Siv

NHS
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Patient safety – learning from incidents

Patient story

Introducing Bhawan:

Bhawan is an 85 year old man who lived at home with his wife, son and daughter-in-law. His wife supported him with all his activities of living including washing and dressing, shopping and provision of meals. He previously mobilised independently with a stick and rarely went outside his house.

He is a type 2 diabetic with hypertension. He has previously had a myocardial infarction, CVA and age related macular degeneration.

He was admitted to the acute hospital following a fall at home and subsequently transferred to Charnwood ward for rehabilitation with a view to being discharged home with the ongoing support of his family.

Emergent issues

08.10.22

One week after this admission, Bhawan was found to have an underlying urinary tract infection and went into urinary retention possibly due to his enlarged prostate. This then led to an episode of suspected sepsis for which he was referred to the GP OOH service. The management plan included; treatment with antibiotics, blood cultures were sent and IV fluids commenced, catheter inserted to resolve retention of urine.

09.10.22

Blood results were received the following day for the GP Out Of Hours (OOH) to review: the impression was hyponatraemia. The management plan was updated as follows; monitor urine output, continue IV fluids and antibiotics and monitor for possible seizures and to escalate any concerns immediately.

10.10.22

The following day Bhawan was reviewed by the Advanced Nurse Practitioner and it was noted that his temperature and tachycardia (fast pulse) were settling and a management plan: to continue with IV antibiotics and if temperature raised again, to contact GP OOH to prescribe a different antibiotic called Meropenem.

In response to the Home First Form being referred as part of his discharge plan from the ward, the Home Assessment Reablement Team (HART) team called and offered to commence a package of care once a day to meet his care needs commencing on 15.10.22

11.10.22

Doctor ward round; OOH notes were reviewed. Management plan changes; IV antibiotics changed to oral as patient now alert, sat in his chair and it is noted in his S1 notes that he appeared alert and well. He was reviewed by the Occupational Therapist on this day too and his discharge plans were discussed with his son with his permission. The discharge plan remained in place to return home 3 days later with care package to commence the morning after his return.

12.10.22

Whilst attending to another patient on the ward, the call bell alarmed and Bhawan was found by staff lying by the side of another patient's bed: he had an obvious head injury as sustained wound which was bleeding and also had suspected fracture as complaining of pain in his right arm.

First aid administered to head wound, full assessment completed and 999 called at approx. 2am.

An hour later, 999 re contacted as wound still bleeding and urgent transfer required as NEWS score 3.

At 03.21am Bhawan became more confused and agitated in behaviour and large haematoma now noted to head which was still bleeding. At this point, the patient had got himself up from the floor and was moving around. The nursing team tried to advise him to stay still but given his confusion, he was unable to concord with advice and therefore, the nursing team called 999 again.

04.10am Bhawan got himself into bed and analgesia was administered as prescribed. Glasgow Coma Score (GCS) now 14 (15 is normal) due to new confusion: he had become less compliant and National Early Warning Score (NEWS) had increased to 5 (normal 0). The nursing team called 999 again.

04.30am Telephone call received from ambulance team – they apologised and informed the nursing team that at that time, they had 88 category 2 calls to attend: one of which was 35 year old at home threatening to hang himself and had already been waiting 8 hours. Bhawan was reported to be low

Emerging Issues contd.

It was explained to the ambulance crew that patient had been waiting 4 hours, the community hospitals do not have a medic in attendance and he needed a CT scan as matter of urgency. Team lead apologised but said that there were no ambulances available but to call back if he deteriorated. The nurse advised that she had already called 4 times for that very reason.

05.00am The ward team spoke to on call manager to escalate to director on call. Half an hour later, the response was given to contact GP OOH. The OOH GP advised that all ANPs were currently out on visits and if he were to send a medic that the 999 call may be de-escalated? He also said if ANP was dispatched that they could only advise calling 999? Patient GCS at this point was 13/ NEWS 3

06.00am Spoke with EMAS service operations manager who advised ambulance should be available in next half an hour. At this point, the patient's wife was called.

06.36am Ambulance arrived on the ward: patient had been sat with nursing staff for last 2 hours at the nursing station on the ward. Patient's wife informed of transfer.

Outcome; ANP spoke with ED ANP

CAT scan result – NAD

X-ray result - NAD

Results shared with family. Patient admitted to acute hospital.

Changes to practice following the lessons learnt

It is to be noted, that in this instance, the ward nursing team followed the correct procedure in terms of completing the SBAR tool and maintained the safety of the patient in line with policy and procedures as far as he tolerated until the ambulance arrived.

- The team recognised the value of contemporaneous documentation: the patient record helped to tell his story following the incident
- The team recognised the value of adhering to patient observation escalation schedule, for example when patient NEWS score triggered that they call for medical advice, this was followed
- The team recognise the value of contacting Out of Hours manager for advice when they were concerned for patient's wellbeing and the importance of good communication across the system to support the patient's wellbeing
- The team recognise the value of a good medical management plan
- The team recognise the value of keeping family informed
- The team recognise the value of sharing their experiences to support other teams who may experience similar situations to prevent further occurrence and welcomed the appreciation showed by the senior team for their efforts in such a challenging circumstance.

The delay in transfer of a patient to the acute hospital for medical attention is not an isolated incident and the challenges around demand versus capacity faced by EMAS are well recognised across our community hospital wards. This patient's story is of valuable learning to all community hospital ward teams in relation to best practice on how best to manage a delay in transfer and has therefore been shared with all ward staff teams.