Inquest touching the death of Tommy Jay Gillman

Response of Sherwood Forest Hospitals NHS Foundation Trust to Regulation 28 report to prevent future deaths.

This is the organisational response from Sherwood Forest Hospitals NHS Foundation Trust to the Regulation 28: Report to Prevent Future Deaths issued by HM Coroner, following the conclusion of the inquest touching the death of Tommy Jay Gillman.

We reiterate our condolences and apologies to Tommy's family, and we hope this response which considers the matters of concern raised by HM Coroner, provides reassurance that the Trust recognises and acknowledges its shortcomings and is committed to ensuring that we learn from this to prevent future deaths.

Matters of concern raised within the report and responses for each point are as follows:

1) At times of high pressure and business, the Paediatric nursing complement is insufficient in the Emergency Department. There are inexperienced Paediatric nurses trying to manage a very high workload, without senior nurse support to try and increase staffing levels on a shift. The Facing the Future (RCPCH) standards for levels of Paediatric nursing are not met.

The Royal College of Paediatrics and Child Health (RCPCH) Facing the Future: Standards for Children in Emergency Care Settings (2018) describe national standards for care applicable to children in Emergency Care settings. Recommendation 10 of these standards states that every Emergency Department (ED) must be staffed with two registered children's nurses on each shift. However, the Care Quality Commission (CQC) and RCPCH recognise the challenges in recruiting Registered Children's Nurses (RNC) and are working to support services through provision of guidance and an audit tool kit.

As a district general hospital recruiting of RNC's is challenging despite active recruitment. Sherwood Forest Hospital (SFH) acknowledge that it is unable to meet the workforce standards outlined by the RCPCH. The following mitigations are in place in line with CQC guidance:

- A profile of when children and young people attend the ED over a 1-year period has been obtained to ensure that RNC's are rostered on at peak times.
- A minimum set of core competencies that adult nurses must have completed prior to caring for a child or young person has been agreed as follows:
    a. Minimum of 18 months post registration experience
    b. Completion of paediatric intermediate life support training
    c. Completion of the internal 2-day paediatric study days
    d. Completion of paediatric sepsis e-learning package
    e. Following completion of the above, an additional day shadowing a trained Registered Children's Nurse will be completed.

- RNC staffing within the ED is recorded on the Trust risk register as a significant risk and is reviewed monthly by the specialty and Trust Risk Committee. This has led to the development of the rotational post (see below).
- Continuous collaborative working between ED and the division of Women and Children to develop a rotation pathway for RNC's is planned to be in place from October 2024.
- ED Adult Nurse released to complete Paediatric Nurse Training (18 months) due to complete in September 2024. This will increase staffing by 1WTE.

Sherwood Forest Hospital provide all newly qualified RNCs with a nominated preceptor, qualified in the same discipline of nursing with at least 12 months experience. All registered nurses within the preceptorship programme undertakes a minimum period of 4 weeks supernumerary practice which includes a Trust Orientation Day and Nursing and Midwifery Induction Programme. During this supernumerary period the RNC preceptee is provided with a local induction pertinent to the ED with a particular focus on children and young people. A preceptor will integrate Trust standards, competencies, objectives and Trust CARE values into practice and contribute to an environment which facilitates learning for the Preceptee to ensure they have appropriate skills to competently undertake their role.

The ED senior leadership team have reviewed the escalation processes in place for proactively reviewing and escalating nursing staffing concerns.

Healthroster, a system for producing rosters which take into account an employee's skills is used to proactively to maximise the likelihood that each department has the appropriate number of staff whilst ensuring there is a safe skill mix. The ED children's area rota is produced by the Band 7 lead nurse a minimum of 6 weeks in advance. An additional Band 5 RN shift has been added to the roster from 4pm-2am to support attendances at peak times. Following the Inquest improvements have been made locally to the Healthroster system to highlight specific nursing shifts for the children's area. This change enables clear identification of where there are gaps in RNC cover thus enabling the ED leads to ensure adult nurses with the minimum paediatric competencies are on duty.

It is not possible to predict sickness and short-term unplanned absence, therefore changes to staffing availability may need to be escalated and acted upon at short notice. At the time of Tommy's attendance, the Band 7 leads were rostered on day shifts and included within the ED staffing figures. In April 2024, a new band 7 supervisory Nurse in Charge (NIC) role has been implemented within ED to ensure there is visible senior support available 24 hours a day for the entire department. At present, the NIC is included within staffing figures, however from July 2024 this role will be supernumerary. Within this role the NIC is required to ensure staff allocation for their shift and the following shift meets the minimum requirements and will be responsible for escalating any concerns to the Division or Duty Nurse Manager to identify additional staff from other clinical areas in the Trust to support ED.

2) Handovers and key conversations between staff, both nursing and medical staff, in ED and with Paediatric staff are not routinely documented, and outcomes from handovers and escalations do not result in clear action plans and allocated tasks.

The Trust recognise the importance of ensuring verbal discussions in relation to a patient's care are documented accurately and contemporaneously within the patients records and that effective handovers are undertaken to ensure unambiguous treatment plans are agreed.

SBAR (Situation, Background, Assessment and Recommendation) is the recognised structure for communication and handing over patients for staff. The ED Registered Nurse local induction covers structured handovers and accountability handover and staff are provided with examples of how to use handover effectively. Whilst structured handovers must be used for any verbal handover there was no documentation requirement to confirm whether this had taken place at the time of Tommy's attendance to the ED. The ED Paediatric triage document has been updated and nurses are now required to confirm an SBAR verbal handover has been provided:

EMAS call sign:	**EMAS pin:**		SBAR recieved
Assigned Nurse ED: (Print) ..... Signed ..... Initials		Date / Time:	☐
Assigned Nurse ED: (Print) ..... Signed ..... Initials		Date / Time:	☐

Compliance with staff signing the accountability handover is to be monitored via the Emergency Department Quality and Safety Assurance Paediatric Monthly Audit registered on AMAT (clinical audit assurance software) and any omissions are escalated in a timely manner to the appropriate managers. The first cycle of audit is June 2024.

SBAR is also a recognised structure for medical handover and all Sherwood Forest clinical staff are required to utilise a structured handover to ensure effective and assertive communication. In addition, use of a structured handover ensures clear recommendations are provided, preventing ambiguity through encouraging clinical staff to repeat the information back to the provider to confirm understanding and allocation of tasks. In addition, changes to the medical model and provision of a designated Tier 3 (previously referred to as a Registrar or Middle Grade) or above Doctor to oversee the care of all children reduces the number of handovers required and improves the continuity of care.

All clinical staff working in ED have been instructed that accurate and contemporaneous record keeping is mandatory, in line with Sherwood Forest Hospitals Clinical Record Keeping Standards Policy (2023). To gain assurance that medical documentation is being completed contemporaneously to a high standard, regular reviews are undertaken, and feedback, education and support provided to any

individuals as deemed necessary. Additionally, nursing documentation is audited monthly, and the audit has a specific question to confirm that all entries made by a student nurse are countersigned by a registered professional thus ensuring a registered nurse has oversight of their documentation.

3) The system for recognising an ill baby in Paediatric ED is not robust- from the point of attendance, through timely triage, timely escalation, and joint assessment by senior ED and Paediatric staff.

SFH provides medical and nursing colleagues with an appropriate range of training specific to their individual roles. In relation to recognising an unwell child or young person in a timely manner, there are a number of tools and processes in place to be used alongside clinical judgement including but not limited to:

Observations recorded and calculated using PEWS on Nervecentre.

At the time of Tommy's attendance to ED children and young people's observations were recorded and calculated manually on paper using the Paediatric Observation Priority Score (POPS). During the Trust's investigation concerns regarding the reliability of this were raised and following extensive consultation between Emergency Medicine and Paediatrics this was discontinued. Children and young people's observations are now recorded on 'Nervecentre' a digital system that allows observations to be recorded and calculated electronically using the Paediatric Early Warning System (PEWS).

To support the visibility of observations every member of clinical staff now has access to a handheld device to record and view observations in real time. In addition, as Nervecentre is used across the organisation for children and young people, the Paediatric specialty have the ability to access patients' observations remotely.

When considering visibility of observations, a further review was undertaken following the Inquest and it was recognised that the methodology to monitor whether patients were receiving observations at the required frequency in real time required improvement. Within both the major's area and children's and young people area large screens which provide a Nervecentre oversight dashboard of a specific task have been installed. The location of these was carefully considered to ensure there was no information governance risk whilst ensuring they were in a location easily visible to departmental staff. Each screen is set to live observation view which enables staff at a glance to identify any patient with an elevated PEWS and time repeat observations are required in line with PEWS escalation guidance. Each patients current PEWS score has a coloured background which automatically updates, White represents scores 1-5, Green 6-8, Amber 9-12 and Red 13 and above. In addition, the time due changes to red if observations become overdue thus facilitating easy identification of which patients are acutely unwell.

With the introduction of the new NIC role, there is now a designated accountable Band 7 lead responsible for ensuring these screens are effectively utilised and monitored to

ensure the staff caring for patients with elevated PEWS Scores are supported by a senior member staff.

Children and young people escalation tool.

In conjunction with changes to visibility of observations, and implementation of a supervisory NIC role the Children and Young People escalation tool has been reviewed to ensure there is clear guidance on escalation triggers and the actions required. One of the specific triggers listed is in relation to triage times thus ensuring all children and young people provide timely reviews. A copy of the Children and Young People escalation plan within appendix 1 has been circulated to all clinical staff within the ED, however staff have been instructed this is not to be used in isolation and clinical judgement and parental/carer concerns should always be taken into consideration. Use of the updated Children and Young People escalation tool will aid timely escalation of any issues identified, ensure senior support is available and appropriate plans implemented to maintain patient safety.

Paediatric sepsis e-learning.

The Trust paediatric e-learning training package has been re-introduced as mandatory for all medical and nursing staff within the ED from 1st May 2024. Compliance is monitored at divisional level fortnightly and reported to the Trust Sepsis group for assurance.

In addition to the above training currently in place to support staff, the Paediatric Sepsis 6 Care Bundle, a document to screen and identify children at risk of sepsis and outline the appropriate treatment is under review by Emergency Medicine and Paediatrics to be completed by August 2024. The proposed changes include specifying that patients with Trisomy 21 and babies under the age of 3 months are at higher risk of developing sepsis to ensure this is taken into consideration when deciding whether to trigger commencement of sepsis treatment.

Implementation of core competencies to care for Children and Young People.

Recognition of an acutely unwell child is the responsibility of both medical and nursing staff within the department. As previously set out, a set of core competencies that adult nurses must have undertaken to care for children and young people is in place. The Standard Operating Procedure for Children and Young People within the Emergency Department, (see appendix 2) has been updated to reflect the new minimum training requirements for medical staff to ensure they have the appropriate skills to effectively identify an unwell child. Staff who do not meet these criteria are no longer directly responsible for the care of children and young people in the ED.

Increase in senior staff availability.

At the time of Tommy's attendance, there was no supervisory Band 7 Nurse in Charge shift. This role is now embedded into the Healthroster, with shifts filled for the

preceding six weeks. This role provides 24-hour senior nursing support to staff caring for children.

Following the Inquest, a further review of Paediatric ED staffing with specific reference to medical cover was undertaken and the medical model of clinicians responsible for the care of children and young people has been amended. The ED now has a designated Tier 3 or above Doctor responsible for caring for this cohort of patients with the support of the consultant in charge.

A Senior Review and Out of hours ED Consultant Call Criteria has been produced and implemented to provide additional guidance as to when a Consultant should be contacted out of hours. This has been shared with all Clinicians. Consultants have confirmed they are engaged and actively promote and encourage staff to contact them for support and guidance. It is however acknowledged that the criteria set out within appendix 3 is not an exhaustive list and any concerns which staff feel requires discussion with a Consultant should continue to take place.

Location for caring for children when the CYP area is closed out of hours.

Previously, children who required care within ED outside the hours of 09:00-02:00 were cared for in various locations across the department. This practice has been reviewed and out of hours all children presenting with a medical complaint are now cared for within a designated area within Majors. Caring for children and young people in a specific area enables the Tier 3 Doctor responsible to have improved oversight and promotes visibility of the patients.

Collaborative working with the Paediatric Specialty.

Sherwood Forest Hospital actively promote interprofessional working. Within the ED children and young people are regularly referred to the Paediatric specialty team through a verbal referral process. Through utilisation of a structured handover clinicians can obtain the required information to agree a plan of care and confirm allocation of any tasks and the priority for these. Joint assessments with a member of both Paediatrics and ED present at the same time are undertaken where deemed necessary, for example an acutely unwell child in the resuscitation area requiring intubation.

A Children and Young People's Working Group has been established with membership from senior medical, nursing and operational staff from the Urgent Emergency Care and Women's and Childrens Divisions. The group is reviewing current policies and Standard Operational Procedures relating to Children and Young People to include opportunities for joint working, clinical pathways, recruitment and operational working.

There is continuous cross-specialty teamwork between the Emergency Department team and Paediatrics to ensure patients receive the best possible care utilising each area's expertise. Collaborative reviews facilitate shared learning and system improvements supporting timely implementation of escalation where required.