Glasgow Coma Scale in intubated patients: a linear regression prediction of the Glasgow verbal score from the Glasgow eye and motor scores. *J Trauma*. 44(5):839-44; discussion 844-5.
- Garrison A, Clifford K, Gleason (2004) SF et al. Alcohol use associated with cervical spinal cord injury. *J Spinal Cord Med*. 27(2): 111–115.
- Forchheimer M, Cunningham RM, Gater DR et al (2005). The Relationship of Blood Alcohol Concentration to Impairment Severity in Spinal Cord Injury. *J Spinal Cord Med*; 28(4): 303–307
- Nursing and Midwifery Council (2005) *Guidelines for Records & Record Keeping*. NMC. London.
- Department of Health (2009). *NHS Code of Practice Part 2*, (2nd Edition). HMSO. London
- Health Professions Council (2007). *Standards of Conduct and Ethics*. HPC. London.
- Brown S, Cooke M, Fisher J (Eds) (2006) *Neck & Back Trauma* in Clinical Practice Guidelines for use in U.K. Ambulance Services. ASA/JRCALC, London
- BTLS Manual 5th Edition ISBN 0-13-112351-3

CQC Standards

Regulation	Outcome	Outcome title
9	4	Care and welfare of people who use services
10	16	Assessing and monitoring the quality of service provision
20	21	Records
23	14	Supporting workers
24	6	Cooperating with other providers

NHSLA Risk Management Standards for Ambulance Trusts 2011-12

Standard	Standard title	Criterion	Criterion title
1	Governance	8	Health Records Management
2	Competent and capable workforce	4	Supervision of Clinical Ambulance Staff
4	Clinical care	2	Health Record-Keeping Standards
5	Learning from experience	3	Concerns/Complaints
5	Learning from experience	5	Investigations
5	Learning from experience	7	Improvement
5	Learning from experience	8	Best Practice - JRCALC & NICE

Recognising Sepsis

Stephanie Birt - Paramedic CTM (Henrietta Street)

Sepsis, also known as Septicaemia, is a potentially life-threatening, time critical condition. It is an illness in which bacteria enters the bloodstream. The bacterial infection can enter the body anywhere (<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001687/>). This article is going to explain Sepsis and how to identify it.

What can cause Sepsis?

Sepsis is most commonly caused by bacteria; however viruses and fungi can also be causes. It can be caused by pneumonia (infection in the lungs), urinary tract infections (infection in bladder and kidneys), appendicitis or peritonitis (infections in the abdomen), meningitis (infection in the layers around the brain), cellulitis (infection of the skin) and post surgery infections (http://www.emedicinehealth.com/sepsis_blood_infection/page2_em.htm). This starts off as a localised infection but if the bacteria, virus or fungi becomes systemic and spreads in the bloodstream it causes sepsis.

Are there any risk factors making people more susceptible to Sepsis?

There are risk factors that make people more susceptible to getting Sepsis although anyone can get it. Sepsis is most frequently seen in the elderly patient, patients with illnesses that predispose them to infection such as diabetes mellitus, liver and renal diseases and patients with immunocompromising illnesses such as HIV/AIDS. Other patients at risk are those who have suffered a complication post surgery, major trauma and extensive burns and those that have internal tubes/devices in situ (<http://emedicine.medscape.com/article/168402-overview#aw2aab6b2b3>).

Signs and Symptoms of Sepsis

In adult patients:

- There should be a proven or suspected source of infection and at least two of the following:
 - Tachycardia (>90 beats per minute)
 - High or low temperature (>38.3°C or <36°C)
 - Increased respiration rate (>20 breaths per minute)
 - Increased blood sugar (except in diabetic patients)

In elderly patients:

- The first sign is often confusion with chills, weakness and the signs listed for an adult patient.

In children, toddlers and infants:

- The signs are similar to those of adult patients but most common are fever and reduced urine output with signs of lethargy.

There may or may not also be signs of a non-blanching rash in all age groups. This rash is a sign of the spreading infection in the blood but it is a late sign (<http://www.medicinenet.com/sepsis/page3.htm>).

What is the pre-hospital treatment for sepsis?

According to an article in the Journal of Paramedic Practice, “paramedics have made a significant contribution to reductions in mortality for the time-critical conditions of Acute Myocardial Infarction (AMI) and Major Trauma (Myocardial Ischaemia National Audit Project (MINAP), 2008), and they will be instrumental in helping to reduce stroke mortality in the near future (Department of Health 2006)”. They go on to say however that although this is all happening in the pre-hospital environment, Sepsis is still not receiving the recognition and treatment that it requires as a potentially life-threatening condition. These patients require high concentration oxygen, IV fluid challenge, IV antibiotics and pre-alerting the hospital, depending on the clinical presentation of the patient (http://www.paramedicpractice.com/cgi-bin/go.pl/library/article.cgi?uid=42060;article=pp_1_5_183_188).

Sepsis is an underestimated illness in the pre-hospital environment and although it cannot be definitively diagnosed by pre-hospital clinicians it can be suspected. If a good, clear, concise history has been obtained about the patient and the observations meet the criteria in the article then initial Sepsis treatment can begin without delaying the care.

References: As per article

CQC Standards		
Regulation	Outcome	Outcome title
9	4	Care and welfare of people who use services

CQC Standards		
Regulation	Outcome	Outcome title
9	4	Care and welfare of people who use services

What's Happening with Clinical Equipment?

Darren Davies – Risk Manager

The Trust's clinical equipment group meet at least six times a year and advises the Trust on matters relating to the specification, procurement and use of clinical equipment for the WMAS. This includes, but is not limited to E&U, PTS, BASICS, CFR and Air Ambulance.

The Service Delivery Director (Operations) chairs the meeting and the group consists of representation from:

- Staffside
- Clinical management
- Training
- Safety, Risk and IP&C
- Special operations
- Purchasing, contracts, logistics and stores
- Service delivery – E&U and PTS
- Finance representative

Source: *Clinical Equipment Group Terms of Reference*



2011 / 12 Workplan objectives

The following objectives have been set for the clinical equipment group.

Many of these have been determined through legislative requirements and identification of risk, through completed WMAS54's, claims and other incidents. Although agreed objectives business cases will be required for each area as required.

1. To ensure clinical equipment complies with CQC requirements
2. To ensure development of and compliance with the Trust's medical devices policy
3. To ensure the ongoing development of clinical equipment risk assessments and risk register - (part carry over from MESWG 2010 – 11 workplan)
4. To ensure adequate battery management of equipment (particularly Zoll defibrillators) – (based on number of adverse incident reports 2010/11)
5. To ensure adequate provision of giving sets (based on reported incidents of failing to flow)
6. To finalise the business case for the provision of additional Stryker chairs throughout the Trust (carry over from MESWG 2010 – 11 workplan)
7. To finalise the business case for the provision of additional Mangar lifting aids throughout the trust (Carry over from MESWG 2010 – 11 workplan)
8. To finalise the business case for the provision of new response bags following the 2010-11 review throughout the Trust (carry over from MESWG 2010 – 11 workplan)
9. To continue the review of current handheld aspirators to ensure operated in a safe manner, whilst considering potential alternative products
10. To ensure the adequate provision of bariatric services throughout the Trust (carry over from MESWG 2010 – 11 workplan)
11. To ensure, in partnership with the vehicle design group the adequate provision and use of child safety restraint systems
12. To determine and implement standard kit lists (e.g. response bags / ECP / RRV and DMV) - (part carry over from MESWG 2010 – 11 workplan)
13. To review the provision of stairclimbers for PTS Services (e.g. C-max chair)

14. To review and determine clinical equipment required for successful implementation for the major trauma project (e.g. EZ IO, bulk dressings, haemostatic gauze, tourniquets and pelvic splints (part carry over from MESWG 2010 – 11 workplan)
15. To review the contract for the provision of Oxygen cylinders (with consideration for reducing the size of cylinder provision – thus reducing weight within response bags)
16. To review the provision of defibrillators (with consideration for reducing weight)
17. To review the regional provision of paediatric equipment
18. To develop an agreed process for review, approval and implementation of clinical equipment

References:

Clinical Equipment Group – Terms of Reference
 Clinical Equipment Group – 2011-12 Workplan

CQC Standards

Regulation	Outcome	Outcome title
16	11	Safety, availability and suitability of equipment

NHSLA Risk Management Standards for Ambulance Trusts 2011-12

Standard	Standard title	Criterion	Criterion title
3	Safe environment	6	Maintenance of Medical Devices & Equipment

Inoculation and Splash Incident Reporting

Diane Hadlington – IPC Lead

A recent review of WMAS54 incident reports has shown that there is sometimes a distinct lack of information completed on the forms regarding why ‘sharps’ incidents have actually occurred. The forms generally state where the sharp penetrated and that the procedures were followed, and this is required and very important. However, equally important to enable assessments to be made on how we can avoid injuries, we also require information on **HOW** the incident occurred.

Further investigation into all of the sharps incidents has revealed a common occurrence, which could possibly have been addressed earlier, if the information had been written on the forms when they were submitted:

A number of these incidents have occurred following a ‘missed’ or ‘failed’ cannulation, where the needle had been left inside the cannula itself preventing the safety mechanism from activating.

This means that some of these could have been avoided if the needle had been completely removed from the cannula so that the safety device activated. So, even with ‘failed’ cannulations, please remember to remove the needle first to activate the safety device, dispose of the needle, then remove the rest of the cannula and place a dressing on the wound.

Other incidents were due to the sharps box not being in the right place at the right time and also where another member of staff leaned over to help, just as the cannula with needle still inside was removed.

To avoid sharps injuries the following advice is given:-

- Always place directly into a sharps container after use
- The container must be placed safely and as near as practicably possible
- Never over fill the sharps container – dispose of when 2/3rds full
- Never re-sheath needles
- If a syringe is attached to a used needle, dispose of as one unit, do not separate for disposal
- Wear gloves



Remember – just because they are ‘safety’ cannula’s – they still need to be handled safely!

Crew Actions following Inoculation or Splash contamination Incident

Definition of inoculation or splash contamination incident:

Any incident where blood or body fluid from another person/patient enters mucous membranes ie. mouth, eyes, nose, or any recent cut or injury to the skin. This could be by means of a sharp, bite or splash incident

Sharps or bite Injury

Splash contamination incident

Running water available:-

Irrigate the wound making it bleed under running water and wash with soap and water

Running water NOT available:-

Gently encourage the wound to bleed, use the hand wipes on the vehicle to wipe the area thoroughly, followed by use of hand sanitizer gel

**Rinse the eye/s or mouth thoroughly with water or sterile saline solution –
If on vehicle, use bag of saline
nb. Do not swallow the water**

Cover the wound with a water proof plaster

- Report the incident to the EOC/Duty Officer
- Seek medical attention at the nearest Accident and Emergency department
- If possible, identify source and name of the patient
- Follow all advice given by A+E Doctor and Occupational Health
- Fully complete a WMAS54 with details of how the incident happened, what has been done and inform your Manager

References:

- Health and Safety Executive: <http://www.hse.gov.uk/healthservices/needlesticks/>
- European Biosafety Network. *Prevention of Sharps Injuries in the Hospital and Healthcare Sector*: <http://www.europeanbiosafetynetwork.eu/EU%20Sharps%20Injuries%20Implementation%20Guidance.pdf>

CQC Standards

Regulation	Outcome	Outcome title
8	12	Infection Prevention and Control

Safeguarding – Is it Worth Making the Referral?

Julie Ashby-Ellis Head of Safeguarding

The number of safeguarding referrals has risen to an average of 600 per month. This equates to a considerable amount of time staff dedicate to making referrals. Do they just disappear into the dark hole of referral or do they really make a difference?

The answer is simple; they really do make a huge difference to the lives of children and vulnerable adults. Unlike the majority of other agencies who visit mostly by appointment, ambulance crews see families at their most vulnerable. This is a unique opportunity to identify children and vulnerable adults who are being abused or at risk of abuse. Work carried out in Birmingham with named nurses for child protection highlighted that WMAS crews identified abuse in children that were not known to any other health or social professionals. Without the referral these children would still be suffering at the hands of their abusers.

Therefore it is important that all WMAS have completed their educare training to ensure that they are able to recognise and respond to abuse appropriately. For registered paramedics safeguarding training is mandatory to fulfill registration requirements.

It is important that all referrals are made via the safeguarding line. There are a number of reasons for this:

1. It is the quickest safest way to ensure that the child or vulnerable adult receives the help they need
2. There is an identifiable audit trail of the referral
3. There is an accurate record of the referral as the call is recorded and a permanent record made on the adastra system which can be updated as information is received
4. The safeguarding team is able to access the referral to ensure the referrals are acted upon and outcomes are obtained
5. Social care or other agencies have an identifiable point of contact if they require any other information

WMAS54 should only be used to highlight additional concerns and not to make a safeguarding referral.

The quality of the referral is only as good as the information gathered. Since the new question sets have been introduced the quality of the referrals has increased. The feedback we are getting from partner agencies is very positive so keep up the good work!

References:

- <http://fflm.ac.uk/librarydetail/4000116> Intercollegiate Document on Safeguarding competencies
- [PO-003 Consent Policy \(v3\).pdf](#)
- [PO-006 Safeguarding Children and Vulnerable Adults Policy and Procedure \(v2\).pdf](#)

CQC Standards

Regulation	Outcome	Outcome title
11	7	Safeguarding people who use services from abuse

NHSLA Risk Management Standards for Ambulance Trusts 2011-12

Standard	Standard title	Criterion	Criterion title
4	Clinical Care	2	Health Record Keeping standards

Burns Management Dressing Guidance

Adele Pearson – Clinical Quality Manager

Rationale

Due to concerns raised, the following guidance is to ensure that all clinicians working for WMAS know the current practice for pre-hospital treatment of burns using cling film and burn shield dressings on burns and scalds. Following current guidance key points are raised in best practice using cling film.

Key points

- Taking cling film from a sealed tagged burns kit, then remove the first two layers from the cling film roll and disregard
- Cover the burn area carefully excluding any air with one or two layers of cling film, not circumferential allowing for any swelling
- If a burn shield dressing is not available to place on top of the burn, irrigate over the cling film to keep wound cool. It is rare to need to irrigate for more than 10 mins.
- Wrap the patient up in blankets or duvet (Cool the burn wound but warm the patient)
- For bigger burns (20%), burns gels and cling film combined help prevent heat loss. Caution is needed for prolonged transfers when wet dressings in situ as this can cause hypothermia.
- In chemical burns cling film theoretically may worsen the chemical burn effect. Irrigate thoroughly until pain or burning has decreased. Go for wet dressings only but beware of powder injuries, which may be worsened with water. Bring data sheet on likely chemical if available with the patient to hospital.
- Once the burn kit has been used it needs replacing at the end of the shift for a sealed burn kit. If the cling film is looking very old or the inner cardboard roll is dirty then discard it.
- Storage of the cling film should always stored in a clean environment in the burn kit bag. All cling film should be the burn film ordered via stores.

Below are the current dressings WMAS use:

BURNS CLING FILM	Each	£2.50
BURNS SHIELD DRESSING 10X10	Each	£1.52
BURNS SHIELD DRESSING 20X20	Each	£4.05
BURNS SHIELD DRESSING 60X40	Each	£13.98
BURNS GLOVE	Each	£2.77
BURNS SHEET	Each	£5.10



References:

- Midland Burns Care Network
- British Burns Association
- JRCALC

CQC Standards

Regulation	Outcome	Outcome title
12	8	Cleanliness and infection control - Hygiene code

NHSLA Risk Management Standards for Ambulance Trusts 2011-12

Standard	Standard title	Criterion	Criterion title
4	Clinical Care	9	Infection control