SPSO decision report

Case: **202002197, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / Diagnosis
Decision: upheld, recommendations

Summary

C, parents of infant child (A) complained about the care and treatment that A had received from the board. C had raised concerns that A's Hickman line (a central line catheter inserted into one of the large blood vessels to allow permanent access for treatment) may be infected and had sought advice at hospital. A swab of the insertion site had taken place, however A had been discharged without further treatment. C complained that the board had failed to provide a reasonable standard of treatment to A during their admission.

C further complained that the following day at a home visit, nurses had proceeded to flush A's line (procedure required to ensure the line remains clear of blood and to prevent clotting) in spite of their concerns it might be infected and without the results of the swab testing. C asserted that as the line had been infected, A had received a septic shower (sudden systemic release of pathogens into the blood stream causing septic shock) resulting in A's sudden collapse.

In their response, the board said that as there had been no diagnosis of a line infection, A's line had been flushed in accordance with the board's Care and Maintenance policy (CVAD policy). However, reflecting on the complaint, the board acknowledged that had there been formal communication between services regarding A's swab testing the evening before, this may have influenced their decision-making to proceed with the flush. They said that as a result of the complaint, they would review and update their CVAD policy to incorporate a standard operating procedure (SOP) and checklist so as to improve information sharing between teams and in circumstances of swab testing, or concerns expressed by families, to ensure medical advice would be sought before proceeding.

We took independent advice from a paediatric nursing adviser and consultant paediatric adviser (dealing with the medical care of infants, children and young people). We found that although the board had correctly considered sepsis in their assessment of A during their hospital admission, they had failed to take appropriate account of the Sepsis 6 guidance, had failed to seek senior clinician advice, and further treatment should have been considered. We also found that in light of the known risk of sepsis associated with central line devices, and given the level of concern expressed by C, it would have been reasonable for the board to have delayed the flush of the line until after the swab results had become available. We also found that the board had failed to correctly follow their CVAD policy, specifically, nurses had not sought senior medical advice before proceeding, and the pro forma maintenance bundle had not been completed or recorded for the flushes of A's line.

C further complained that in investigating their complaint the board had failed to seek their account of events, and had only raised a DATIX (incident report) after they had made their complaint. We found that the board had failed to correctly manage the incident in accordance with their adverse event management policy and procedures which resulted in the family being denied the opportunity to present their evidence. We also found that there had been an unreasonable delay in reporting the DATIX, and the incident had not been escalated for consideration as a potential Serious Adverse Event Review.

We fully upheld all aspects of the complaint. However, in making our recommendations we took account of the

board's proposed improvements to their existing CVAD policy which we considered adequate to address the failings identified.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to take appropriate account of the Paediatric Sepsis 6 guidance in their assessment of A, failing to consider further treatment in line with the Paediatric Sepsis 6 treatment pathway, failing to seek senior clinician advice and failing to ensure formal communications with the ICCN team regarding A's attendance at the paediatric unit. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C for failing to correctly follow their AEM policy and procedures by unreasonably delaying the DATIX and not escalating the incident for consideration as a potential SAER, for failing to carry out a reasonable investigation by not reporting events as a SAER or commissioning a SAER report and for failing to allow the family the opportunity to participate in the adverse review process. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C for proceeding to flush A's central venous line without the results of the swab testing, for failing to act on their concerns that the line may be infected, for failing to give fuller consideration to the known risk of sepsis associated with CVAD, for not adhering to the Hickman Patency Troubleshooting guide by failing to seek senior medical advice before proceeding with the flush and for not completing or recording the CVAD maintenance bundle for A's central venous line flushes. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- The board should ensure relevant staff are reminded of the Scottish Patient Safety Programme Paediatric Sepsis 6 Guidance when considering treatment, specifically that there is a lower threshold for consideration of sepsis in patients with indwelling devices/lines, complex medical conditions and significant parental concern. The board should ensure that where there is a lower threshold for consideration of sepsis, senior clinician advice is sought.
- The board should ensure relevant staff are reminded of the board's adverse event management policy and procedures, and published best practice (HIS and IHI guidance) with regards to reporting, managing and analysing significant adverse events. The board must also ensure effective communication with families throughout the SAER process, and during any parallel complaint investigation.
- The board should ensure that when carrying out care and maintenance of central venous access devices in the community, that the CVAD maintenance bundle, including associated checklist, is completed and recorded in the clinical records.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.