Formerly Risky Business

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

Learning from deaths

Many patients will experience excellent service from the NHS during their lifetime, however death may be an inevitable outcome following hours, days, months or years of care.

If mistakes happen or things could have been done better, we need to do more to understand why this occurred. Introduced in 2017, the 'National Guidance on Learning From Deaths' describes key requirements to ensure we understand the causes of death in a patient and share the learning on why this occurred.

One of the minimum requirements was that each Trust should introduce a structured case record review process. The Trust has circa 2,000 adult inpatient deaths per year and during 2017/18 475 structured judgement mortality reviews (SJR) were completed. The key themes emerging from these reviews, in order of frequency, were:

- Poor fluid balance monitoring
- Inappropriate reasons for DNACPR for example Down's Syndrome, learning difficulty and learning disability.
- Lack of knowledge in recognising the dying chronically ill patient resulting in unnecessary interventions and treatment
- Delay in antibiotic administration for patients with sepsis
- Unnecessary hospital and ward transfers
- Poor documentation of conversations with families when end of life is approaching.

As part of the SJR process, an assessment of the standard of documentation is also made. The standard of documentation has significantly improved, however **always remember to put the date, time and sign and print your name.**

Coming soon: In July 2018 the national Quality Board published additional guidance for trusts on working with bereaved families and carers. Next month will see the launch of a new information leaflet to be given out to bereaved families. If anyone requires training in undertaking structured judgement mortality reviews or any further information on this matter, please contact Mandy Dalton on mandy.dalton1@nhs.net.

Advice from a patient

This may seem like a normal day at work for you,
But it's a big day in my life,
Remember I am not usually this needy or scared,
I am here because I trust you, help me stay confident,
I may look like I'm out of it,
But I can hear your conversations,
I'm not used to being naked around strangers,
Keep that in mind.

I'm impatient because I want to get out of here.
Nothing personal,
I don't speak your language well,
You're going to do what to my what?
I may only be here for 4 days,
But I'll remember you for the rest of my life
Your patients need your patience.

Print the poem **here**.

Quote of the month

There was an important job to be done. Everybody was sure that Somebody would do it. **Anybody could have done it, but Nobody did it**. Somebody got angry about that, because it was Everybody's job. **Everybody thought Anybody could do it, but Nobody realised that Everybody wouldn't do it**. It ended up that Everybody blamed Somebody when Nobody did what Anybody could have done.

Think **kidneys**

Acute Kidney Injury (AKI) is a sudden and recent reduction in a person's kidney function. It is not a physical injury to the kidney and usually occurs without symptoms, making it difficult to identify. Late diagnosis can miss opportunities for early treatment leading to prolonged and complex treatment and reducing the chances of recovery.

Patient AKI Risk	AKI Risk Event
Age > 75 yrs Chronic kidney disease	Sepsis e.g. pneumonia, cellulitis, UTI
Previous AKI Diabetes mellitus	Toxins e.g NSAIDs, Gentamicin, herbal remedies
Heart failure Vascular disease	Hypotension e.g relative to baseline BP
Liver disease Cognitive impairment	Hypovolaemia e.g haemorrhage, vomiting diarrhoea
	Major Surgery planned or emergency

We received a Patient Safety Alert about the risks to our patients from AKI in 2016. When this occurs, this means there is an emerging pattern at a national level and appropriate guidance needs to be developed.

The best way of monitoring patients intake and output is by using a fluid balance chart. We have designed a new fluid balance chart to compliment the NEWS2. After a successful pilot across 12 wards, the new fluid balance chart is for use in all areas (WPR44741). The new fluid balance chart is now incorporated onto the daily IV prescription (WPR42321) These changes have been made to save lives. Monitoring fluid balance for patients at high risk of AKI can help spot a change in a patient's kidney function before a blood test confirms it. **A new poster** has been developed to promote these changes and our colleagues in pharmacy have helped write guidance on medicine optimisation.

The pee plotter is a chart designed to help you calculate urine output for your patients, hourly, 6 hourly, 12 hourly and finally at 06.00 (this time has changed to ensure a senior clinician is available to review patients if there is a problem).

Clinicians: Assess fluid-status, clinical examination and daily-weights. If oral intake inadequate consider barriers to intake, such as fear of incontinence, falls and lack of access to fluids. Involve family and carers where appropriate. Supplemental enteral or parenteral fluids if still unable to maintain fluid balance.

Message of the month

Prevention: Patients need to stay well hydrated. For patients having general anaesthetic, the requirements for nil by mouth are: Six hours for food and fat/milk based liquids. Two hours for clear fluid (water and black tea & coffee).

Falls and bone health

Falls are the most frequently reported harm to patients at the Trust. Since 2014 a lot of work has been going on to improve falls for all patients. Dr Vicky Barradell is our Falls Lead and is supported by Esther Lockwood, Falls Prevention Practitioner. Each year we continue to see a reduced number of patient falls and harm from falls. From 2014/15, this number has decreased for 476 falls with harm to 269, however there is still work to be done. Within the Trust we are beginning to change our culture to reflect that falls prevention is **everyone's responsibility.**

The National Audit of Inpatient Falls was completed by The Royal College of Physicians in 2017. The results for the Trust were as follows:

- DRI performed **better** than the national average, at 55% of the 22 measured standard
- For a further 23% of the standards our results are within 10% of the national average
- Performance has **significantly improved** since the National Audit for Inpatient Falls 2015 where we were above national average only in 13% of the 23 measured standards.

We need to continue to improve in many of the falls prevention measures, by using the Enhanced Care Plan with all our patients over 65 years (or under 65 who are judged to have complex needs) we will be able to help improve the care of our patients by identifying and addressing their individual falls risk factors. Next month's newsletter will focus on the Enhanced Care Plan (WPR44091) Each quarter, the Falls and Bone Health Group meet to discuss and share best practice.

What did we learn

- A lying and standing blood pressure assessment may have prevented a patient fall.
- Poor communication and documentation may have led to a patient being on bed rest for 6 days causing de-conditioning.
- Consideration of a patient's ability to use their call bell in the toilet may have prevented a fall if a staff member had stayed with the patient.
- Daily assessment of a patients supervision needs would have identified an increased supervision need, which, if implemented may have prevented the patient falling.
- Not using safety sides, (where it was identified it would not be safe to do so) and using a low bed may have prevented a patient climbing over the sides of the bed and falling.

How can we improve

- **Perform** a lying and standing blood pressure assessment on all patients over 65 years at least once during admission and if a deficiency is found escalate to senior nurse or doctor.
- **Ask and Discuss** what is the plan with the patient? Can we do anything else?
- **Know your patients** - are they safe to be left? Do they understand the advice you are giving them?
- **Remember** to assess all patients identified as needing amber, red or purple level of supervision DAILY and implement the level of supervision required.
- **Think** is it safe to use safety sides with this patient or do other options need looking into?

Read our safety policies: Inpatient Falls Prevention and Management

Should we? Ban the beaker

All of our staff play a part in helping to keep patients safe from AKI and can make sure they have a drink in reach. Patients often prefer to drink from something they recognise, like a cup or mug. Our Speech and Language Team (SALT) advise that there can be an increased risk of aspiration for patients using a plastic-spouted beaker. Please ask your patient, or their carer, what they normally drink from. Preparing patients for drinks, such as sitting them up and or out of bed, or in a communal area for social dining is essential.

The Person Centred Care Team

Ted the Therapy Dog

Improving **Enhanced Care**

The provision of enhanced therapeutic care (previously referred to as specialing) is a significant challenge for many trusts across the NHS, including our's. Increasing numbers of patients admitted to hospitals have confusion, delirium and dementia or are at risk of harm from falling or leaving the ward unsafely. Equally, patients may present with mental health needs that require additional therapeutic care in order to holistically support and maintain safety and reduce the risk of harm.

When we use a lot of bank or agency staff to provide the enhanced care, this means that patients may be cared for by inexperienced, temporary staff who may restrict or limit patient movement, who at times have not known the patients name by the end of their shift.

Our response to the increasing needs for enhanced care was to develop a daily supervision and engagement assessment document. This helps to guide staff on the simple, yet effective interventions that may keep their patients safe.

Sometimes we have found that staff have asked for additional nurses to look after these vulnerable patients, without considering the interventions in the guidance. This has included patients who have found to have been in acute retention of urine, constipated, in pain, thirsty, hungry and tired.

Read our safety policies: Enhanced Patient Supervision and Engagement.

To help support you to keep patients safe and provide enhanced therapeutic care, we have recently appointed Emily King as Enhanced Care Practitioner. Emily will be available to support patients, family and ward staff at DRI and MMH in caring for these vulnerable patients. You can contact Emily (emily.king18@nhs.net). For patients at BH, Mandy Tyrell will continue her role as ACP in care of Older people for patients who may benefit from Comprehensive Geriatric Assessment. You can contact Mandy Tyrell (mandy.tyrell@nhs.net).

Education

The Trust provides a full study day on Person Centred Care in response to the needs for falls prevention training, dementia and delirium awareness and guidance on how to provide enhanced care. You can contact Beth Cotton Lead Dementia Nurse at b.cotton@nhs.net and Esther Lockwood, Falls prevention Practitioner at esther.lockwood@nhs.net.

What are we doing **next?**

For wards who have a lot of patients needing enhanced care – we would like to invite you to be part of our 'DBTH Improving Enhanced Care Collaborative'. This will involve ensuring that all your ward staff have attended the Person Centered Care day and then releasing a critical mass of staff to attend the second half-day on enhanced therapeutic care.

The aim is to educate and support wards to keep their patients safe, whilst decreasing the reliance on temporary staff to look after your most vulnerable patients. Teams also have the opportunity to ask more questions in a smaller group. If you would like your ward to be part of the 'DBTH Improving Enhanced Care Collaborative', please contact Emily King via email (emily.king18@nhs.net).

Improving patient experience

At the Trust we are committed to improving the experience of our patients, families and carers. This means we want to work with Team DBTH and patients to seek opportunities to improve the quality of care that we provide. We are constantly learning from the feedback that we receive and want to actively listen to our patients to understand what matters to them. We also recognise that sometimes we don't always get it right. By Sharing How We Care each month, we can work together to make sure that our patients care meets the expectations we would want for ourselves and that their stay in hospital is as safe as possible.