We care

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

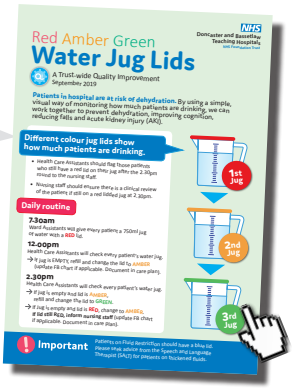
Michael's Story and We Care for your Kidneys

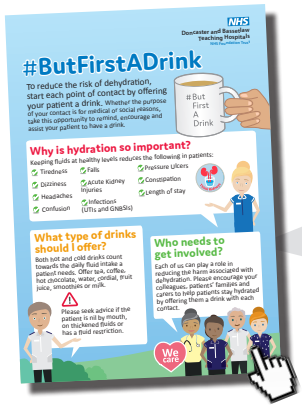
On World Patient Safety day on 17 September, we launched the work we are doing to improve hydration for all patients and prevent harm from Acute Kidney Injury (AKI) across adult wards at DBTH. See more about the day here

This included our new patient story, a powerful video about Michael, who suffered an Acute Kidney Injury while having routine elective surgery. Further drop in sessions were held across the Trust throughout October 2019. Over 200 people have now heard Michael's story and what work we are doing to ensure that patient's hydration and observations are recorded and escalated appropriately.

Traffic Light Water Jug Lids

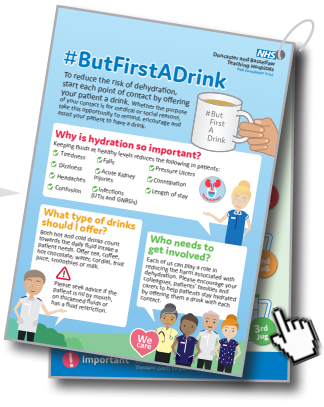
This is a simple, innovative traffic light lid system for our patient's water jugs. The poster includes all the information about how to implement the traffic light system and also gives advice for patients on restricted fluids. These jug lids will launch in November 2019. All the lids have been ordered and we are waiting for a delivery date. For FAQ, click here



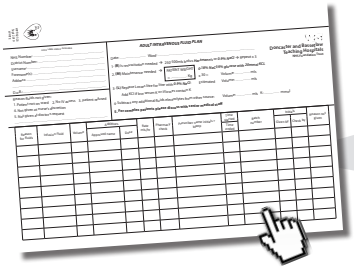


#ButFirstADrink

#ButFirstADrink is a simple concept where we can all work together to reduce the risks of dehydration, whether you are the patient's family, therapist, pharmacist, doctor, nurse or volunteer, start and end each patient contact by offering the patient their drink.



The posters have been adapted into keyring cards for Trust staff to keep as a handy guide to remind everyone of the new systems.



New fluid balance and Pee Plotter

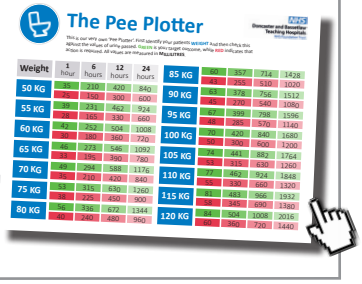
The new fluid balance chart (WPR42323) is the only one now in use across the Trust. This is a 24 hour fluid balance with a cumulative intake and output performed at 06.00 where there is more chance of a senior review.

Follow these links to the Think Kidneys national website to access further information on AKI.

Acute Kidney Injury - a quick reference guide

Risk and Prevention Guidance for Secondary Care

An encapsulated version of the Pee Plotter has been printed to be available at every adult bedside at DBTH.



Recommendations for **pre-operative starving**

Prolonged pre-operative fasting can be an unpleasant experience and has the potential to add patient safety risks. Evidence is revealing that excessive fasting results in negative outcomes and delayed recovery, yet some specialties still advise to fast patients from 2am.

See here for evidence from the NICE website.

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, black tea and coffee).

What is next?

eObservations, provided by Nervecentre, is an extension of Hospital@ introduced to the Trust in early 2019, and helps in the recording and distribution of tasks within wards and departments between health professionals. Similar to the former system, observations are logged centrally on the system, with an accompanying patient record and related notes and alerts visible to trained users. The system will also work out the frequency of required observations, helping clinicians to make the most of their time.

Lee Cutler introduces eObservations

The system is currently being rolled-out to the six adult wards of Bassetlaw Hospital, as well as Endoscopy and Day Surgery. If everything goes to plan, a further deployment will commence in Doncaster Royal Infirmary and Montagu Hospital later this year and early next.

After eObservations, the Sepsis IPOC and Fluid Balance modules will be added to ensure that all the current paper charts we currently use are converted to electronic systems.

Medicines Safety

From the annual inpatient survey, we know that patients are often unsure about changes to their medication following a hospital admission. This can be a significant patient safety risk if patients don't know what medications they should be taking and why.

To help communicate medication changes with patients, carers and families, the pharmacy team have developed a helpful patient information leaflet. You can access it here.

This information is also included on the new ward welcome boards as a QR code for patients and carers to scan with their mobile phones, as well as given out by pharmacists on the wards.

Medicines Incident – feedback from reporting

A high risk near miss on one of the medical wards occurred recently when the nursing staff administered the patient's own controlled drugs.

In this case 6 x 20mg immediate release capsules were administered on several occasions instead of 1 x 120mg MR tablet. Luckily, the patient did not suffer any harm as a result of this error. We do not stock immediate release oxycodone capsules within the Trust because of the risk of error, and only the liquid should be used for breakthrough pain.

The learning from this case is to send patients own controlled drugs home wherever possible to minimise risk (and to save time counting patient's own controlled drugs every day).

Baby loss awareness week

The care that bereaved families receive from health and other professionals, following pregnancy loss or the death of their baby, can have long-lasting effects. Good care cannot remove parents' pain and grief, but it can help them through this devastating time. In contrast, poor care can significantly add to their distress.

Originally starting in 2002, baby loss awareness soon extended to a full week with events across the UK. On 15 October, teams at DBTH arranged for the Wave of Light service to be held at 18.45 in both chapels. Staff, patients and visitors were welcome to attend and leave a candle in remembrance for their loss.

Many charities involved in Baby Loss Awareness Week work every day to prevent baby and infant deaths, pregnancy loss and maternal deaths. But this Baby Loss Awareness Week aimed to encourage conversation about what could be done right now to better support families affected by the death of a baby.

To help break the silence, we saw the work of the Early Pregnancy Assessment Unit (EPAU) teams at Bassetlaw create a butterfly wall. Each butterfly represents a loss within the EPAU since January 2019.

At Doncaster, a memory tree was displayed at the entrance of the Women's and Children's Hospital, with patients, staff and relatives encouraged to write a message on a ribbon if they wanted to. Any staff member who wanted a ribbon badge could find these available from the main reception at Bassetlaw and Women's and Children's Hospital at DRI.

For more information about baby loss or to purchase your own badge, please click here

Learning from deaths report: Q1 2019/20

The "National Guidance on Learning from Deaths" (National Quality Board, March 2017) stated that all Trusts must publish their numbers of in-hospital deaths, including those in the Emergency Department on a quarterly basis.

We have produced a Learning from Deaths quarterly report since April 2017. The contents of this report have evolved over time as it has become apparent at a national level that a review of ALL deaths is neither achievable nor indeed necessary.

What is the learning from this quarter?

- There have been 448 in hospital deaths. Doncaster: 321 Bassetlaw: 127.
- 273 (61%) of all deaths have been scrutinised, this is 4% more than last quarter. 240 have been screened and 33 have had a structured judgement review (SJR) undertaken.
- Of the 240 case notes screened, 22 (7%) were escalated for a full review at DRI and 11 (9%) at BDGH. Of these 33 cases, 18 completed SJR's have been submitted. The other 15 are being pursued via the clinical governance teams. 15 of the SJRs concluded that the care was either very good or excellent. 3 of the cases identified either issues with poor communication around discharge planning, lack of recognition of the dying patient and a delay in starting the EOL care plan or poor documentation.
- The standard of care, as evidenced by good documentation in the case notes, is generally good and certainly over time there has been a significant improvement. However, there are still times when poor handwriting, no printed name and the lack of a date and time of entry makes it difficult to identify the correct clinician for further information. This also causes a considerable problem when attempting to identify an appropriate Doctor to complete an MCCD.
- There were 7 elective admissions this quarter where the outcome was death. The purpose of the review of elective admissions is two-fold: to determine accuracy of mode of admission and to identify any quality of care issues. There are some cases where the method of admission may be amended by the clinical coding manager. All of these cases have now been reviewed and all 7 confirmed to be true elective.
- There was 1 death of a patient with a Learning disability this quarter which has been referred to LeDeR. An internal review of the case was undertaken in conjunction with the Learning Disability liaison nurse and the care was concluded to have been of an excellent standard.

From April 2019, a screening tool has been implemented, to filter the case notes of deceased patients, ensuring that all the following cases are escalated for a full Structured Judgement Review (SJR):

- All deaths where bereaved families and carers, or staff, have raised significant concern about the quality of care provision.
- All deaths of those with a learning disability.
- All deaths following an elective admission.

1. Cremation forms and additional clinical scrutiny

When a deceased patient is to be cremated there is a booklet to be completed in 2 parts.

Part 1 (Cremation form 4) is completed by a doctor who saw and treated the patient whilst alive and during their last 14 days.

Part 2 (Cremation form 5) is completed by a more senior doctor, usually a consultant/pathologist. This clinician has to confirm they agree with the cause of death and confirm they have questioned either the doctor or nurse who last treated the deceased. This represents an additional layer of scrutiny. Currently in the Trust this relates to approximately 70% of cases. During Q1 70% of deaths at DRI were for cremation and 69% at BDGH.

2. Completion of a Medical Certificate of Cause of death (MCCD)

The timely issuing of a MCCD is crucial to ensure that bereaved families and carers can register the death and progress other essential activities following the death of their loved one. Registration of death where there is no Coroner involvement should be completed within 5 days. This is only possible once an MCCD has been issued.

From 1st April 2018 we set an internal target for the completion and issuing of MCCDs to 3 days.

During Q1 we have met this target at DRI in 89% of deaths and at BDGH, 96% of deaths. This is a very significant improvement of 68% last quarter.

Since January 2018 when the registration of deaths within 5 days fell to 42% in Doncaster we have maintained good communication with the Superintendent registrar and significant improvements have been seen.

This improvement has been recognised nationally and reported back to the Trust by the Superintendent Registrar.

Although last quarter we plateaued, extra efforts have been made and despite very challenging times in terms of staffing numbers, this quarter has shown a significant improvement.

Deaths registered within 5 days in non-coronial situations:

April 19	May 19	June 19	YTD
89%	92%	80%	87%

3. Referral to HM Coroner

There are certain deaths which must be referred to a Coroner and this must be undertaken electronically and as soon after the death as possible.

Once a referral has been made, this triggers an e-mail to both the legal team and the bereavement office. Systems are now being developed to ensure that any referral made will be scrutinised by the legal department, lead nurse for bereavement and the deputy medical director. This will ensure that any case which may go on to inquest or may have some triggers for internal learning will be picked up quickly and acted upon.

During quarter 1, 173 deaths were referred to HM Coroner, (104 DRI and 69 BDGH).

4. Bereaved family contacts and issues

The bereavement booklet is now available in all wards and departments and is to be given out to every bereaved family. Further copies can be obtained from the bereavement office at Doncaster and the General Office at Bassetlaw.

The majority of contacts made by family members to the bereavement office are to enquire as to when an MCCD will be available. Because families are under pressure to register a death within 5 working days, they require the MCCD to be able to do this. The bereavement officers have daily difficulties in identifying a Doctor who is able to complete an MCCD. The lack of printed names, bleep numbers and /or mobile numbers adds to this frustration.

There has been a significant increase in the number of requests to view deceased patients in the Mortuary, putting extra pressure on the staff within. These are often patients who have died in the community and brought into our mortuary. Processes are currently being reviewed with regards to this.

5. Medical Examiner (ME) Team

We are making very good progress in establishing a medical examiner team and it is hoped that this team will be in place to begin a phased implementation by April 2020. A full time Medical Examiner's officer was appointed this month and she will be in role by November. The team will be supported by the current bereavement officers, though there is new appointment here also, replacing a part time officer who left in July.

Contact has also been made with the new Regional Medical examiner, Mr Graham Cooper, who will be in post from October and will then work with each of the Trusts within his region and support the implementation.

Documentation of the ME activity is going to be crucial in ensuring that the correct payment is received from the DHSC for this activity once fully implemented.

The National ME, Alan Fletcher attended the Trust on September 13th and delivered a lecture on the role and function of the ME team.

6. Summary, conclusion and learning

- There have been 448 in hospital deaths this quarter. DRI = 321 BDGH = 127
- 273 (61%) of all deaths have been scrutinised, this is 4% more than last quarter. 240 have been screened and 33 have had a structured judgement review (SJR) undertaken.
- 18 SJR's have been submitted and the other 15 are being pursued via the clinical governance teams. 15 of the completed SJRs concluded that the care was either very good or excellent. 3 of the cases identified either issues with poor communication around discharge planning, lack of recognition of the dying patient and a delay in starting the EOL care plan or poor documentation.
- Timeliness of completing a medical certificate of cause of death (MCCD) and referring a death to the Coroner within 3 days is the biggest challenge. However, this month we have made significant improvements here. Bereaved families have received the MCCD within 3 days in 89% of the cases at DRI and 96% at BDGH. The figure last quarter was 68%.
- Although the number of medical notes screened have not increased significantly, (though there has been a small increase), the numbers of MCCDs available to families within 3 days has vastly improved. This quality improvement is remarkable and is one area that the Trust feels very strongly about and is pleased to report on. It is expected that once the new MEO starts in post, the numbers of screened notes will increase too.
- Findings from the SJR's have generally been very positive, with the majority of reviews demonstrating good/excellent care. The 3 areas for awareness raising and learning that have been highlighted this quarter, though it must be emphasised that these were only 3 cases, are:
  - A lack of documentation around discharge planning.
  - A delay in recognising a dying patient and an apparent reluctance in starting the EOL IPOC
  - A lack of documentation of date, time and name of the scriber.

For more information about learning from deaths, please contact mandy.dalton1@nhs.net or g.wheatcroft@nhs.net

End of Life Care

NICE have written recommendations, intended to help healthcare professionals to recognise when a person may be entering the last days of their life, or if they may be deteriorating, stabilising or improving even temporarily. It can often be difficult to be certain that a person is dying.

Click here to access the new recommendations.

The recommendations supplement the individual clinical judgement that is needed to make decisions about the level of certainty of prognosis and how to manage any uncertainty.

Print and display the Dying Matters posters for your areas to encourage patients and families to talk about palliative care and dying.

For more information about End of Life care, please contact karen.lanaghan@nhs.net

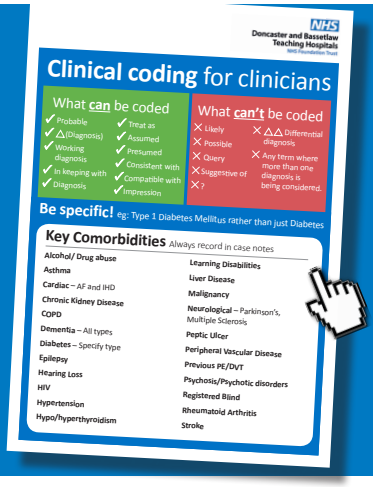
Help and support about End of Life care at DBTH can be found here.

Message of the Month

Clinical coding is completed after the patient has been discharged from hospital or has died.

For our work to Learn from Deaths, we recognise that the Clinical Coders are entirely dependent on accurate and timely information regarding diagnoses and procedures. This helps to produce a true picture of hospital activity and demonstrate the complexity of our patient case mix.

Download the RCP top ten tips for coding here



Print and display this poster in your clinical area.

Patient Safety Learning

The Patient Safety Learning Awards 2019 celebrated how Patient Safety Learning can play an important role in supporting healthcare organisations around the world to make positive changes and move towards a culture that better supports patient safety learning.

On 2 October 2019, a small team went to the annual Patient Safety Learning conference to present the work DBTH has been doing. This includes how we are making shared learning from patient safety incidents available to everyone who works at DBTH, woven around our Trust values. We were delighted to accept the award for Shared Learning for this newsletter and annual conference.

What's next? We received £500 prize to visit another area who had successfully implemented a patient safety project.

Watch out for further developments in future editions of the SHWC newsletter. For more information and ideas shared on patient safety, you can register for the Hub here.

Thanks this month go to: Cindy Storer, Mandy Dalton, Hannah Stirland, Karen Lanaghan, Rachel Wilson, Helen Meynell, Paula Fores, Joanne Sayles.