Introduction

For this edition of Nevermore we look at two system failures within our Trust; one which resulted in a Claim, the other involving a child where we missed opportunities to identify their illness.

We also examine two Serious Incidents; one which involves a patient with cognitive impairment who put a foreign substance in their mouth, and a patient who died from diabetic ketoacidosis (DKA).

Regards,

Lisa Pinkney
Patient Safety Manager
A patient suffered a fall at home sustaining an injury to the hip. They then attended the Emergency Department with gastroenteritis. On admission, the team were concerned about possible malignancy. An MRI scan and CT scan were carried out twelve days following admission which confirmed a fracture of the right femur, which was healing. Later that day a Waterlow risk assessment placed the patient in the ‘low risk’ category of pressure ulcer development, which was found to be inaccurate. Falls risk assessments carried out showed that the patient was at ‘high risk’ of falling and required assistance to mobilise. The patient was treated for the effects of gastroenteritis and the plan was for them to be discharged five days later. However, on the morning of the discharge day, the patient suffered a fall and fractured the left hip whilst attempting to get out of bed alone.

The patient underwent surgery the next day where a left dynamic hip screw was inserted, and they transferred hospitals for rehabilitation. During their stay in hospital the patient also developed an ulcer to the labia due to a urinary catheter and a Category 2 pressure ulcer on the sacrum.

It is alleged that there were failures in the nursing care provided, including failure to implement adequate fall prevention and pressure ulcer prevention measures.

Findings

With clinicians’ agreement, the Trust admitted that there had been failures in care with regard to communicating the patient’s high risk of falling, lack of observation/supervision, and lack of adequate pressure ulcer prevention measures. Since this time the Trust has introduced more robust risk assessment processes for both falls and pressure ulcers.

E-learning is available for staff in both falls and pressure ulcer prevention. For falls training please access: https://learninghub.yorkhospitals.nhs.uk/course/view.php?id=1844
For pressure ulcer training please access: https://learninghub.yorkhospitals.nhs.uk/course/search.php?search=pressure+ulcer

A child underwent surgery for a break to the radial head of the left elbow, and was discharged the next day. The elbow had a partial cast/back slab applied with the arm wrapped with a crepe bandage. A follow up appointment was made for eighteen days later.

However, during this time the child slipped at school and fell on the same arm, and was taken to a Minor Injuries Unit where the arm was x-rayed. The nurse who reviewed the child advised that everything looked fine and the child returned to school.
Two days after the fall, the child became ill at school and was picked up by their aunt and taken again to the Minor Injuries Unit where they were reviewed. The child was very unwell and needed a wheelchair as they couldn’t stand. The nurse reviewed the child and thought they had “a sickness bug.” As the child’s mother raised concerns, the nurse arranged for an ambulance to transfer the child urgently to the Emergency Department (ED) for further review.

On arrival in the ED the child had developed diarrhoea and a rash. The doctor who reviewed the child diagnosed them with gastroenteritis. However a high PAWS (Paediatric Advanced Warning Score) was noted, and the doctor was concerned so spoke with the Paediatric on-call doctor, who felt that the high PAWS score could be explained by a diagnosis of gastroenteritis. The child was then discharged.

The following day the child deteriorated and was seen by a GP via NHS 111 who diagnosed scarlet fever and prescribed penicillin.

Three days later, the child was brought into ED by ambulance. They were rushed into the resuscitation area; the child was suffering from staphylococcal toxic shock syndrome, sepsis and multi organ failure. A decision was made to intubate the patient and start inotropic support, they were then transferred out to a PICU.

The patient suffered toxic shock syndrome, renal failure and sepsis due to the failure to recognise and escalate appropriately. Fortunately the child made a full recovery.

Investigation findings

- There were numerous missed opportunities by different agencies for this child’s illness to be picked up at an earlier stage. Improved training and communication,

- listening to and acting on the parent’s concerns would have helped in this situation.

Recommendations

- More thorough Induction for ALL Foundation doctors (in paediatric and emergency department) mirroring the full induction given in August and February.

- Access to e-learning package for recognition of the sick child for Paediatric and ED staff. Accessible at: https://learninghub.yorkhospitals.nhs.uk/course/search.php?search=sick+child

- Multi-speciality Simulation training (CRUMPT) for ED staff.

- Sepsis – training and awareness on paediatric sepsis for all staff in all the agencies involved. The sepsis awareness e-learning can be found here: https://learninghub.yorkhospitals.nhs.uk/course/search.php?search=sepsis

- Awareness of doctor’s grades and limits of responsibility on telephone advice.
Case Study 3

An 89 year old patient was admitted to the Acute Medical Unit (AMU) via the Emergency Department (ED) following a fall, two possible seizures and confusion. Initial diagnosis was head injury, and a head CT scan was requested.

The patient was transferred to an Elderly Medicine ward.

Two hours following admission, the Registered Nurse (RN) in charge of the patient’s care found them with white crystals in their mouth; this was a Vernagel sachet that the patient had removed from an empty urinal and put in their mouth. The RN immediately summoned help from the rest of the team and removed the substance from the patient’s mouth; they also used suction to remove the substance from the back of the patient’s throat. The nursing staff ensured the patient was upright in bed, oxygen was administered at 2 litres and the doctor was called to review the patient.

A senior review by the Ear, Nose and Throat specialist was requested, who on examination saw remaining crystals around the patient’s vocal cords and oesophagus. The patient was taken to theatre for removal of the crystals and spent a short post-operative period on the Intensive Care Unit until they were stable. They then returned to the Elderly Medicine ward. The patient acquired an aspiration pneumonitis as a result of the incident, which was successfully treated with intravenous antibiotics.

Investigation Findings

- Vernagel is a substance in a small sachet that is put into urinals at ward level to solidify urine to avoid spillages.
- The patient had cognitive impairment and did not recognise or understand what the sachet was.
- There was no risk assessment carried out for the patient prior to the use of the product as per COSHH instructions.
- COSHH instructions note that Vernagel should be used under close supervision, with a risk assessment undertaken of patients/individuals.
- Those using the product need clear instructions on the product use and the hazards/risks involved.
- There was no training for staff on the use of the product at induction or on introduction to the Ward.

Recommendations following investigation

- Vernagel should not be put in urinals and left unattended at the patient’s bedside on
any ward across the Trust.

- Training and education should be given to all current staff in the Trust in the use of Vernagel and the COSHH assessment. This has since been carried out in bitesize training during daily safety briefs.
- Use of Vernagel should be included in all staff induction.

### Case Study 4

A patient was brought by ambulance to York Hospital. They had been found by a passer-by and were hypothermic and confused. The patient was assessed in the ED department and treated for sepsis.

It was noted during AMU clerking that the patient was Type 2 Diabetic and being treated with insulin. They also had vascular dementia. The patient was seen by the Consultant, and was still confused and thought to be hypothermic and in delirium. The patient was now eating and drinking so their IV fluids were discontinued and usual insulin started.

The patient was then transferred to a Short Stay Ward where they remained in a confused state and were wandering. During the patient’s stay their blood glucose levels remained unstable and they became aggressive towards staff. The patient had a review by the Mental Health Liaison Team who recommended transfer to an Elderly Medicine Ward but no bed was available. Their clinical state remained very similar over the next few days until the patient was found unresponsive, hypotensive, with high blood glucose. An assessment suggested the patient had diabetic ketoacidosis (DKA) and possible sepsis. They received appropriate resuscitation but died later that day.

### Investigation findings

- At the time of admission the Registrar documented that the patient was a Type 2 diabetic. This was incorrect as the patient was a Type 1 diabetic. This was not picked up until after the patient’s death.

- The patient’s diabetes was difficult to manage as Blood Glucose levels were unstable throughout their stay.

- On one occasion it is unclear if the patient was given insulin at teatime. The standard drug chart was signed by the nurse but the insulin chart was not signed showing the drug as administered. The patient received a late dose of insulin. This caused difficulties for the Diabetic Specialist Nurse (DSN) in predicting insulin requirements.

- The patient was seen by the DSN and a care plan documented which stated blood glucose levels were elevated at 33 so a dose of insulin was prescribed with
instruction to monitor blood glucose and to check for urine ketones. If ketones were positive a venous blood gas was to be performed to check for DKA. In addition a review to check for dehydration was advised. These checks do not appear to have been performed systematically. Blood glucose was checked but infrequently, and did not appear to have been entered into the E-Observation system which would have provided the prompt to follow the hyperglycaemia protocol.

- Following the DSN review there is no subsequent comment regarding assessment for dehydration by either the medical or nursing staff. The ward staff report being exceptionally busy that day with another patient with challenging behaviour and so appear to have overlooked the notes entry from the DSN asking for hydration status to be assessed.

- Blood glucose measures were consistently elevated and this was discussed between the agency nurse and the nurse in charge. This was not escalated as it was felt that the patient was not unwell and was known to have high blood glucose in the preceding few days. This is not hospital policy, which if followed would have prompted earlier intervention.

- The patient was nursed by several agency nurses throughout their stay. Whilst the agency nurses were noted to be competent and capable they were not familiar with hospital systems and could not use all of the Trust hospital IT systems.

**Recommendations**

- Review of training in the management of diabetes for nursing staff and particularly focusing on agency staff to include recording of blood glucose using the E-observation system. This is now included in statutory and mandatory training.

- Review of Inpatient Diabetes Team to include support from the consultant diabetologist.

- Inpatient Diabetes Team to review admission diagnosis recorded in the patient’s notes at the time of first contact with the patient (to confirm type of diabetes as Type 1 or 2).


For any further information about Patient Safety, or if you have any cases you would like to be included in Nevermore, please contact Lisa Pinkney, Patient Safety Manager, on 771 2860, or email: lisa.pinkney@york.nhs.uk