SIRG Trust Thematic learning Log

Portsmouth Hospitals NHS

WEB-Reference	Description of Incident	Root Cause	Actions	Theme
August 2015				
WEB-40245	A member of Portsmouth Hospitals NHS Trust's (PHT) Information Services Department sent an email with a spread sheet attached containing Personal Identifiable Data (PID) for over 8,000 dementia patients (Surname and NHS number). The email was sent via NHS.net; unfortunately the wrong recipient was accidently selected (City Healthcare Partnership CIC). Both the actual recipient and the intended recipient shared identical names and their nhs.net addresses were 2 characters different. The individual had on previous occasions sent the email to correct person and the incident was thought to have been human error	• **Deviation from SOP** As detailed in the service delivery section of the report above, control has been established via a formal verbal warning to the individual and a reminder to all staff regarding the use of the secure mail service NHS.net. The Properties section of NHS.net mail provides identification of the potential recipient, down to organisation level. • **Human error** The only prevention of this incident from occurring would have been a senior member of the team (the individual that composed the SOP) sitting with the member of staff compiling the report. Whilst there would have been no change in the physical output of the report, they may have spotted that the incorrect email address was entered on NHS.net mail.	• All staff keep their Information Governance training up to date at all times Monthly checking by line management, with plans in place to take training within 8-weeks of deadline being breached. • All SOPs that support reporting where PID is shared externally to cite the mandatory step of getting a line manager to sign off reporting at email stage • All tasks to be reviewed where PID is shared externally. Their SOPs to be edited to include this step of checking/sign off by line manager • All SOPs that support reporting where PID is shared externally to cite the organisations who will receive the information, alongside the named individual with email address. SOPs additionally to note the mandatory step of selecting the recipient's email address via the "Properties" section of NHS.net mail, which will clearly list name and employing organisation. • All tasks to be reviewed where	Human Error

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			PID is shared externally. Their SOPs to be edited to include these steps/actions. • All SOPs that support reporting where PID is shared externally to cite the mandatory step of ensuring the file is password protected. The password must be shared with the intended recipient on a separate correspondence where the PID is shared. All tasks to be reviewed where PID is shared externally. Their SOPs to be edited to include these steps/actions.	
WEB-37699	Patient had a chest x-ray on 06.05.15 which showed an abnormality in the left lower lobe (LLL). When comparison was made by the reporting Radiologist with a chest x-ray that the patient had a year previously via ED, it was felt that this abnormality had been visible on this earlier image. The LLL abnormality has since been confirmed via CT biopsy as squamous cell carcinoma of the left lung lower lobe.	• Failure of the ED Doctor to note an abnormality on the ED chest x-ray in 2014 • Failure of diagnostic imaging to report on the ED chest x-ray in 2014.	• Review current Trust policy for evaluation of x-ray images and escalation of concerns to Trust Board via CSC risk register Radiology and Clinical Support management teams to review current processes for reporting of ED x-rays • Review provision of chest x-ray interpretation teaching for ED doctors ED Educational Supervisor to review x-ray teaching for ED Doctors • Discussion of case at Imaging Discrepancy Meeting Discussion and sharing of learning amongst	Failure to identify abnormality on a plain film

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			Radiologists • Dissemination and discussion of report findings at ED Clinical Governance meeting Discussion and sharing of learning amongst ED medical teams • Dissemination and discussion of report findings at Imaging Clinical Governance meeting Discussion and sharing of learning amongst Imaging Clinical Governance team	
WEB-32565	Patient was transferred from Cedar Ward, Petersfield to the Emergency Department on 6/1/15 with hospital acquired pneumonia and a documented Grade 2 pressure ulcer to sacrum. The patient arrived at ED at 20:25 hours. The RN who came on duty at 21:15 hours recalls this gentleman and believes that he was on a hospital bed when he took over his care. It was an extremely busy shift in ED and whilst staffing was not at a shortfall, the RN described how the acuity of the patients in his care, meant that he was not able to provide the pressure ulcer prevention plan that the patient required.	Failure to implement pressure ulcer prevention strategies, to prevent further deterioration of the grade 2 pressure ulcer whilst in the Emergency Department.	• Organisational action plan in place to support improved patient flow. • Share incident with ED staff to demonstrate importance of early skin assessment and prevention strategies • Share a summary of the incident and lessons learnt in the Emergency Medicine Governance and Quality Newsletter • Contact the patient's next of kin with the outcome of the investigation and lessons learnt.	Failure to undertake the required pressure ulcer prevention strategies and operational pressures

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WEB-38536	The incident is a fall of a baby from the mother's bed resulting in a fracture of the skull. The baby was in the care of its mother on the post natal ward. It is not anticipated that there will be any long term consequences for this baby.	Fractured skull on a newborn caused by a fall from a hospital bed onto a hard floor due to the mother having the baby in bed with her rather than in the cot provided.	Maternity services cannot be assured that all women are fully aware of the dangers of babies falling and therefore posters will be put up in rooms so that mothers are aware of the danger of having babies in bed with them and the risk of harm should they fall.	Accidental Injury
WEB-39247	Patient attempted to mobilise independently and had an unwitnessed fall beside her bed (bedspace 19) on D6 ward sustaining a laceration to her left forehead and a fractured left hip	Falls pathway was not updated formally when risk was increased Fluctuation in mobility was not recognised as a falls risk. Due to the layout of ward it was possible for patient to stand without being observed Staffing levels and experience	• Physiotherapy to attend falls training and to use the falls pathway • All staff to complete Datix form if equipment is required by the individual but unavailable and escalate to senior staff i.e. the orthopaedic bleep holder. Alternative preventative measures such as close observation by staff to be used until such equipment is available. • Incident to be shared with all staff to raise awareness • Falls pathway audit to look at the importance of recognising high risk patients and the compliance with lying/standing Blood Pressures	Lack of documentation
WEB-38254	On 20/5/15 at approximately 04.45 the patient was found on the floor following the staff hearing a thud. Patient told staff	Patient did not ask for assistance to the toilet or use his frame. Darkened room meant patient had difficulty finding toilet	• Falls pathway to be commenced on admission for patients identified as being at risk. • Pre and post Falls protocol	Failure to identify risk

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	he had been to the toilet and was looking for his bed. Observations stable. Immediate Injuries assessed by nurses- cut to forehead and pain to spine and Left Hip. Hospital at night team called and matron attended. Hovermat obtained and used to transfer patient back to bed and examined by a doctor. Falls pathway commenced. Datix completed. Steristrips to wound. Patient sustained a fractured neck of femur from the fall		adherence essential – timely assessment and re assessment on transfer	
WEB-38876	Patient found bleeding profusely in bed by mother at approximately 04:30 in the morning of 04 June 2015 after attending for Haemodialysis (HD) 03 June 2015. Patient had been reviewed twice in preceding 10 days by PHT medical staff for bleeding from fistula with appropriate treatment. Patient attended ED at QA but was asystolic on arrival. Resuscitation was unsuccessful.	Fistulas are dangerous and there must always be a high level of suspicion that catastrophic bleeding may occur. The issues identified in this case were not ignored and appropriately reviewed by nursing and junior medical staff. With over 600 patients on HD across our region, we could not admit all the patients that have bleeds that are not easily controlled with pressure. High risk fistulas (ones with thin skin and scabs of > 3 to 4mm in diameter) are regularly referred for further assessment and treatment. This particular fistula did not appear to fall into this category and therefore I am unable to criticise the treatment given. As a regional service, we need to continue our awareness of the bleeding risks, our vigilance of fistulas and education of both	No specific lessons, but the need for a continued high level of vigilance and continued education of patients, staff and carers on the risks of fistulas and the warning signs of an impending bleed.	Education of staff and patients

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		patients and staff.		
WEB-38052	An 85 year old man was referred by his GP 8/5/15 with vomiting, fever and hypotension with a working diagnosis of a urinary tract infection. He had a background of ischaemic heart disease and possible dementia (no formal diagnosis) but was living independently prior to admission. The patient was initially seen in ED and diagnosed with urosepsis, acute kidney injury and urinary retention – IV fluids and antibiotics commenced and urinary catheter inserted. There were ongoing concerns regarding the patient's constipation and distended abdomen. An ultrasound scan of the abdomen performed 13/5/15 showed dilated fluid filled small bowel loops. A CT scan was recommended by reporting sonographer following discussion with a GI radiology consultant. A CT scan and surgical review were requested on 14/5/15. The patient was seen by on-call surgical registrar who felt the presentation was more in keeping with pseudo-obstruction but	Failure to review admission abdominal x-ray Delay in obtaining a CT scan following the abdominal ultrasound performed on 13/5/15 – a CT was requested on 14/5/15 and does not appear to have been prioritised as urgent by the on-call radiologist.	Nothing to note	Failure to identify abnormality on a plain film

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	advised to proceed with planned CT scan. At 0139h on 15/5/15 the patient suffered a PEA cardiac arrest with unsuccessful attempts at resuscitation. A subsequent coroner's post-mortem examination established cause of death as perforated caecum secondary to a stenosing sigmoid adenocarcinoma. A formal complaint has been received from patient's family regarding his care – the main concerns are that his presentation strongly pointed towards an obstruction and the delay in requesting/obtaining a CT scan.			
WEB-28488	Patient transferred from ward C6 to ward C5 at 13:00. At 14:00 found on the floor in the bath room, in room 8.Unwitnessed fall. Patient admitted to the ward at 13.00 and slightly confused. Patient was detoxing from alcohol. No obvious injuries noted. Patient stated he "did not hit his head". Patient sustained a fractured neck of femur from the fall	Patient's unstable clinical condition and developing sepsis caused him to be at risk of falling and although this was not communicated on transfer to C6, the care provided to him on transfer would not have been changed	Patient assessed incorrectly on the initial falls assessment. Transfer checklist not completed Observations not recorded immediately prior to transfer.	Lack of communication on transfer