Northumbria Healthcare NHS
NHS Foundation Trust

Patient Services and Quality Improvement

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Our ref: 11/12.Inq.37

Your ref: KLD/WRD/651/15

Date: 7 December 2015

Mrs Karen Dilks
H.M. Senior Coroner for Newcastle upon Tyne
Coroner's Court
Civic Centre
Barras Bridge
NEWCASTLE UPON TYNE
NE1 8PS

Dear Mrs Dilks

Inquest into the Death of Patrick Carrick – Response to Regulation 28 Report to Prevent Future Deaths

I write in response to your Regulation 28 Report following your investigation into the death of Patrick Carrick. As you will be aware, the Trust takes all patient deaths very seriously and this case was no exception. The Trust has carried out a huge amount of work to improve care since Mr Carrick's death, 4 years ago, and I understand that you heard some evidence around the issues identified at the inquest. I have also asked relevant staff to consider these and respond as follows:-

There was a significant department from a patient's management plan without explanation and this was compounded as it occurred in a period of rapid deterioration.

All staff are aware of the importance of following a management plan. In order to check if management plans are being followed Matrons carry out monthly spot audits on a minimum of 5 patients on all surgical wards across the Trust. These audits check if documentation is being completed correctly, such as NEWS, fluid and urine output charts, and will identify if management plans are not being followed; such as observations not being carried out within the agreed timeframe.

If the Matrons identify any issues during the audit, these are passed to the Ward Managers who provide feedback at ward meetings and to individual members of staff. If further training or support is required this will be arranged. The Matrons can also add items to check during their next audits if they have a particular area of concern or they have received a complaint.

In addition to the above, the Trust now runs daily safety huddles on ward rounds that include a "STOP" system where patients with a high NEWS score or a particular concern are discussed and management plans are reviewed. This includes a discussion as to whether there is a need to involve others such as critical care.

Administering of antibiotics:

As part of the Matrons' monthly audits they will also identify if medications, such as antibiotics, are being administered at the times prescribed. The Trust has also identified the importance of timely antibiotics in cases of sepsis and in May 2014 launched a "Surviving Sepsis" campaign with a 150 delegate event including all disciplines. One of the key interventions was the implementation of the Sepsis Six across all 52 wards which is a set of six interventions including:

- Administering high flow oxygen
- Taking blood cultures
- Giving broad spectrum antibiotics
- Giving intravenous fluid challenges
- Measuring serum lactate
- Measuring accurately hourly urine output

Clinical teams now receive weekly reports showing their performance against Sepsis Six compliance Trust wide.

Whilst the Trust has done a lot with regards to the implementation of antibiotics in cases of sepsis, it is important to note that the slight delay in the delivery of antibiotics to Mr Carrick was of no clinical consequence as he was not clinically septic.

Crucial blood analysis results were not actioned

Once bloods are available they can be viewed and actioned on the electronic ICE system which creates an electronic audit trail. As explained at the inquest, bloods were taken on the ward on 24 January 2012 at 11:43, received in the laboratory at 13:21, reported by the laboratory at 14:33 and viewed and actioned by [redacted]

"Actioning" of bloods on ICE requires that an action button is pressed on the ICE system for each blood result. This presents a conscious statement from the member of the medical team that they have viewed, interpreted and where clinically necessary, actioned the blood results. The key to the "actioning" of results is interpretation and integration into the patient's management plan and the following initiatives have or are being implemented to ensure that this continues to happen in a safe, consistent and effective manner:

- The implementation of the SBAR (Situation, Background, Assessment and Recommendation)
  methodology to assist with the safe and effective handover of clinical information between shifts and staff groups.
- The use and completion of blood result sheets in patients' notes to document both individual results and demonstrate trends.
- Induction sessions with junior doctors at each change of rotation in relation to NEWS, sepsis, SBAR and escalation of care.
- Collaboration with Mr [redacted] at Royal Infirmary of Edinburgh on his research project entitled "The Assessment of Surgeons and Patient Safety Issues in Surgery" using Non-technical Skills for Surgeons (NOTTS). This will facilitate improved structure and function of ward round practice including dissemination of information.

Inadequate completion of nursing and medical notes

In addition to training on the importance of good record keeping, the Trust carries out the following audits to identify any documentation issues which require action:

- Monthly Matron audits as described above.

- Environmental audits of patients' mealtimes: this is performed on specific medical wards by the clinical audit team and includes an assessment of both the presence and accurate completion of fluid balance and urine output charts. This was last performed in October 2015 and achieved 100% on all wards audited.

- NICE clinical guideline 174: this clinical guideline offers evidence-based advice on intravenous fluid therapy for adults in hospital. It contains recommendations about general principles for managing intravenous fluids, and applies to a range of conditions and different settings. It does not include recommendations relating to specific conditions. Compliance against this guidance is audited by the Trust.

- Annual documentation audits: The clinical audit team perform annual documentation audits rotating through specific areas checking that documentation is complete.

<u>NEWS:</u>

As [redacted] explained at the inquest, the Trust has done a significant amount of work around NEWS documentation and NEWS practice since Mr Carrick's death, focusing on quality improvement, education and communication. This has resulted in the Trust being a leading organisation in relation to NEWS as stated by [redacted] at the inquest.

NEWS compliance is now reported by each ward to the Business Units on a monthly basis as a NEWS performance. This is scrutinized in terms of compliance at governance meetings, business unit boards and the senior nurses' forum. A new NEWS document has been written and rolled out with an educational package, including training on the importance of completing NEWS in accordance with the timescales set by the NEWS score and/or clinical direction. Staff have also been reminded of the importance of recording urine output on NEWS, which is monitored as part of the monthly audits.

Recently, there have been further changes to NEWS to incorporate sepsis management and more escalation responses, including physiological escalation planning. The Trust is also in the final stages of a £1.7 million procurement of an electronic track and trigger system across the organisation which will provide additional safety benefits to patients in the use of the NEWS system, task management and escalation of patient care.

I hope that the information provided offers you the necessary assurances that the Trust have invested significant time, effort and resource into investigating the issues you have highlighted, with a view to improving patient care and safety and reducing the risk of any adverse incidents or outcomes in the future.

Patrick Carrick's death was a tragedy and we will continue to strive to make improvements wherever possible.

Yours sincerely

DAVID EVANS
Chief Executive