Surrey and Sussex NHS
Healthcare NHS Trust

TRUST BOARD IN PUBLIC	**Date: 29th September 2016** **Agenda Item: 2.1**	
REPORT TITLE:	Death of a patient with unclear clinical responsibility	
EXECUTIVE SPONSOR:	Dr Des Holden Medical Director	
REPORT AUTHOR (s):	Des Holden, Medical Director	Katharine Horner Patient Safety & Risk Lead
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	N/A	
Action Required:		
	Discussion (√)	
Purpose of Report:		
To discuss learning and what progress has (and has not) been made in relation to the death of a patient		
Summary of key issues		
This case demonstrates that the presentation, admission, investigation, early and on-going pathways of treatment for acute patients can be complex and can fail to address the needs of the patient. This patient story describes the sad death of a patient in our care where we did not make a diagnosis in a timely way, but also did not have a single team clearly responsible either for reviewing results, or sited on the lack of effectiveness in treatment.		
Recommendation:		
Some aspects of learning have been acted on immediately. Handover of clinical responsibility between teams remains a system that whilst in the patient best interest is complex and also has risk. Safety and Quality Committee should take a paper looking at the theme of incidents relating to handover between teams and oversee changes that make handovers less frequent and less fallible.		
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	Lack of clear responsibility by a named clinician is a patient experience issue and theme in complaints	
Risk & Performance Management	Risk arises from handover and from patients not accessing the best bed and team as early	

	as possible in their journey.
NHS Constitution/Equality & Diversity/Communication	
Attachment:	
N/A	

Trust Board Report – 29th September 2016
Patient story

A 67 year old man with worsened shortness of breath was brought to ED by ambulance. He had many co-morbidities but also gave a story of diarrhoea. He was nursed in a cubicle and then, even though no diarrhoea was observed was admitted to the side room of clinical decision unit. He was reviewed on the post take ward round by an elderly care physician and a cardiology referral was made. This happened promptly and although the cardiologists thought the principle problem was worsening of respiratory disease they ordered an echocardiogram. This investigation was performed very swiftly and showed a marked deterioration of cardiac structure and function. The paper report was hand delivered back to the ED and was filed separately from the notes.

The following day (a Thursday) no medical review occurred. The nursing team called a bleep which wasn't assigned to the medical team (so no one answered) and escalated to chief of medicine who asked cardiology to re-review. A middle grade doctor attended, noted the patient was awaiting an Echo, and hand wrote a referral to the respiratory team.

During this time the nursing documentation states the patient was becoming more confused with his son raising concerns during visiting time that his father was not exhibiting his normal behaviour. The following day (Friday) again no medical review occurred and nurses again escalated to chief of medicine who asked a respiratory consultant to see the patient. Nursing and medical notes both record that this occurred and both document that the echo was awaited. This consultant did not think the main problem was respiratory and requested head imaging to explain the mental deterioration. Blood tests at this point were abnormal and rung through to the department, and escalated within the ED although it is unclear from the notes that a medical review within Ed occurred. The patient was then transferred Friday night to a medical ward.

On the Saturday the patient became even more confused and peripherally swollen. The patient who had transferred in to the ward in the evening was not on the list for review that day and was not reviewed. The following day he was again not reviewed, and in the evening, after visiting time reported feeling dizzy and hot with an elevated temperature. Shortly afterwards he had a cardiac arrest, CPR was unsuccessful and he died.

Care and service delivery problems

1. The patient was placed in a clinical area not appropriate to their needs (they never had witnessed diarrhoea and could have been moved earlier). Infection control did not document their review in the notes.

2. Early warning score was not calculated correctly on day 2, so opportunity to spot and act on deterioration was missed.

3. The acute delirium was not recognised (by staff) or acted on.

4. The echo was not recognised as having been done largely because it was not filed in the same way it would have been in other ward areas. This led to a delay in recognising pulmonary hypertension and a failing heart.

5. No formal handover back to the medical team occurred so lack of ownership of the patient went unnoticed

6. The bleep list was not up to date.

Recommendations

- The ED side rooms will no longer be used for outlying specialty patients (done)
- Formalised system of handover for outlying patients between medical teams (done)
- Bleep audit to accurately ascribe bleep numbers and check wards have up to date lists (done, but needs to be ongoing)
- ED staff receiving abnormal blood results must act on or assure themselves that the managing team are acting on the results (in progress through education)
- Echo results must be scanned and posted onto Cerner (done and now active)
- IC team document every review of patients in clinical records (feedback given and accepted)
- Supportive conversation with agency nurse in ED about documenting phone conversations with doctors.
- Investigation shared with patient's relatives, Coroner and staff involved with patient.

Dr Des Holden
Medical Director
September 2016