LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

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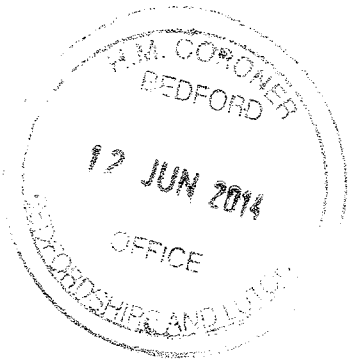

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Our ref: PMP/ams

12 June 2014

Mr T Osborne
HM Senior Coroner
The Court House
Woburn Street
Ampthill
MK45 2HX

Dear Sir

Inquest touching the death of Sari Marlene KEEN
Inquest held on 19 March 2014 at Coroner's Court, Ampthill

I am writing in response to your Regulation 28 Report, dated 16th April 2014, in response to the death of Mrs Sari Keen.

The Trust has considered three issues:

1) medical and nursing staff numbers;
2) the ability of staff to escalate their concerns; and
3) the role of the Crash Team

Medical and Nursing Staff Numbers

Nursing Staff establishments are reviewed every six months using a number of different approaches. This includes using the expert opinions of the Chief Nurse, dedicated specialty matron and ward manager who have greater insight into the local clinical need and context of each ward setting. The establishments are also reviewed in the context of the wider quality performance of the ward which includes key nursing quality indicators, patient experience scores and workforce indicators such as sickness and turnover rates. In fact following our most recent establishment review the actual numbers of nurses on ward 22 at night has been increased.

In addition to the agreed staffing numbers per shift, operational meetings are held three times a day, led by the Chief Nurse, Deputy Chief Nurse or Matron to review the staffing numbers on a shift by shift basis using a risk assessment process. This includes all clinical wards across the Trust. Decisions are made, if required, to move nurses across clinical settings to ensure that all areas are safely staffed.

Out of hours, doctor ward cover is provided by the on-call surgical team. For General Surgery, this includes a junior surgical doctor in training (FY2), a senior surgical trainee (SpR/middle grade) and the on-call consultant. Additional cross-cover is provided by the Orthopaedic on call team (similar team structure), and this can be called upon if necessary.

The Divisional Director for Surgery has confirmed the processes are in place to ensure that adequate medical staffing numbers are in place and adhered to.

The ability of staff to escalate their concerns

On the night of the 23rd of October 2013 the nurse in charge of the shift did not escalate to the senior night nurse for support or advice as the House Officer was already on the ward for the majority of the night and the senior nurse felt, at the time, that the House Officer was managing the situation accordingly. In hindsight, the staff recognise that they should have escalated to the senior nurse regarding the nursing workload as it was extremely challenging for the nurses to manage this level of acuity.

The following actions have been undertaken to minimise the risk of this happening again:

- The ward manager has raised this issue with her staff and stressed the importance of early escalation when the existing nurse staffing is insufficient to cope with the unpredicted patient acuity. This is discussed at the daily 'safety briefs'.
- We have introduced a more robust process for identifying the patients who are particularly unwell/at risk of deteriorating by providing the senior clinical sister on night duty with an up to date list. This enables patient reviews to be prioritised.

For doctors, in cases where a deteriorating patient requires specialist input, escalation is by the surgical on-call team to the Medical registrar, the ITU registrar, ITU outreach (during their hours of operation 08.00 – 22.00) or the link anaesthetist. If they foresee that they will be unable to respond within an appropriate timescale, it is their duty to inform the referring doctor of this at the time, to allow additional assistance to be sought.

We acknowledge that there is a culture within the L&D whereby some junior medical and surgical staff do not like to disturb senior colleagues out of hours, despite being told explicitly during their induction that it is their duty to do so where they have concerns for their patients. There is an ongoing dialogue with junior staff about senior doctors' expectations with respect to being notified about a deteriorating patient, and it has been made clear to all consultants that they are expected to respond appropriately to all juniors requests for support.

- The requirement to escalate is also reinforced by the Director for Medical Education as part of the junior doctor's training programme.

In addition in HDU, we have adopted a policy a few months ago that empowers nursing staff to escalate concerns regarding a deteriorating patient directly to the consultant if they feel that appropriate action is not being taken quickly enough, and we will look at the feasibility of extending this to all ward areas. This has worked well.

All members of staff have a professional accountability to escalate concerns about their patients, and they should never feel unable to do so. This is reinforced at induction and ongoing junior doctor training.

Further actions include:

- Improving the management of the deteriorating patient. This is a key quality objective for 2014/15 and a dedicated steering group has been set up with a key focus on identifying the barriers to the effective management of the deteriorating patient.
- A revised Root Cause Analysis (RCA) process for investigating all cardiac arrests has been introduced which is now being led by the Consultant responsible for the patient rather than the former process which was led by the resuscitation officer.
- A revised observation and escalation process is currently being piloted on 4 wards. A key change is the introduction of registered nurses to undertake the observations of all patients who require observations more than 4 hourly. Health Care Assistants also undertake observations but it was noted that the registered nurse has a greater ability and opportunity to identify other factors that might indicate deterioration where a Health Care Assistant would not be skilled enough to identify the patient during the actual observation process. Early indications are that there is a more timely escalation from nurses at the earlier signs of deterioration.
- Re-launch of the standard communication tool - SBAR (Situation, Background, Assessment, Recommendations.) Analysis of the RCAs for cardiac arrests has identified the importance of communicating in a clear and concise way. The drive to standardise the communication is being led by the Critical Care Outreach Team and this should provide clearer details regarding the deterioration of the patient. This in turn will promote a more timely medical response and enable the medical staff to prioritise their workload more effectively.
- The Trust has also undertaken a review of the clinical support available at night across the Trust. Further work is underway to develop a revised 'hospital at night' model to meet the national strategy requirement of a robust 24/7 service.

The role of the Crash Team

We have very clear and specific protocols for activation of the cardiac arrest process, which every member of staff is expected to be conversant with. It is taught through basic life support, which is an element of mandatory training for all clinical staff.

In addition, we have a separate "Medical Emergency Team" policy, designed to be activated in situations where a patient is deteriorating but is not yet in cardiac arrest. This involves activation of the bleeps of the medical registrar and the ITU registrar by switchboard with a message asking the medical emergency team to go to ward X immediately.
For patients deteriorating between 8am and 10pm, we have the third option of summoning the ITU Outreach team to review the patient. This can be initiated by either medical or nursing staff, and results in a review by a nurse trained in assessment of critically ill patients who can then escalate to either the medical team or the ITU team as appropriate.

It is unacceptable that any member of staff feels that an "unrecordable blood pressure" is not a medical emergency, and this will need to be addressed across the whole Trust.

- The process of escalating to the Medical Emergency Team was widely publicised at its inception, and its availability is being emphasised to all staff groups during basic life support mandatory training.

- Evaluation of the current training for nurses and doctors on the identification of the deteriorating patient is in progress with a proposal to improve the content as reflected in the learning from Root Cause Analysis of cardiac arrests.

- This case will be presented at the Grand Round, Trust Patient Safety Meetings and Senior Nurse meetings so that learning can be shared.

I trust the information contained in this letter will provide you with the assurance that we have taken appropriate in response to your Regulation 28 Report.

Yours sincerely

Pauline Philip
Chief Executive Officer