Appendix 3 Bradford Teaching Hospitals NHS Foundation Trust: A learning organisation: Responding and Improving

Issue 4 February 2018

Bradford Teaching Hospitals NHS
NHS Foundation Trust

RESPONDING & IMPROVING

Focus on Mortality

Responding and Improving

When a serious incident occurs we need to make sure that it cannot happen again.

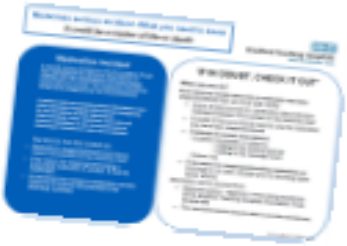
During the investigation a number of recommendations are usually identified, some are very specific to the incident, some have implications across the Trust.

We work hard to respond to recommendations. We also work hard to make sure any of the actions we take are effective and we have made sustainable improvement, meaning that we have confidence that the incident should not happen again.

Stopped medication

In 2016 the Trust was informed about the death of a ninety one year old lady by the Coroner. The cause of death was recorded as pulmonary thromboembolism (PE), occurring after a period of immobility due to a fractured ankle. The coroner noted this lady had been prescribed Apixaban (a drug used to reduce the risk of stroke and serious blood clots in certain patients with Atrial Fibrillation (AF)) which was stopped on admission and subsequently was not restarted at discharge.

The Trust conducted a serious incident investigation which found that the root cause of the PE still remains unknown. Apixaban, previously used as prophylaxis for AF, was not recommenced at discharge and could have been a contributing factor to the subsequent PE.



An audit of missed doses took place and a learning matters bulletin was distributed throughout the Trust to share learning from the incident. An assurance review of the action plan provided confidence that effective action has been taken to ensure an incident like this should not reoccur.

The inquest was heard at Coroner's Court. Within the summing up, the Coroner confirmed that they were most grateful to the Trust for investigating the number of missed opportunities to re-prescribe the Apixaban and accepted the medical cause of death as proposed by the pathologist.

Alleged inpatient illicit drug taking

In 2016 a patient death was referred to the Trust from the Coroner's office as they had been informed by the referring doctor that the death could possibly be linked to a patient having taken illicit drugs supplied to her by an external source whilst an inpatient at the Trust. The Coroner requested the Trust investigate the alleged incident and include details of the actions taken following the alleged incident.

A Serious Incident Investigation took place and although the investigation team were unable to prove or disprove whether the patient had been taking illicit drugs whilst an inpatient recommendations were made to prevent occurrence of similar incidents. The policy for the Safe Management of Controlled Drugs: section 27: illicit substances' was amended to include actions to take in the event of patients allegedly taking illicit drugs whilst in hospital, the importance of timely incident reporting was reiterated to staff and findings from this case were discussed at the Deteriorating Patient Collaborative.

An assurance review of the completion of the action plan took place which provided confidence that actions have been completed and the Policy for the Safe Management of Controlled Drugs has been amended and has clear and concise steps to take if this incident was to occur again.
The Incident Reporting and Investigation Policy has also been reviewed and includes the process and responsibilities for incident reporting.

Head injury sustained by an Inpatient

In December 2015, a patient left the Acute Medical Unit, whilst in an altered state of mind, and sustained a life changing head injury which later contributed to their death. This was investigated as a serious incident.

The investigation concluded that the patients head injury might have been prevented if staff had had clearer guidance and training on the application of the Mental Capacity Act and Deprivation of Liberty Standards. An action plan was developed and implemented.

In September 2016 a ProgRESS review was undertaken into the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS). This gave the Trust confidence that recommendations in the Serious Incident Investigation had been completed and staff awareness of MCA and DoLs has improved.

At a glance guidance for staff who are dealing with a patient who lacks capacity, including guidance on preventing a patient leaving a ward area has been developed and implemented and can be found here. Advice can also be sought from the Safeguarding Team on 01274 364345 and out of hours by contacting the Clinical Site Matrons/ On Call Manager.

Spot light on Mortality Reviews

It is expected that when an inpatient dies, their care will be reviewed in compliance with our mortality review processes. A standardised case note review approach is used called the Structured Judgement Review (SJR) method. SJR is nationally recognised and is also recommended by the national mortality programme. The review method combines structured reviewer comments with quality of care scores to assess the care of people who die in hospital. The SJR method also encourages reviewers to identify and celebrate good care as well as poor care and facilitates the identification of actions for improvement, suggesting lessons that may be learned and cascaded widely. All staff involved in mortality reviews are expected to use this method.

The Trust aim is that 25% of patients who die in hospital will receive a review. From 2017 to date, this figure stands at 13%. For more information contact Chioma.Obasi@bthft.nhs.uk

Support to the 'second victims' of patient safety incidents

The Yorkshire Quality and Safety Group undertook a review into support to 'second victims' of patient safety incidents (PSI). A staff survey was sent to all healthcare professionals working in BTHFT, to gather information on personal experiences of being involved in patient safety incidents.

The aim of the survey was to understand what support they received or would have liked to have received during the time that followed the incident. The results from this survey will be used to help inform the research teams at BIHR in developing resources to improve the support systems available to healthcare professionals both locally and nationally.

The results found that :

- respondents generally agreed that their organisation understands that staff can suffer after being involved in a PSI and need help to deal with it. Despite this, not many respondents felt that their organisation provides a variety of resources to help in the aftermath of a PSI, or that their wellbeing is a priority for the organisation.
- Most respondents did not take time off work after the PSI, despite many wishing for a break from work.
- The PSI knocked respondents' confidence in their abilities.
- A key theme was that respondents wished to be kept involved in the investigation process and updated on the patient's health.

The full report can be viewed here.

Responding and Improving is developed by the Learning and Surveillance hub. For more information please contact Saba Chaudhary on extension 3081 or by email Saba.Chaudhary@BTHFT.NHS.uk