Surrey and Sussex NHS Healthcare NHS Trust

TRUST BOARD IN PUBLIC	**Date: 31st March 2016** **Agenda Item: 2.1**
REPORT TITLE:	**Patient Story** - Death from VTE and pulmonary embolus in a patient with reduced mobility after a mechanical fall and pubic ramus fracture.
EXECUTIVE SPONSOR:	Dr Des Holden
REPORT AUTHOR (s):	Des Holden
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	N/A

Action Required:		
	Discussion (√)	

Purpose of Report:

To highlight the errors which occurred within our risk assessment and processes in relation to venous thrombosis and embolism, in the case of an elderly female patient who died as a consequence. To discuss changes that are being made as a consequence.

Summary of key issues

A 72 year old lady was admitted with a pubic fracture. Her vte risk assessment was ticked but this did not result in appropriate action. The patient was discharged after 48h and readmitted two weeks later with a presumed side effect of her opiate analgesia. However, she deteriorated medically and her worsening EWS did not result in appropriate medical review or action. The patient suffered cardiac arrest and died. Her case was referred to the Coroner who ordered a post mortem and an inquest. The PM showed cause of death to be pulmonary embolus. The Coroner recorded a narrative verdict commenting on the inadequate VTE risk management.

This case demonstrates that despite local and national focus on safety and preventable harm and very specifically around risk of VTE, our pathways still are not faultlessly reliable in preventing harm or death.

Recommendation:

To note the recommendations from the SI investigation have been adopted with changes to process within the CDU and presentation of the case within the division.

Although we collect data on initial risk assessments (target nationally of >95%), the national drive now is for assessment of on-going need for protection after discharge. This patient did not receive this assessment further missing a chance to have reduced her thrombo-embolic risk and her subsequent death.

Relationship to Trust Strategic Objectives & Assurance Framework:

SO1: Safe -Deliver safe services and be in the top 20% against our peers
SO2: Effective - Deliver effective and sustainable clinical services within the local health economy
SO3: Caring – Ensure patients are cared for and feel cared about

Corporate Impact Assessment:	
Legal and regulatory impact	Relevant to regulation
Financial impact	minor
Patient Experience/Engagement	Poor experience for patient and family
Risk & Performance Management	Relevant particularly in relation to patient discharges and use of discharge lounge
NHS Constitution/Equality & Diversity/Communication	
Attachment:	
N/A	

TRUST BOARD REPORT – 31st March 2016
Patient Story

A 72 year old patient fell at home and was brought to ED by ambulance in pain. A diagnosis of fractured pubic ramus was made and the patient was admitted to the clinical decision unit for analgesia and occupational and physiotherapy assessments. A junior doctor performed a risk assessment for thrombosis risk but did not prescribe heparin (the appropriate drug). A second doctor suggested compression stockings should be applied. Two successive consultant ward rounds noted risk assessment had been performed. Neither ward round checked that appropriate action had been taken as a consequence of the risk assessment. It is unclear from the notes whether the compression stockings were ever actually administered. The patient was discharged after 48h and was readmitted two weeks later with apparent constipation and drowsiness. The working diagnosis at the time was of opiate analgesia side effects. On the second day of admission the patient became hypertensive, her EWS deteriorated and she was inadequately reviewed by medical staff. In the early hours of the morning she suffered a cardiac arrest and could not be resuscitated, and the patient died.

This death was reported to the Coroner and the patient underwent a PM which showed death to be caused by a large pulmonary embolus. The care the patient received was the subject of a complaint by her family which led to face to face meetings with the division and staff involved in care. A Coroner's inquest has returned a narrative verdict.

A serious incident was declared and an investigation was performed. This investigation concentrated on the events of the first admission and did not focus on issues relating to the EWS not prompting adequate medical review. The investigation found that the emphasis placed on performing a vte risk assessment is so great that it distracted from checking that the correct actions flowed from the assessment. It recommended that we talk about vte risk management (not assessment), that we audit both assessment and prescription in all future audits; that we re-emphasize that the responsibility for accuracy of management lies with the consultant, and that we link the assessment electronically with appropriate prescribing through the proposed EPMA.

Dr Des Holden
Medical Director
24.3.16