National Mortality Case Record Review Programme

Training Case Notes Guide

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Foreword:

These guidance notes have been produced as an accompanying script for trainers using the teaching case notes as part of the National Mortality Case Record Review Programme. This is a non-exhaustive list that describes both the good and not so good care processes contained in the training case notes.

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CASE NOTE 1

Case Description: 75 year old male admitted with haemoptysis and dorsal chest pain to the Medical Admissions Unit on 25th October 2015.Deceased on 29th October 2015. Cause of death listed as bronchopneumonia with COPD.

GOOD CARE	SUBOPTIMAL CARE
• Thorough admission clerking • Timely senior registrar review on admission • Early specialist input	• Missed opportunities to treat a sick patient appropriately and in a timely manner • Lack of an escalation plan in the management of a sick patient • Inadequate senior review and leadership in the patient's overall management • Fluid balance and monitoring poor • Poor infection management • Lack of communication with patient's family • Inadequate end of life care planning • No objective evidence to back diagnosis made.

FURTHER DESCRIPTION

- Ongoing hypoxia without escalation of care.
- Delay in reversing high INR
- Early input from haematology registrar.
- 3 units of blood transfused overnight in a breathless patient
- Initial hypercalcaemia not monitored
- Intravenous fluids infused at a higher rate than prescribed
- No documented consent for chest drain insertion
- Invasive procedure (femoral cannula) performed on day of patient's death
- ICU team left to make escalation plan and decision regarding resuscitation
- No blood cultures taken in a pyrexial patient
- Antibiotics changed three times without microbiology input
- Death certificate incorrect
- No discussions with Coroner's Office regarding a potential work related illness.

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CASE NOTE 2

Case Description: 85 year old female admitted with increasing shortness of breath on 1st February 2015. Treated for a chest infection and atrial fibrillation. Started on Digoxin on 7th February 2015. Died on 20th February 2015 following a cardiac arrest.

GOOD CARE	SUBOPTIMAL CARE
• Do Not Resuscitate form for an unwell, elderly patient with multiple co-morbidities was completed in a timely manner. • Escalation decision made early by registrar • Good multidisciplinary team input	• Missed opportunities and delay in initiating treatment on admission • No capacity assessment documented for a confused patient • Medication errors • Poor communication with relatives • Poor fluid balance management • Delay in discharge of a medically fit patient • Inadequate documentation

FURTHER DESCRIPTION

- Delay in administration of intravenous fluids and intravenous antibiotics
- Family not informed of resuscitation decision
- Nursing Home records 5 years out of date.
- No nursing documentation till 2nd February 2015
- No documentation of urinary catheter insertion
- Rate of fluid administration not monitored appropriately
- Fluids incorrectly stopped on patient's ward transfer
- Continued administration of digoxin despite signs suggesting probable toxicity. Reversal agent not considered.
- Resuscitation of patient started following cardiac arrest despite Do Not Resuscitation form.

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CASE NOTE 3

Case Description: 96 year old female patient admitted on the 15th April 2016 with a neck of femur fracture following a fall**.** Hemiarthroplasty performed on 16th April 2016 and patient died on 24th April 2016.

GOOD CARE	SUBOPTIMAL CARE
• Prompt surgery within 24 hours of admission • Good multidisciplinary team input • Good assessment and management plan for pressure sores	• Incomplete initial assessment • Consent form not completed • Surgical site not marked • Medication errors • Lack of senior support to junior doctors • Poor fluid and sepsis management • Delay in completing Do Not Resuscitate form

FURTHER DESCRIPTION

- No collateral history obtained regarding patient's fall
- Patient's signature not on surgical consent form
- Student nurse's documentation not countersigned by staff nurse
- Student nurse administrating medications including controlled medication without countersignatures from staff nurses
- Controlled drug administered despite drug not being signed by prescriber on chart
- Patient seen by Orthogeriatrician, pain team and physiotherapist promptly
- No Orthopaedic consultant review documented
- Unwell patient managed overnight primarily by junior doctors without registrar or consultant support
- Delay in starting antibiotics in a patient with suspected infection
- Second urinary catheter insertion not documented
- The Hospital Do Not Resuscitate form not completed till the 23rd April despite patient having a community Do Not Resuscitate form

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