Patient Story – Serious Untoward Incident

Author: Director of Safety and Risk Sponsor: Medical Director **Trust Board paper C**

Executive Summary

Context

1. As part of the Board's wish to regularly hear the patients' voice and really understand and learn from when things go wrong, it was agreed that the Director of Safety and Risk would bring patient stories quarterly to the Board which detailed a safety incident with the purpose of hearing and understanding the human story behind it.

2. Today Mr and Mrs Saujani are attending Trust Board to present their story of their son Krishan. Krishan died within 24 hours of admission to UHL as there was a delay in the in the recognition and management of his deteriorating condition due to sepsis.
Sepsis is a time critical condition and it is evident that there were missed opportunities to have identified the child's deteriorating clinical picture and intervene with a robust management plan and appropriate treatment earlier.

3. Joined by Dr Samantha Jones, Consultant in Paediatric Emergency Medicine, their story will re-tell the case of Krishan Saujani, their three year old son who died and, from the medical and family perspective, what one child could teach us all that working with families and as a team, genuine lessons can be learned.

Questions

1. Is the Trust seeking to hear the human stories behind incidents?
2. Is the Trust learning when things go wrong?
3. Have sufficient actions been identified and implemented since this patient safety incident?

Conclusion

The full impact of a safety incident on the patient is sometimes little understood by an organisation. The patient story behind it, seeks to expose the patient's and family's experience, anxieties and concerns and in this case the momentous grief from losing a child.

Input Sought

Trust Board members are invited to listen to this patient story and discuss the issues raised. The Board is also asked to note the learning and actions detailed in the paper.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Not applicable
Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	Not applicable
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Yes
Financially sustainable NHS organisation	Yes
Enabled by excellent IM&T	Not applicable

2. This matter relates to the following governance initiatives:

Organisational Risk Register	No
Board Assurance Framework	Yes

3. Related Patient and Public Involvement actions taken, or to be taken: [Insert here]

4. Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5. Scheduled date for the next paper on this topic: Quarterly

6. Executive Summaries should not exceed 1 page. My paper does comply

7. Papers should not exceed 7 pages. My paper does comply

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

REPORT BY: **MEDICAL DIRECTOR**

DATE: **4th JULY 2019**

SUBJECT: **PATIENT STORY**

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1. INTRODUCTION

1.1 As part of the Board's wish to regularly hear the patients' voice and really understand and learn from when things go wrong, it was agreed that the Director of Safety and Risk would bring patient stories quarterly to the Board which detailed a safety incident with the purpose of hearing and understanding the human story behind it.

2. KRISHAN'S STORY

2.1 Today Mr and Mrs Saujani are attending Trust Board to present the story of their son Krishan. Krishan a three year old child with Trisomy 21 (Downs Syndrome) was admitted to the Paediatric Emergency Department (PED) at the Leicester Royal Infirmary (LRI) on 7 November 2015 at 18:51 with a one day history of diarrhoea and a three day history of feeling generally unwell with a high temperature, feeling lethargic and vomiting. The vomiting had stopped prior to admission. The child had a history of a small patent duct arteriosus and was under the Cardiology team. Krishan was last reviewed by the Cardiology team on 1 October 2015 with a plan for the next follow up to be in 3 years. On the 6 November 2015, the child had been reviewed by his GP and treated for possible viral symptoms. No antibiotic therapy was prescribed at that time.

The following day (7 November 2015), having had several episodes of diarrhoea and a persistent high temperature, Krishan was transferred with his family to the PED by ambulance. In the PED he was reviewed immediately and triaged by a Registered Children's nurse where paracetamol was administered. Krishan was then assessed by a Consultant in Emergency Medicine, who has a subspecialty interest in Paediatrics (Consultant 1). The initial diagnosis was dehydration, presumed to be secondary to gastroenteritis for which he was commenced on an oral fluid challenge. Krishan had 2 further episodes of profuse diarrhoea and was again reviewed by Consultant 1. The plan of care at this time included fluid resuscitation with a bolus of intravenous fluids, followed by intravenous maintenance fluids. A number of blood tests were taken.

During cannulation Krishan had dropped his oxygen saturations and there was a concern that this may have related to his underlying heart condition. He was transferred to the Resuscitation area (Resus) of the Emergency Department and referred to the Children's Intensive Care SpR A for possible admission to Children's Intensive Care Unit (CICU) / ward 12 for a high dependency care bed (HDU).

The Specialist Registrar (SpR) A for CICU reviewed Krishan at this time. The plan of care included transferring him to the Children's Assessment Unit (CAU) for further management when a bed was available. This was communicated to both the Emergency Department and the CAU SpR. Blood tests were taken.

Krishan remained in Resus for a further 5 hours due to the unavailability of a side room on the Children's wards, which was required due to the history of diarrhoea. During this

period of time he was monitored (pulse and oxygen saturations) quarter hourly. Medication to help reduce his temperature were prescribed and administered as required.

On transfer to CAU at 03:30 hours he was immediately reviewed by the Deputy Sister and referred to the CAU SpR for review. Following the SpR review a management plan was agreed which included follow up of blood results, strict recording of input/output, 4 hourly nebulisers and to continue with full maintenance intravenous fluid therapy. In view of the fact that some of the blood results indicated that he was having a systemic reaction to an infection, intravenous antibiotics were prescribed and administered as per the SEPSIS guideline. Krishan received 1:1 care and observations were recorded every 30 minutes. At 05:00hours his observations deteriorated. A fluid bolus was administered and a blood gas measurement was repeated.

At 05.45 hours his respiratory rate increased and his oxygen saturation levels dropped. He was treated with a series of nebulisers and his condition appeared to improve. At 06.45 hours there was a further deterioration in his condition. The oxygen was increased to 15 litres per minute. The CICU SpR and CAU Consultant were immediately contacted to review the child. At 06.55 hours he arrested and full resuscitation was undertaken. Krishan was intubated at 07.05 hours. At 07.57 hours resuscitation was discontinued with the agreement of the team and sadly he was pronounced dead.

2.2 Joined by Dr Samantha Jones, Consultant in Paediatric Emergency Medicine, Krishan's parents will tell the story of their three year old son who died and, from the medical and family perspective, what one child could teach us all that working with families and as a team, genuine lessons can be learned.

2.3 This incident was investigated as a Serious Incident within UHL and was subject to a Coroner's Inquest.

2.4 The principal issue was delay in the recognition and management of a deteriorating septic child.

2.5 The investigation also acknowledged that there were several contributory factors in relation to this incident;

- High levels of admissions and activity in the Children's hospital
- Delay in accessing blood results
- Delay in transfer of the child from ED to CAU
- Lack of clinical responsibility whilst the child was in ED
- Incomplete observations and failure to use an 'early warning score' tool on the child whilst in ED

3. LEARNING AND ACTION POINTS

3.1 Krishan's story is rich in learning and the Trust has addressed these issues:-

- Blood pressure should be considered when undertaking the initial assessment in ED when clinically indicated. This will give a baseline for that child.
- Where a child remains in ED for a prolonged period of time they should be placed on a PEWS observation chart as this identifies if deterioration is occurring
- Results of blood samples taken in ED and sent to the laboratories should be checked on electronic system 1 – 2 hours after being obtained.
- Where blood samples are taken and sent to the laboratories the management plan should clearly include the review of results and a timeframe for completion.

- When observations are undertaken a full set of observations should be completed and any abnormality should be escalated as indicated on the observation chart
- It is important to identify a timeframe and who is responsible for the completion of any investigations requested
- At times of high activity and limited bed capacity and when delays in transfers are a possibility, there should be a collaborative agreement between ED and the service accepting the patient for admission with regard to who is going to lead on the care of the patient whilst they remain in ED.

3.2 Following this incident, all actions from the investigation were completed and there has been a determined focus on sepsis as part of the national CQUIN programme and the drive to reduce harm by improving recognition of the deteriorating patient.

3.3 Safety improvement work to try and reduce harm from sepsis and improve learning from incidents remains a key priority to reduce harm within UHL.

4. RECOMMENDATIONS

4.1 Trust Board members are invited to listen to this patient story and discuss the issues raised. The Board is also asked to note the learning and actions detailed in the paper.

Moira Durbridge,
Director of Safety and Risk
July 2019