Introduction

Welcome to the second edition of “Nevermore”. The feedback from the first issue was good in that people found the publication clear and easy to read. This publication focusses on acute care situations and we’ve an additional publication which will be distributed to our colleagues soon.

Never Events and Serious Incidents are not just about reporting and investigating, nor counting the numbers. It’s about the effect they have on the patient and their relatives but also the very real effects on the staff who have been involved in an incident, the so-called “third victims”.

Our policy “Being Open” provides guidance as to how to respond to patients and their relatives when things go wrong and how to observe our now statutory, Duty of Candour. A short slide presentation on this is available on the Learning Hub. We also have guidance for staff, “Supporting staff involved in a traumatic incident, complaint or claim”, which is available via Staffroom.

Nevermore 2 explores issues such as Serious Incidents, DNA CPR and give a summary of our “Sign up to Safety” pledges.

I hope you find it helpful.

Ed Smith
Interim Medical Director
Never Events

Please remain vigilant and aware of what constitutes a Never Event


We recently had an incident of methotrexate being prescribed (but not administered) daily for an inpatient. **Methotrexate should not, unless specifically authorised by a Consultant be prescribed to in-patients and it should NEVER be prescribed daily.**

DNA CPR

It is important to try to discuss DNACPR decisions with patients or their next of kin before making a final decision. It should be recorded on the DNACPR form whether or not a discussion has taken place with the patient and if a discussion has not taken place the reason must be specified. If a conversation has taken place with the next of kin then it must be recorded on the form.

It is over six months since the Court of Appeal’s decision about consulting patients when making decisions involving life sustaining treatment. Has your practice changed? If not, does it need to? Please follow the link below for additional guidance from Stephen Evans of Hempsons Solicitors.

Q:\York Hospitals Trust\Never Events and Learning\A Matter of Life or Death DNACPR article V2.doc

Learning from Serious Incidents

Below are four case studies of Serious Incidents which happened recently in our Trust.

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**Case Study 1 – Delayed Diagnosis**

A patient was referred for admission to hospital twice in nine days with both GP letters raising the possibility of spinal cord pathology, as the patient presented with altered sensation and leg weakness. On the first occasion the letter was not acted upon and on the second an outpatient MRI scan was requested but it took a further 14 days to be done. The combination of these delays resulted in a delay in diagnosis of the patient’s spinal tumour.

The patient was seen by a junior doctor in the Emergency Department (ED) who did not know about the GP letters - which explicitly mentioned the possibility of a Spinal Cord lesion. The junior doctor diagnosed possible constipation and referred the patient back to the GP.
Nine days later the patient was referred back to the hospital after discussion with the orthopaedic consultant who accepted the need for imaging. But on arrival the patient saw the junior orthopaedic doctor who discussed the case with the orthopaedic registrar and advised discharge with an MRI to be arranged as an outpatient. Again there was no acknowledgement of the previous GP letters.

The patient went to the ED 14 days later on the advice of NHS 111 due to lower limb neurological symptoms. The neurological symptoms were found to be unremarkable and the patients was discharged home again and attended the following day for MRI.

Two days later the patient was admitted to hospital, the consultant noted the abnormal MRI results and arranged further urgent imaging which showed a large mass compressing the spinal cord. The patient was transferred to Hull for emergency decompressive surgery.

**Learning**

Carefully consider any referring correspondence. Investigations as an outpatient may be appropriate BUT ensure the patient and relatives understand the plans for follow up. If patients repeatedly presents, consider urgent investigation.

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**Case Study 2 – System Failure**

In October 2012 regional support for the implementation of Customised Growth Charts for pregnant woman was agreed.

Training was provided and the growth charts began to be used for pregnant ladies booking from 26 weeks gestation.

An increase in the number of growth restricted babies was identified but sadly a stillbirth occurred where the scan result was not recorded on the customised growth chart.

During an audit, concerns were raised by midwives and doctors about poor compliance with recording of results and the use of customised growth charts.

The Head of Midwifery, Clinical Lead and Midwives attended the training provided by the Perinatal Institute prior to roll out of the system. However there is little evidence of training or documentation to support implementation and roll out and there was an assumption that all clinical staff had been trained.
Some staff were measuring and plotting correctly on the growth charts, but unfortunately, not all staff.

There were also problems in that the growth charts prompted a rise in ultrasound scanning and it soon became apparent that the scan requirement was significantly more than anticipated and more than we had capacity to support.

There were a number of other issues identified from this incident including failure to discuss the need for additional scans with the Radiology Department, an unplanned increase in referrals to the Antenatal Day Unit, an increase in induction of labour and caesarean sections.

**Learning**

*It is important that when new systems are introduced that a planned training programme is developed, that all staff who are to be involved receive training and that the effectiveness of the training is evaluated.*

*Consequences of new systems should be evaluated prior to implementation to determine any potential stress or additional demand on existing systems.*

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**Case study 3 – Failure to follow up on results**

After the death of a patient, the GP discovered in the case notes a letter which said the patient would be reviewed at an MDT meeting and further follow up would be advised by the hospital. This never happened.

The patient had an outpatient review, following which there was conflicting data from investigations about the exact nature and severity of her problem. As a result of the uncertainty around the need for surgery the consultant planned to discuss the case at the MDT meeting.

Prior to review by the MDT, the patient’s clinical notes went to the coding team for processing and from that point there was neither further follow up nor discussion.

The main findings from the investigation relate to inadequacy of the administrative processes for the MDT. There was no system for recording that the patient’s clinical notes had been seen by other teams, or systems for recording in advance that patients’ were to be reviewed at the MDT meeting. Similarly there was no formal system in primary care for following up patients who had been referred to the hospital but for whom the outcome of investigations was unknown.
Learning
*We should not rely on an individual’s processes or memory for follow up.*

*MDTs should be adequately resourced to ensure that treatment is provided as deemed necessary.*

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**Case Study 4 - Patient Abscond**

A 26 year old patient, who was a frequent attendee to the ED and known to Mental Health Services, was admitted following ingestion of foreign objects. As the patient was refusing surgical treatment – and given their presentation - they were referred to Mental Health Services and placed under Section 5:2 of the Mental Health Act (MHA). The patient absconded shortly afterwards. Security staff and the police were informed, they located the patient and she was brought back to the hospital. The following day the patient was reviewed by Mental Health Services and placed under Section 3 of the MHA. The instruction was that she was to receive 1 to 1 care.

The Ward Sister advised Matron of the patients' needs and attempts were made to increase nursing staff. Whilst this was being organised the patient was escorted to x-ray by imaging support workers but despite supervision the patient absconded again. A thorough search of the site was made and security staff and police informed.

The patient was found and brought back to hospital almost 90 minutes after absconding. During this time the patient had reached a bridge spanning the river, had jumped in and was rescued by a passer-by.

Learning
*Patients who have a history of self-harm should have a Safety Assessment Management Plan which is easily accessible to all staff involved with caring for them.*

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**Policies Update**

The Trust has joined the Sign up to Safety Campaign which aims to reduce avoidable harm by 50% and save 6,000 lives and to join must make a number of pledges.

The Trust pledges are;

**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/