1. THE CASE

WHEN DETERIORATION IS NOT RECOGNISED

A patient.
A postoperative complication.
A missed opportunity to intervene.
A life changed forever.

“What went wrong?”

The question is: Why was it not recognised in time?

2. WHAT WENT WRONG?

NOT SIMPLY A MISSED HAEMATOMA.

A failure to recognise deterioration.

A changing clinical picture was not recognised as an impending emergency.

The issue is not simply whether observations were recorded.
The issue is whether somebody understood what they were telling us.

3. CLINICAL REASONING

OBSERVATION ≠ CLINICAL REASONING



What do these findings mean when I put them together?

The purpose of observation is not documentation.
It is prevention of harm.

4. STAFFING & COMPETENCE

ARE WE MATCHING COMPETENCE TO ACUITY?

QUALIFICATION	What formal preparation does the nurse have?
COMPETENCE	What can the nurse actually recognise and manage?
EXPERIENCE	Has the nurse encountered deterioration before?
SUPERVISION	Is appropriate support immediately available?
PATIENT ACUITY	What does this particular patient require?

The question is not: “Who do we put in the bed?”

It should be:
“What does this patient need?”

5. THE MEDICO-LEGAL PATHWAY

FROM BEDSIDE TO MEDICO-LEGAL CLAIM



The claim is the end of the story.

The patient-safety failure came first.

6. THE HUMAN COST

THE COST OF POOR CARE IS NOT ONLY FINANCIAL.

A life changed.

A family changed.

A carer created.

A future lost.

Behind every medico-legal claim is a human being.

7. THE MESSAGE

THE MEDICO-LEGAL CRISIS IS A PATIENT-SAFETY CRISIS.

Prevent the harm
before we argue about the claim.

Quality care is not an aspiration.
It is our professional obligation.

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