Cautionary Tales:

Learning from Incident Reporting and Near Misses

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Background and Aims

Many groups within our trust and the wider NHS review serious untoward incidents (SUIs), but communicating the learning gained from this can be difficult. *Cautionary Tales* is a quarterly newsletter, that shares learning points from incident reports which have been reviewed by the Division of Medicine Clinical Governance Group.

The newsletters aim to improve patient safety and maintain high quality of care, by highlighting key messages, recurrent themes and new services.

Cautionary Tales

Sharing learning to prevent reoccurrence

Clinical Governance is essentially a process of maintaining high quality care and promoting patient safety. Through Cautionary Tales we aim to disseminate key messages and highlight common themes. In this edition, we focus on 2 recent falls Serious Untoward Incidents (SUI), learning from a complaint and report a CAS alert for Hyperkalaemia.

Inpatient falls – 2 SUI cases

SUI – Fall with a delayed fracture diagnosis

Situation A 90 year old patient was admitted with cognitive impairment and delirium. He had an inpatient fall resulting in a periprosthetic hip fracture, diagnosed by a Radiologist after a repeat X-ray for pain 8 days later.
Background Throughout admission the patient had been extremely agitated and mobile. The Mental Health Liaison Team (MHLT) were involved and made recommendations for antipsychotic initiation prior to the fall. At the time of the fall 1:1 supervision was unavailable due to staffing pressures. A pelvic X-ray was carried out post-fall but the fracture was not identified by the medical team. Following this fall he commenced on IV antibiotics for infection and sedation for his delirium, which meant he was mainly cared for in bed. Due to his cognitive impairment he did not demonstrate pain typically. Pain was only reported when he became mobile after the delirium improved many days later, triggering a repeat X-ray. Review of this image and the earlier X-ray by a Radiologist confirmed the fracture.
Assessment *Notable practice* Falls care plans were well completed pre/post fall. MHLT were closely involved. *Root causes* Due to extreme agitation the fall may not have been preventable. 1:1 supervision may have prevented his escalating agitation and need for restraint.
Recommendations Always obtain formal X-ray reports in suspected fractures. The Abbey pain score can be used to detect pain in patients with Dementia.

Postural Hypotension is an abnormal fall in BP on standing. Resulting cerebral hypoperfusion can lead to syncope and falls. A significant change is:

- Systolic drop of ≥20mmHg with/without symptoms
- Systolic drop to <90mmHg with/without symptoms
- Diastolic BP drop of ≥ 10mmHg with symptoms

Symptoms include dizziness/light-headedness, pallor vagueness, visual disturbance or palpitations.

Common in unwell hospitalised patients (usually due to hypovolaemia or medication changes) simple treatment measures include improved hydration, medication review, increased dietary salt, avoiding straining (e.g. constipation) and head up bed tilt at night. Common medication causes include alpha-blockers, diuretics, tricyclics and antihypertensives.

CQUIN 2019/20 - 3 high impact actions to prevent hospital falls (>65 years)

CQUIN stands for Commissioning for Quality and Innovation. It is designed to promote evidence based good practice that is already being rolled out across the country. There is a £575K incentive if targets are met. There are more than 235,000 falls incidents in inpatient areas in England annually; 3,000 of these falls result in hip fracture or brain injury. If we achieve 80% compliance it is estimated the RUH would have 250 fewer falls, including 4 fewer hip fracture/brain injuries.
The 3 CQUIN actions for those over 65 years are:

1. Lying/standing BP recorded once in inpatients
2. Review and provide rationale for all hypnotics, anxiolytics and antipsychotics
3. Mobility assessment and provision of correct walking aid within 24 hours of admission

SUI – Fall after change in medication

Situation An 85 year old patient was admitted with a with STEMI and was recuperating on ward post-angiogram with new cardiac medications started. 9 days after admission she fell whilst trying to pick up a zimmer frame, sustaining a fractured neck of femur.
Background The patient had history of declining cognitive impairment without formal diagnosis. She was usually independently mobile at home. She was identified as a falls risk on admission; all those over 65 years are considered high risk of falls. On this occasion she mobilised without calling for assistance despite reminders from staff to do so.
Assessment *Notable practice* There was prompt review and investigations immediately after fall, with referral to the Orthopaedic team. *Root causes* Patients with cognitive impairment have a higher risk of falling. Antihypertensives were started as part of routine post-STEMI medical management, however lying and standing BP readings were not recorded so postural hypotension cannot be excluded as a cause for the fall.
Recommendations Lying and standing BP should be completed in all patients aged >65 admitted to hospital. It is good practice to repeat this after initiating/titrating antihypertensive medication.

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Methods

The newsletter is written by junior doctors for junior doctors, and circulated by email. It is also displayed in the trust library.

Key points are collated from multiple sources:

- Serious Untoward Incidents (SUIs) are summarised in an SBAR format, highlight notable practice and root causes, as well as new guidelines and services.
- CQUIN targets, inform on evidence-based good practice.
- Central Alerting System (CAS) alerts communicate urgent safety guidance based on national reporting.

Learning from Complaints

Case study - a communication failure

Situation An older patient was admitted with a head injury. Inadequate communication on discharge led to several mistakes in the follow up of this patient's care.
Background The patient was diagnosed with an intracranial bleed and prescribed levetiracetam for seizure prophylaxis for 5 days. He was discharged home after a 48 hour period of observation. The patient had Dementia, with his daughter holding Power of Attorney. The patient's daughter reported to PALS that she was not given enough information about medication, did not receive a copy of the discharge summary and information sent to the GP was unclear. Subsequently the patient took levetiracetam for 2 months before the mistake was identified and did not have a timely anticoagulation review with his GP.
Assessment Investigation found pharmacy had issued a large supply of levetiracetam without a stop date. The stop date was not on the prescription TTA but was written in the discharge Summary. In addition whilst the discharge summary documented the need to consider re-starting anticoagulation 2 weeks post injury, the family weren't given this information so did not know to make an appointment with his GP.
Recommendation In response to the complaint the department liaised with pharmacy regarding medicine reconciliation and pharmacy resources were expanded in this area. Education and support were provided for staff involved in the case. This case highlights the importance of good communication, especially with NOK of those with cognitive or sensory impairments. It demonstrates how vital it is that the patient & next of kin are provided with a clear discharge summary at the point of discharge.

Understanding patient complaints: a survey of 40 junior doctors at the RUH

Background In 2017-2018, the NHS received around 570 complaints per day, of which poor communication was the leading cause[1]. Complaints may be viewed as frightening and stressful by doctors but we are all likely to be involved in complaints during our careers and they can be a great source of learning and development.
RUH Survey Of 40 junior doctors surveyed at the RUH in January 2019, 14 had been involved in a complaint that they were aware of. Several doctors commented that information about complaints is not routinely fed back to junior doctors. Of note, almost all (90%) of doctors felt that they received 'little' patient feedback and only 10% of doctors thought that feedback from patients was 'usually' taken on board on their ward.
Learning from complaints Listening to patient's feedback is vital to improving hospital services. Feedback, including complaints, should be fed back to ward juniors where possible, to facilitate learning. In particular we should focus on improving communication with patients as this is often an area of concern.
Patient Advice & Liaison Service (PALS): This is a free service located in the hospital Atrium for patients/relatives to discuss suggestions and complaints with the RUH. If a complaint cannot be easily resolved, PALS offer information on the hospital's formal complaint procedure. At this point the complaint is escalated to the ward sister/consultant responsible for that patient.
Support Support for junior doctors is available from PALS, your clinical or educational supervisors and the BMA or your medical defense organisation (MDU or MPS).

1. Data on Written Complaints in the NHS 2017-18 Report. NHS Digital

CAS alert - Hyperkalaemia

Patient Safety Alert

Overview of RUH guidance

In the last three years, the National Reporting and Learning System (NRLS) received reports of 35 patients suffering cardiac arrest whilst hyperkalaemic. Issues identified included:

- lack of urgency of treatment ("the day team can deal with it")
- missed opportunities to re-review patients after initial treatment
- local guidance was not evidence-based, or unhelpful in emergency situations

Mild K⁺ 5.5. – 5.9 mmol/l | Moderate K⁺ 6.0 – 6.4 mmol/l | Severe K⁺ ≥ 6.5 mmol/l

Initial Management ABCDE, ECG, lab bloods, IV access

Identify cause & Address History & exam (esp. renal & bladder) Medication review

Mild Hyperkalaemia
Remove Potassium from Body
- Calcium Resonium: 15mg TDS PO

Reassess
- Monitor K⁺ at 1,2,4,6, and 24 hrs
- IF K⁺ > 6.5 or ECG change persist, consider haemofiltration/ furosemide & 0.9% NaCl. At this point discuss with senior doctor.

Moderate or Severe, or ECG changes
Shift Insulin Into Cells
- Actrapid: 10 units in 125ml 20% glucose IV (effect in 15 min, lasts 2-4 hrs)
- Salbutamol: 10-20mg nebulised (effect in 30 min, lasts 2 hrs)

Severe Hyperkalaemia or ECG changes
Protect the Heart
- Cardiac monitoring
- Calcium gluconate: 30ml of 10% IV over 5 min (effect in 2-3 min, lasts 30-60 min)
- Repeat > 10 min if still ECG changes

Depressed R wave amplitude; Tall, peaked T wave; Wide, flat P wave; Depressed ST segment; Prolonged PR interval; Widened QRS

Outcomes

Cautionary Tales reaches about 260 junior doctors every three months. Recommendations are tailored to our hospital and often highlight new and existing guidelines or services, such as a new anticoagulation clinic. It also aims to share access to support for junior doctors, for example those involved in complaints.

Feedback has been very positive: 90% of survey respondents felt the content was at an appropriate level and 96% stated they had changed their practice as a result of reading it.

Future

We are currently writing the next edition of Cautionary Tales, to be published in January under a new editorial team.

The project was presented to a hospital wide audience at a recent local conference, and in response to audience feedback, will now also be distributed to our nurse practitioners and consultants.

Future editions will include 'Exemplary Tales', which aim to share learning from and celebrate excellence in patient care.

Many thanks to the Royal United Hospital Bath for the ongoing support of this project.