Patient safety

About Bob

Bob was a 72-year-old gentleman who was running his own Telecommunications business, Bob lived in Leicester and had a keen interest in Rugby and Football. Bob had two daughters who enjoyed family holidays and spending time with his granddaughter. The family spoke very highly of Bob and explained to the lead investigator of the SI that Bob was a pillar of the community and a highly intelligent man.

Bob was a fit, able, and active independent gentleman. He had a past medical history of Gout and a stomach ulcer but was not taking any regular medication. He was admitted to the LRI on the 2nd February 2021 with a recent history of confusion, headaches, visual disturbance and vomiting. Bob had a CT scan completed and it showed a left acute/subacute infarct (stroke).

Bob was admitted to LRI and reviewed by the consultant on the 10th February 2021. A CT scan was completed which showed an enlarged spleen with no malignancy and was noted that Bob had a change in bowel habit and weight loss. A urinary catheter was inserted for urinary retention, which started to drain dark urine. Bob had a slight left sided weakness, expressive dysphasia with slight ataxia. (affecting co-ordination, balance, and speech)

Bob was transferred to Snibston Stroke Ward on 11th February 2021 to continue his rehabilitation journey. During this time there was restricted visiting on the ward in adherence to Trust-wide infection control restrictions due to the coronavirus pandemic.

Bobs family were informed of his transfer to Snibston Stroke Ward.

Bob arrived on the ward at around 23.00 hrs on the 11th February 2021. A nursing admission and assessments were completed and the next day he was clerked in by the Advanced Nurse Practitioner (ANP). An assessment was also completed by the physiotherapy team.

Between the 12th – 14thth February 2021, Bob declined the drinks offered to him, the ward team had identified that Bob was not taking his drinks. The review of his care noted that this was discussed between staff at shift handovers, however it was not escalated for a medical review until 15th February

Bob's family raised concerns to the ward staff surrounding the fact that Bob was not eating and drinking and expressed how much they needed to visit him to encourage him. This was not supported by the ward due to the Covid 19 visiting policy.

On 17th February Bob was again assessed by the ANP and a review of his blood results indicated stage 3 acute kidney Injury (AKI). Bob was then transferred back to the LRI.

learning from incidents

Circumstances leading up to Bob's death.

Following his admission to the ward it was noted that Bob was declining to eat or drink. This continued throughout his admission until he was readmitted to the LRI on the 17th February with stage 3 acute kidney injury. He remained at the LRI until his death on the 23rd February 2021.

- 11/2/21 – Transferred to Coalville Ward 1. Nurse admission completed, ANP review, and therapy review completed. Recorded oral intake 1000ml output 850ml. There was not a clear management plan documented for oral intake and output.
- 13/2/21 – continues declining oral intake, medication, and food oral intake 310ml output 600ml
- 14/2/2021- continues to refuse oral intake 210ml intake output 250ml
- 15/2/2021 – further refusing food. Family brought food in for Bob but still declining, oral intake 350ml output 1150ml
- 16/2/2021 – reduced oral intake continues. Speech and Language Therapy (SALT reviewed) and Naso Gastric (NG) feeding discussed. ANP prescribed 500ml sub- cut sodium chloride which was commenced at 14.00hrs, noted that 80ml oral intake and the 500ml sub cut in progress. 500mls output, bloods taken.
- 17/2/2021 – bloods reviewed indicating stage 3 acute kidney injury. Transferred to LRI
- 23/2/2021 – Bob Died at the LRI

Emergent issues

During Bobs time on Snibston Stroke Ward

- The fluid balance charts were not regularly reviewed and escalated appropriately.
- The family could have visited, through exceptional circumstances to support and encourage Bobs oral intake however were not granted permission.
- There is no documentation to record Bob refusing the NG insertion as per medical plan
- When staff couldn't insert the NG tube there was no escalation or alternative plan made
- Poor documentation from all members of the MDT team

Changes to practice following the lessons learnt

- We have shared Bob's experience with the ward team and across the service line. We are reviewing our fluid balance charts to include an early warning system to support decision making, and implemented the new hydration pack process across our wards
- We have carried out supervision sessions to highlight the importance of considering the impact of depression post stroke. The MDT are also completing an eLearning package which has modules which covers supporting mental health post stroke, delirium and we will be developing further stroke training moving forward
- Supervision sessions have been completed to ensure that all staff understand the circumstances when an exceptional visit would be appropriate and the importance of ensuring family are involved when the patient is low in mood and has reduced eating and drinking.
- The trust visiting policy has been reintroduced and awareness raised with staff how they can support patients and their families.
- The family were offered to the opportunity to make a filmed family story, which has been completed. The story details the impact and distress, the decision to not allow them to visit and support their father to improve his mood and to eat and drink. The family story has been shared with staff across all ward sisters, therapy leads and ANPs.
- Spot checks have been completed of our records, News 2 training has been revisited, completed and re-embedded within our teams.
- Feedback given to all staff directly involved in Bobs care.

Changes to practice following the lessons learnt

- Improved communication with families and staffing surrounding supported visiting
- Introduced the new Hydration Policy.
- Hydration assessment packs – including new fluid balance charts, Fir charts
- Sharing of family story with all clinical leads
- Spots checks on documentation, fluid charts as part of the Matron's observations and walk rounds.
- Development of a trust wide teaching package involving Bob's story