NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

Learning from Inquests

An inquest is an inquiry into the circumstances surrounding a death. The purpose of the inquest is to find out **who the deceased person was and how, when and where they died** and to provide the details needed for their death to be registered. It is not for the Coroner to determine, or appear to determine, any question of criminal or civil liability or to apportion guilt or attribute blame. It is a fact-finding hearing and not a trial.

Advice for staff who have been asked to attend an inquest can be found here

Between April 2018 and December 2018, **there were a total of 68 inquests**, with the highest number in November 2018 (11 in total). The average length of time for an Inquest to be heard in 2018 was 138 days, however the Trust has been asked to prepare 4 inquests in less than 33 days (one Inquest notification has been as short as 12 days).

12 of the 68 inquests have taken over six months to be heard and of those, three have been listed over 12 months after the initial notification from HMC.

DBTH covers two coronial jurisdictions. These are: Her Majesty's Senior Coroner, South Yorkshire (East District) and Her Majesty's Senior Coroner, Nottinghamshire.

Inquests involving the Trust may sometimes be held in neighbouring jurisdictions such as Sheffield, Leeds and Wakefield by the respective Coroner for these areas.

81.9% of Inquests were held at Doncaster Coroner's Court, 13.7% in Nottingham Coroner's Court. There has been one Inquest heard at Sheffield.

Inquests April – December 2018

By speciality	Emergency Department	19	Critical Care	3
	Thoracic and Respiratory medicine	11	Surgery (other)	2
	Trauma and Orthopaedics	9	General Medicine	2
	General Surgery	7	Obstetrics	2
	Care of Older People	5	Other	1
By division	Clinical Specialties	6	Results: Narrative verdict	45.6%
	Medicine	38	Accidental death	19.1%
	Surgery and Cancer	21	Natural causes	17.7%
	Women's and Children's	2		
	External to the Trust	2		

Serious Incidents and Inquest

It is completely normal for there to be an investigation following an incident; this is to ensure that all aspects of the incident are understood, and is not aimed to apportion blame to individuals.

Being open and honest with patients when things go wrong with their care which have caused or could lead to significant harm in the future is your legal duty. There are other important reasons why openness and honesty is encouraged following a patient safety incident: disclosing incidents to patients and families is important in helping you to deliver person-centred care, and essential for a relationship of trust between yourself and the patient

There has been a rise in the number of Inquests that have been investigated as Serious Incident (SI). 11 cases were investigated as an SI this financial year; all of these cases were investigated before the Inquest was heard. This improvement shows that we had already reported and recognised the potential for learning from the incident.

Supporting clinicians when something goes wrong

Second victim' is the term used to refer to healthcare workers who are impacted by patient safety incidents. Whilst patients and families will always be the first priority following safety incidents, the wellbeing of staff involved is often overlooked but can leave staff lacking confidence, unable to perform their job, requiring time off, or leaving their profession.

There is existing evidence on the importance and effectiveness of support programmes for such staff and their potential to counter the negative impact outlined above to result in more positive impact for staff and patients alike.

The second victim website has been developed with key stakeholders such as the Improvement Academy and the Royal College of Physicians as well as second victims themselves.

It include a selection of short videos in which staff share their either their personal experience post incident, including what helped or hindered this and tips for others, or how they supported a team member or colleagues in this situation.

The website was launched at the end of 2018/early 2019, user evaluation and feedback has and will continue to inform its ongoing development.
http://secondvictim.co.uk

> **To err is human.**
> **To cover up is unforgivable.**
> **To fail to learn is inexcusable.**
> Sir Liam Donaldson, Chief Medical Officer, England.

Prevention of Future Death (PFDR)

Coroners have a statutory duty to issue a Prevention of Future Death (PFD) report to any person or organisation where, in the opinion of the coroner, action should be taken to prevent future deaths.

The report is sent to whoever the coroner believes has the power to take such action and the recipient then has 56 days to respond. A copy of the PFD report is sent to the deceased's family as well as the CQC.

The best way to allay a coroner's concerns about future risks is to ensure that any potential failings in systems/care connected with a death are properly investigated and more importantly that actions taken can be properly evidenced.

Serious Incidents and action plans for learning are presented at Patient Safety Review Group (PSRG). This is to help share learning across the Trust, but also to provide governance around outstanding action plans.

There have been 5 PFDRs over the last 2 years up to December 2018. These cases are being shared with you to help you understand why it is important that all staff keep themselves up to date with changes in documentation, policy or quality improvement.

> **Some is not a number.**
> **Soon is not a time.**
>
> Donald Berwick

Case 1

Patient was admitted to Doncaster Royal Infirmary with a suspicion of infection but no clear focus. Prolonged assessment and investigations delayed the provision of antibiotic therapy. Had antibiotic therapy been commenced at the time of his admission it is likely he would have survived.

HMC Concerns:

- Poor ineffective communication between medical and nursing staff groups as well as with external agencies.
- Poor and inaccurate completion of physiological observation charts.
- Timing of antibiotic administration
- Failure by staff to recognise a lack of improvement in the patient's condition.

Action Taken:

- Introduced a robust process of escalation to the clinical site management team of sick patients on the ward.
- Introduction of Safety Huddles
- Policy review and the introduction of a bereavement pack.
- Review of equipment availability and staff training needs.

Case 2

Patient admitted with a history of chest pains to side of chest, radiating to shoulder and lower back and a 4-6 week history of breathlessness. Discharged two days later following which the patient developed a rash over his abdomen. Patient was seen in ED and discharged. Patient was later found dead at home seven days later. The patient died of a PE.

Coroners Concerns:

- Failure to accurately complete VTE risk assessment.
- Delay in providing Thromboprophylaxis.

Action Taken:

- Re-launch of the "Stop the Clot" campaign Trust wide.
- Awareness raised with staff through existing forums of the need to complete VTE risk assessments and of the need for appropriate prescribing of prophylaxis
- Support for junior staff through the review of VTE risk assessments and prescribing of prophylaxis during post-take ward rounds by consultant staff.

Case 3

Patient found unresponsive by his partner and was admitted to hospital. The patient presented with a 7 day history of vomiting and 1 day of abdominal pain. A CT scan showed splenic bleed. He also had a previous history of illicit drug use.

Medical cause of death 1a) Splenic rupture, combined morphine and methadone toxicity.

Coroners Concerns:

- Poor documentation - medical notes and observation charts
- Lack of a defined procedure for prescribing of drugs during an emergency situation.

Case 3 continued

Action Taken:

- Introduction of scribes during emergency situations
- Review of staff competencies for IV administration
- Circulation of IV drug administration policy to staff.

Case 4

Elderly patient suffered a fall at home and then suffered a further fall on the ward.

Coroners Concerns:

- Poor compliance with enhanced care plan paperwork
- Lack of action by senior management to address the issue of escalation.

Action Taken:

- Trust has a strategic approach and focus on preventing falls, with the development of policies, assessment tools and compliance to NICE guidance in respect of falls prevention.
- Corporate action plan in place for falls prevention and management
- Audit of completed documentation
- Tier 2 falls prevention and management education including falls documentation is provided to all frontline Trust staff within the Person Centred Care study day.
- Introduction of ward falls accreditation.
- Introduction of the enhanced care prescription assessment and escalation process.

Case 5

Patient was admitted to Bassetlaw Hospital following a fall outside his home. X-ray showed fracture left neck of femur. The following day the patient was transferred to DRI where he underwent surgery to repair a fracture. Patient died 5 days after admission.

Coroners Concerns:

- The EWS policy was not adhered to and the scores were miscalculated.
- Poor record keeping by medical staff.

Action taken:

- Reminder to all staff of Trust policy relating to EWS and escalation of the deteriorating patient
- Introduction of department based simulation training with respect to the deteriorating patient
- Incorporation of EWS, Sepsis, Acute Kidney Injury and Fluid balance into current training programme relating to the deteriorating patient
- Reiteration of the need for contemporaneous record keeping and the introduction of a monthly documentation audit.

Sharing how we care

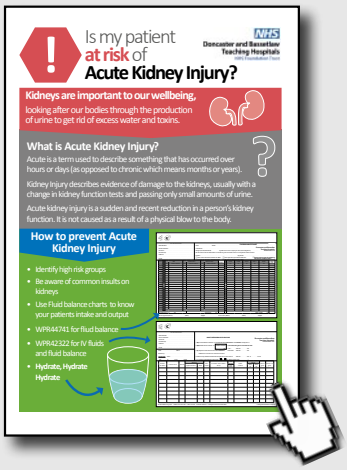
You may be aware of work we have shared in previous editions of Sharing How We Care to improve the care given to our patients.

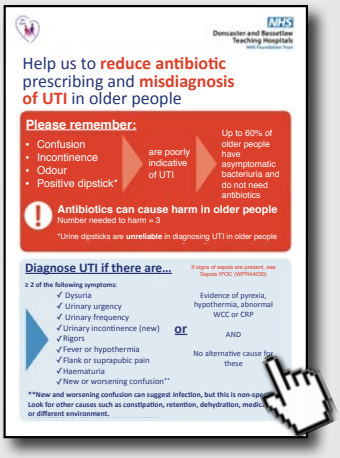
Patients and families who have been affected by harm tell us they don't want the same thing to happen to another patient. This can sometimes mean adapting to changes in how we provide care, attending new training and getting used to new documentation to provide a safe record of the care delivered.

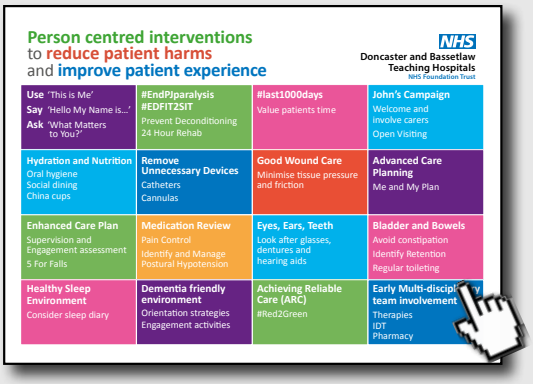
Here are some examples of guidance and documents that we have worked on to keep our patients safer:

NEWS2 IPOC

SEPSIS IPOC







What else are we doing?

Introduction of a Medical Examiner.

Over the next year – medical examiners will be employed in the NHS system with a separate professional line of accountability, allowing for access to information in the sensitive and urgent timescales surrounding death registration – but with independence necessary for the credibility of the scrutiny process.

Medical examiners will be the last piece of the jigsaw of ensuring patient safety when someone dies; their role is not to investigate but to detect and pass on.

This will ensure that incidents requiring learning from them are reported appropriately and families kept informed of the process.

Your Health & Wellbeing

At DBTH, Staff involved in the investigation process will have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. You will also be provided with information about the stages of the investigation and how you will be expected to contribute to the process.

There are a variety of services available to support you at DBTH. Click on the Health and Wellbeing flower logo above to see what help and support is available.

If you are a learner or trainee at DBTH then support can be gained from your LEM, mentor or educational supervisor.

Rule 23

Since May 2018, there has been an increase in the number of cases heard where Rule 23 (where witness statements are read into evidence) has been applied. This has meant that fewer members of staff have been required to attend court to give their evidence in person thus reducing the negative effect on the continuity of clinical activity.

This can also be a reflection of the quality of statements provided to the Coroner.

Advice and support in writing a statement for the Coroner can be found here

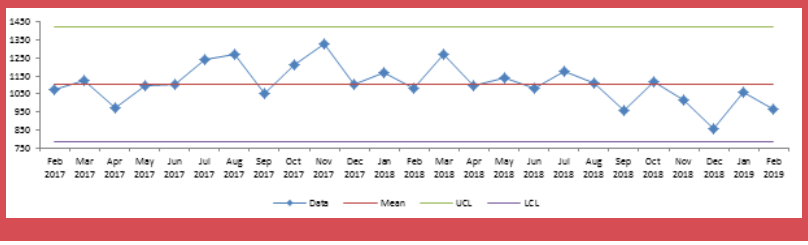
Recording incidents protects patients from harm and saves lives

When things go wrong in care, it is vital incidents are recorded to ensure learning can take place. By learning, we mean people working out what has gone wrong and why it has gone wrong, so that we can reduce the risk of similar incidents occurring again.

We are aiming for **a reduction in our serious and moderate harms** to patients but a **maintained rate of reporting incidents with no harm or a near miss**. Generally, hospitals with good reporting rates are much safer for patients as this evidences a good safety culture. High reporters aim to learn from incident reporting to make patient care safer.

In September 2018 – we saw a reduction in the number of incidents reported which was a worrying trend. Please be assured that every incident reported makes our patients safer.

This SPC chart shows our Trust reporting rates which are looked at each month and shared to the National Reporting and Learning System (NRLS).



Compliments of the month Posted on NHS Choices

Medical Imaging

"I attended the X-Ray department at 09:20 for a chest x-ray ordered by my GP. I was greeted in a friendly way by the receptionist. I was directed to a clean and well-furnished waiting area, from where I was called within a few minutes. The radiographer greeted me and directed me to a changing booth, telling me I could keep my tee-shirt on. He then asked me if I'd had a chest X-ray before. The whole process was smooth, efficient and reassuring, and I was out by 09:35. What a brilliant service."

Ophthalmology

"My daughter has been under this department for three years. I can't say anything bad about them. They have treated my daughter and saved her sight. You are treated respectfully by each member of staff. The consultant was superb and nothing was too much trouble. I am truly grateful to him. Keep up the good work, we in Doncaster are truly blessed to have such great staff to take care of us. THANK YOU.

Gynaecology

"I had a TAH in 21st August 2018 after years of problems. My consultant was great from start to finish. He listened to me and really helped with my fears. He did a fantastic job and I am recovering well. The hospital was clean and the care I received was great. I am grateful to everyone who played a part in my care. So many people working really hard day in day out doing their very best. All too easy to criticise yet how often do we take the time to recognise when things go well. Thank you everyone.

Contributors **Thanks this month go to:** Tim Noble, Cindy Storer, Michelle Corbett and Bonny Stevenson.