Patient Story

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

Executive Summary

Context

1. Following the AQuA Trust Board session on the 1st and 2nd March 2016, 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 really hearing and understanding the human story behind it.

2. Today Mrs. Jan Walker is attending Trust Board herself to present her story. In July 2017 Evelyn Simpson an 87 year old lady (Jan's mother) was admitted to Ward 23 Glenfield Hospital (GH) after presenting to Vascular clinic with an infected diabetic foot ulcer and right foot pain following falling and cutting her foot three months previously. She was commenced on intravenous (IV) antibiotics and IV fluids for her infected foot ulcer. Evelyn was a known Type 2 insulin dependent diabetic and from admission her blood glucose levels were noted to be unstable on the ward with episodes of hypoglycaemia.

   Nursing staff failed to realise that Evelyn was self-administering her insulin. The episode of hypoglycaemia at bedtime which led to Evelyn having a preventable cardiac arrest was not managed appropriately as staff did not follow the treatment of hypoglycaemia guidelines and give her a long acting carbohydrate snack.

   Evelyn survived the cardiac arrest but her health declined as a result and she lost her independence. Evelyn sadly died in February this year.

Questions

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

Conclusion

1. 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 as following the cardiac arrest Evelyn's health

declined and she required more care and support which impacted on her and the whole family until she sadly died in February this year.

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 – Trust Board 4.10.18

6. Executive Summaries should not exceed 2 pages. 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: **DIRECTOR OF SAFETY AND RISK**

DATE: **5th JULY 2018**

SUBJECT: **PATIENT STORY**

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1. INTRODUCTION

1.1 Following the AQuA Trust Board session on the 1st and 2nd March 2016, 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 really hearing and understanding the human story behind it.

2. JAN'S STORY

2.1 Today Mrs. Jan Walker is attending Trust Board herself to present her story. In July 2017 Evelyn Simpson an 87 year old lady (Jan's mother) was admitted to Ward 23 Glenfield Hospital (GH) after presenting to Vascular clinic with an infected diabetic foot ulcer and right foot pain following falling and cutting her foot three months previously. She was commenced on intravenous (IV) antibiotics and IV fluids for her infected foot ulcer. Evelyn was a known Type 2 insulin dependent diabetic and from admission her blood glucose levels were noted to be unstable on the ward with episodes of hypoglycaemia.

2.2 Jan will tell of the impact that this incident has had on her and her family's life. Evelyn's health declined and she required more care and support which impacted on her and the whole family until she sadly died in February this year.

2.3 This incident was investigated as a Serious Incident within UHL, with Heather Leatham, Assistant Chief Nurse as the Chair for this investigation.

2.4 The principal issue was the failure of nursing staff to realise that Evelyn was self-administering her insulin. The episode of hypoglycaemia at bedtime which led to Evelyn having a preventable cardiac arrest was not managed appropriately as staff did not follow the treatment of hypoglycaemia guidelines and give her a long acting carbohydrate snack.

Root causes for this incident were identified as;

- Failure to realise and respond that Mrs ES was self-administering her Insulin.
- Failure to check that Mrs ES had surrendered her entire stock of medication.
- Sub optimal management of hypoglycaemia at bedtime on 14th July 2017.

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

- Routine non-compliance with the safe storage of medication and lack of compliance with the self-administration of medicines policy.
- Inadequate handover to ensure safe management of the patient.

3. LEARNING AND ACTION POINTS

3.1 This patient story and incident investigation are rich in learning points, many of which have been addressed. Following this incident, training has been commenced for all medical and

nursing staff on the ward and increased levels of support from the Diabetes Specialist Nurse team and in reach services are now in place.

3.2 Since this incident, the ward has undertaken a review of current handover process against Trust handover standards to ensure nurse handover is appropriate and safe for ward 23. Afternoon ward rounds are now documented in the medical notes using the ward round stickers available on the ward and there are now regular monthly audits of medicines storage on the ward.

3.3 In regards to Self-Administration of Medicines (SAM), the Trust has agreed that we will now pursue the rollout of SAM across the three sites following a pilot phase. This is to allow patients to self-administer their medications including insulin following assessment. A SAM team has been set up which has been focusing their attentions on planning a full trust rollout which will aim to start in August 2018. This work includes:

- Review of the self-administration of medications policy an update of SAM patient information leaflet.
- Focus group meeting which was held on 2nd May 2018 with key stakeholders involved to discuss SAM and future plan.
- Working with the diabetes team to ensure that insulin is embedded within the assessment and training.
- Revising all materials associated to SAM: policy, assessment booklet, new ward suitably checklist.
- Create a new e-learning package with associated videos to ensure quicker training of all staff as currently training is face to face and provided by 4 people.
- Devising a robust rollout plan.

3.4 Insulin safety remains a key safety improvement priority to reduce harm and has been included in the safety plan in the Quality Commitment for 2018/19.

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 2018