Introduction

In this issue we look at a Serious Incident case regarding a medication error in which a patient was over-prescribed steroid medication.

We also examine a Serious Incident regarding a systems failure, during which staff missed three opportunities to refer a child, who had suffered sexual abuse.

There is also information in this issue about our Trust's Patient Safety Conference, which is now in its third year, following two previously successful events.

Regards,

Lisa Pinkney
Patient Safety Manager
Case study 1: Medication Prescribing Incident

A 74 year old gentleman died of bronchopneumonia following a five week course of Dexamethasone 8mg twice a day

The Dexamethasone was originally prescribed whilst the patient was in hospital receiving support for cerebral metastasis. However, the high dose was continued on his discharge prescription and then by his GP until the patient was reviewed in the hospital Outpatients department five weeks later. The patient died and was referred to the Coroner.

The Coroner felt that the Dexamethasone had contributed to the patient’s death, in that this had reduced the body’s ability to withstand infection and made the patient more susceptible to pneumonia.

There were several contributory factors in this case, the two main themes were that there are no Trust guidelines to support prescribing of steroids in palliative care, and the patient was not followed up in an appropriate time scale.

Recommendations following investigation:

- An indication and review date should be annotated on all prescriptions for oral steroids.

- There should be clear instructions regarding length of oral steroid courses and reducing doses on discharge prescriptions.

- 16mg of Dexamethasone is equivalent to over 100mg Prednisolone and the Trust would not, normally, discharge a patient on this dose.

Lessons learnt

The palliative care team are currently working on guidelines to support steroid prescribing. However, to make sure patients are maintained on the lowest possible dose, please can prescribers ensure that the indication and a review date is documented for all patients on dexamethasone in the notes, on the drug chart and on the discharge letter.

Case study 2: System Failure

A child (Patient A) attended the Emergency Department (ED) with thoughts of self-harm. The child shared their experience of previous sexual abuse with the doctor, and was then referred, seen and assessed by the Child and Adolescent Mental Health Services (CAMHS) in ED, who documented that Patient A was safe to go home under the care of their parent. No consideration was given to discussing the need for an assessment by a paediatrician specialising in Child Sexual Assault (CSA) and there was no discussion regarding accessing sexual health services at this attendance.
Patient A attended the ED a second time (one month later), having taken an overdose of Paracetamol. The patient disclosed previous experience of sexual assault but again there was no discussion with a paediatrician who specialises in CSA or a referral to sexual health services. On this occasion Patient A was admitted to the children’s ward and assessed by CAMHS, who documented that there was a safety plan in place. The patient was discharged home two days later with a follow up appointment with CAMHS for four days after discharge.

Ten days after the CAMHS outpatient review, the patient attended the Genito-Urinary Medicine (GUM) clinic without a parent. Patient A requested a chlamydia test at the reception and disclosed to the receptionist that they had previously been sexually assaulted. The receptionist spoke to the Sexual Health Nurse who advised that an appointment be made to attend the clinic. At this stage the nurse was not aware that the patient had presented to the clinic and thought there were on the telephone. Patient A was given an appointment for later that day but did not attend.

On the following day, the Lead Nurse in the GUM clinic emailed the Sexual Assault Centre to check if Patient A was known to them. At this point they were not, therefore a further appointment was made which Patient A attended and was seen jointly by the Lead Nurse for Sexual Health and the Lead Nurse, Child Sexual Assault Assessment Centre.

**Findings**

This investigation highlighted a failure to seek advice for Patient A on three occasions from a paediatrician specialising in Childhood Sexual Abuse, or to refer to the GUM clinic to ensure all services and support were offered. These were missed opportunities to provide support.

**Recommendations following investigation:**

- Raise awareness about the sexual assault centre service and the process to escalate to a paediatrician where CSA is suspected. Review current training provision in relation to child sex exploitation.


**Lessons learnt**

All children who present to the Emergency Department or Children’s ward who disclose sensitive information of sexual assault, whether or not a child protection plan is in place should be referred to a paediatrician who specialises in CSA for advice.
**Preliminary Agenda**

09.00 – 09.40  Registration, refreshments, exhibition and poster gallery

09.45 – 10.00  Opening address

10:00 – 11:15  Leading to High Reliability: A Cultural Transformation  
                Dr. Lori Paine, Armstrong Institute for Patient Safety and Quality, John Hopkins Medicine, Baltimore

11:15 – 12:00  Safe, Effective Person Centred Care in Reduction of Mortality  
                Dr. John Harden, Quality and Safety Lead, Scottish Government

**12:00 – 13:00 Lunch, exhibitions and poster gallery**

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| Pressure Ulcer Prevention and Chronic Wound Management  
Prof. Jane Nixon | Application of Human Factors Methodology  
Dr. Shelly Jeffcott | How to write a grant application | |
| Improving Safety for Patients who have Delirium and Dementia  
Dr. Rod Kersh | The Value of Accurate Record Keeping  
TBC | How to write for publication | |
| Involving Patients in Improvement  
Dr. Beverly Slater | An Introduction to the York Care Collaborative  
Dr. Andrew F. Field and  
Mr. Steven Reed | Statistical support | |

15:00 - 15:15  Anaesthesia Clinical Services Accreditation and Patient Safety  
Dr. Nigel Penfold

15:15 – 16:00  Medical Manslaughter: Individual and collective responsibility/culpability  
Mr. Simon Jackson Q.C.

16:00 – 16:10  Presentation awards

16:10 – 16:30  Closing remarks  
Mr. Patrick Crowley

If you would like to submit an abstract for an oral or poster presentation, please register your entry on the proforma available on the Trust website: [https://www.yorkhospitals.nhs.uk/about_us/patient_safety_/patient_safety_conference_2017/](https://www.yorkhospitals.nhs.uk/about_us/patient_safety_/patient_safety_conference_2017/). Email your completed entry to字符.Craig@york.nhs.uk. The closing date for submissions is **Monday, 15th May**. For additional guidance and support on abstract submissions please contact lisa.pinkney@york.nhs.uk.

To reserve a place, please contact Liz Jackson on ext (772)1216 or liz.jackson@york.nhs.uk

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