Surrey and Sussex NHS
Healthcare NHS Trust

TRUST BOARD IN PUBLIC	**Date: 25th August 2016** **Agenda Item: 2.1**	
REPORT TITLE:	Patient Story	
EXECUTIVE SPONSOR:	Dr Des Holden Medical Director	
REPORT AUTHOR (s):	Dr Des Holden Medical Director	
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Patient Safety Executive	
Action Required:		
Approval ()	**Discussion (√)**	**Assurance (√)**
Purpose of Report:		
Patient story to share with the Board.		
Summary of key issues		
A 65 year old woman presented to ED with shortness of breath with a significant past history of medical illnesses and admission to hospital. A diagnosis of community acquired pneumonia was made and the patient agreed to be admitted. While waiting for a bed she left ED with her husband and collapsed at the toilets near to Boots. A MET call was activated and the patient was transferred back to ED. there was then a period of confusion resulting in a lack of recorded physiological observations for approximately three hours after which, while she was being reviewed by the medical team, she collapsed and died. A post mortem examination showed pulmonary embolus. An SI was declared on basis of unexpected severe outcome. The investigation concluded that departmental busyness contributed to an environment in which a failure in communication between senior nurse, agency and junior nurse. As a consequence there was a lack of clarity over who was responsible for documenting and reacting to changes in condition.		
Recommendation:		
For information and discussion		
Relationship to Trust Strategic Objectives & Assurance Framework:		
SO1: Safe – Deliver safe high quality and improving services which pursue perfection and be in the top 20% against our peers **SO3:** Caring – Working in partnership with staff, families and carers **SO4:** Responsive – Become the secondary care provider of choice our catchment population		
Corporate Impact Assessment:		
Legal and regulatory impact	Potential impact to CQC rating if we do not listen and learn from patient feedback	

Financial impact	Nil
Patient Experience/Engagement	It is important that the organisation can demonstrate that it listens to and learns from patient feedback
Risk & Performance Management	NA
NHS Constitution/Equality & Diversity/Communication	It is important that the organisation can demonstrate that it listens to and learns from patient feedback
Attachment:	
N/A	

Trust Board Report – 25th August 2016
Patient Story

Details of case

A 65 year old woman was seen in ED with shortness of breath. She had a past history of valvular heart disease, chronic obstructive pulmonary disease, ear nose and throat and musculoskeletal problems. An initial diagnosis of an infective complication on top of her lung disease was made and she was seen in the ED by senior medical staff who commenced antibiotics. There was discussion about the need for admission (the patient did not want this) but as a plan of care this was agreed.

While waiting in ED for a bed to become available the patient was accompanied out of the department to toilets near Boots as the ED toilet could not accommodate her wheelchair. In this location she became acutely unwell and collapsed. A medical emergency team call was placed and the team arrived quickly and brought the patient back to the department. At the time of this incident there were 77 patients in the department. The senior nurse transferred the patient to the high dependency area where there was an experienced agency nurse where she made some recovery. Normal practice in this area, which can accommodate four patients, is for the nurse in the area to look after all 4 patients. However a junior nurse (who had her own case load of patients in the main department was asked to settle the patient into the bay and perform initial observations.

A misunderstanding arose at this point with the agency nurse believing the junior nurse was to provide on-going care. This was not what the junior nurse understood and she returned to looking after her other patients. This was not apparent to the agency nurse who needed to leave the high dependency area to accompany another patient. The result was that whilst automated readings of pulse and blood pressure and oxygen saturation so were being performed, no one was documenting or acting on these.

When the agency nurse returned to the bay the patient was being re-reviewed by the physician team and during this review the patient became acutely unwell, reported they couldn't breathe and suffered a cardiac arrest. A resus call was put out and CPR commenced at which point the patient's partner confirmed to the team that the patient had an active DNAR decision in place. The team stopped CPR and the patient was pronounced dead.

Post mortem examination confirmed the cause of death as pulmonary embolus. This diagnosis had been considered by the medical team and a plan had been made that if further signs of this presented appropriate imaging should be requested. Investigation revealed the miscommunication and misunderstandings that led to observations not being recorded or acted on. It is unlikely that these failings caused the outcome, which was likely to have occurred even if this documentation had been excellent. The investigation concluded that whilst extreme busyness did not cause the miscommunication it was an environmental factor that contributed.

The Board is asked to note and discuss this case.

Dr Des Holden
Medical Director
August 2016