NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Sharing how we care

Learning from deaths

Between July – September 2018, there were 446 in hospital deaths.

191 (44%) of these cases have been scrutinised, 62 (32%) have had a structured judgement review (SJR) undertaken and 129 (68%) have been screened.

There have been 2 deaths of patients with a learning disability this quarter. Both cases have been reviewed and also referred to the LeDeR programme. The internal reviews, undertaken in the presence of the Learning Disability liaison nurse, demonstrated good multidisciplinary care. No concerns with the management were identified.

The SJR proforma now includes a section on the identification of problems in care by the following categories:

- Problems in assessment, investigation, diagnosis
- Problems with medication/IV fluids/oxygen
- Problems related to treatment and management plan
- Problems with infection management
- Problem related to operation/invasive procedure
- Problem in clinical monitoring
- Problem in Resuscitation

Only 1 of the SJR's described poor care during the admission stage of care. This was with regards fluid management and a delay in escalation of a deteriorating patient. The ongoing care was ultimately very good and so the overall assessment score was concluded to be adequate.

2 cases identified a lack of recognition of a dying patient and subsequently a delay in starting the end of life care pathway. These cases have been raised with individual clinicians.

There were 4 cases of poor documentation within the patient records. This was either related to the lack of documentation of discussions with family members (2) or the lack of senior medical staff documentation, illegible writing, no name/signature.

The lack of filed records in all 4 of these was very apparent. Large unfiled sections of case notes are becoming an increasing problem.

What is the learning?

Recognition of the dying patient is crucial in ensuring that patients are not exposed to unnecessary interventions and tests. If juniors consider a patient is approaching their end of life they must discuss this with a senior and with the patient and/or family to ensure that appropriate dignified care is provided.

Documentation of conversations with families when end of life is approaching are essential and still lacking in some areas.

The date and time of any case note entry must be detailed along with the clinician's signature and printed name.

REMEMBER: Death is inevitable and a natural event for all of us, and not all deaths will represent a medical failing or problem in the way the person has been supported during their life. Many deaths that occur in hospital are anticipated or expected. When clinicians recognise that a patient may be in the final stage of their illness, or that death is imminent, it is important they meet and talk openly with the patient and their family. Openness, transparency and listening to a patient and family concerns and expectations at this stage are all very important. This helps in what many will find frightening and difficult circumstances that they may never, or rarely, have faced before-unlike clinicians. Good communication and relationships when a death is expected or is imminent, are likely to lead to good communication and compassionate care of families after death.

Bereavement Services and Support

It is essential that following the death of a patient, the families/carers are given information on what happens next. A bereavement information booklet is currently being finalised and will feature in the next newsletter. However, in the meantime please inform families of the following:

- They will be contacted by the bereavement team within 1 working day of their loved ones death to explain the process of issuing a medical certificate of cause of death (MCCD). They need this certificate to be able to register the death.
- They will also be informed if the doctor has been required to refer the death to the Coroner.

In the unusual situation that they do not receive this call within 2 working days please provide the following numbers:

Doncaster 01302 642516
Bassetlaw 01909 572753

Medical Certificate of cause of Death (MCCD)

A medical certificate of cause of death, completed by a Doctor, is required before a death can be registered. A death should be registered within 5 days. It is therefore essential that the MCCD is completed as soon as possible after death when there is no Coroner involvement.

We have set an internal target for the completion of an MCCD to 3 days. This then gives the families 2 days to collect it and arrange to register the death.

Over the last few months much progress has been made which has resulted in a significant increase in the number of times families have been able to register a death within 5 days. Last year 71% of deaths were registered within 5 days and as of December 2018 we were at 86%.

ReSPECT

To help improve how we discuss end of life decisions, the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) will be implemented across DBTH in April 2019 and will supersede the current DNACPR policy and document and the Advance Decision to Refuse Treatment (ADRT) policy.

ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommen-dations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning.

The plan is created through conversations between a person and their health professionals. The plan is recorded on a form and includes their personal priorities for care and agreed clinical recommendations about care and treatment that could help to achieve the outcome that they would want, that would not help, or that they would not want.

ReSPECT can be for anyone, but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.


Listen to Barry and Sheila's story here

Watch out for the Lunchtime Lectures on ReSPECT and what you need to know in your area. The ReSPECT document will replace the current DNACPR document in April 2019.

Message of the month

Clinical coding is the process whereby information written in the patient notes is translated into standardised codes (using ICD-10 and OPCS-4 classifications), and entered onto the Patient Administration System.

Clinical coding is completed after the patient has been discharged from hospital, and the Clinical Coders work to strict deadlines to ensure that the Trust receives payment for the treatment they have given to the patient.

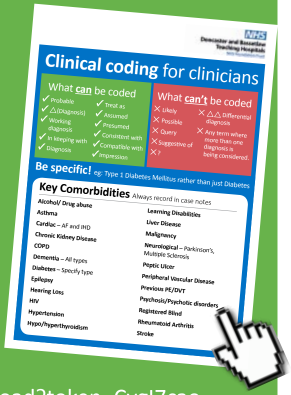
Clinical Coders are entirely dependent on complete accurate and timely information regarding diagnoses and procedures in order to produce a true picture of hospital activity and demonstrate the complexity of the case mix.

The clinically coded data is vitally important, and is used for:

- ✓ Monitoring the provision of health services across the UK
- ✓ Research and the monitoring of health trends, variations and outcomes
- ✓ NHS financial planning and Payment by Results
- ✓ Local and national clinical audit and case-mix analysis
- ✓ Clinical governance

For more information on clinical coding, please contact Julie England, Clinical Coding Manager julie.england2@nhs.net

Print and display this poster in your clinical area



Clinical coding for clinicians

What **can** be coded
- ✓ Probable
- ✓ △(Diagnosis)
- ✓ Working diagnosis
- ✓ In keeping with
- ✓ Diagnosis
- ✓ Treat as
- ✓ Assumed
- ✓ Presumed
- ✓ Consistent with
- ✓ Compatible with
- ✓ Impression

What **can't** be coded
- ✕ Likely
- ✕ Possible
- ✕ Query
- ✕ Suggestive of
- ✕ ?
- ✕ △△ Differential diagnosis
- ✕ Any term where more than one diagnosis is being considered.

Be specific! eg: Type 1 Diabetes Mellitus rather than just Diabetes

Key Comorbidities Always record in case notes

Alcohol/ Drug abuse
Asthma
Cardiac – AF and IHD
Chronic Kidney Disease
COPD
Dementia – All types
Diabetes – Specify type
Epilepsy
Hearing Loss
HIV
Hypertension
Hypo/hyperthyroidism
Learning Disabilities
Liver Disease
Malignancy
Neurological – Parkinson's, Multiple Sclerosis
Peptic Ulcer
Peripheral Vascular Disease
Previous PE/DVT
Psychosis/Psychotic disorders
Registered Blind
Rheumatoid Arthritis
Stroke

Download the RCP top ten tips for coding:

https://www.rcplondon.ac.uk/file/193/download?token=CvgI7cao

Fetal heart rate monitoring

A recent case was shared by NHS Resolution (NHS R) following notification and investigation of a potential claim. Read the story here.

This case was referred to NHS R as part of the Early Notification scheme in light of the severe neonatal brain injury sustained at birth. The case will be reviewed to consider whether the injury could and should have been avoided. If appropriate, NHS R will work with the family to ensure that they are fully compensated, and that they and the staff involved are fully supported throughout the process.

It is very important to note that no amount of money is comparable the loss of a child or a child living with lifelong neurological injuries. Where poor outcomes occur as a result of deficiencies in care, and families are entitled to be fully compensated, NHS R aims to resolve all such cases fairly and as quickly as possible.

The current compensation cost to the NHS for a baby who has a long term severe brain injury is, on average, £10 million.

The human costs to the baby, families and clinical teams involved as a result of such cases are immeasurable.

Introducing the Healthcare Safety Investigation Branch (HSIB)

The Healthcare Safety Investigation Branch (HSIB) began operating on 1 April 2017 they are a team of experienced safety investigators.

HSIB is funded by the Department of Health and hosted by NHS Improvement but they operate independently. They have two arms the National investigation team and the Maternity investigation team. They both work differently and with different remits.

HSIB, within England, investigate up to 30 safety incidents each year in order to provide meaningful safety recommendations and share what they learn across the whole of the healthcare system for the benefit of everyone who is cared for by it and works in it.

Within Maternity, HSIB their investigations will replace the internal Trust investigation for the criteria listed below. They will investigate cases of intrapartum stillbirth, early neonatal deaths and severe brain injury diagnosed in the first seven days of life, when the baby:

- ☑ was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); or
- ☑ was therapeutically cooled (active cooling only); or
- ☑ had decreased central tone and was comatose and had seizures of any kind.

They will also investigate direct or indirect maternal deaths in the perinatal period. HSIB will work alongside staff in the local organisations, as this clinical knowledge is key to building their understanding as well as offering support and guidance on investigative techniques and practices. We will share learning from HSIB investigations with you in this newsletter.

Information, help and support for families during a loved ones Critical Illness

Critical illness can be a devastating, frightening and debilitating condition for patients and harrowing for their loved ones. Many patients in critical care die. As healthcare professionals we are rarely shocked by this – we have seen it so many times. But for families they often think we can do miracles. Of those who do survive – the recovery can be very protracted and difficult. Even when patient return home – they can face months or years of after-effects and many never fully recover or regain their former function and quality of life.

Healthcare professionals are faced with the daily challenge of giving useful information to service users. But frightened and anxious families need just the right amount and format of information. It helps them anticipate what is around the next corner and cope with the 'then' and 'now' of their experience. They have so many questions and struggle to understand and retain what we tell them. As an expert critical care nurse and service lead I have been a long term observer of the challenges faced by both service users and staff. I came to the conclusion that we needed to try a new approach to giving information to critical care families.

What did we aim to do?

We wanted to provide a very comprehensive information source in the visitors area so that families could read it at their convenience – returning to it when they wanted to. We also wanted to signpost to other sources of information.

How did we decide what information to include in the poster?

It was important to involve families and patients in helping us decide what information to include. We worked closely with the members of our critical care support group. In one particular session we dedicated the whole meeting to writing ideas on sticky notes and pasting then on a draft poster.

It was also important to review the important research that has been published about the whole journey through critical illness and recovery. We read the key studies and attempted to narrow the vast range of information and statistics available into the key headlines we thought families should know.

We shared a draft of the poster with multidisciplinary staff in our critical care unit and also at a further meeting of the critical care support group. This allowed us to make the final changes and complete the poster.

How was the poster designed?

We commissioned Ben, a talented designer with skills in presenting user-friendly graphical information. We spent many days rearranging the content using specialist software.

We couldn't add all the information we wanted so we decided to use QR codes to direct people to other sources of information – such as websites, on-line booklets and support groups.

The final version of the poster was approved by the critical care clinical governance group and the 'information for service users' group within the Trust.

Where is it now?

The poster was completed in June of 2018. It is now displayed in the visitors waiting area outside critical care on floor 7 (see Photo's)

Who else is displaying the poster in the NHS?

Staff from other critical care units who knew we were designing the poster asked for a copy. So we decided to share it throughout the NHS via the Critical Care National Network Nurse Leads group (CC3N). That lead to many enquiries from throughout the NHS.

For a small fee our designer agreed to change the logo on the poster for any units that wanted their own version. Over 50 critical care units in the NHS have so far adopted the poster and others have commissioned an adapted version or asked for modifications so that it suits their local needs.

What do visitors to our unit think of the poster?

All feedback so far has been positive. Families obviously spent time reading and re-reading the poster. Staff also find that the information in the poster helps them reinforce key messages and direct families to other resources.

Dr Lee Cutler, Consultant Nurse, Critical Care, with his son, Ben Cutler.

For more information please contact:
Lee.cutler@nhs.net

Patient Safety Alert

Over the past 3 years there have been 35 incidents reported in the NHS where patients have suffered cardiac arrest due to hyperkalaemia.
You can view the alert here.

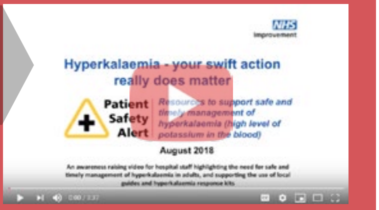
Remember hyperkalaemia is a medical emergency!

The way the body responds to hyperkalaemia – a higher than normal level of potassium in the blood – is unpredictable; arrhythmias and cardiac arrest can occur without warning. It is potentially a life-threatening emergency. Timely identification, treatment and monitoring, during and beyond initial treatment is essential.

This alert sign posts to a set of resources that can help organisations ensure their clinical staff have easily accessible information to guide prompt investigation, treatment and monitoring options.

Remember to review blood results, perform 12 lead ECG, Stop any IV infusion containing potassium and review medication the patient maybe taking that contains potassium.

Here is a helpful patient safety video to share with your colleagues and teams.



NHS
Improvement

Hyperkalaemia - your swift action really does matter

Patient Safety Alert

Resources to support safe and timely management of hyperkalaemia (high level of potassium in the blood)

August 2018

An awareness raising video for hospital staff highlighting the need for safe and timely management of hyperkalaemia in adults, and supporting the use of local guides and hyperkalaemia response kits

Stevens Story and support for patients with Learning Disability

Having a learning disability (LD) includes the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently.

Steven required cataract surgery but had many areas in which he needed support for his LD. The main one being a fear of hospitals; he had limited home support, is a hoarder who self-neglects, was struggling with his failing sight but continued to be very independent.

Stevens day-care facility had supported him with many of his needs but his failing sight required addressing. The LD health facilitator spent 6 months with the support of the Stirling Day Centre doing desensitization, until the day Steven was ready to attend hospital.

Steven arrived for his outpatient appointment and his support did not. He couldn't decide what to do. He noticed that everyone else was using a machine but sat for a long time, becoming very anxious. When he asked for help, he was pointed to the self-check in machine. Steven couldn't use the machine so ran home. He was then discharged by the consultant back to his GP as a DNA (Did Not Attend).

Help was given by our Learning Disability Health Action Team. A meeting with the Consultant and Steven was arranged and he was put back on the waiting list. More desensitization followed with a careful plan for Steven's care. Surgery was finally performed and Steven says that being able to see has changed his life.

For more information, help and support for patients with LD in hospital please contact:

Doncaster: Glynis Smith, email Glynis.smith1@nhs.net

Bassetlaw: Chris Adkins, email Christine.adkins2@nhs.net

Communication about the support available for patients living with Cancer

In the summer of 2017, more than 100 patients and carers gave feedback about the information and support services that were available to patients living with cancer and told us they needed help, advice and support. Patients told us that having somewhere at the hospital for this information would be good for when they attended appointments.

We have worked with Macmillan and their environments team to develop an information and support service that meets the needs of our patients.

The 'POD' unofficially opened on the 3rd of December and was specifically placed for where patients could easily find it.

During the first 3 weeks, 388 people visited the POD for help, support and advice.

The team have noted this significant increase from men and that many are coming into the pod wanting to talk about their experience of living with cancer.

The POD is open 8.30am-4.30pm, Monday to Friday. Any patient or relative can drop in whether they are an outpatient or inpatient.

You can make a difference, one patient at a time!

A old man was walking along a beach one morning after a storm. In the distance he could see someone moving like a dancer. As he came closer, he saw that it was a young woman picking up the starfish and gently throwing them back into the ocean.

"Little lady, why are you doing this? Look at this beach! You can't save all these starfish. You can't begin to make a difference!"

The girl listened politely, then she bent down, picked up another starfish, and hurled it as far as she could into the ocean. Then she looked up at the man and replied, "Well, I made a difference to that one!"

— Adapted from 'The Star Thrower' by Loren C. Eiseley.

Compliment of the Month

G5 Women's Hospital received the following comment on NHS Choices Website in October 2018:

I wish to extend my thanks to all of the staff working on ward G5 and also in Theatre. I attended on the 9th October for a laparoscopy and although extremely nervous I was made to feel at ease from start to finish. You all do an amazing job on a daily basis and I cannot fault the level of care I received and fantastic communication throughout.

Well done to all the staff involved.

Contributors

We want to say a big thank you to our Sharing How We Care contributors:

Tim Noble, Cindy Storer, Mandy Dalton, Julie England, Jo Hadley, Liam Wilson, Lee Cutler, Glynis Smith and Stacey Nutt.