Surrey and Sussex NHS
Healthcare NHS Trust

TRUST BOARD IN PUBLIC	Date: 31st January 2013 Agenda Item: 2.1
REPORT TITLE:	Patient Story
EXECUTIVE SPONSOR:	Dr Des Holden Medical Director
REPORT AUTHOR:	Dr Des Holden Medical Director
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Management Boards, Divisional Governance Meetings and with the PCT.

Purpose of the Report and Action Required:		(√)
To provide the Board with a specific understanding of how we as an organisation learn lessons from serious incidents.	**Approval**	
	Discussion	√
	Information/Assurance	

Summary: (Key Issues)

A patient may have hidden conditions that contra-indicate the treatment of more obvious diagnoses. All clinicians must fully explore the likely and the possible associated diagnoses when commencing investigations and treatment. Further review offers an opportunity to re-examine diagnosis and care and systems have to work to promote this, with fail-safes understood by all when the pathway of care is (reasonably) delayed.

Relationship to Trust Corporate Objectives & Assurance Framework:

Objective 1: To deliver a safe, high quality service & duty of candour.

Corporate Impact Assessment:	
Legal and regulatory implications	N/A
Financial implications	N/A
Patient Experience/Engagement	Demonstrates how action to improve the patient experience has been undertaken.
Risk & Performance Management	As discussed at relevant divisional and management boards, and reported externally
NHS Constitution/Equality & Diversity/Communication	N/A

Attachments:

N/A

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PATIENT STORY

1. Summary of Events

A 78 year old male was brought to the Emergency department by ambulance having fallen at a bus stop. The crew reported the fall had been witnessed and preceded by a period of general unsteadiness. It was documented there had been no loss of conscious- ness (LOC). The patient was triaged and seen by the ED team two hours later. The locum doctor elicited a history of collapse and hitting his head when falling, with possible LOC. The patient had suffered a heart attack two years previously. On the basis of the history, ECG and blood tests a diagnosis of acute coronary syndrome was made. The doctor telephoned the medical registrar on call and commenced the acute coronary syndrome care pathway, administering aspirin, clopidogrel and clexane. Throughout this period the patient remained alert and communicative. He was recorded on the electronic patient tracker as referred to medics though at the handover to the night shift this had still not occurred. The patient remained apparently well and was transferred to AMU. Two hours later the patient's oxygen saturations dropped, as did his Glasgow Coma Scale. He was reviewed by the medics, an urgent CT scan of his head performed and a massive sub-dural haematoma with contra-coup injury was diagnosed. An IMCA was involved in the decisions taken as there was no identified next of kin. The patient was intubated and ventilated and his care discussed with St George's who recommended conservative management. The patient was declared dead on brain stem criteria several hours later.

2. Contributing factors

The doctor in ED (and the ambulance crew and the nurses in both ED and AMU) failed to recognise a head injury had been sustained, even though the doctor took a history which implied head injury.

The diagnosis of acute coronary syndrome was reasonable, but anti-coagulation of such patients is contra-indicated if there has been a significant head injury.

There was a delay in the medical on call team reviewing the patient.

3. Lessons learned and changes made

- Better induction package for exclusion of head injury through early CT scan where there is a suspicion of significant head injury.
- Better description of roles for use of electronic patient tracker for delayed review at handover.
- Protocol for escalation where patient review is delayed.

4. Conclusion

This patient's death was deemed possibly preventable. The case was declared as an SI, shared with the PCT, and discussed at ED and division of medicine governance meetings, and at the management board for quality and risk. Protocols for head injury and collapse, and for use of patient tracking systems were re-written.