NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Risky Business

Learning from deaths

Since the launch of the National Guidance on Learning from Deaths by the National Quality Board in March 2017 the Trust has completed 567 structured judgement mortality reviews.

This equates to 67% of all in hospital deaths. This figure has been recognised by the regional mortality programme as excellent. We continue to strive to improve on this figure month on month.

96% of the reviews have recognised very good/excellent care throughout each phase of a patient's journey, which again is an extremely positive finding. However, 4% of the reviews have identified less than adequate/poor care and it is these that we must learn from. **See our recurring themes below.**

If anyone requires training in undertaking Structure Judgement mortality reviews or any further information on this matter please contact Mandydalton1@nhs.net or tel: 01302 644403.

Poor recognition:

All too often clinical staff are seeing patients on a daily basis and repeating tests, documenting the same findings, suggesting that a patient is coming to the end of life but not making a decision and not setting a ceiling of care. Timely recognition results in a more comfortable and dignified death.

Poor documentation:

Clinical staff must ensure that families and carers are aware of the condition of their loved one when approaching end of life. Do not be afraid to inform them that their loved one is dying and that there is nothing more we can do but to keep them comfortable. Document, date and sign these conversations.

Poor initiation:

Be sepsis aware always. Always ensure that all immediate treatment is carried out. The timely prescribing of antibiotics is all well and good but the 'Adminstration of Antibiotics' is crucial as is the 'Accurate Recording of Fluids'. These are two areas that we sometimes fall down on and need to improve.

Poor DNACPR:

Unnecessary and futile resuscitation is distressing to a dying patient. Ensure DNACPR discussions and decisions are had as soon as practicably possible. If a clinical judgement is made not to resuscitate with no DNACPR in place, ensure accurate documentation of that decision is made but DO NOT complete a DNACPR form after the death.

"**Death** is an incident producing clay. **Use** it, **mold** it, **learn** from it."

- John Gilling

The team

Please note new and amended numbers

Head of Patient Safety & Experience
Louise Povey: *642277*

Legal Services Manager
Michele Corbett: *642167*

Patient Experience Team Leader
Joanne Blockley: *642768*

System Analyst and Admin (Datix)
Tracy Evans-Philips: *642275*

Patient Safety Leads
Debbie Swift: *642274*
Mark Race: *642273*
Linda Mcloughlin: *642719*
Maggie Gregory: *642719*
Emma-Louise Drabble: *642274*

Risk Management Co-ordinator
Diane Crozier: *642276*

Legal Services Admin
Angela Giblin: *642272*

Patient Safety Facilitator
Andrea Berry: *642272*

Patient Experience Officers
Gary Metcalfe: *642766*
Jenny Olma: *642765*

Patient Safety & Legal Admin
Julie Scarborough: *642272*

Patient Experience Admin
Sarah Maye: *642764*
Elaine Green: *642764*
Deborah Cummins: *642764*
Amy Farrington: *642764*

"The single biggest problem in communication is the illusion that it has taken place."

- George Bernard Shaw

Communication, communication, communication

Patient A, a 64 year old gentleman attended the Emergency Department with increased shortness of breath.

He was treated for a chest infection and despite a swollen calf and a suspected DVT, neither prophylactic nor therapeutic anticoagulation was commenced.

Plans to carry out a Doppler investigation throughout his stay this did not occur until seven days following his initial attendance in ED due to a systems failure.

The Doppler showed a DVT at the junction of a deep artery in the thigh. Patient A was informed of his diagnosis of a DVT and a possible diagnosis of a pulmonary embolism as a consequence of this which could explain his increased shortness of breath and an apology was offered due to the delay.

Therapeutic dalteparin was commenced. Four hours later patient A suddenly became acutely short of breath, deteriorated and had a cardio-respiratory arrest and died.

Root Cause:

There was a delay in prescription of therapeutic anticoagulation despite the possibility of a DVT being investigated.

Lessons Learned:

1. Clinician teams have a responsibility to ensure investigations are carried out timely for their patients.
2. The ICE system will be reviewed to ensure clinicians understand where in the process their investigation request is.
3. Communication between healthcare professionals must be clear and concise.
4. The radiology department are looking at an alternative way to manage appointments rather than cancelling them for them to be rebooked.

Further learning

DBTH has formed a new Lessons Learned Group. This will be a proactive group to identify opportunities to disseminate learning across the Trust.

We need your lessons learned from either incidents of any kind or learning from excellence. Please contact Louise.Povey@NHS.net, Head of Patient Safety & Experience, Ext 622447.

The Patient Safety Risk & Legal Team have moved offices, still within C block, to the back of the building into the former Finance Office.