Introduction

In this edition we feature a formal complaint and a serious incident report, including learning points from both of these cases. These are published here as a reminder that sometimes things do not always go as planned and that support for patients, relatives and staff on such occasions is very important. To emphasise these issues, we have included information about the Being Open Policy and Duty of Candour regulation for staff to familiarise themselves with.

And finally, to make it easier for you to access the full reports which are featured in Nevermore we have created a folder on Staffroom. It can be found under the heading Corporate Information. Then simply click onto Patient Safety where the copies of Nevermore can be found, along with the reports featured in them.

Incident reporting

Reporting of incidents is important to ensure that the organisation develops by learning from mistakes.

Some incidents warrant detailed Root Cause Analysis to be undertaken, such as Patient Falls and Pressure Ulcers which have resulted in moderate or severe harm. Continued reporting may indicate that further changes are required.

Below is a comparator table of the top ten incidents reported in the Trust comparing a period last year to the same period this year.

The Trust reported in excess of 6,300 incidents via the Datix Adverse Incident Reporting System (AIRS) during the first six months of 2016. These are compared with the previous year’s figures.
The top 10 categories of incidents reported for 2016 were as follows:

For the previous year (January to June 2015) the following were the top ten categories:

This year slips, trips and falls are no longer the highest reported incident; clinical incidents overtook these as the most reported. Incidents categorised as clinical include such things as admission/transfers, clinical assessment, communication problems, dietetics/nutrition, infection control, patient complications and radiation issues.
Medication errors remain similar to last year, as have staff incidents. Equipment issues are, however, now in the top ten community incidents, in contrast to last year, and security issues are no longer in the top ten reported incidents.


The report identifies the level of reporting and the timing of uplifting that information to the NRLS. It also looks at the level of harm the incidents were graded as. This information is used to identify trends or significant incidents and as a result of this reporting, the NRLS issue alerts to NHS bodies via the Central Alerts System (CAS).

These alerts are coded in terms of importance and have timescales for implementation. NHS bodies are monitored on their compliance with these alerts and information on compliance is published by NHS England. This information is then published on the NHS Choices website so that the public can see how their local Trust is performing. It is important in terms of Patient Safety that these alerts are actioned.

Our Trust lies within the middle group of reporters for comparative trusts. We do have a good culture of reporting to build upon, but are continually looking at ways to improve our systems and processes.

To read the report, go to [https://report.nrls.nhs.uk/explorerTool/default.aspx](https://report.nrls.nhs.uk/explorerTool/default.aspx)

**Datix update**

At the request of several members of staff there have been some changes to the Patient Falls section of the incident reporting system. This was in relation to tidying up the section and making some of the questions more focused. The subcategories were also changed to be made more specific.

The new complaints module went live on Datix in October last year, so Senior Managers can now access and manage complaint information directly. The system now allows reports and dashboards of trend data to be easily developed, so that staff can see where improvements are necessary and when they have been achieved. This will ultimately help towards identifying themes and trends to improve the quality of the patient experience.

Step by step guides are available for staff using the new module.

Following the successful roll out of this module the next step will be to upload the PALS module.

**Learning from complaints**

As well as learning from incidents and litigation, complaints provide another important source of learning.
We always aim to resolve patient complaints and concerns by responding directly in person or in writing. Occasionally complainants are not satisfied with the response we send them. In that circumstance we get the opportunity to provide a further response. If the complainant still remains unsatisfied then they can go to the Parliamentary and Health Service Ombudsman (PHSO) to seek resolution.

If the Ombudsman upholds the complaint then the Trust must report on learning and improvements made since the complaint. Sometimes we are also required to make a payment (financial remedy) to the individual involved.

Case Study One – Failed discharge

The case study presented below relates to a patient who was admitted for a day case procedure at Bridlington Hospital and whose follow up care failed in relation to their anticoagulation needs.

The patient was advised to start their Warfarin the day following the procedure and was advised to have their INR checked by their GP. The patient contacted the GP surgery but was told this was not the GP practice’s responsibility. The patient then made several phone calls over the following days to both the GP practice and the hospital to try and resolve the situation.

Staff at Bridlington Hospital eventually sorted the matter by directly speaking with the GP practice and made an appointment for the patient to be reviewed.

The patient then made a formal complaint, which was subsequently investigated by the PHSO.

PHSO response
The Trust is required to carry out a number of recommendations in relation to anticoagulation on discharge. The patient was not provided with sufficient information about what to do following discharge and when to recommence anticoagulation medication.

The PHSO concluded that:

*Information provided to patients about anticoagulation medication on discharge needs to be made very clear and specific so they know what to do with medication and when to take it.*

*Information should be given to patients to advise when they should re-start Warfarin therapy post operatively, the time-frame in which to re-start it and when their INR should be checked by their GP. This information should be included in patients' discharge advice.*

It should be noted that whilst the Trust did provide information to the patient the PHSO did not feel that this was robust enough, hence the recommendations.
Learning and action

The Pharmacy Directorate have produced an ‘Information for patients restarting Warfarin post-surgery’ sheet which should be provided to patients on discharge from hospital.

Anti-coagulant guidelines and further documentation including the guidance for patients can be accessed through:
http://staffroom.ydh.yha.com/policies-and-proceduresclinical/anti-coagulation

Febrile Neutropenia. An audit of current management – Dr Claire Wesley

An audit of febrile neutropenia was undertaken in oncology patients presenting to the children’s ward in York Hospital. There is a clear guideline from the tertiary centre that children with suspected febrile neutropenia need to receive antibiotics within 60 minutes of arriving in the hospital. The audit highlighted that this had only been achieved in less than half the cases. As a consequence of this, a febrile neutropenia checklist was developed to be used on admission. This was discussed in a governance meeting, teaching sessions were done with the junior doctors, and issues were raised with ward staff. This Checklist is now used in both York and Scarborough Hospitals. A re-audit has been carried out and, to date, the checklist has improved clinical care and nurses and doctors are working closely together to ensure that as soon as the patient’s central line is accessed, antibiotics can be given. This has also improved the feedback from the parents and tertiary centre around treatment.

A link to the checklist can be found here: Q:\York Hospitals Trust\Never Events and Learning\Nevermore 4\Paediatric Febrile Neutropaenia checklist CW.docx

Case Study Two - Serious Incident: Sub Optimal Care

The patient attended the ED by ambulance at 10.50. The ambulance report indicates that the patient had apparently fallen the day before, but had refused to attend the hospital. At some later stage, they had fallen again and had been unable to get back up onto their feet.

The patient was assessed by a triage nurse (time of assessment and identity not recorded in the notes) who recorded significantly abnormal observations (specifically HR 115, BP 97/42, T 33.7) with a NEWS score of 9. The patient was identified for “see and treat” (as soon as possible), priority of care.

The patient was assessed by Dr A at 11.10, who documented a similar history to that recorded on the ambulance sheet. Dr A noted the previously recorded abnormal observations.
On examination no focal signs were found in the chest. Dr A thought the patient might be in urinary retention and requested a bladder scan. There were no signs of head, limb, hip or pelvic injuries.

Dr A’s clinical impression was of no apparent injury other than complaining of back ache. (Although not formally documented, the subsequent management plan suggests that the patient was considered septic from a possible chest infection).

IV access was secured. Baseline blood tests were obtained including a venous lactate evaluation which was markedly raised at 7. In the context of the patient’s presentation this would suggest likely septic shock. X-rays of the chest, pelvis and lumbar spine were requested. Intravenous fluids were commenced at 11.45. A broad spectrum antibiotic (Tazocin) was given at 12.15. A urinary catheter was requested (ultimately being inserted at 14.50 and yielding a urine specimen suggestive of a co-incidental urine infection). The chest x-ray indicated that the patient had a right basal pneumonia.

The patient was referred to the bed managers (at 13.40) to organise an inpatient bed and on the basis of the high NEWS score, Dr A informed Dr B (at 13.45) of the admission.

An arterial blood gas was obtained at 14.38 at which time the lactate result was still markedly raised at 4.7. A urinary catheter was inserted and urine output monitoring was initiated. The patient remained anuric during the ED stay, despite receiving a total of 4 litres of IV fluids.

The patient underwent regular observations whilst in the ED at between 45 min and 2 hourly intervals. These indicated that there was a raised respiratory rate throughout, a labile blood pressure and persisting hypothermia. The patient was obtund and had a NEWS score of between 6 -15.

Dr B reviewed the patient at 16.45 (3 hours after the original referral). By this time the baseline blood tests had already confirmed the onset of multi-organ failure. The management plan at this time was to organise an ultrasound scan of the renal tract, to exclude any obstruction, (although it was recognised that this wouldn’t change the immediate management) and to repeat the ECG, venous blood gas and general observations prior to transfer to AMU.

An entry in the notes by Sister Y at 19.12 suggests that Dr B was still concerned and reviewing the patient. Further fluid resuscitation was given as the patient had still produced no urine. At 19.55 a discussion was held between Dr E (ED middle grade) and Dr B in relation to escalating the treatment plan to involve the intensive care team. At 20.50 the patient was reviewed by Dr B once more who repeated the blood gas (the lactate at this time was 5.4). At 21.40 Sister Y asked Dr B (who was reviewing other patients in the ED) about the updated management plan for the patient, and was advised that the night duty Medical Registrar (Dr C) would be asked to review the patient.

At 22.30, the patient was reviewed by Dr C who concurred with the previous findings and recognised that the patient required a higher level of care than AMU would be able to provide including possible inotropic support and haemofiltration. The ITU team was informed and were requested to review the patient in the ED.
At around 23.30 the patient was reviewed by both the ITU Middle Grade Doctor D and Consultant 1 (Care of the Elderly). The patient’s care was discussed with Consultant 2 (ITU Consultant), who advised that no ITU beds / nurses were available to escalate the patient’s care and that they would have to be transferred to another hospital for this.

At 23.40 the patient went into cardiac arrest. Dr C deemed that resuscitation attempts would be futile and these were not commenced.

Following a Root Cause Analysis of the events a number of recommendations were made as follows;

- To develop a policy to guide the appropriateness of escalation of care to Critical Care following 'home team' review. This to also include a timescale for when patients can reasonably be expected to be reviewed, along with an escalation policy to senior clinicians if this is not achieved.

- A suggested timeframe of 2 hours to review (allowing time for initial resuscitative measures to have been initiated and results of investigations to have become available) and a definitive management plan including an assessment of appropriateness of escalation being put in place.

- Escalation of ‘concerning cases’ with no timely specialty review to the ED / Medicine / Care of the Elderly consultant on duty (on basis of NEWS score).

- Review of Medical Registrar working practices and level of support received during the day from Gen Medicine / Care of the Elderly Consultant on Duty.

- Training in determining appropriate ceiling of care assessments.

- To expand the medical staff induction section on deteriorating patients to include escalation.

- Review of number of ITU / HDU beds within the Trust, in relation to demands that often exceed availability, which has the potential of rationing optimal patient management.

A full copy of this report is available on Staffroom in Corporate Information/Patient Safety/Nevermore and Serious Incidents.

Sign up to Safety pledges

Being Open Policy and Duty of Candour
One of our pledges as part of Sign up to Safety is to be transparent about our progress to tackle patient safety issues and to support staff to be candid with patients and their families if something goes wrong.

The Trust also has a statutory duty under the Health and Social Care Act (2008) to notify patients and their relatives when things go wrong.

The Being Open Policy was reissued in December 2014 and in the policy there is guidance for staff about the Duty of Candour and who is responsible for taking the lead.

A template letter has been developed to help staff to provide the relevant information to affected persons and this can be found within the Datix system at the reviewer stage and at this link; Q:\York Hospitals Trust\Never Events and Learning\Nevermore 3\Duty of Candour letter.doc

**As a reminder of what should be reported under the Duty of Candour;**

Anything unintended or unexpected if it causes or is expected to cause:

• Death or severe harm relating to an incident/action rather than a disease.

• Moderate harm that is significant and requires a moderate increase in treatment and harm that is significant but not necessarily permanent.

• Prolonged psychological harm for a minimum of 28 continuous days.

In our pledge we said we would finalise the policy and would provide training and guidance for staff. We have completed this pledge and have provided staff with pocket cards as an aide memoire and Core Bundles for easy reference.

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