EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**30 OCTOBER 2014**
SUBJECT:	**PATIENT STORY**
REPORT FROM:	**CHIEF NURSE & DIRECTOR OF QUALITY & OPERATIONS, DEPUTY CHIEF EXECUTIVE**
PURPOSE:	**Discussion** **Information**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The Board of Directors have been using patient stories to understand from the perspective of a patient and/or a carer about the experiences of using our services.

Patient stories are a key feature of our ambition to revolutionise patient and customer experience. Capturing and triangulating intelligence pertaining to patient and carer experience from a variety of different sources will enable us to better understand the experiences of those who use our services.

Patient stories provide a focus on how, through listening and learning from the patient voice, we can continually improve the quality of services and transform patient and carer experience.

SUMMARY

This month's story relates to the experiences of an 83 year old lady who was admitted on the 13th March 2014 to the Emergency Department (ED) at Queen Elizabeth Queen Mother (QEQM) Hospital from her own home. A diagnosis of possible abdominal sepsis and community acquired pneumonia was made. On day 2 of her stay the patient was transferred to Deal ward from the Clinical Decision Unit (CDU). Five days later, whilst an inpatient on Deal ward, she had an un-witnessed fall. The lady had not previously attempted to mobilise independently. Following a medical review an urgent CT scan of her head was requested and the results showed a bleed and bruising in her brain.

This incident was subject to a detailed root cause analysis (RCA) investigation which highlighted a number of areas for improvement. These included:

- The falls risk assessment had not been fully completed – however it was decided at the RCA that the fall could not have been avoided;
- Neurological observations were not completed in line with current NICE guidance (reduced number of staff were on shift);
- There was a delay in the patient receiving intravenous therapy (no vascular access service);
- Poor nursing documentation.

A number of improvement actions are being implemented as a result of the learning and these are summarised on page 3 of the patient story.

Post fall, despite the best efforts of staff, there was a general clinical decline in the patient's health. End of life care was discussed with her family and implemented on 4th April 2014. The patient died on 9th April 2014. This was some 20 days post fall and intracranial bleed.

RECOMMENDATIONS:

The Board of Directors are invited to note the key themes of this story and the actions in place to prevent reoccurrence.

NEXT STEPS:

None. The actions outlined in the story are being monitored via the Quality Assurance Board.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Improving patient experience and satisfaction with the outcomes of care are essential elements of our strategic objectives.

LINKS TO BOARD ASSURANCE FRAMEWORK:

This story links to AO1 of the BAF: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

The risks identified in this story were around staff not being aware of current NICE guidance, and therefore not undertaking neurological observations in a timely way; lack of a falls risk assessment; the competence to undertake complex intravenous access procedures out of hours; and poor documentation. The action plan in place addresses these issues which will be monitored by the Quality Assurance Board.

FINANCIAL AND RESOURCE IMPLICATIONS:

None

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

None

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES:

None

ACTION REQUIRED:

(a) Discuss and agree recommendations.
(b) To note

CONSEQUENCES OF NOT TAKING ACTION:

If we do not learn from events such as these there is an increased risk of further occurrences which may adversely affect both patient experience and outcomes.

Board of Directors
Patient Experience Story
October 2014

Introduction and Background

This month's story relates to the experience of an 83 year old lady who attended the Emergency Department (ED) at the Queen Elizabeth Queen Mother (QEQM) Hospital from her own home on the 13th March 2014. Although she was living at home, she required carers to assist her with washing and dressing. The carers noticed blood staining to her incontinence pad, and they sought advice from the GP who advised dialling 999, which they did. This elderly lady was admitted to the Clinical Decision Unit with a possible diagnosis of abdominal sepsis and community acquired pneumonia. On day 2 of her stay she was transferred to Deal Ward for the remainder of her treatment and care.

The Patient Story

This elderly lady lived at home alone. She had limited mobility and carers visited her daily to assist with washing, bathing and dressing. She was not in the best of health having lived with heart disease, high blood pressure, diabetes and diverticulitis for many years. She was on a range of medications. On admission to Deal ward she was noted to be very frail, confused and in danger of getting lost if she wandered. She often 'called out' at times and was not orientated to time or place. She also came in to hospital with two category 2 pressure ulcers on her buttocks.

She was commenced on the routine treatment of fluids and antibiotics for her chest and urinary infections. She had a drip in place and was on oxygen. She was only eating small amounts of food and required help with this at mealtimes. On day 3 she had three episodes of diarrhoea and was moved to a side-room on the advice of the Infection Control Team. By now she was beginning to get better; was eating and drinking more and was being seen by the Physiotherapists who were helping her gain confidence with mobilising. However, she remained confused at times, particularly during the night. On the 20th March (day 7 of her stay) she became unwell again.

That evening, the nurses heard a noise from her room and found her on the floor. Nobody witnessed her fall, and she was unable to recall the events leading up to her falling, indicating that she may have lost consciousness for a short while. The Doctor who examined her noted reduced power in her right hand when he asked her to grip his hand. Other than that there were no other concerns in her condition at this time. As per protocol, a CT scan of her head was ordered and the patient was placed on hourly neurological observations to ensure her conscious level was being monitored. She was also placed on a 'low bed'. Two hours later the result of the CT scan showed that she had suffered a cerebral bleed and bruising of her brain.

Over the next few days she continued in much the same condition receiving her antibiotics, physiotherapy and she was eating and drinking. After a week, her condition slowly began to decline. She was showing signs of a worsening chest infection. She became more drowsy and required a urinary catheter to monitor and measure her urine output. This was to ensure she was receiving enough fluids and that her kidneys were functioning effectively. She also had a low blood pressure at times and was not well enough to receive her physiotherapy treatment and her regular review by the Dietician. This slow decline led the medical and nursing teams to discuss with her family the best management plan for her. It was around this time that her cannula for intravenous therapy required changing. Unfortunately this did not take place due to difficulty in siting a new one and because the Vascular Access Team were not available. This meant she was left for 2 days without a cannula. Furthermore, the situation was not escalated to anyone to be remedied. By the third

day after the new cannula was placed, she was assessed as dehydrated and required fluids to be administered quickly to correct this.

On the 28th March she began to have seizures, was unresponsive with a low blood pressure recorded. Her condition had deteriorated markedly and she continued over the next few days unwell, unstable and drowsy gradually becoming more and more unresponsive. Her family were with her during this time. The Palliative Care Team were actively involved and with her family present she died on the 9th April, some 20 days after she was admitted.

Care and Service Delivery Problems
This event was reported as a serious incident on STEIS. The team underwent a full root cause analysis investigation and a number of care and service delivery problems were identified. These included:

Prior to the fall:
- The Falls Risk Assessment and Care Plan were incomplete. Full consideration and solutions for harm prevention were not met and there was little documentation that harm prevention strategies had been considered.

Following the fall:
- Neurological observations were not completed in line with current NICE guidance. Hourly neurological observations are not frequent enough to pick up deterioration in conscious levels which can occur very suddenly and quickly;
- There were reduced numbers of staff on duty that shift which may have impacted on staff members' ability to adhere to the requirements of the neurological observation protocols in line with current NICE guidance. However, there were robust processes in place to monitor staffing levels and address deficits. Unfortunately there are times when cover cannot be found and the staff prioritise their workload accordingly.

Additional points:
- There was a delay in the patient receiving intravenous therapy;
- Numerous entries (medical and nursing) within the Healthcare records were not were not signed, dated or timed;
- There were also some omissions of information from the Healthcare records;
- There is no space on the Integrated Care Pathway for nursing staff to date, time or initial their entries;
- VitalPac does not prompt for neurological observations;
- There was a delay in obtaining intravenous access for fluids for the patient as a result of no 24/7 Vascular Access Service.

The investigation team concluded that this patient's fall may not have been avoided (even if risk assessments had been completed). This lady had not previously shown any signs of attempting to mobilise unaided and there was no clinical indication prior to the fall that she was agitated. The root cause of her death was attributed to her general poor health and long term conditions, exacerbated by her cerebral bleed diagnosed after her fall in Deal Ward.

Learning and Actions
The RCA highlighted a number of areas of learning which the Division has set out in their action plan. The learning and action points are:

1. <u>Staff must comply with the falls protocol.</u> Letters have been written to every member of staff and an audit of 10 sets of notes will take place to ensure compliance. The results of the audit will be shared with the ward team and reported to the Quality Assurance Board. This audit will be completed by the

end of October by Matron Houlihan and the Ward Manager. Results will be available for review during November;

2. Neurological observations must be carried out in a timely manner. The NICE guidance was not adhered to, plus a contributory factor was that VitalPac does not trigger when to undertake neurological observations. All staff have already been made aware of their role and responsibilities around timely neurological observations and escalation and that they must follow the guidance rather than rely on VitalPac for this aspect of care;

3. Investment in the Ward Staffing Establishment. Deal Ward was working to a staffing establishment that did not include the unfunded eight beds that were regularly opened and used. Following an Executive Patient Safety Visit and the regular review of the ward staffing establishment, the Ward has had these 8 beds funded. Recruitment is in progress with overseas nurses filling the Registered Nurse vacancies, and NHSP covering the bay in the meantime. There are three HCA staff also about to commence on the ward. The additional band 6 (from the Trust wide Ward Staffing investment) has helped with leadership and supervision.

4. For complicated vascular access requirements, the Vascular Access Service was not available 24 hours per day. There was poor escalation around the difficulties in cannulating this lady that left her without intravenous fluids and drugs for 2 days. As well as ensuring medical and nursing staff get help from others around this, the ward have identified a core number of staff to be trained in complex cannulation skills to prevent recurrence of this event. Matron Houlihan has met with the Vascular Access Service Team and is currently awaiting the training records of those staff who have completed the training. She is also providing the training needs analysis for those who still require the specialist training. The timeline for this action is the end of October 2014;

5. Documentation needs to include the time, date and grade of staff as per Trust policy. As well as staff not documenting accurately their interventions, it also transpired that the integrated care pathway and admission documentation do not allow documentation of the time and date and name for the entries. Several actions have been taken around this, firstly letters have been sent to all nursing and medical staff with the NMC/GMC record keeping guidance. Ten sets of clinical notes will be audited for record keeping compliance and the results will be shared with staff and with the Quality Assurance Board. Matron Houlihan is awaiting the audit results that are due to her by the end of this month. Secondly, a request to the Clinical Records Committee to change the documentation in order to incorporate a layout that facilitates nurses to date, time and initial entries is being made by Matron Houlihan.

Summary

An 83 year old lady who was admitted on the 13th March 2014 to the Emergency Department at QEQM Hospital from her own home and subsequently transferred to Deal ward had an un-witnessed fall. The lady had not previously attempted to mobilise independently. Following a medical review an urgent CT scan of her head was requested and the results showed a bleed and bruising in her brain.

After this fall, despite the best efforts of staff, there was a general clinical decline in her health. She died on 9th April 2014 some 20 days post fall. This incident was subject to a detailed RCA investigation which highlighted a number of areas for improvement that are being addressed and monitored by the Division. The Quality Assurance Board has received this RCA report and will receive updates regarding progress of the action plan.