Introduction

In this edition of Nevermore we focus on incident reporting.

It is important that when something untoward happens that action is taken as soon as possible to rectify the situation and it is also important to report it. If incidents are not reported then potentially harmful practices or system errors may continue.

We have had a number of Serious Incidents and Never Events, which have not been reported on Datix, and which we only became aware of via different means. This resulted in delays in the investigation and more importantly in ensuring that patients are safe.

Don’t forget that whenever an incident occurs we should offer a verbal apology to the patient or their relative and in the case of incidents resulting in moderate or severe harm this should be followed up with a written apology.

A link for the template for the written apology is included in this issue.

Recently we launched the Trust Whistleblowing Helpline. If something at work is troubling you and you can’t get a resolution with your manager, then you can raise your concern via the Whistleblowing Helpline at 01904 724488 or 7724488.

Regards

Ed Smith
Interim Medical Director.
Never Events – Changes from April 2015

The list of Never Events has been revised.

The amended list is available via the following link, as is a short synopsis of the changes. It is vitally important that we report Never Events as soon as they are recognised Q:\York Hospitals Trust\Never Events and Learning\Nevermore 3\Never Events 2015 doc.doc

Learning from Serious Incidents

Below we present a summary of two Serious Incidents (SIs) that have significant learning.

A key feature of these is that they were not recognised at the time of the event, the Trust being alerted to them only when the Coroner contacted the Trust to advise that inquests were to be held.

Case Study One- Death following Liver Biopsy.

A male, aged 74 was admitted and found to have abnormal clotting, raised liver enzymes and possible metastases in the liver. Liver biopsy under ultrasound control was performed, although the patient remained on low molecular weight heparin (LMWH). The consent procedure was not followed. The Cardiovascular and Interventional Radiological Society of Europe (CIRSE) checklist, that may have identified this anomaly, was not used. The patient deteriorated a few hours after biopsy and was reviewed by a locum SpR who made the diagnosis of sepsis, which subsequently proved to be incorrect. He also made the decision that resuscitation was not appropriate. The patient died and post mortem showed that he had suffered an intra-abdominal haemorrhage.

Findings from the incident investigation.

- The patient had a liver biopsy urgently when it should have been delayed until the blood abnormalities had been corrected.
- There was failure to identify and treat the haemorrhage. This ultimately resulted in the patient’s death.
- The pre procedure checklist was not used.
- The consent procedure was not correctly followed.
Contributory factors

- Human error in not obtaining an up to date INR/clotting screen in relation to the timing of the liver biopsy and the need to stop heparin/aspirin.

- Failure to recognise and manage post procedure bleeding despite significant evidence to suggest this, and failing to seek senior advice.

- No clear and agreed protocol in Radiology, specifying what form of consent is needed for procedures and investigations, nor how that consent will be recorded, and no clear agreement regarding criteria for safe liver biopsy.

- CIRSE patient safety checklist was not used.

- Standard request card design is inadequate for interventional procedures.

- The locum SpR had never worked in the Trust before.

A full copy of the report is available on the Patient Safety intranet page. Go to Staff Room/Corporate Information/Patient Safety/Nevermore and Serious Incidents.

Lessons learnt

Clear documentation including protocols and consent forms for all interventional procedures should be in place to prevent assumptions being made about the patient’s status to undertake any procedure. Local induction of temporary staff should always take place and available checklists must always be followed.

Case Study Two – Delayed Diagnosis.

An 80 year old patient presented to the ED following a fall at home down the stairs. The patient was complaining of neck pain and was admitted to hospital. The patient continued to complain of neck pain, but x-rays were reported by Radiology as showing no fracture. The patient was noted to be in retention of urine but did not develop any other gross neurological signs until approximately one week after admission, when they were noted to have marked weakness of both arms.

Urgent MRI scan of the spine showed a marked subluxation of C6 on C7 with associated cord compression at that level. The patient was transferred to the
care of the neurosurgeons in Hull but died of bronchopneumonia and venous thrombo-embolism.

Findings from the incident investigation

- The significance of the findings of on-going neck pain and stiffness in this patient were not appreciated (or acted upon) by a number of clinicians who were involved in the patient's care. False reassurance was provided by the x-ray report of “no fracture” that came from radiology.

- It was also noted that the patient had not had prophylaxis against venous thrombo-embolism prescribed on the drug chart, despite relative immobility after admission to hospital. It is postulated that inadequate thrombo-prophylaxis may have contributed to the development of the venous thrombo-embolic disease that led to the patient's death.

Contributory factors

- In this case there were no contributory factors noted.

A full copy of the report is available on the Patient Safety intranet page. Go to Staff Room/Corporate Information/Patient Safety/Neverymore and Serious Incidents.

Lessons learnt

All clinicians have the potential to miss injuries, especially those that present in subtle or atypical ways. If such an injury is suspected, get help from the appropriate specialty in assessing the patient.

Do not rely on radiology reports alone as plain radiography in particular is far from perfect in excluding bony injuries that may be subtle or simply invisible on the initial studies. A high clinical index of suspicion should lead to further examination and/or imaging at any stage of a patient's admission.

Post Take Ward Round (PTWR)

The use of the PTWR checklist is mandatory.

It is vitally important that the checklist is used along with other relevant documentation i.e. SBAR, to ensure the safety of all our patients.

Case Study

A 69 year old man presented with a three day history of cardiac sounding chest pain. He was assessed by a doctor in ED at 17.42 and was thought to have
probable cardiac chest pain. He was given Aspirin 300mg and was admitted to AMU.

On the ward he was clerked by a doctor at 07.45 the following morning. There was no mention in the clerking as to whether the ECG was reviewed or whether a drug chart was written out. The patient was seen soon after by a Consultant on the PTWR. As there is no time on the PTWR entry in the notes, it is difficult to know when the patient was seen. Some of the boxes in the PTWR checklist had been ticked as having been done. These include bloods, VTE assessment and drug chart.

Unfortunately there was no signature at the bottom of the PTWR entry to determine who had completed the list. It was decided on the PTWR that the patient was describing angina and needed cardiology referral. There is an entry in the case notes at 12.00 from one of the AMU nurses documenting the fact that there was no drug chart and that the patient would be transferred to another ward.

There was no SBAR form in the notes relating to the transfer. It has emerged that the patient was transferred by a transfer team member who did not know the patient and only read what had been written in the notes. The nurse has also confirmed that when the patient was handed over, she was told that the patient had a normal Troponin measurement, although this was incorrect as the Troponin was raised.

The patient remained without medications until 10.30 am the following day. The consultant on that day noted that the Troponin was elevated at 259 and therefore took a referral to Cardiology. Before he could come back and write in the notes, the patient had been reviewed by the Consultant Cardiologist on call and he expressed concern that the patient had had no senior assessment and that the patient was not on any medications. The drug chart was written up by another Consultant straight afterwards.

The patient was subsequently found to have a 99% distal RCA stenosis on angiography and went on to have stents.

Beware the nocturnal headache!

There have been some cases of misdiagnosis of headache in patients presenting to the Emergency Departments over the last few years. It is very difficult to make positive diagnosis of causes of headache on clinical findings alone unless classical features are present. Patients will often give a family history, or even a personal history, of migraine. However be very wary of making a new diagnosis of migraine in patients that present in the middle of the night.

The cases that we have seen locally have usually turned out to be Subarachnoid Haemorrhage (without a classical presentation for that condition), however other
patients have had strokes and the most recent case (a young man who was found dead at home shortly after being discharged from ED with a migraine diagnosis), was probably suffering from meningoencephalitis.

The additional effort required to present acutely at 0500 rather than 1700 is considerable. That must always be taken into consideration when forming a diagnosis in patients with headache who attend the ED. If in doubt, admit and observe. Get a senior review. But be very cautious about discharge.

**Saying sorry……**

Saying sorry when things go wrong is vital for the patient, their family and carers, as well as to support learning and improve safety. Of those that have suffered harm as a result of their healthcare, fifty per cent wanted an apology and explanation. Patients, their families and carers should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has occurred.

Follow the link to read the full guidance

**…… and Duty of candour**

It is very important when things go wrong that an apology and a full and prompt explanation is given to the patient and their relatives. In cases of moderate or severe harm we have a statutory obligation to write to those involved advising them of the process of investigation and giving them a timescale in which we will contact them. A draft template letter has been developed for those staff who will be sending these letters and this is available using the following link: Q:\York Hospitals Trust\Never Events and Learning\NM 3 Community\Duty of Candour letter.doc

**Litigation update**

Clinical negligence claims brought against the Trust are managed within the civil litigation process. A claim is against the Trust, not an individual. Clinicians are indemnified for their NHS work, by the Trust’s membership with the NHS Litigation Authority (NHSLA) called the Clinical Negligence Scheme for Trusts (CNST).

A claim will succeed if it is accepted that there has been a breach of duty (care fell below an acceptable standard) and that this caused an injury or damage to the patient.

The following tables provide information from the NHSLA’s database of York Teaching Hospital NHS Foundation Trust claims.
Number of Claims

Top Claim Specialty - Volume
For claims settled 2012 – 2014 the common themes were:

- Failure to adequately interpret radiology.
- Results not acted upon.
- Failure to investigate further.
- Inadequate nursing care e.g. lack of risk assessment for falls or pressure ulcers, lack of observations.
- Inadequate surgery e.g. intraoperative fracture, failure to identify structures, excessive use of diathermy, failure to identify intraoperative problems.

In terms of actions to address the root causes of the claims Directorates are sent the outcomes of the claims and are asked to develop action plans. The actions on learning from claims is monitored by the NHSLA as part of assessing the Trusts CNST contribution.

**Patient Safety Conference – May 2015**

General feedback on the day was very positive with delegates saying there was a “buzz” about it but also that it felt relaxed. They also said they thought the quality of the agenda and speakers was good. Feedback from the opinion survey has ratified these comments.

In terms of organisation, delegates felt they had had enough information up front to make decisions about attending and which sessions they would choose.
The morning session started with an entertaining speaker who some said set the
tone for the day. Positive feedback has been received about all the key note
speakers.

Feedback from the Poster competition was excellent with 43 entries being
received and the final 3 making informed presentations at the end of the day to
the delegates.

Trust staff provided us with some information stands which proved very popular
and these were interspersed with commercial exhibitors.

A planning committee is being set up for next year’s conference; anyone
interested in joining should contact Diane Palmer, Deputy Director of Patient
Safety on ext 1998.

**Mental Capacity Act/Deprivation of Liberty**

**Case Study**

A patient was admitted to Care of the Elderly via the ED. The patient was
referred by their GP for an x-ray as, although no case of trauma was known, they
had been unable to weight bear for several days. X-ray indicated fracture left
neck of femur.

The patient was admitted for surgical repair in accordance with the fractured
neck of femur care pathway.

**Review**

There was evidence from the onset of admission that the patient’s capacity
should have been assessed. Cognitive difficulties had been cited on a previous
capacity assessment.

It appears that the patient had fluctuating capacity which then gave rise to
uncertainty about the Mental Capacity Act framework. There was also a
difference of opinion by professionals regarding the patient’s capacity.

Matters were further complicated by the patient consenting to treatment then
“changing their mind”.

Best interests were discussed despite the anomalies over capacity.

**Best Practice within Mental Capacity Act Framework**

A patient’s capacity should be assessed based on the specific decision and in
a timely manner by the medical team proposing treatment. If, at the point of medical treatment proposal the patient lacked capacity then best interests consultation and actions should follow.

There was no reason to suggest the patient’s partner was not acting in the partner’s best interest. Their involvement supported the patient’s previous views within best interest discussions and the option of “No surgery” (least restrictive) would have been included in this.

There was no requirement for an Independent Mental Capacity Advocate (IMCA) unless it was believed that the patient’s partner was not acting in the patient’s best interest.

If the patient was assessed as having capacity and refused surgery then appropriate measures should have been instigated to proceed with discharge and aftercare.

Any capacity assessment should include whether the patient was likely to regain capacity. “Would the patient be able to regain sufficient capacity to understand the proposed treatment?”

It was documented that the patient suffered multiple anxiety issues and physical bouts of confusion. This could have indicated that regaining sufficient capacity to understand the impact of the patient’s decision may not be possible. An early assessment of capacity could have established this.

**In this case there was confusion regarding:**

1) Who should perform an assessment of capacity.
2) When this should be done.

The patient’s fluctuating capacity also contributed to staff confusion.

There appeared to be a lack of confidence in taking ownership of the decision to either state that the patient lacked capacity and therefore proceed to best interests or acceptance that the patient’s decision to not have surgery was capacious and to discharge the patient with the appropriate aftercare.

There was no application for a deprivation of liberty authorisation – this may have been necessary if the patient had lacked capacity to consent to the treatment.

**Outcome for patient**

The patient’s partner disputed the fact that the patient had capacity. This was taken to the Court of Protection and the Trust incurred the costs. The court order agreed that the patient lacked capacity and that surgery should only take place in the patient’s best interests.
The court order also stated that a Deprivation of Liberty authorisation should be sought.

**Learning**

Assessment of capacity should be embedded within the admission process for patients. Support mechanisms for managing Mental Capacity and Deprivation of Liberty matters are available though clearly not widely known.

The Trust Statutory and Mandatory Training programme includes Mental Capacity Act and Deprivation of Liberty Training. An intranet resource page has been made available which includes the guidance and paperwork necessary together with contact information.

The Trust Safeguarding Adults team have begun a regular ward contact programme to reinforce the support available and capture any immediate issues.

A pocket guide for all potential decision makers is also being distributed. Decision makers should also be aware of their own responsibilities under the Mental Capacity Act and Deprivation of Liberty codes of practice.

In mitigation there has been a change to the criteria in which Deprivation of Liberty (Cheshire West Supreme Judgment) may apply which has a huge impact on patients in our care who are viewed to lack capacity. There has been limited guidance on how to implement this judgement in acute settings. However an implementation plan has been submitted to the Board of Directors and the Safeguarding Adults Team continue to target specific high risk areas with support.

**Useful links:**


http://staffroom.ydh.yha.com/Learning-Development-and-Professional-Registration/safeguarding-adults

Follow the link to Q:\York Hospitals Trust\Never Events and Learning\Nevermore 3\Mental Capacity Act 2005 (A7).pdf