Introduction

In this issue we look at a Serious Incident investigation regarding a patient fall with severe harm in a community hospital.

We also examine a Claim regarding a Category 4 pressure ulcer, during which staff failed to assess and monitor a patient correctly.

Finally, we examine a Never Event where a drug was mistakenly administered to a palliative care patient in a community hospital.

We hope you are continuing to find Nevermore for the Community interesting and informative. We have published previous editions and linked Serious Incident reports on our Staffroom/Patient Safety intranet page. You can find this by looking under Corporate Information: http://staffroom.ydh.yha.com/corporate-Directorate-Information/patient-safety/nevermore-and-serious-incidents
Also published there are Sign up to Safety updates.

Regards,

Lisa Pinkney
Patient Safety Manager
A 94 year old patient was admitted to St Helens Hospital for rehabilitation, following an inpatient stay at York Hospital after a fall at home two weeks before. The patient had a confirmed medical history of dementia, ischemic heart disease and macular degeneration. On initial assessment at St Helens the patient was identified as being at risk of falls, as there was a clear history of falls both at home and as an inpatient at York hospital. The initial assessment identified an increased need to monitor the patient to ensure falls risk factors were controlled.

Interventions were put in place which included being nursed in a high observation area of the ward, falls sensors placed on the bed, arm chair and wheelchair and hourly rather than two hourly COMFE rounds.

A Montreal Cognitive Assessment (Mo.C.A) was performed by the occupational therapist which demonstrated that the patient had a lack of cognitive ability.

Some three months later the patient was still in hospital and was walking with a frame to the toilet with the assistance of two members of staff. The patient stated they were falling. The staff members used a controlled lowering technique to get the patient safely to the floor. This was reported as a near miss on the Datix incident reporting system at the time. Following this it was agreed by the MDT that the patient should mobilise with two staff for safety.

A day later, the patient was left unattended in the wheelchair while a staff member went to find someone to assist with their transfer back to an arm chair. Whilst the patient was left unsupervised another member of staff walked past the patient's room and witnessed the patient trying to stand. The staff member rushed towards the patient but failed to get there before the patient fell to the floor. It is unclear from the records and staff interviews if the call bell was with the patient at the time of the incident. The falls sensor was in place but did not alarm at the time of the incident and the staff nurse attending the patient reported that the falls sensor had not been connected.

The patient’s son was informed of the fall and an apology was given by the staff nurse.

Following the fall, the patient’s hand was reviewed daily by medical staff, ACPs and nursing staff, pain was documented as gradually increasing and a week later a nurse asked for the ACP to review again when swelling was still noted on left hand. The ACP requested an X-ray, the patient attended the same day and a fracture of left metatarsal was confirmed.

**Findings:**

This investigation found that the patient was left unattended without a falls sensor connected and possibly without reach of a call bell even after continued and on-going risk assessments had indicated that the patient was at risk of falls.
Reassessment of the patient’s transfers and mobility should have been reviewed and clearly documented following the patient having diagnosis of urinary tract infection and increased confusion. A care plan should have been initiated to monitor the patients hand and pain as a seven day delay was evident in diagnosing the fracture.

**Recommendations following investigation:**

- Confused patients or patients with sensory deficits should not be left unattended in wheelchairs.

- Staff need to check that falls sensors are connected and in full working order. Patients with a falls sensor in place need to be on one hourly Comfe rounds.

- Care plans need to be initiated to monitor patients after a fall.


- The new e-learning fall training is now on-line. Please go to: [https://learninghub.yorkhospitals.nhs.uk/auth/saml/login.php](https://learninghub.yorkhospitals.nhs.uk/auth/saml/login.php)

**Lessons learnt**

*The nurse call bell should always be left in reach of the patient. If patients do not or cannot reliably use a call bell there should be increased patient checks in place (Comfe round) to ensure patients are safe and have everything they require.*

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**Case study 2: Pressure Ulcer Claim**

The Claimant was receiving daily home visits from the Community Nursing Team, and a pressure risk assessment was carried out. The level of risk was recorded as low to medium. The Claimant was using an air mattress at this time, but the visiting nurse felt that a foam mattress would be more than adequate for the patient, and advised on the benefits of changing to a foam mattress. The Claimant was initially reluctant to do so; however a month later agreed to change the mattress to foam.

At this time the Claimant began to receive further daily home visits from the Community Nursing Team for treatment for a Category 2 pressure ulcer to the sacrum area. Three days following the Category 2 diagnosis, a pressure risk assessment was repeated, and recorded as high risk. Following advice from the District Nurses a day later the Claimant was provided with a double air
mattress and an air cushion, and was again reviewed by the District Nurse, who found that the air mattress was not working and had a faulty pump. This was exchanged for a single alpha mattress. The Claimant was advised of risks of a single mattress on a double bed. Two days after this, it was noted that there was a deterioration of the ulcer by the District Nurse who found that the wound was now approximately 5 x 7cms either side of sacral cleft and possibly a Category 3 ulcer. The Claimant was prescribed antibiotics, and further daily visits were made by Community Nursing team. It was noted that there was no signs of clinical infection upon review. A week later, the Claimant complained of pain when visited by the District Nurse, and deterioration of the pressure ulcer was noted from Category 3 to Category 4. The wound was dressed as per the wound care plan, and pressure relief advised.

Findings:

Although the pressure ulcer was noted to have developed unavoidably, it was accepted that once it had developed there was a failure to adequately assess and monitor the wound, and failure to involve the Tissue Viability nurse. Had this occurred appropriately the deterioration may have been avoided.

Recommendations following investigation:

- The new Pressure Ulcer Prevention and Management Policy has a mattress choice chart as an appendix. Please follow the link: http://staffroom.ydh.yha.com/policies-and-procedures/clinical/a-z-list-of-clinical-policies/a-z-integrated-documents/pressure-ulcer-prevention-and-management/view

- Staff members are encouraged in the new Trust Pressure Ulcer Screening and Risk Assessment Tool to assess patients as either ‘not at risk’ or ‘at risk’ and follow the care plan guidance arising from this. This is also in the new Pressure Ulcer Prevention and Management Policy.

Case study 3: Never Event-Wrong Route Medication

A patient was receiving palliative care in the last days of life at a Trust community hospital when this event occurred. The patient was reviewed by the Consultant and an infusion of analgesia via a syringe driver for pain relief was prescribed. The syringe driver was commenced, which contained morphine and midazolam.

A day later, (Day 2) the syringe driver was renewed as it was pulled out by the patient. At this point the prescription chart was not signed correctly. The Controlled Drug register (CD) however, was updated appropriately.
On Day 3 the syringe driver was renewed again by RN 1 and RN 2. There was no record of morphine being administered in the CD register on Day 3.

On Day 4, the syringe driver was again renewed. The discovery was made at this point that morphine was not documented in the CD register, and a stock check identified that none had been used for previous syringe renewal. The next day (Day 5) the Deputy Sister asked the RN on duty to ascertain what had been done on Day 3. RN 1 involved in the syringe set up on the day of the error was asked why the morphine had not been recorded on the CD register. They then realised that Oramorph had been put in the syringe.

The patient died peacefully the next day of adenocarcinoma of the oesophagus.

Following a review of the incident report this was identified as a Never Event.

Findings:

- Syringe driver checks were not consistently carried out every four hours, as per requirements of the policy. At around 19.00 on Day 3 the syringe driver started to alarm and needed a new syringe. RN 1 did not want the patient to be in distress so felt she should renew the syringe. She knew she had not had any training but could remember how to carry out the task from her student nurse observations which she had just recently completed.

- RN 2 had not had any experience or training with syringe drivers. RN 1 spoke with RN 2 and told her she had used syringe drivers before and that the syringe needed renewing and asked that RN 2 came to meet her in the drug preparation room. RN 1 reviewed the chart and saw that Morphine was prescribed and thought it must not mean Morphine Sulphate. She therefore thought it was not a controlled drug as it is stored in the drug trolley.

- The bottle of Oramorph did not have a purple bottle adaptor in it therefore there was no physical visual prompt to remind staff that this was an oral medication and also allowed the medication to be drawn up in a none oral syringe.

- On Day 3 the patient required five doses of Oramorph suggesting the syringe driver was not effectively managing pain.

- The Ward Sister informed the lead investigator that over the last two years they had only had three patients requiring a syringe driver. All the staff that used the syringe driver had been trained but evidence suggests they had not maintained competence, with the exception of
the two staff members involved in the actual incident, who had not had any syringe driver training.

**Recommendations following investigation:**

- All registered nursing staff are required to undergo refresher training for T34 syringe drivers. Training has now been carried out. The Policy for syringe drivers can be found at: [http://staffroom.ydh.yha.com/policies-and-procedures/clinical/a-z-list-of-clinical-policies/a-z-integrated-documents/t34-syringe-driver-protocol-on-the-use-of/view](http://staffroom.ydh.yha.com/policies-and-procedures/clinical/a-z-list-of-clinical-policies/a-z-integrated-documents/t34-syringe-driver-protocol-on-the-use-of/view)

- The two RNs involved in the incident are required to demonstrate competence in medicines administration.

- Pharmacy to review the process for purple bottle adaptors. Since this Never Event, Pharmacy Dispensary now dispenses oral bottle adaptors for Oramorph which do not fit other drivers. Pharmacy dispensary has also worked on a SOP around this process, which will be available soon.

*Nevermore is produced by the Patient Safety Team and we welcome contributions. Please email: Lisa.pinkney@york.nhs.uk*