TRUST BOARD IN PUBLIC	Date: 27 June 2013 Agenda Item: 2.1
REPORT TITLE:	A Patient Story
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REPORT AUTHOR:	Dr Des Holden, Medical Director
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	

Purpose of the Report and Action Required:		**(√)**
	Approval	
	Discussion	*
	Information/Assurance	

Summary: (Key Issues)

High quality care and as a consequence patient safety rely on a structured approach to each clinical contact with a patient, and a culture within the team that everyobne can make a valuable contribution to care. The introduction of a ward round check list can ensure that key components within the patient review are performed, allow a better educational experience and promote the team approach to quality. This paper gives illustrative examples from two SI, describes the checklist and the progress made with its introduction at SaSH

Relationship to Trust Corporate Objectives & Assurance Framework:

To deliver a safe, high quality service.

Corporate Impact Assessment:

Legal and regulatory implications	Helps demonstrate reduced risk for external assurance
Financial implications	Better care is generally believed to reduce cost
Patient Experience/Engagement	Improved communication within the team and with the patient
Risk & Performance Management	Reduces risk for in-patients
NHS Constitution/Equality & Diversity/Communication	

Attachments:

Appendix ….

TRUST BOARD REPORT – 27th JUNE 2013
A PATIENT STORY

1. Patient story (#1)

An elderly patient was admitted with constipation and infected leg ulcers. She was treated with antibiotics and laxatives. Five days later she had a cardiac arrest and died unexpectedly. At post mortem a previously undiagnosed strangulated inguinal hernia was discovered. The SI review found that there had been a delay in ordering an abdominal XR and there was no evidence that this had been seen by a senior member of the team. The XR suggested a hernia. Review of the patient's care suggested that they had not been selected from the board round for senior review after the post take assessment although there had been no result from the treatment of the constipation. On the day of death it was documented that a change in symptoms and a deterioration of observations had occurred prior to cardiac arrest.

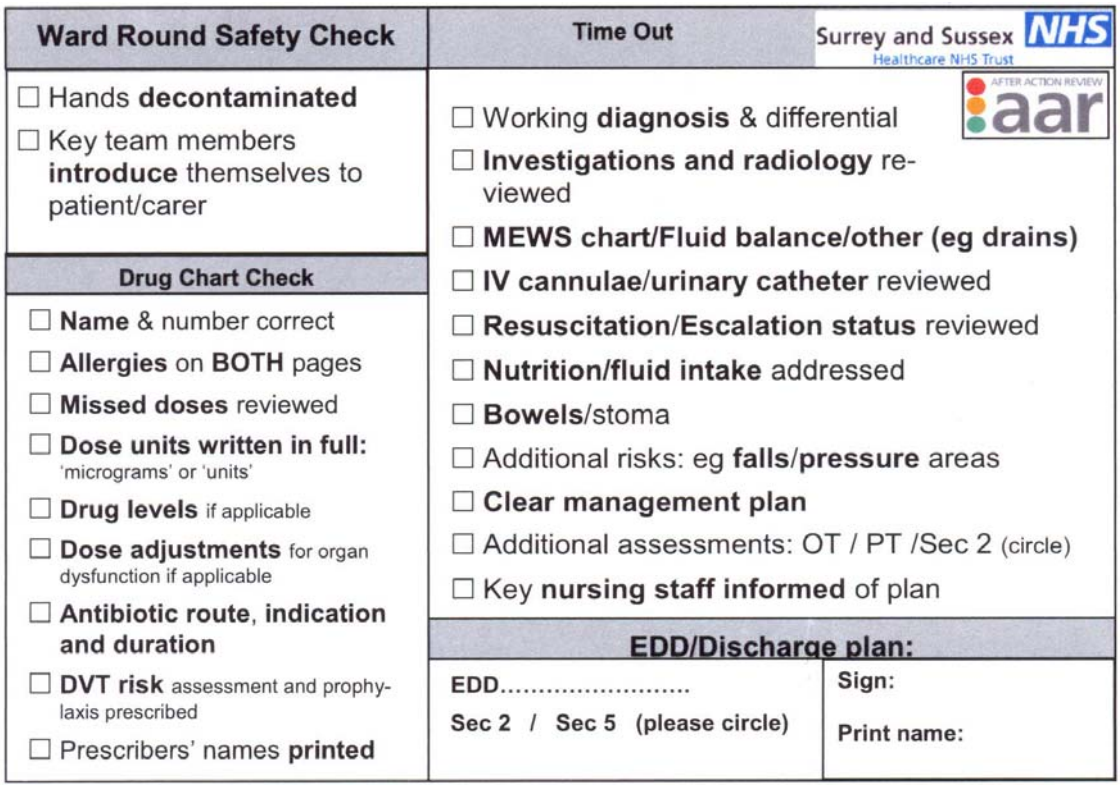
2. Patient story (#2)

A middle aged patient was seen in the ED with a history of overdose of an antidepressant. They were admitted to the CDU and reviewed the following morning at which point they were found to require admission to ICU. The patient was subsequerntly discharged with no residual consequence. Review of care showed the original diagnosis and estimate of severity had been to low and the plan for care (frequency of observations) had consequently been inadequate. While the patient may have required ICU admission anyway an earlier opportunity to intervene was not provided.

3. Narrative

Although medicine is increasingly based on science, it remains hierarchical and it is often practiced as an art. Ward round s are generally led by the most senior medical member of staff who does their best for each of the clinical (patient) contacts that they have until the ward round ends. At best a ward round will be supported by people who have additional information they can bring to the review and decision making process (for instance the senior nurse on the ward, allied health professions, a patient advocate), and will have adequate time so the consultation is unpressured.

This model is shown as weak when things go wrong, and evidence that things do go wrong comes from a variety of sources including analysis of incidents, patient complaints and the in-patient survey (for instance the response to the question of information about medication). At SaSH the AMU has introduced a ward round check list (see below) which provides structure to the clinical consultation the ward round is. It offers, or mandates, an opportunity for the team members to introduce themselves, to ensure they are reviewing the correct patient, and to look carefully at medications (a theme in a number of SIs including the Dispatches SUI). It ensures that the team are reviewing and working to the same differential diagnosis, that all investigations have been reviewed and interpreted consistently and that plans are being made which deviation from can be acted on (for instance EDD and MDT appropriate for discharge).



Ward Round Safety Check

- ☐ Hands **decontaminated**
- ☐ Key team members **introduce** themselves to patient/carer

Drug Chart Check

- ☐ **Name** & number correct
- ☐ **Allergies** on **BOTH** pages
- ☐ **Missed doses** reviewed
- ☐ **Dose units written in full:** 'micrograms' or 'units'
- ☐ **Drug levels** if applicable
- ☐ **Dose adjustments** for organ dysfunction if applicable
- ☐ **Antibiotic route, indication and duration**
- ☐ **DVT risk** assessment and prophylaxis prescribed
- ☐ Prescribers' names **printed**

Time Out

Surrey and Sussex NHS Healthcare NHS Trust

AFTER ACTION REVIEW aar

- ☐ Working **diagnosis** & differential
- ☐ **Investigations and radiology** reviewed
- ☐ **MEWS chart/Fluid balance/other (eg drains)**
- ☐ **IV cannulae/urinary catheter** reviewed
- ☐ **Resuscitation/Escalation status** reviewed
- ☐ **Nutrition/fluid intake** addressed
- ☐ **Bowels**/stoma
- ☐ Additional risks: eg **falls/pressure** areas
- ☐ **Clear management plan**
- ☐ Additional assessments: OT / PT /Sec 2 (circle)
- ☐ Key **nursing staff informed** of plan

EDD/Discharge plan:

EDD.....

Sec 2 / Sec 5 (please circle)

Sign:

Print name:

The checklist is now being rolled out to other medical wards and the surgical division have recently decided to adopt it (with modification) and a lead for this has been identified. This work has been presented at conferences and has won employee of the year at registrar level at the national medical leaders conference 2012. Brighton and Sussex Medical School have asked for SaSH to teach their medical students about productive and safe ward rounds building on the placement teaching which has occurred in the simulation suite and on our wards.

There is value from following the checklist for each patient contact, as there is for pre-flight checks on an aeroplane. However, as on an aeroplane, the significant added value is the expectation that any member of the flight team will raise concerns despite a similar hierarchy, appreciating that no checklist is a guarantor of safety.

Des Holden
Medical Director