Introduction

The feedback we have had from the Nevermore publications has been very positive, thank you.

Also published there are the Sign up to Safety updates.

In this edition we look at an audit conducted into the management of Hyponatraemia. We continue to look at Serious Incidents and the key learning points from them; one of these is a Never Event.

There is also an important reminder about where to file documentation. We must ensure we comply with the Data Protection Act, and that we are always able to reassure patients that information regarding a complaint or litigation claim is kept completely separate from their medical records. Patients worry that if they make a complaint or a litigation claim that this will reflect in any future care they receive.

Regards,
Lisa Pinkney
Patient Safety Manager
Hyponatraemia is the commonest electrolyte abnormality occurring in inpatients. 5% of patients admitted to hospital are due to hyponatraemia (20% of which require ITU admission). 15-20% of hospitalised patients have mild hyponatraemia and 70% of patients admitted with hyponatraemia already have the condition.

The management of this condition can be complex, costly and controversial. Severe hyponatraemia can cause substantial morbidity and mortality. Patients are also more vulnerable to longer hospital stays compared to those with a normal serum sodium concentration.

A retrospective audit was conducted of the management of patients with hyponatraemia in Scarborough Hospital in 2014. It was found that 85% of patients with hyponatraemia were elderly (over the age of 75). The main causes of admission were medications, falls, confusion and post operation complication. 93% of patients had chronic hyponatraemia (low serum sodium of more than 48 hours duration).

68% of patients had further appropriate investigations. Only 33% of patients were referred to Endocrinologists. Assessment of fluid status is very important in the management of hyponatraemia but 63% of patients included in the audit were not assessed (or fluid status was not documented). 56% of patients had a mild degree of hyponatraemia (serum sodium 125-134), 37% had moderate (serum sodium 115-124) and 7% had severe hyponatraemia (serum sodium <115 mmol/l).

Serum osmolarity, urine osmolarity and urine for electrolytes are the main components of investigations for hyponatraemia assessment but 50% of patients did not get those investigations. 55% of patients were found to have drug induced hyponatraemia.

In terms of hospital length of stay, 28% of patients were discharged within seven days. For the majority of patients’ (64%) discharges were delayed by 7-21 days. 18% had up to 28 days of hospital stay. 5% were deceased at the time of auditing the outcome.

The audit highlighted that there is an increased mortality with hyponatraemia but it is uncertain whether this is a direct adverse effect, or simply a marker of a “sicker” patient.

Conclusions
Hyponatraemia is one of the commonest electrolyte abnormalities in inpatients, particularly in older populations and post-operative patients. In the audit, medications, falls and confusion were the main reasons why patients with
Hyponatraemia were admitted from the community, although post-operative patients were also very prone to the condition.

Recommended planned actions resulting from this audit are:
- Early referral to an Endocrinologist/Nephrologist.
- Dissemination of findings among healthcare professionals who manage patients with hyponatraemia.
- Production of a local guideline in line with NICE Clinical Knowledge Summaries and recommendations following discussion with different groups of clinicians.
- Re-audit after a new local protocol is set up and education sessions delivered.

Staff completing the audit were Dr Emma Sienko, Laura Muro, Dr Yo Yo Poon, Dr Sheereen Bhalyat and Dr Alex Ward.

Supervisors of the project were Dr T Pawlak, Dr Y Kyaw and Dr Imola Bargaoamu.

For further information and Trust guidance about hyponatraemia please go to http://staffroom.vdh.yha.com/clinical-Directorate-Information/renal and choose ‘hyponatraemia and SIADH guideline’

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**Serious Incident Reports**

**Case Study 1 – DNACPR Incident**

This case study refers to a patient who was admitted, discharged then readmitted to hospital, had a cardiac arrest and was resuscitated, despite having an active DNACPR in place.

The patient was first admitted to Scarborough Hospital with an acute confusional state and a past history of TIA, dementia and adenocarcinoma of the colon. They were diagnosed with transient visual hallucination, with raised CRP at 90, but otherwise bloods, urine, chest x-ray and ECG were normal.

Discussion took place with the patient’s son, who was happy to look after the patient; so they were discharged. However, the following day the patient was readmitted via the GP following a fall, confusion, and hallucinations. On admission the patient was found to be pyrexial, however, at the post take ward round by Dr A, it was noticed that the patient was now orientated in time, place and person, and eating and drinking. Diagnosis was noted to be resolving delirium. The plan was for the patient to have a CT of head, physio/OT, but not for IV fluids.

A nursing entry eight hours later states the patient called nurses, due to feeling unwell, and was agitated with shortness of breath. Oxygen was applied and a
doctor called. Staff were unable to record any observations. The patient stopped breathing therefore an arrest call was made, CPR was commenced.

The cardiac arrest was called. After 30 minutes of resuscitation there was no spontaneous circulation. Death was confirmed.

The family informed nursing staff that the deceased had a DNACPR in the Community.

Findings from the investigation.

- The patient’s GP has been contacted and stated that the patient had a planned 3 monthly transfusion and the DNACPR was agreed at that time. There is no record in the hospital notes of that discussion.

- The patient was 93 years of age and had two admissions very close together because of confusion and hallucinations. On neither occasion does the documentation make any mention of a community DNACPR being in place.

- There is a completed DNACPR form in the notes which dates from a previous admission on 1st December 2014. This was filed in the body of the main notes rather than the front so would not have been easily visible. In addition, it has become common practice on many of the wards in Scarborough Hospital for only the notes relating to the current admission to be immediately available in the patients’ folders that are used for day to day management.

- There is no reference in the CAS card,GP letters or EDNs from any of the admissions in December 2014 or 2015 mentioning either the in-house or community DNACPR ordered, nor is there a black bordered DNACPR form in the notes.

- The hospital’s DNACPR guidance suggests that if a patient is admitted to the hospital with a completed DNACPR form the decision should be reviewed and a new form completed and filed in the front of the notes and indeed it specifies that any DNACPR form in place should be filed in the front of the notes.

- Although the patient had a post take ward round on both admissions, the post take ward round check list was not completed. However, although the list prompts for a decision on ceiling of care there is no guarantee that even if it had been used that the existence of a previous DNACPR would have been noticed and/or a further decision to DNACPR made.

- Dr A was not aware of the existence of a community DNACPR and did not consider the patient at immediate risk of arrest. The previous DNACPR from December 2014 would have remained in the body of the main notes and would not be noticeable to doctors using the day to day folder containing the notes from that admission.
The nursing staff were advised of the Community DNACPR by the family after the incident although the family did not have a copy of the DNACPR. The Trust has been unable to confirm this with the family as there has been no response to requests.

Although with hindsight, it was appropriate that this patient had a DNACPR in place, the staff involved sought to act in the patient’s best interests on the basis of the information available to them.

Recommendations

- Staff must follow DNACPR Trust guidance in all cases
- The Trust DNACPR guidance is being reviewed in the light of this case to improve changes in procedure, which may reduce the likelihood of similar events in the future.
- The post take check list should be used appropriately.

Lessons learnt

Trust guidance to be followed by staff at all times with review of DNACPR for each admission.

Case Study 2 – Never Event

A 35 year old patient was referred by the GP due to leg ulcers in December 2014, seen and assessed by the consultant surgeon in the vascular surgery clinic in January 2015.

A venous duplex scan was organised to look for venous insufficiency. A scan was performed in March 2015 and it revealed bilateral sapheno-femoral junction and great saphenous venous (GSV) incompetence along with small saphenous venous (SSV) incompetence on the right side.

The patient was reviewed in clinic in June 2015 and was listed for radio-ablation (VNUS) of right great and small saphenous veins under local anaesthesia (LA). This procedure was performed on 7th November 2015. The post-operative note on the electronic discharge letter from the day unit documented further listing of this patient for left GSV VNUS under LA. The consultant surgeon emailed the waiting list office on 7th November 2015 stating: “Please list this man for surgery on the other leg in 6-8 weeks”

Following on from this request the patient was listed on the waiting list by the waiting list co-ordinator and subsequently on the operating list for ‘right GSV and SSV VNUS’.
The patient attended the day unit surgery on 11th June 2016, was seen by the surgical middle grade doctor, and consented for ‘right GSV and SSV VNUS under LA’. At this stage the patient did not mention about the surgery on the veins on the right side in November 2015.

The patient was taken to theatre and no question about the site of the surgery was raised by any member of the team, including the patient himself at the time of the pre-anaesthetic / pre-incision.

The operation note states: “Patient was initially prepped and draped for a right SSV VNUS. US showed small SSV, cannulated and unable to pass wire so surgeon asked the patient if he had had previous surgery on the right. Patient said yes, the surgeon looked at CPD and saw that according to his previous documentation he was due to be listed for a Left GSV VNUS not right. The surgeon apologised and proceeded to treat the left leg.”

Findings from the Investigation

- There was a failure in communication and misunderstanding concerning the email request from the consultant.
- There was failure to obtain correct consent as the core patient database was not checked.
- The patient did not challenge the information during the consent process.
- Due to the move towards a paperless NHS and being in the transition phase, case notes alone are no longer safe and adequate to obtain detailed history of the patients.

Recommendations:

- The waiting list booking form must be used in all instances where an elective operative procedure needs to be arranged. Where the operative procedure involves laterality (a single limb or one of a pair of organs) then the side must be clearly stated as left or right (not r or l).
- When undertaking the pre-operative check the patient’s clinical details should be checked from the core patient database (CPD) rather than the handheld case notes alone.

Lesson learnt

Ensure that all relevant doctors involved in booking patients to a waiting list, and consenting them, adhere to the above mentioned recommendations

Documentation issues

When dealing with complaints and claims the Trust has always been very clear in its policies and guidance about the filing of documentation created as part of the investigation and responses/reports prepared.
Any documentation in relation to these issues should never be filed as part of the patient’s medical records but should be held in a separate file.

Below is the guidance from the complaints policy.

4.4.6 Confidentiality

Patient confidentiality will be protected throughout the complaints process and when the complaint is closed. This will ensure, for example, that the requirements of data protection legislation are met and reduce the likelihood that complainants are discriminated against as a result of making a complaint. All records relating to a complaint will be kept confidential and separate from patient medical records.

Recently it has been noticed that with the improvements and advancements that have been made with CPD over the years, staff are now scanning or importing correspondence regarding complaints and claims (emails and summaries of telephone conversations) into the Letters and Documents section of CPD so that they can be viewed. This contradicts our Trust’s policy.

One of the reasons for not keeping this documentation within the patients’ records is to address the issue of patients being worried about complaining/claiming, as they think it might affect the care that they receive. This means that we are always able to reassure patients that information regarding complaints/claims is kept completely separate from their medical records.

It also ensures that we comply with the Data Protection Act, in that personal information is not shared with anyone who does not have a right or a need to see it. Datix has a module for complaints, which is ‘Patient Experience’ and this is now the system in place in which to store any correspondence relating to a complaint. Any documents, created in relation to claims and litigation, are not automatically disclosable and so should not be stored in the medical records which can be disclosed to the patient. Staff should ensure they file any correspondence in relation to a claim in a separate confidential file, and never in CPD.

If staff have any queries regarding the filing of correspondence in relation to complaints they can contact the Lead for Patient Experience, Hester Rowell on ext 772 5291 or for claims the Legal Services Manager, Sarah Fletcher on ext 772 5135.

If staff have any queries about other record keeping or retention of files they should refer to the Trust Records Management Policy available on Staffroom or contact Kate Ayres, Governance Healthcare Facilitator on ext 772 6201.