Introduction

Welcome to the first edition of Nevermore for the Community. Our Hospitals and the care we provide in the community are now safer than ever and yet still patients suffer avoidable harm. Learning from harm is inconsistent and at times we see events recur with similar or even identical causes.

Sir Liam Donaldson launched the World Alliance for Patient Safety thus:

“To err is human, to cover up is unforgivable and to fail to learn is inexcusable.”

For patients who have been harmed, for their families, for the coroner and others who regulate our practice day to day, evidencing learning from harm is key. Experience over recent years has taught me how difficult this can be across an organisation and hence the advent of “Nevermore for the Community.”

This publication is intended to be largely clinical and we will look at harm identified through the Adverse Incident Reporting System (AIRS), in particular pressure ulcers and falls. I would urge you please to look through this and consider how it is applicable within your own practice; relatively few such events have implications exclusively for the clinical area in which they occurred.

By changing our culture of responding to harm we can make our hospitals and care in the community safer still.

Dr Alastair Turnbull
Medical Director
Never Events

Never events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations are followed.

There are 25 categories of Never Events and if you think one may have occurred in your area please look at the definition carefully and discuss with the Risk and Legal team.

A list of definitions for all the Never Events can be found at Q:\York Hospitals Trust\Never Events and Learning\Never Events list 2013 2014.pdf

So, has our Trust had any Never Events recently?

Unfortunately the answer is yes, 4 in the last 16 months.

We have identified two incidents of Retained Foreign Object, one Wrong Site Surgery and one fatal Air Embolus.

Nationally between April 2014 and October 2014 Wrong Site Surgery was the most frequently reported Never Event at 71 (16 being wrong tooth removed and five wrong lesions). The second highest reported in this period was Retained Foreign Objects at 53.

Never Events in the Community are not as frequently reported as they are in hospital settings, although they have occurred.

Summarised below is a medication related Never Event which was identified when a patient was admitted to one of our community hospitals.

The patient was admitted to Whitby Hospital and was prescribed and administered daily Methotrexate (twice) - contrary to guidelines and an NPSA alert.

When the patient was admitted they did not have with them the booklet which stated on which day of the week they took the drug.

They were not well enough to discuss their drug regimen so the doctor wrote up the prescription and left unmarked as to which day of the week the drug should be administered. They did however write special instructions stating that the drug should only be administered once a week. Unfortunately the nurse administering the drug did not see this and administered the methotrexate.
DNACPR (Do not attempt cardiopulmonary resuscitation)

It is now over six months since the Court of Appeal’s judgment about consulting patients when taking decisions involving life sustaining treatment. Has your practice changed? If not, does it need to?

Stephen Evans, Partner at Hempsons Solicitors, outlines below some important points.

A Matter of Life or Death

In *R (on the application of Tracey) v Cambridge University Hospitals NHS Foundation Trust* the conclusion was that there is a duty to consult a patient in relation to DNACPR, unless the clinician thinks that consultation is likely to cause physical or psychological harm to the patient; - this is more than just causing distress.

The judgment was that DNACPR decisions engage Article 8 ECHR, the right to a private and family life. There is a presumption in favour of patient involvement. *So, there needs to be convincing reasons not to involve the patient.*

Why is DNACPR different?

A criticism of this case has been that CPR is often clinically inappropriate and clinicians are not required to advise patients of other treatments that are inappropriate.

There are, perhaps, two reasons why CPR is different:

1. In most cases you do not actually make a formal decision not to give clearly inappropriate treatment. However, clinical decisions are made, and recorded, about CPR in advance of the point where the treatment might be needed.

2. The public perception of CPR is different. It is commonly perceived as the last thing to try and that it can restore life. On the other hand, deciding not to give CPR is often seen as having “given up” on survival. A longer term consequence of this case may be a heightened awareness of the need to educate the public about the realities of CPR.

The case does NOT say that clinicians must give CPR if the patient wants it. Patients can only choose treatment from the options a clinician considers to be clinically appropriate, or they can ask for a second opinion.
If you decide CPR is not clinically appropriate then the consultation required is more a matter of informing the patient of the decision so that they can, if they wish, seek a second opinion. You should be prepared to re-consider your clinical view in the light of any information given by the patient during the discussion.

**How to do this:**

- Ask yourself “Is it clinically appropriate to make a decision about DNACPR?” If no decision is being made there is no obligation to discuss it. However, this should only exclude those situations where it is not anticipated that CPR will be needed. It is not an excuse to ignore the issue and avoid consultation.

- The clinician needs to consider whether the DNACPR decision should be discussed. The decision imposes an obligation on clinicians to discuss DNACPR decisions with patients (and/or families if appropriate) unless to do so would cause the patient physical or psychological harm. Anticipating that the patient will be distressed by a discussion is not sufficient reason to avoid this.

- Discuss the decision with the patient. The patient is entitled to refuse to discuss it. If s/he does, ask permission to discuss the issue with the family.

A failure to take these steps appropriately could be a matter of professional misconduct and would mean that the Trust would be acting unlawfully.

The judgment does not directly deal with the position of patients who lack capacity. The Mental Capacity Act (2005) requires decisions for those who lack capacity to make the decision for themselves to be made in the individual’s best interests. When deciding best interests a clinician is required to take in to account “if practicable and appropriate to consult them” the views of anyone, engaged in caring for the individual or interested in their welfare. If there is no one else to consult then an Independent Mental Capacity Advocate (IMCA) must be appointed for decisions about serious medical treatment (s37 MCA – unless the need for, or withholding, the treatment is urgent). The Court clearly considered a DNACPR decision to be one about serious medical treatment.

If you cannot talk to the patient then talk to the family. Confidentiality may, occasionally, be an issue but do not let it become a barrier to discussion or, worse, an excuse.

**Conclusions**

My experience has been if patients or families find that a DNACPR has been made without discussion that often leads to anger even fear about clinician’s intentions and can undermine any trust in their treatment.
Ideally, the decision should be accepted as a positive opportunity to consider how patients/families are involved in all decisions about treatment especially those about potentially life saving treatment.

**Action points:**

- Discuss DNACPR issues with patients before making a final decision, if they are willing and able to discuss them.
- Inform the patient of the final decision and consider offering a second opinion if the decision is to not resuscitate even though the patient wants resuscitation.
- If the patient agrees involve or inform family members.
- If the patient lacks the capacity to be involved than consult a family member or other people concerned with the patient’s welfare. If there is no one else to consult appoint an IMCA but do not delay urgent decisions if the IMCA is not available.
- Record discussions and decisions in the clinical records, including efforts to discuss that have been declined and/or reasons for not discussing the issue on the basis of likely harm, and complete the DNA CPR form carefully.
- A significant part of the facts underpinning the judgment related to the lack of notes.
- Make sure you know the Trust’s policy on resuscitation and involving patients.

Review professional guidance, including the updated Resuscitation Council (UK)/BMA/RCN Joint guidance.

**Infection Prevention and Control**

Infection Prevention and Community Care staff work very closely together to implement a clear approach to Infection Prevention, to reduce harm from avoidable infection and lapses in care. The expectation is prudent antimicrobial prescribing, bare below the elbows and effective hand hygiene are implemented rigorously by *all staff for all patients*.

**Pressure ulcers**

Reduction of harm from pressure ulcers is one of our priorities.
All patients are potentially at risk of developing a pressure ulcer. They are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. Pressure ulcers can cause serious pain and severe harm to patients. They are said to affect up to 20% of patients in acute care, 30% of people in the community and 20% of people in nursing and residential homes. This translates to 700,000 people each year, across all care settings (including patients in their own homes), with the most vulnerable of patients aged over 75 years. The NHS spends up to four billion pounds treating pressure ulcers and related conditions each year and the costs of treating the most severe cases ranges from £11,000 to as much as £40,000 per person. If left untreated or infected, pressure ulcers can lead to severe pain, serious harm or even death.

80 to 95% of pressure ulcers can be avoided by simple measures such as those listed below:

- Pressure relief by means of repositioning and/or the use of pressure redistributing equipment
- Consideration of the needs of the patient when seated in relation to pressure relief
- Improvement of nutritional status
- Skin care including on-going monitoring of skin status and any indications of pressure damage.

It is not possible to prevent all pressure ulcers, but with appropriate care the severity of harm can be significantly minimised. At a very simple level, prevention means identifying those at risk and instigating appropriate prevention according to the needs of the individual.

When harm occurs we need to learn. The Root Cause Analysis (RCA) investigation completed after a patient has developed a category three or four pressure ulcer helps identify how and why the pressure ulcer developed and what could have been done differently. Let’s all make a pledge today and adopt ‘a zero tolerance’ approach to pressure ulcers through learning, prevention and changing practice.

Sign up to Safety
The Trust has joined the Sign up to Safety Campaign which aims to reduce avoidable harm by 50% and save 6,000 lives. Our five pledges are listed below.

**Pledge 1 - Put Safety First**
Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

**Pledge 2 - Continually Learn**
Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

**Pledge 3 - Honesty**
Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

**Pledge 4 – Collaborate**
Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

**Pledge 5 - Support**
Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

Find out more at: [http://www.yorkhospitals.nhs.uk/about_us/patient_safety_/sign_up_to_safety_campaign/](http://www.yorkhospitals.nhs.uk/about_us/patient_safety_/sign_up_to_safety_campaign/)

**Policy Update**

An important policy has been revised recently.


**Flu vaccinations**

To date only 50% of our staff have had their flu vaccination.

There is still time to get vaccinated so contact Occupation Health today!