The Faculty of Intensive Care Medicine

Safety Bulletin

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Introduction

Through a data sharing agreement, the Faculty of Intensive Care Medicine can access a record of incidents reported to the National Reporting and Learning System (NRLS). Available information is limited and from a single source; all that we know about these incidents is presented in this report. The *Safety Bulletin* aims to highlight incidents that are rare or important, and those where the risk is perhaps something we just accept in our usual practice. It is hoped that the reader will approach these incidents by asking whether they could occur in their own practice or on their unit. If so, is there anything that can be done to reduce the risk?

Case 1 | Focused bedside echocardiography (Prevention of Future Deaths Report)

A 17 year old patient presented to the emergency department. The patient decompensated over a short period of time on a background of a previously undiagnosed pre-existing arrhythmogenic cardiomyopathy. Unfortunately, the patient subsequently died. The coroner raised several concerns in a prevention of future deaths report, including the lack of timely bedside focused echocardiography.

Comment

Whilst GPICS V3 is still in the consultation phase, FICM is supportive of the reliable provision of emergent echocardiography for those who need it, across all UK hospitals. Intensive care doctors who perform echocardiography do so as part of a wider hospital system and within their own scope of practice.

In the ICM curriculum, echocardiography would feature as part of HiLLO 6:

"Intensive Care Medicine specialists will have the knowledge and skills to initiate, request and interpret appropriate investigations and advanced monitoring techniques, to aid the diagnosis and management of patients with organ systems failure. They will be able to provide and manage the subsequent advanced organ system support therapies. This will include both pharmacological and mechanical interventions."

It is a stipulation of the GMC that a specific course or accreditation cannot be specified in the curriculum, and we recognise the challenges and regional variability in echocardiography training. The FICM Training, Assessment and Quality Committee are currently preparing to submit some clarifications to the GMC, which include the use of point of care ultrasound.

FICM shares HM Coroner's concerns about governance, including the lack of infrastructure for storing ultrasound images. These aspects will be further addressed in GPICS V3.

Case 2 | HIV testing

A patient was diagnosed with HIV infection at a late stage (CD4 count less than 350 cells per mm^3). Several years previously they had been admitted to an ICU with an HIV indicator condition. No HIV test was performed at that time.

Comment

Late diagnosis remains a leading cause of morbidity and mortality in HIV, and testing is a priority in the goal to eliminate HIV transmission in the UK. An indicator condition is any medical condition associated with an undiagnosed HIV seroprevalence ≥1 per 1000; a list of HIV indicator conditions can be found in appendix 1 of this guidance from the British HIV Association. Included are several that are commonly seen in our units (e.g. community acquired pneumonia).

Case 3 | Retained introducer

A patient was transferred between ICUs with a bowel management system in situ. As part of the investigations for ongoing sepsis with an unknown source, a CT was performed. This showed a foreign body in the rectum and an associated perforation. At laparotomy, the plastic introducer from the bowel management system was removed from the rectum and a defunctioning colostomy formed.

Comment

Reported complications of bowel management systems include ulceration, haemorrhage, autonomic dysreflexia and fistulation. An observation study in Melbourne, Australia reported a major adverse incident occurring once every 200 device days - this included 2 of 99 patients requiring laparotomy and one requiring a 23 unit blood transfusion.

Not all devices require use of an introducer; use of an alternative device would avoid this particular risk, however enhanced documentation, a checklist/LocSSIP or two person confirmation of disposal are other options that could be considered.

Case 4 | Contrast extravasation

A patient underwent a contrast CT. After administration of 90ml contrast via a peripheral cannula, the arm became swollen and tense. Immediate blisters were noted, with mottling and pallor on return to the ICU.

Comment

Whilst most contrast extravasation does not result in severe harm, this presentation warranted immediate surgical review given the extent of tissue damage and possibility of compartment syndrome.

As a quality standard, the Royal College of Radiology state that all radiology departments should have a local protocol concerning contrast extravasation. To help healthcare organisations to create local infiltration and extravasation guidelines, policies and protocols, the National Infusion and Vascular Access Society (NIVAS) have produced this toolkit. A useful topic review is available in the European Radiology journal.

Case 5 | Dose confusion

During an emergency intubation, a doctor was asked to give 20mg of propofol, but gave 20ml (200mg).

Comment

The doctor probably heard what they were expecting to hear or simply misheard in a stressful environment, but this incident also raises an issue concerning the ability to describe drug administration by both volume of solution and dose. Similar issues were raised at inquest following a death resulting from local anaesthetic toxicity; the inquest heard that local anaesthetic was sometimes specified in millilitres and sometimes in milligrams (The Safe Anaesthesia Liaison group responded to this unfortunate death via a prevention of future deaths report request).

Consistency and clarity are vital. It could be argued that in emergency situations, volumes may be safer as the receiver then doesn't have to convert dose to volume. This does, however, introduce the risk of the transmitter not being aware of the actual drug dilution. In a critical situation, expecting a request in terms of volume of solution, concentration and required dose risks overwhelming the short term memory. Repeating back the instruction (readback) is not perfect, as the aviation examples in a recent article, and an article from NASA 37 years ago show, but may well have a place.

Case 6 | Passy Muir valve

A patient was weaning via a tracheostomy. The bedside nurse placed the speaking valve (Passy Muir valve) however did not deflate the tracheostomy cuff, resulting in a cardiac arrest.

Comment

The MHRA have become aware of reports of tracheostomy cuffs being inflated whilst a Passy Muir speaking valve (PMV) was in situ, resulting in harm. They promote the use of supplied warning labels and ensuring all relevant staff members have received appropriate training.

Case 7 | Chlorhexidine allergy

Before attaching an infusion of iv fluid, the hub of a central venous catheter was cleaned with a chlorhexidine containing wipe. The patient was known to have a chlorhexidine allergy, and unfortunately an anaphylactic reaction resulted.

Comment

After antibiotics and muscle relaxants, Chlorhexidine was the third most common trigger agent for anaphylaxis in the perioperative period reported in the RCoA's 6th National Audit Project. It has been described as the 'hidden allergen' because of its widespread use in everyday clinical settings. The implication of chlorhexidine wipes in anaphylaxis when preparing the skin for peripheral cannulation or other surgical procedures is well described, but this study sought to investigate the entrainment of chlorhexidine when it is used for peripheral cannula port cleaning. They found that after using 2% chlorhexidine and 70% alcohol swabs, entrainment of chlorhexidine was universal. Does your unit have a readily available alternative?

Safety News

SHOT is the UK's haemovigilance system. They collect and analyse data related to transfusion incidents, reactions and near misses, publishing them in an annual report, which has recently been released. As well as the report, SHOT has made available several other useful resources; a new webpage summarising the risks of transfusion, the 'My Transfusion' app to help support consent discussions and shared decision-making, and a framework of safety standards.

The MHRA have launched a monthly 'Safety Roundup', which provides a summary of all the safety alerts for the past month. You can signup via the MHRA website.