EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS – 7 JULY 2014**
SUBJECT:	**PATIENT STORY**
REPORT FROM:	**CHIEF NURSE AND DIRECTOR OF QUALITY & OPERATIONS**
PURPOSE:	**FOR INFORMATION AND DISCUSSION**

CONTEXT/REVIEW HISTORY

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 story describes the experience of a patient following the development of a temporary paralysis due to a medication side effect. It describes the fear and distress the side effect caused for the family, not only because of the paralysis, but also because unfortunately the wrong information was given to the patient and family about why the paralysis occurred. There was also a delay in obtaining the right drug to treat the side effect due to a supply of the medication not being easily available in the Ward or in Pharmacy.

The story demonstrates how careful and sensitive we need to be when communicating information to our patients and their families and that we must ensure we prepare well before imparting any clinical information. It also shows that we must remain empathetic and monitor the effect of how and what we say on others continuously.

The story describes an unusual event, but one where lessons have been learned and acted upon. Although in this case there were no medical errors, the importance of the Patient Safety Collaborative national work, and the development of the Medication Safety Thermometer in preventing medication errors and improving safety are discussed.

Patient Experience Story
June 2014

Introduction and Background
This month's story relates to an issue around medication administration, availability of specialised medications and the distressing experience of a reaction to a medication that can sometimes occur with patients.

This story holds current relevance with the national focus on patient safety. NHS England are developing a new way of addressing safety concerns called the Patient Safety Collaborative. Their development is in response to the Berwick report (2013 – A Review into Patient Safety) where it is espoused that the NHS should become:

"…*more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end*."

The Patient Safety Collaborative initiative involves a number of proposed work stream groups that are nationally steered and locally managed that focus on key areas of current patient safety concerns. The four national work streams comprise:

1. **Leadership for Patient Safety** - Delivering improvement requires leaders in every organisation to put safety first. Executive leaders and Boards will be the focus in the first year;

2. **Measurement for Patient Safety -** Using data well is crucial to all quality improvement;

3. **Pressure Ulcers -** There are clear interventions that can deliver significant improvement in the burden of harm represented by pressure ulcers, but clearly they remain a significant burden, particularly outside the acute sector;

4. **Medication Errors -**The prescribing, dispensing and administration of medicines is an area where error and poor process has the potential to affect large numbers of patients, making this a priority area for reducing harm (Cummings 2014 – Board Paper NHS England).

The Patient Safety Collaborative encourage whole systems working across all of the health economy so that best practice and learning can be shared rather than there being 'islands of excellence'. Their aim is to achieve sustainable and significant reductions in patient harm and support the development of a patient safety culture across the NHS. One component of these safety improvement initiatives on medication is called the Medication Safety Thermometer. This focuses on:

1. **Medication Reconciliation** – This is making sure that when a patient crosses a care setting, such as being admitted from home to hospital, that the medication they are prescribed in hospital is what they were supposed to be prescribed as set out by the GP or other previously seen specialist;

2. **Allergy Status** – This is making sure that any allergies are accurately and clearly recorded for everyone to see and act on;

3. **Medication Omissions** – This involves us checking that we do not miss any doses of a medication a person is due to receive at a certain time and frequency;

4. **Identifying Harm from High Risk Medications** – This requires us to interrogate the Datix reports to determine areas for prevention, improvement and action.

These data are collected as a monthly snapshot across the health economy. In addition, the Kent and Medway Area Team have set up a Kent and Medway wide collaborative. One of the work streams in this collaborative is also medicines management, led by a Senior Clinical Pharmacist.

The Patient Story
AM, who was 17 at the time, was admitted to William Harvey Hospital (WHH) Emergency Department in December 2013 after showing signs of dehydration. She had been vomiting for several days post aural surgery at the Chaucer Hospital in Canterbury. She was placed on an intravenous infusion of fluids and given an injection of Stemetil, an anti sickness medication. Her condition then improved and became much more stable.

A Junior Doctor from the Ear, Nose & Throat (ENT) Department assessed AM's condition. During the examination the Doctor shared with AM that she had only been working in the hospital for a day and a half. This information made AM feel rather nervous. The teenager was shortly admitted onto Rotary Ward. Around this time AM's mother telephoned the Ward to check on her progress. Her daughter was distressed and crying, asking to go home. AM's mother Mrs M told us that the Ward Sister replied to her that her daughter was fine and said 'you know what teenage girls are like'. This remark upset Mrs M.

One hour later, the teenager's parents were contacted by phone and asked to come to the hospital. This was because their daughter had become unresponsive and totally paralysed; she looked like she had suffered a stroke. Naturally her parents felt in total shock.

At this point AM was sent for an emergency CT scan to check if there was anything wrong with her brain that may have caused this deterioration in her conscious level and mobility. Once she had returned to the Ward the Consultant examined the results of the CT and could find no abnormalities. It was hoped it was a reaction to the intramuscular Stemetil injections that had been administered. She had been given 3 injections over approximately a 12-hour period. Unfortunately, a rare side effect of this drug is experiencing abnormal movements, particularly of the face, lips, jaw and tongue, while taking this medicine.

Because the teenager had developed this rare side effect, she appeared to be paralysed (dystonia). The Doctors then prescribed the drug Procyclidine for her. This is a drug more commonly used for patients with Parkinson's Disease but was appropriate on this occasion for treating her dystonia. The Procyclidine needed to be administered to AM but was not available on Rotary Ward or in the Pharmacy and was finally located in one of the hospital Theatres. Unfortunately, this resulted in a delay in treating this distressing condition, but once Procyclidine was administered the patient showed signs of improvement.

A while later, Mrs M was sitting with her daughter at her bedside when the nurse came round with the drugs cabinet and asked AM if she needed any pain relief or anti-emetics. She replied that she did not, but when mother asked what anti-emetic she would be given, the nurse replied she was written up for Stemetil and there had been no changes made to the patient's drug chart or any allergies noted since her experience. Clearly this was a cause of concern for AM and her mother given her reaction to the drug earlier.

The teenager was discharged on 7th December 2013. Her mother spoke to one of the ENT team who explained that her daughter's crisis had been due to a medical error and not an allergic reaction. In fact, this was not the case, and AM had unfortunately had experienced a rare, but documented, side effect. Hearing that there may have been a medical error left Mrs M with a number of concerns about the care of her daughter. These were:

- Should a Junior Doctor assess a patient in A&E who is recovering from postoperative surgery?
- Who mentors and checks what a Junior Doctor is recommending and prescribing?
- Why was there no Procyclidine on the ward or in the Pharmacy? The delayed administration extended the patient's frightening situation.
- Why was the patient's drug chart not changed immediately?

Following the first response from the Surgical Services Division, the teenager's mother later requested clarification asking:

- What evidence was there that warranted two further doses of intramuscular Stemetil when her daughter was able to eat and drink without feeling nauseous?
- Why was it not administered orally?

The parents describe in their letter to us that they felt the incident could have been avoided if we had given oral Stemetil after the initial injection. They describe the crisis their daughter and themselves experienced as extremely frightening. They also felt that the medical and nursing staff did not know what exactly was wrong with their daughter. The delay of one and a half hours obtaining the Procyclidine meant that their daughter was completely paralysed, yet fully aware of what was happening around her. This incident has damaged all of their confidence resulting in them feeling very anxious about her future care of her long term ear condition.

The Division provided a thorough response to Mrs M's concerns and indeed retracted the notion of her suffering side effects from a medical error, as originally told to Mrs M, to the experience being caused by a rare recognised side effect now recorded as an incident (rather than medical error). The prescription written did not follow the usual pathway which is normally that an injection is followed by oral medication. In this patient's case she received further injections, which were indeed appropriate given that she was unable to keep any tablets down without being sick.

This incidence reflects how important it is to make sure we are careful in the way we communicate information to distressed relatives when an unexpected event happens. Although technically the prescription was not as per the drug formulary guidance, we probably should have explained this to AM's mother. If she had understood that it was perfectly acceptable, and indeed good clinical practice to administer the anti-sickness drug by this route, we may have alleviated the additional confusion and unnecessary distress. However, given that she did develop a rare side effect, we should have considered scoring off the drug and writing up an alternative for nausea, should she have required it, which fortunately she didn't on this occasion.

With regard to Mrs M's concerns about a Junior Doctor reviewing her daughter, the Consultant reassured Mrs M that it is usual for a Junior Doctor to first assess a patient in the Emergency Department who is recovering from postoperative surgery. If the surgery that was performed is not something that the individual Junior Doctor is familiar with then they will discuss the patient with their senior colleagues, which is

what occurred in this case. She was discussed with the ENT Consultant as soon as AM had been seen on the first evening she was admitted.

The Ward Manager of Rotary Ward has commented that the Ward has limited availability for drug items and Procyclidine is rarely used and therefore not kept as a stock item. However, this is now available on the Ward as a learning point from this incident. The Senior Clinical Pharmacist has also advised that Procyclidine was not routinely held as stock in Pharmacy at the William Harvey Hospital. Therefore, when the request arrived in Pharmacy, the Pharmacist managed to obtain this from Main Theatres and supply it to Rotary Ward. Unfortunately, there was a delay of around 1.5 hours. The Senior Clinical Pharmacist has given assurance that Procyclidine is located in the Emergency Department, Main Theatres and the Day Surgery Unit so that it is available for emergencies both inside and outside routine Pharmacy hours. In addition, as a result of this patient story, the Pharmacy team have arranged for the injection to be available at other key locations around the hospital site including in the Pharmacy.

Summary

This story describes the experience of a patient and their family's distress and discomfort following the development of a temporary paralysis due to a medication side effect. It highlights how careful and sensitive we need to be when communicating information to our patients and their families. Although the staff were committed to caring effectively for this teenager, informal and inaccurate comments were made that caused further distress to the patient and her mother. The story highlights the importance of ensuring we prepare well before imparting clinical information and the importance of monitoring the effect of what we might say has on others.

The story describes an unusual event, but one where lessons have been learned and acted upon. Although in this case there were no medical errors, the importance of the Patient Safety Collaborative national work, and the development of the Medication Safety Thermometer in preventing medication errors and improving safety can be seen. Below are listed the learning and action points that arose from this patient story.

Learning and Actions
The key actions that have been taken are:

- Wards now keep Procyclidine in their Ward stock;
- The Pharmacy Department now keep Procyclidine in stock;
- This unusual case has been discussed at audit meetings and the learning shared among the teams. As a Consultant body, the ENT team has emphasised the importance of early recognition of this issue;
- This case has also been discussed with the individuals associated with the prescription by the Consultant and he comments that they have learned a great deal from this incident;
- Once it was understood that the reaction was a side effect and not a medical error, the event was raised as an internal clinical incident and investigated by the ENT Consultant. It transpires from the investigation that this reaction to Stemetil is not dose dependant. This means this reaction can occur after only one dose.

Following completion of the investigation and consideration of the case, we have offered £500 compensation to the family as part of the redress process in recognition of the stress and trauma caused to their daughter and themselves.