Patient Story

Author: Senior Patient Safety Manager Sponsor: Medical Director **Trust Board paper C**

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	x
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board		
Trust Board Committee		
Trust Board		

Executive Summary

Context

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.

Questions

1. What was the learning from this serious incident?
2. Have the Trust taken robust actions following this incident to reduce the risk of recurrence?

Conclusion

1. This patient story and incident investigation are rich in learning points, many of which have been addressed. Lessons learned from this incident are;
    - LocSSIP was not followed
    - The NG 4 point placement check not completed

- External tubes and wires were not moved out of the chest x-ray field
- Verbal orders were taken which is not normal practice

2. Following this incident, the electronic version of the NG LocSSIP safety checklist has been piloted within the Adult Intensive Care Unit. There is also a plan to devise and implement a robust process of image reviews on the 'cold zone' viewing monitor with results being fed back to the 'hot zone' clinical team and for imaging viewing monitors to be accessible to clinical staff in the AICU Hotzone. Safety improvement work to try and reduce Never Events and improve learning from these remains a key priority to reduce harm and has been included in the priorities within the new Becoming the Best Strategy for 2020/21 within the Safe Surgery and Procedures program of work being led by Colette Marshall, Deputy Medical Director.

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

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes]
Improved Cancer pathways	[No]
Streamlined emergency care	[No]
Better care pathways	[No]
Ward accreditation	[No]

2. Supporting priorities:

People strategy implementation	[No]
Investment in sustainable Estate and reconfiguration	[No]
e-Hospital	[Yes]
Embedded research, training and education	[No]
Embed innovation in recovery and renewal	[No]
Sustainable finances	[No]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? n/a

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required. None required

- How did the outcome of the EIA influence your Patient and Public Involvement ? n/a

- If an EIA was not carried out, what was the rationale for this decision? n/a

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	x	Patient Safety
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: January 2021
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

REPORT BY: **MEDICAL DIRECTOR**

DATE: **1ST OCTOBER 2020**

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. Mr V's STORY

2.1 Today we will be presenting the story of Mr V. Mr V was a 60 year old gentleman who was under the care of the oncology team following a previous diagnosis of Dukes B carcinoma of the caecum. He had undergone a right hemicolectomy in October 2019 and was receiving adjuvant chemotherapy following the surgery. He presented feeling unwell on 25th March 2020, with a high temperature and rigors. He was tested for COVID-19 and was found to be positive. He was transferred to the Adult Intensive Care Unit (AICU) on 31st March 2020 as he required intensive ventilatory support due to his deteriorating respiratory function as a result of the illness.

On 11th April 2020, Mr V had a re-insertion of Nasogastric (NG) tube after he accidently pulled it out. This was required for administration of medication and enhanced nutritional support. This was placed by Doctor 1 at 11.00. A chest x-ray (CXR) was requested to confirm that the NG tube was in Mr V's stomach so that feeding and medication administration could commence. Mr V was in the 'hot zone' of AICU with other COVID-19 patients, and as a result of this portable x-rays that were required in the hotzone are carried out at in one allotted time unless the imaging was clinically urgent. This x-ray was planned appropriately as non-urgent.

The CXR was undertaken at 14.20 and reviewed by Doctor 2. It was advised the NG tube was in correct position, but required advancement. This was carried out and the nursing team were advised that a further CXR was not required and feeding could commence. No NG aspirate was obtained, but as placement was confirmed 10ml/hour of feed was commenced and prescribed drugs were administered.

At approximately 18.30 Mr V''s condition began to deteriorate and he required an increase of oxygen to support his respiratory system along with tracheal suctioning. At this stage thick secretions were noted but there was no evidence of feed material. The night nursing team took over the care of Mr V. All safety checks were completed and it was noted that the feed was running at 10ml/hour. It was also noted and discussed that the medical team had verbally agreed that the NG tube was ok to use but this was waiting to be documented in Mr V's medical notes. At 22.00, the feed was stopped as it was not possible to obtain an aspirate prior to medication administration. The medical team was informed and a chest x-ray was requested.

The CXR was undertaken at 23.34 and showed that the NG tube was misplaced in the right main bronchus; extending to the bronchial tree. It showed that the NG Tube was in the pleural space and that he had sustained a pneumothorax (punctured lung). Therefore feed and medication had been administered in to the lungs.

For Mr V, this meant that his Covid associated lung damage was further compounded by this incident. Mr V sadly died of Covid a few days later.

2.2 Mr V's family are still very much grieving the loss of their husband and father and so did not wish to partake today but still wanted his story to be shared anonymously with the Trust Board.

2.3 This incident was investigated as a Never Event within UHL, with Colette Marshall, Deputy Medical Director as the Chair for this investigation.

2.4 Contributory factors identified in this incident were:

- Misinterpretation of the chest x-ray image
- Failure to follow Guidelines/policies and Procedures (LocSSIPS)

2.5 Following investigation it was concluded that the ultimate cause of the event was a misinterpretation of the CXR undertaken to confirm placement of the NG tube in a pressurised environment. It is felt the 4 point check, if undertaken, was not done thoroughly by following a safety checklist; and an external portion of the tube mimicked the path of the oesophagus misleading the doctor into thinking the tube was in the oesophagus but short of the stomach. This resulted in the instruction to Doctor 3 to advance the tube to reassure doctor 2 that the NG tube was below the diaphragm. The language used by Doctor 2 stating "it is in the correct place just require advancing 5 cm" felt to the investigation team that this may have implied a further x-ray was not required and this may have been further supported as doctor 2 had not requested a further x-ray. The clinical team of the investigation team feel strongly that this is a highly unusual x- ray which was easy to misinterpret.

3. LEARNING AND ACTION POINTS

3.1 This patient story and incident investigation are rich in learning points, many of which have been addressed. Lessons learned from this incident are;

- LocSSIP was not followed
- The NG 4 point placement check not completed
- External tubes and wires were not moved out of the chest x-ray field
- Verbal orders were taken which is not normal practice

3.2 Following this incident, the electronic version of the NG LocSSIP safety checklist has been piloted within the Adult Intensive Care Unit. There is also a plan to devise and implement a robust process of image reviews on the 'cold zone' viewing monitor with results being fed back to the 'hot zone' clinical team and for imaging viewing monitors to be accessible to clinical staff in the AICU Hotzone.

3.3 Safety improvement work to try and reduce Never Events and improve learning from these remains a key priority to reduce harm and has been included in the priorities within the new Becoming the Best Strategy for 2020/21 within the Safe Surgery and Procedures program of work being led by Colette Marshall, Deputy Medical Director.

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.

Claire Rudkin,
Senior Patient Safety Manager **October 2020**