Introduction

In this issue we look at three incidents which occurred in the community: two Serious Incidents referring to pressure ulcers, and a Claim against the Trust related to a series of falls. Although the cases have different presentations they offer some similar learning points. These highlight that general issues regarding Patient Safety are not always specific to one clinical area, and do not always result in Serious Incidents, yet we can still learn from them.

Additionally, we introduce you to the NHS Improvement Report, which is a response to all nationally reported incidents. Often, when frontline staff report an incident they do not receive feedback or response about how the information is used nationally to improve practice and share learning. This report, which we welcome, details the National Reporting and Learning System’s actions in response to incident reports submitted to them, with an online link to the report for further reading.

We publish 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 patient was initially referred to the District Nurse (DN) team due to deteriorating mobility associated with Multiple Sclerosis (MS). The patient had a full assessment, which included a mobility assessment and pressure risk screening. The patient was provided with a profiling bed and static foam mattress. At this stage the patient’s pressure areas were intact and advice was given regarding pressure area care. The patient was mostly able to manage their own care needs with support from their son and daughter. Offers of a formal care package were declined at this stage; the patient had full capacity to make this decision and felt they were managing well and living a fairly active life. The patient was discharged from the DN caseload following this episode of care.

One month later the patient was again referred to the DN team for a review of continence products. The assessment highlighted that the patient had an increased level of incontinence that required a more absorbent continence product. A holistic assessment including a pressure risk assessment was not undertaken at this point, the patient was again discharged from the DN caseload, and the patient informed the nurses that they were able to manage their care with family support.

A couple of weeks later, the patient’s son contacted the DN team to report that the patient had a pressure injury. The patient was visited that evening; an unstageable pressure ulcer was identified on the sacrum and a Category 2 ulcer identified on their left lateral malleolus. A full pressure ulcer risk assessment was carried out the following day by the DN and at this visit the left malleolus was re-categorised as Unstageable and an appropriate dressing plan was put in place.

The patient was reported to be thin, with leg contractures; these were being treated with Botox. During the ten days since the patient was last seen by the DN team they had rapidly deteriorated with reduced mobility, deterioration of bladder control, lethargy, reduced appetite and lack of motivation.

The patient was already using a profiling bed with a high risk static foam mattress and this was upgraded to a replacement alternating air mattress. Information and education were given regarding pressure ulcer prevention. This included a pressure ulcer prevention leaflet and repositioning advice. Referrals were made to the Tissue Viability Nurse (TVN), Wheelchair Service, Social Services, Occupational Therapy Physiotherapist, Rapid Response Care Team, Safeguarding Adults Team, GP and Dietitian.

An appropriate plan of care was put in place for the DN team to care for the wounds; this included a foam dressing to the sacral wound to prevent over granulation and an alginate gel to debride the malleolus wound. The TVN debrided the sacral wound and it was then categorised as Category 3. The left lateral malleolus was categorised as Unstageable due to being 100% sloughy.

Findings
• The DN team failed to carry out a holistic risk assessment including a screening, which would have led to a full risk assessment during the second referral visit.

**Recommendations following investigation**

• Ensure that holistic assessments are carried out rather than tasks only.

• The importance of documenting and adhering to the Trust policy regarding Pressure Ulcer Risk Assessment.

• Share the RCA report with teams to highlight the importance of completing holistic assessments.

**Lessons learnt**

• *The importance of carrying out pressure ulcer screening, in that every contact with a patient is an opportunity to holistically assess them.*

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**Case study 2: A Claim Following a Series of Falls**

The patient had a known history of falls and severe dementia, and attended an Emergency Department at the Trust following a fall at home. They sustained a fractured neck of femur and underwent surgery with no complications. Three days following admission to hospital the patient fell and banged their head on the floor. Observations were taken, the doctor was called to review the patient, and their bed was moved closer to the nurses’ station to aid observation in an effort to prevent further falls.

One week later, the patient was transferred to a Trust Community Hospital and suffered a number of falls during admission. The patient underwent a hip x-ray which confirmed no new bony injury, and a falls risk assessment was then completed which highlighted a high risk of falls. The patient suffered a further fall on the day after transfer to the Community Hospital, and complained of pain to their right shoulder with some bruising. An urgent x-ray was carried out which did not show any evidence of fracture but possible mild subluxation of a previous shoulder replacement. No further treatment was initiated and the discomfort settled. The patient suffered further falls but none of these resulted in significant injury.

The patient made a claim against the Trust following the series of falls above, and the Trust admitted a failure to complete a falls risk assessment and implement a falls care plan on admission within a reasonable timeframe. It was also noted that falls risk assessments were not repeated on transfer, and that the level of observations provided was inadequate and should have been more frequent given the patient’s condition. With regards to Causation, it was also accepted that if a medical review had been requested following the second fall, the injury would have been detected earlier and the patient’s pain and discomfort would have been treated earlier.
This claim settled for £5,000.

This claim did not result in a Serious Incident investigation, as none of the in-hospital falls caused serious harm to the patient, yet they did not receive appropriate care. This was recognised by both independent legal experts and the Trust. This case highlights the necessity of carrying out falls risk assessments, and getting a medical review following a fall at all times for patients.

Case study 3: Pressure Ulcer Incident

This incident refers to a patient with a Category 3 pressure ulcer to the sacrum.

The patient had been discharged from Scarborough Hospital following a stroke. A full package of care and appropriate pressure relieving equipment was in place on discharge. Following discharge, the patient was being visited regularly by the Specialist Stroke Team, Occupational Therapist (OT) and Speech and Language Therapist (SLT). The OT regularly gave advice to the patient and their carer (family member) regarding positioning and pressure area care.

On the day of discharge a referral was made to the District Nursing (DN) Team for a continence assessment only. The continence assessment was carried out by the Community Health Care Assistant (HCA). No further assessment took place and the patient was discharged from the DN caseload.

On three further occasions the patient was referred to the DN Team by the GP practice for blood tests. Again, no further assessments were undertaken and the patient was discharged. These were missed opportunities for the DN Team to provide further advice and support to the patient, the family carer and the care agency.

Four months later, the patient was referred to the DN Team by the care agency as they were concerned about the patient’s skin integrity to the sacrum. The patient had been unwell and spent the previous ten days in bed; and this was found to be a contributing factor to the deep tissue damage that occurred, which was an Unstageable pressure ulcer and a moisture lesion.

Two days after this referral the Specialist Stroke Team OT visited. The patient’s carer stated that the patient had been unwell and not been out of bed for the previous two weeks. During this time the family carer had not nursed the patient on their side as they were not able to feed them in this position. The OT again emphasised the importance of repositioning and sitting out of bed to reduce the risk of pressure sore development.

Three weeks later, the Specialist Stroke Team OT re-visited the patient; the patient’s carer reported that the mattress was not working correctly. The OT
contacted the equipment provider to report the fault and was informed that it would be repaired the same day.

Two days later the Community Nurse identified that the pump for the alternating mattress was still not functioning properly; there was a delay in this being replaced due to the out of hours service provided by the equipment company. However, the mattress being used was still able to provide a degree of pressure relief. This may have been a contributing factor to the deterioration in the pressure ulcer. A new mattress and pump was delivered the following day. A Datix Report was completed for the pump failure issue.

On this day the ulcer was re-categorised from Unstageable to Category 3; this was confirmed by the Tissue Viability Nurse (TVN).

One month later, the patient was admitted to the Community Hospital for end of life care.

Findings
- When discharged from hospital the patient should have undergone a full risk assessment by the DN Team. The referral came via Single Point of Access (SPA) requesting a continence assessment; this task was dealt with by the HCA who completed the request. Better communication and referral information between hospital and community staff would have been beneficial.
- The patient could have been changed on to a very high specification mattress (mercury advanced is deemed appropriate for patients at high risk).
- Earlier intervention would have been beneficial for support and education for the husband and carers; this may have resulted in a referral to the DN Team when the patient was unwell and unable to get out of bed.
- Failing equipment.

Recommendations following investigation
- The RCA report should be shared with the multi-disciplinary team to highlight the importance of carrying out holistic assessments rather than focusing on tasks.
- Closer liaison with the SPA Development Project Group would be helpful regarding referral information.
- Failing equipment should be reported and escalated to the line manager and contracting, if this is an issue. Highlight alternative options to staff.
- Care agency staff should be contacted and met with to discuss the incident and triggers for referrals to the DN Team.
- DN Team should discuss incident with Adult Safeguarding Team.

Lessons Learned for all Three Cases

In all three of these summarised cases, the recurring findings from investigation relate to failure to promptly and adequately complete the
appropriate risk assessment. They offer similar learning for staff around the need for holistic assessment of patients and for staff to think about the patient and their individual needs carefully, rather than basing the care on specific tasks.

**NHS Improvement Report**

**NHS Improvement report**

Reporting to the National Reporting and Learning System (NRLS) continues to grow and they now receive over two million incident reports each year. This report explains how they reviewed those reports in the period between April and September 2016 and describes the action they took as a direct result – whether by issuing a Patient Safety Alert or working with partners.

The NRLS offer a number of cases in their report which have prompted further action nationally. Two are described below.

**Risks with text messaging in community nursing teams**

We identified risks associated with community nursing teams using text messaging in two separate NRLS incident reports. Text messages were used to communicate important information about the care and treatment of patients but this was either not transmitted or not read in a timely manner.

In the first incident report the phone company’s processing of the message delayed its receipt. The second report referred to delays in the recipient of the text message being aware that information requiring action had been sent. We were concerned about a potential impact on patient safety unless there was a systematic approach to checking messages had been received and teams had capacity to respond. We asked the Royal College of Nursing (RCN) to address the issue. Its District Nurse Forum worked with its membership to ensure community nurses understood the problem and developed a protocol with safeguards for the use of text messaging. For further information about this protocol please go to:

https://www.rcn.org.uk/professional-development/publications/pub-004230
Falls from hospital beds used in people’s homes due to the design of bed brakes

A coroner’s Regulation 28 letter raised concerns regarding the home use of hospital-style beds. A patient had died after falling from a bed with brakes on each of its four wheels. When the bed was placed in the corner of a room against a wall, only three brakes could be locked, allowing the bed to move away from the wall and the patient to fall to the floor through this gap.

We worked with the Medicines and Healthcare products Regulatory Agency (MHRA) and the following stakeholder groups: College of Occupational Therapists (COT), Royal College of Nursing (RCN), National Association of Equipment Providers (NAEP), Independent Standard Body for Disability Equipment (CECOPS), Carers UK.

We asked them to consider changes in equipment design, instructions for use, and guidance for professionals and carers to reduce the risk. To help this information reach the right audiences, all stakeholders agreed to place relevant information on their public websites and COT agreed to produce a Practice Briefing for professional staff who linked to these. The Practice Briefing was circulated to the membership of these stakeholders and reached a wide range of staff providing care in people’s homes. Please see the following link for further details:

https://www.rcot.co.uk/practice-resources/occupational-therapy-topics/topics

For other cases similar to the two described above go to:

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