East Sussex Healthcare NHS
NHS Trust

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Your Ref: VHD/TS/TUCKER

29 March 2018

Dear Madam

**Trust Response to Regulation 28 Report - Barry John Tucker**

In response to the Regulation 28 Report you made at the conclusion of the inquest into the above named's death on 17 March 2017 [inquest heard on 11, 12, 16 January 2018] please find herewith the Trust's Response.

**Documentation**
In preparing this Response we have considered:

- The patient's concurrent medical records;
- Review of clinical guidelines/ best practice;
- Face to face discussions with all staff involved;
- Staff statements/written accounts;
- Patient/family account of event and perspective obtained through discussion with them;
- Group discussion (After Action Review);
- Staff support for investigation;
- Staff feedback from incident and findings.

**Brief background:**
Mr Tucker was a 71 year old man admitted to Eastbourne District General Hospital (EDGH) to undergo a robotically assisted radical cystectomy and ileal conduit formation for bladder cancer on 11th September 2017.

Four days later he was discharged home with open access to the Urology Assessment Unit. Mr Tucker was readmitted on 16th September. The next day he underwent surgery at Brighton and Sussex University Hospital (BSUH) and an emergency laparotomy (surgical opening of the abdominal cavity) was performed. He was subsequently transferred to the Intensive Care Unit (ICU) post operatively where his condition deteriorated further.

Mr Tucker died on 17th September 2017. The cause of death was recorded as 1a. multiple organ failure, 1b. small bowel ischaemia due to septic shock and bronchopneumonia, 1c.

papillary transitional cell carcinoma of the bladder and 2.superior mesenteric artery atheroma.

The post mortem findings did not highlight a problem from the initial surgery undertaken at EDGH. It is unclear if the rapid decline in condition could have been predicted or identified earlier had there been improved documentation with patient information and consultant input.

**Key Time Line Events:**

| | | |
|---|---|---|
| **July 2017** | | Mr Tucker was seen at BSUH with symptoms of haematuria and following investigations a diagnosis of invasive transitional cell carcinoma of the bladder was made. The Multi-Disciplinary meeting between BSHU and East Sussex Hospitals NHS Trust determined the most appropriate course of action was surgery for Cystoprostatectomy (removal of the bladder and prostate) which would be undertaken at Eastbourne District General Hospital (EDGH). |
| **20th July 2017** | | Reviewed by the Consultant Anaesthetist and a nurse for pre assessment and was deemed fit for surgery. |
| **11th September 2017** | | Admitted to EDGH to undergo a robotically assisted radical cystectomy and ileal conduit formation for bladder cancer. |
| **12 September 2017** | 18:45 | Mr Tucker was transferred to the private patient unit. |
| **14th September 2017** | | On the morning round, the surgical fellow noted Mr Tucker was nauseous however, his abdomen was soft and non-tender.<br><br>Mr Tucker underwent an oesophago duodenoscopy (OGD) the procedure notes that there was moderate oesophagitis and the stomach was full of thick liquid and food and therefore the procedure was abandoned and advised to rebook OGD. |
| **15th September 2017** | | Mr Tucker was discharged home with open access to the Urology Assessment Unit. (The blood results and all observations were within normal limits)<br>There is no record of the discharge advice given. |
| **16th September 2017** | | Mrs Tucker telephoned the Urology Assessment Unit at EDGH for advice as Mr Tucker was reporting back and abdominal pain despite taking the prescribed analgesia. Advised to return to EDGH for stronger pain relief. |

| | | |
|---|---|---|
| **16th September 2017** | **20:40** | Mrs Tucker contacted the unit again and was advised that Mr Tucker should return to EDGH and an emergency ambulance was offered. |
| **16th September 2017** | **21:30** | Paramedics discussed with the on-call Urology Registrar to return to EDGH. Unfortunately there was rapid deterioration so he was taken to the nearest A&E at BSUH |
| **17th September 2017** | **04:00** | Mr Tucker underwent surgery at BSUH and an emergency laparotomy (surgical opening of the abdominal cavity) was performed. |
| **17th September 2017** | | Mr Tucker was transferred to ICU post operatively where condition deteriorated further. |
| **17th September 2017** | **20:35** | Mr Tucker died. Cause of death recorded as multiple organ failure, small bowel ischaemia due to septic shock and bronchopneumonia, papillary transitional cell carcinoma of the bladder and superior mesenteric artery atheroma. |

**Coroner's Concerns:**

**(1) Mr Tucker received no pre-op preparation**

Trust Response

According to the records, Mr Tucker was seen in the pre assessment clinic at EDGH on 20th July 2017, both by the nurse and anaesthetist in preparation for his surgery. It is documented in the anaesthetist's letter to the consultant, GP and patient, that Mr Tucker needed to contact the GP for blood pressure monitoring.

Mr Tucker was pre-operatively assessed at EDGH and saw a nurse and consultant anaesthetist.

There is no record of what patient information leaflets were given. The Trust acknowledges that good record keeping was below par in this instance and has undertaken to retrain staff about the importance of recording all instances of doctor – patient contact.

**(2) The urology consultant was away during his admission and he had no senior input.**

Trust Response

The consultant responsible for the care of Mr Tucker was on annual leave and therefore no other senior clinician was appointed to cover. There was an experienced doctor seeing Mr Tucker each day while he was on the ward. This doctor was a surgical robotic fellow who had completed his training and was applying for consultant posts. He was experienced in robotic surgery and was working at the level of a consultant. In addition

there was a urology consultant of the week in place who was available for additional support and advice or contact with the visiting BSUH consultant. There is no record in the patient notes of any escalation to the urology consultant of the week and this was most likely due to no concerns identified by the doctor to escalate.

Mr Tucker was reviewed by a Consultant Anaesthetist on 14 September 2017.

| Recommendation | Action | Source of assurance action embedded in practice | Lead | Deadline | Date completed |
|---|---|---|---|---|---|
| Patients must be assigned to a consultant who is present (to see the consultant of the week to cover for annual or study leave) | Discussed at Clinical Governance meetings | Observed at safety huddle on ward | Clinical lead | Feb 2018 | 1 Feb 2018 |
| Patients must be reviewed by a consultant daily post-operatively. | Job plan to be amended to include daily rounds | Audit of notes in 3 months to ensure consultant review has taken place | Clinical lead | Job plan amended Feb 2018 for audit May 2018 | |

**(3) The Enhanced Recovery Nurse Specialist was also away during his admission. He never met her or received any paperwork from her.**

Trust Response

There is an Enhanced Recovery (ERAS) nurse in the Trust with expertise in this type of surgery; however, they were on annual leave during Mr Tucker's stay. This nurse would have visited Mr Tucker while he was on Michelham ward to ensure he was progressing well.

| Recommendation | Action | Source of assurance action embedded in practice | Lead | Deadline | Date completed |
|---|---|---|---|---|---|
| Review the request for funding a second ERAS nurse and if not possible ensure that appropriate mitigations and leave cover arrangements are put in place. | Ward team to be aware of ERAS nurse leave and provide the expertise. Application for second ERAS nurse to division | ERAS support evident in patient notes and process for leave cover to be monitored | Head of Nursing | May 2018 | |

**(4) He never received a copy of the leaflet "Enhanced Recovery after having a Cystectomy"**

Trust Response

There is a care pathway document for Cystectomy patients which contains detailed discharge planning information, including prompts and checks which assist in documenting the key stages of the post-operative period and plan of care. That care pathway documentation was not used and the nursing and medical notes do not contain a great deal of detail of Mr Tucker's post-operative progress. The Trust acknowledges the learning opportunity presented here and has implemented the action plan below.

| Recommendation | Action | Source of assurance action embedded in practice | Lead | Deadline | Date completed |
|---|---|---|---|---|---|
| The Cystectomy Pathway patient documentation must be updated and used for all surgical cases no matter what ward to include the latest Cystectomy Enhanced Preparation Event and Recovery Pathway (CEPER) guidance and ensure clear to what patient information is provided and when (with sign off to state completed) and the discharge process/ requirements; | The pathway documentation it to be reviewed and circulated to key stakeholders | Audit of documentation at 3 months | Lead consultant surgeon | May 2018 | |

**(5) Mr Tucker's hospital notes arriving from Michelham Ward were suboptimal, lacking continuity, incomplete and unhelpful**

Trust Response

The Trust acknowledges that the hospital records were not entirely optimal. However, Nursing care records are documented daily, per shift and Mr Tucker's medical post-operative care rounds were also recorded in his patient notes. There was a plan noted however, it was not always confirmed that it was completed. Mr Tucker was transferred to ITU post operatively and all relevant documentation was completed. Mr Tucker was then transferred to the private patient unit on 12 September 2017 at 18:45.

The nursing care plan from the private patient unit documents the following: bloods tomorrow; hourly urine measurements; Fortisip supplements; light diet; physiotherapy; pain team review; stoma team review.

Hourly measurements of urine are noted on the fluid chart 12/9/17 but the fluid input/output is incomplete on 13/9/17.

The pain team reviewed Mr Tucker on 14/9/17 when he reported no pain, but was experiencing nausea and vomiting. Analgesia was amended and adjustment to anti emetics.

A note was made to check pain levels on mobilising and to contact the pain team if further adjustment required.

There are daily ward round records from the medical team, which provide a comprehensive record of the post-operative round which reflects the key stages in post-operative recovery, however they contained limited detail as to how Mr Tucker progressed against the plan.

**The post-operative daily round documentation has since been amended to include more detail.**

(6) **Eastbourne DGH's system for recalling patients to the Urology Ward following discharge, if they need to go by ambulance, is flawed.**

Trust Response

If Mr Tucker was stable when the ambulance crew assessed him, he could have returned to EDGH where he had recently been cared for. The policy for South East Ambulance NHS Trust is to take patients to the ***nearest*** emergency unit to ensure swift access to investigations, imaging and surgical interventions if a patient is highly clinically unstable, as Mr Tucker was. The crew on scene did contact EDGH who had agreed to accept Mr Tucker; however the ambulance crew could not get the ambulance down a long drive and had to call for 4x4 vehicle for this. During the time the crew were on scene, Mr Tucker deteriorated further and the operational manager who also attended the scene made the decision to take Mr Tucker to the nearest hospital which was Royal Sussex County at Brighton.

There was no delay in transfer due to communication between the Ambulance Service and Eastbourne Hospital.

The delay on scene was due to the complex extrication from the home to the Ambulance and the clinical condition of Mr Tucker.

**(7) There is no coherent discharge planning protocol in place for enhanced recovery procedures in respect of urology patients**

Trust Response

A protocol is in place and the discharge process has been reviewed.

- Post-operatively Mr Tucker was discharged from ICU to the private patient unit (patient choice). This is not a specialist Urology Unit, which would have been more suitable for his post-surgery care.

- The discharge notification document did not include the nausea and vomiting and oesophago duodenoscopy (OGD) required to be completed at out-patient clinic. Mr Tucker's bloods or clinical observations upon discharge did not indicate sepsis.

- There is no record of any concerns that were escalated to the ESHT on call consultant or the BSUH surgeon. The team caring for Mr Tucker did not have/identify any concerns other than the nausea and vomiting which they felt was being managed appropriately.

- There are documented care records on 13/9/17 by the physiotherapist who stated that the patient was asleep and there was a plan made with Mrs Tucker to walk with the patient later in the day.

- Mr Tucker's bowels should have been starting to work again before discharge.

- Bowel sounds were noted. Stoma was noted to be healthy and abdomen was soft. The nursing notes note a small bowel movement on 14/9/17.

- On 14/9/17 the physiotherapist reported that patient declined to walk or practise stairs. Cough was noted to be strong and dry and no further input from physiotherapy was required.

- Mr Tucker was reviewed by the medical team, physiotherapist, acute team and stoma nurse prior to discharge.

- The discharge planning documentation was completed in the care record.

- The gastroenterology team were consulted and changed the OGD plan although the documentation around this change of plan is poor.

- There is no record of the post-operative discharge information given to Mr Tucker.

As a result of the learning taken from this episode of care, the Trust will be implementing the action plan below.

| Recommendation | Action | Source of assurance action embedded in practice | Lead | Deadline | Date completed |
|---|---|---|---|---|---|
| Patients undergoing major urology cancer surgery should be cared for on the urology ward, with more experienced doctors and nurses. These patients are not suitable for private patient unit. | Private patient unit advised not to accept bookings for these patients | Admissions monitored | Michelham unit administrator | Feb 2018 | Feb 2018 |
| Urology specialty documentation audit to identify themes and improvements in documentation. | Conduct urology specialty audit to review core criteria and determine if accurately reflects care records. Action identified gaps/learning. | Completed audit | Specialty lead | April 0218 | |
| The urology specialty to agree a robust process for ensuring Electronic Discharge notification is signed/checked by a senior doctor; | Key personnel to be identified to complete documentation for discharge and audit over 3 months | Audit May 2018 | Clinical lead | Doctors identified 1 Feb 2018 | For audit May 2018 |

I trust the above Response sufficiently answers the matters raised in the Regulation 28 Report.

Should you require any further information please do not hesitate to let me know.

Yours sincerely

Dr Adrian Bull
Chief Executive