APPENDIX A: Specialist medical and nursing review criteria for the 32 patients who died within the Emergency Department:

A. Agreed criteria to review the care provided to patients referred to a medical specialty:

- An overview of the care provided to the patient
- Length of stay in ED including from decision to admit (DTA)
- Was there a ReSPECT form in place?
- Were any medication issues / concerns identified?
- Were observations completed in accordance with National Early Warning Score (NEWS2) criteria?
- Was the patient seen by more than one specialty consultant during the time in ED?
- Were any issues with 'ownership' of the patient identified, including difficulties accessing the specialty team?
- Were there any discrepancies identified with protocols used in ED to those which would have been used if the patient had been admitted to the ward?
- Was admission to the ED appropriate in the first place?
- Review of the post-take ward round – if multiple ward rounds, were there problems identified with the plan of care / changes to the plan of care?
- Were there any human factors issues identified relating to the staff working outside their usual area of practice as a result of patients who should have been admitted to a ward being cared for by ED staff? It was acknowledged that this may be difficult to identify this from the notes, however consideration would be given during the review of the patient.
- Were any communication issues identified?
- What was the time interval between the ED referral to specialty and the subsequent medical review (as detailed within the medical records)?

B. Agreed criteria to review the nursing care provided to the patients:

3	**Documentation**
3.01	Has the CAS card been completed in full within 2 hours?
3.02	CQC R31 – Check that the Manchester Triage Score has been recorded – this will be either recorded on the CAS card or in SEMA
3.03	CQC R31 - Check the time of arrival for adult patients, has the patient been assessed within 15 minutes of arrival in ED?
3.05	CQC R31 Has the patient had on arrival in ED a complete set of observations documented in full? (Including pain) *(Vitals in place for Adults, otherwise paper charts)*
3.06	CQC R31 Were observations completed in line with the frequency set?
3.07	Has the patient safety checklist has been commenced with in 1 hour of arrival and reviewed with in the time frame?
3.08	CQC R31 - During initial assessment has Sepsis risk been completed?
	(CAS card pg2; Sepsis tool pg4
3.09	CQC R31 - If patient is high risk has appropriate action been taken and actioned timely as part of Sepsis 6? (N/A = not sepsis)
3.10	All entries should be dated, timed and signed with the first entry from the RN on shift to include printed name and designation (in line with NMC standards including counter signatures for student nurses)?

3.11	Identify a patient who is awaiting admission to a ward - Is transfer supported with clear and concise documentation?
3.13	The prescription chart has a patient label or full patient details
3.14	The prescriptions are clearly legible with date, time, dose and signature of prescriber *(NB. it is good practice rather than a legal requirement for Dr's to print their name)*
3.15	Check the medications are prescribed and administered correctly.
3.16	Same chart, has the allergy section has been completed on the prescription chart.
3.17	Same prescription chart, have any omission code/s have been recorded correctly and action recorded?
3.18	Check a patient who is receiving oxygen therapy, has this been prescribed properly?
3.19	If the patient is on anti-biotics has the reason and duration for prescription been completed?
3.20	Is there documentation of ID wristband.
	- Known allergies and intolerances must be documented or no known drug allergies (NKDA) written in the box. Document as much information as possible about the nature of reaction and sign/date the entry. This should be completed by the prescribing doctor but may be completed by a registered Nurse, Pharmacist, Pharmacy Technician (Pharmacy staff can help with identifying reactions) o. All allergies should be reported to sath.allergyalerts@nhs.net o
4	**Tissue Viability**
4.01	Has a Waterlow Score been documented within 6 hours of attendance?
4.02	If patient identified as at risk is there documented evidence that pressure areas have been evaluated whilst in ED?
4.03	Check whether patient is being repositioned according to the requirement?
6	**Nutrition & Hydration**
6.01	Does the patient require fluid balance monitoring as per Trust guidance - Has a fluid balance chart been commenced?
6.02	If the patient is receiving IV fluids - Are the fluids prescribed and accurately correlate with the fluid balance chart?
6.03	Evidence of food provided
6.04	Is there a blood glucose is documented?
6.05	Evidence of nurse's interaction with family members?
6.07	Evidence of ReSPECT form?
6.08	Evidence of Swan Care Plan?

APPENDIX B: Comparative data for Q4 2021-22 and 2022-23

A deep dive review of patients who died in the ED within Q4 2022-23 was not the primary focus of this assurance review. However, as the increase in deaths within the ED was sustained throughout this period, some preliminary comparative data was obtained which was used to support the Q3 2022-23 review detailed in section 4. This includes:

- Comparative data from Q4 2021-22 to confirm whether the increase in deaths related to patients who were under an ED Consultant at the time of their death or whether they had been referred to a specialty team and were awaiting admission to a hospital bed. Inpatient mortality data reviewed.
- Length of stay for patients referred to a specialty team.
- Expected versus unexpected deaths.

No deep dive clinical reviews have been undertaken to explore the quality of the medical and nursing care provided to patients within this Q4 cohort and no wider triangulation has been completed at the time of writing this paper.

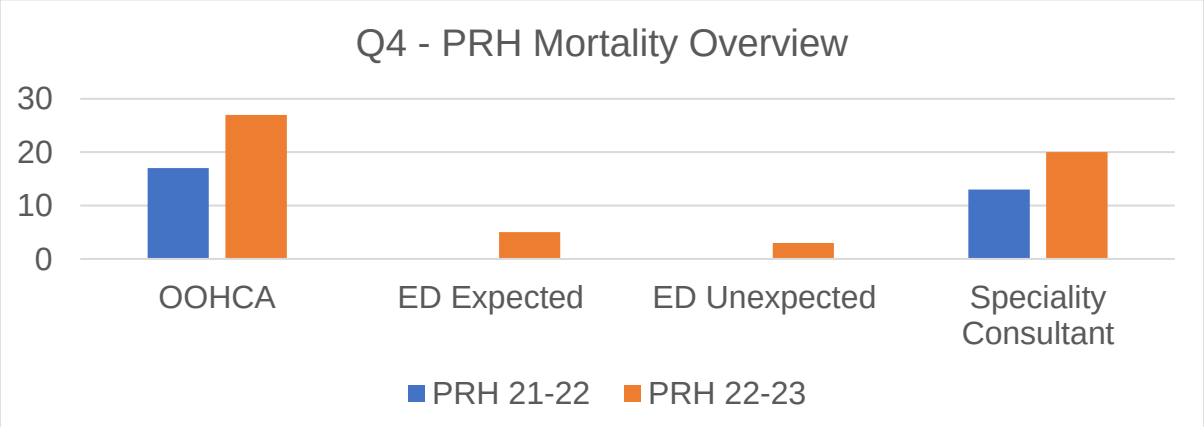
In accordance with the same questions posed for deaths during Q3 2022-23, the following were considered:

1. Was there an increase in the number of deaths in the ED specifically under the care of an Emergency Consultant during Q4 2022-23?
2. Was the increase in mortality rate during Q4 2022-23 due to the increased length of stay of speciality patients who remain in the geographical location of the ED due to wider capacity and flow issue across the Trust?
3. Where do the patients under the care of an Emergency Medicine Consultant reside?
4. Was there an increase in the number of expected deaths?
5. Is there any concern around 30-day mortality?

1. Was there an increase in the number of deaths in the ED specifically under the care of an Emergency Consultant during Q4 2022-23?

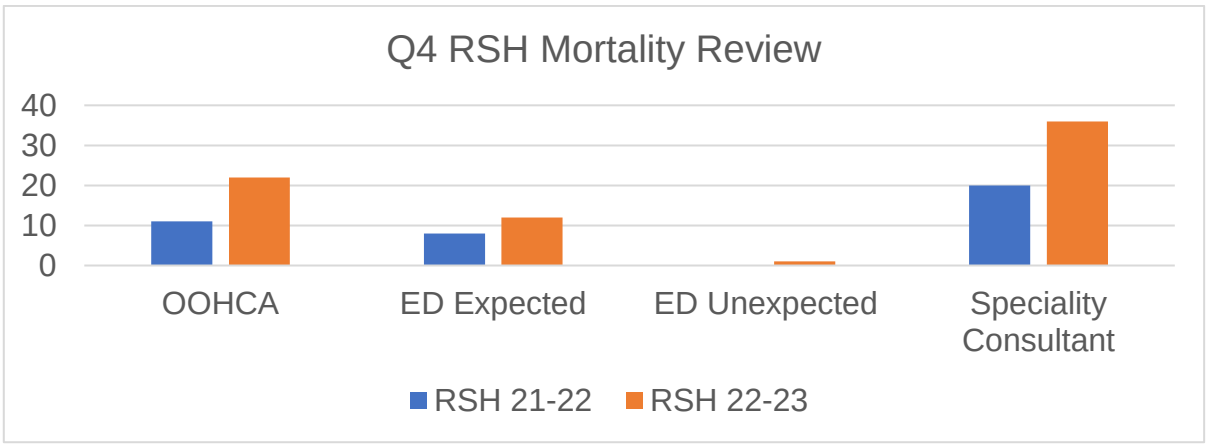
PRH

Although there is an increase in the number of deaths under the care of an Emergency Medicine consultant, there is a significant increase in the number of pre-hospital cardiac arrests and those who are under the care of a speciality consultant.



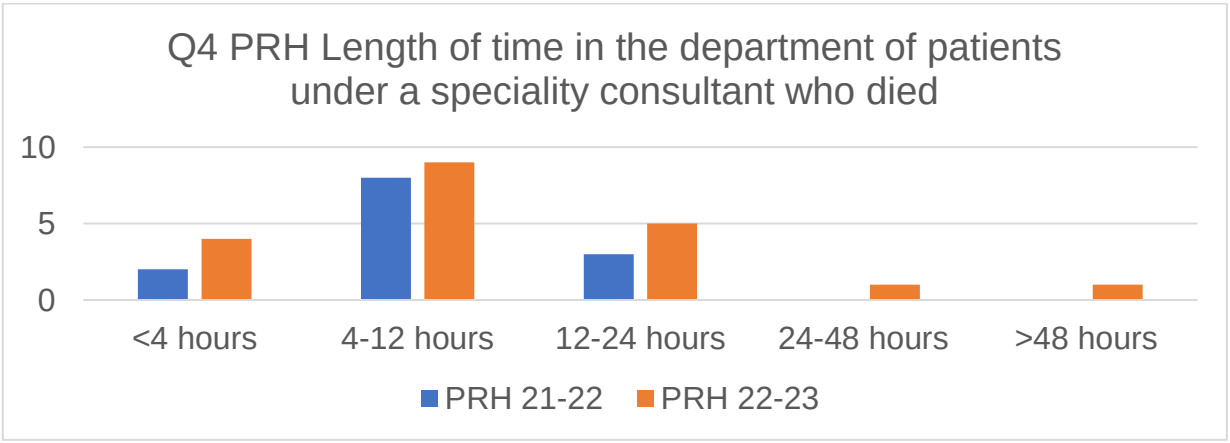
RSH

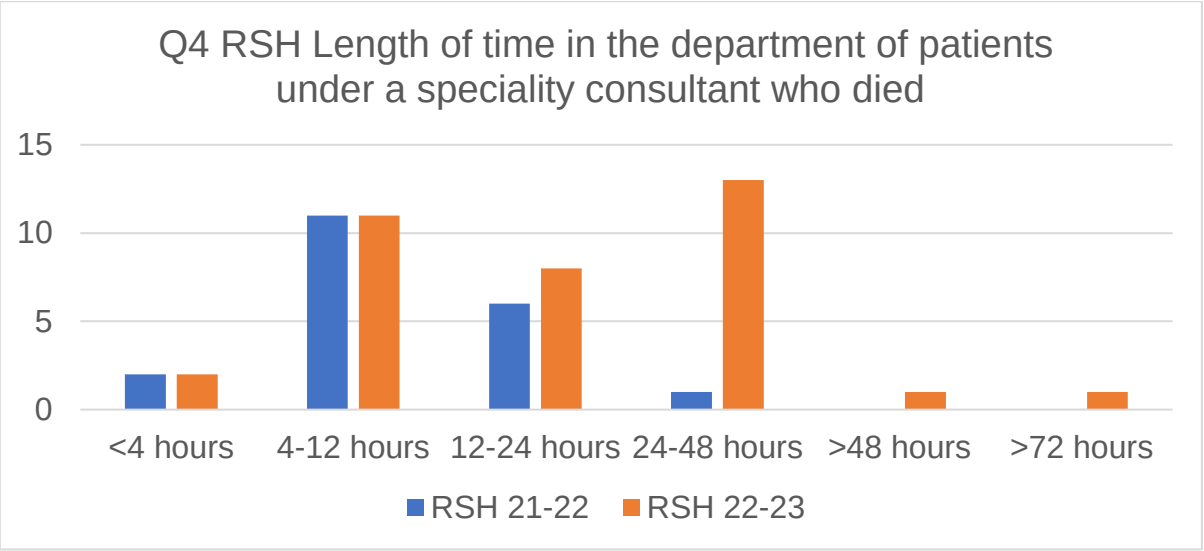
Similarly, an increase in the number of deaths under the care of an Emergency Medicine consultant was seen, and a significant increase in the number of pre-hospital cardiac arrests and those who are under the care of a speciality consultant.



2. **Was the increase in mortality rate during Q4 2022-23 due to the increased length of stay of speciality patients who remain in the geographical location of the ED due to wider capacity and flow issue across the Trust?**

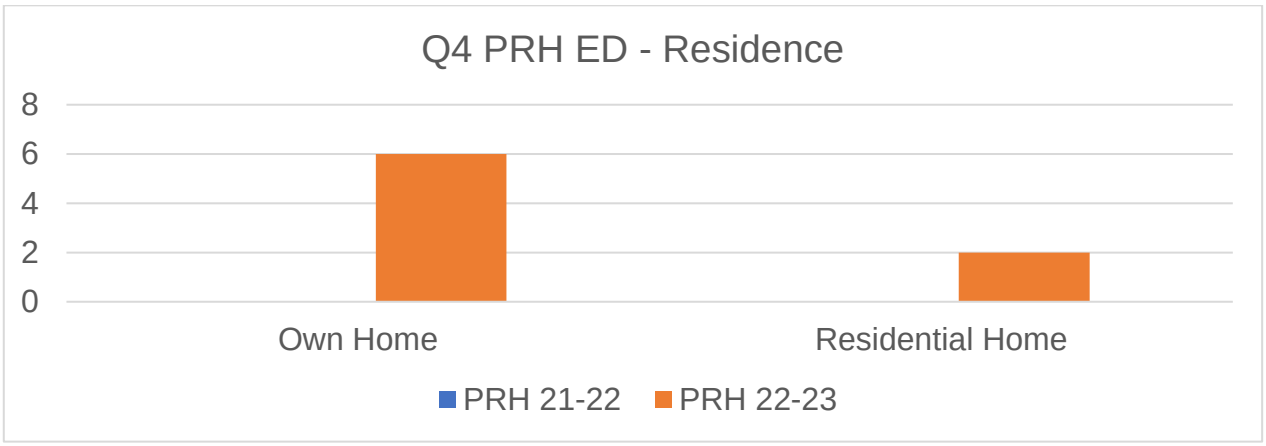
On both sites the average length of stay in the ED increased. This resulted in patients residing in the Emergency Departments routinely for over 12 hours in both Emergency Departments. If there had been capacity on the wards, a significant number of patients would have died on the ward rather than within the Emergency Departments. See graph below for the number of patients who died within the Emergency Department, stratified into <4 hours, 4-12 hours, 12-24 hours, 24-48 hours, >48 hours and >72 hours.

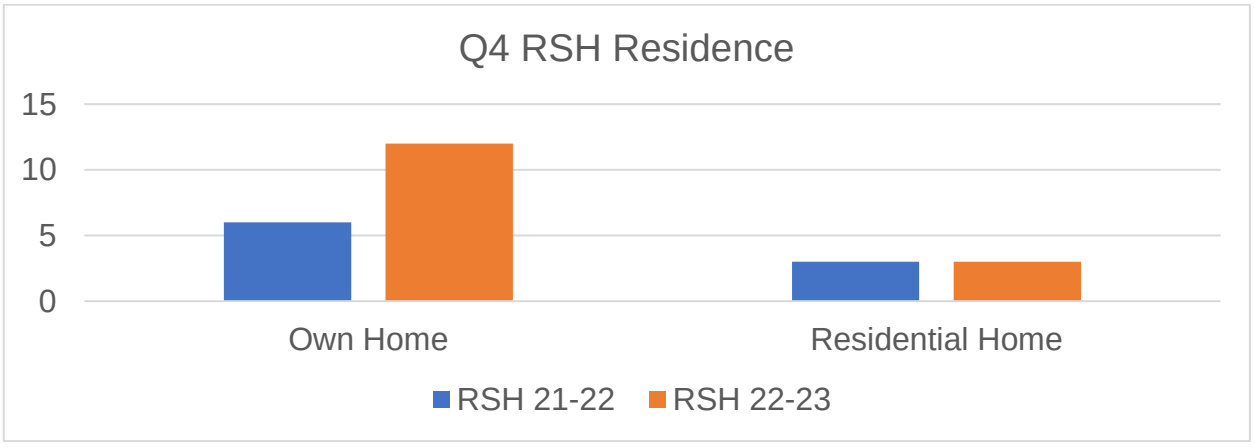




3. Where do the patients under the care of an Emergency Medicine Consultant reside?

The data demonstrates an increase in the number of people presenting from their own homes who died in the ED under the care of an ED Consultant during Q4 2022-23.

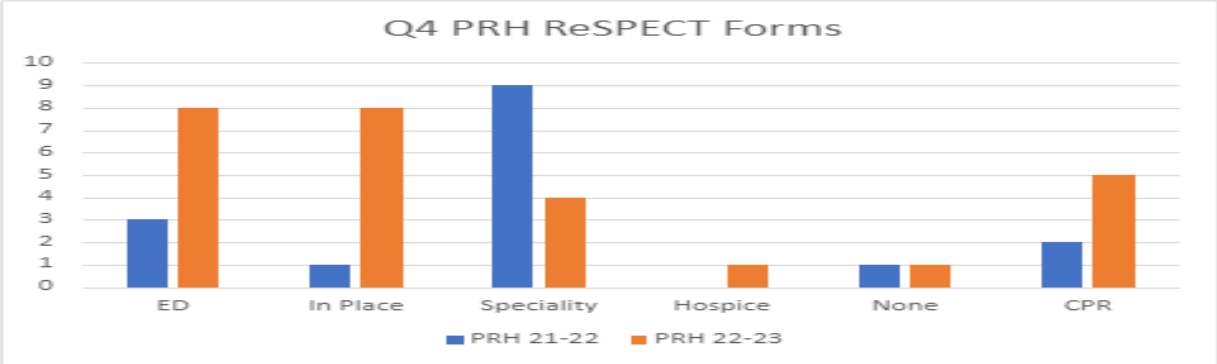




4. Was there an increase in the number of expected deaths in Q4 2022-23?

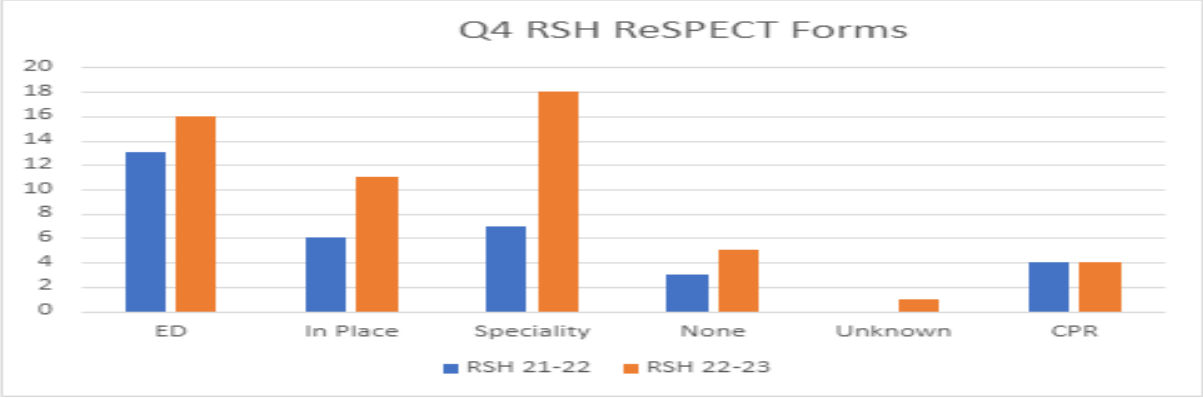
PRH

In PRH there is an increase in the number of ReSPECT forms being completed by the Emergency Medicine team and an increase in the number of patients who present with a ReSPECT form. The number of patients who underwent CPR increased from 2 to 5.



RSH

There was an increase in the number of ReSPECT forms done by the Emergency Medicine team, the speciality teams and an increase in number of patients who presented with a ReSPECT form in place. The number of patients undergoing CPR did not change.



5. Are there any concerns around 30-day mortality during Q4 2022-23?

January 2022 to March 2022

PRH

There were seven patients who died within 30 days of discharge who presented to the ED.

4 patients were under the care of the medical team.

1 patient was under the care of the surgical team.

2 patients were discharged by the ED team.

- Patient 1 – under palliative care team and patient requesting symptomatic relief.
- Patient 2 – exacerbation of COPD – patient requested to be discharged.

RSH

There were seven patients who died within 30 days of discharge who presented to the ED.

3 patients were under the care of the medical team.

1 patient was seen by the medical team in the ED and was discharged.

3 patients were discharged by the ED team.

- Patient 1 – presented with AF with a fast ventricular response and troponin raise. Re-presented haemodynamically unstable with AF.
- Patient 2 – treated for TIA. Seen in TIA clinic. Also recalled due to raised D-Dimer and had CTPA (normal).
- Patient 3 – seen by frailty team and discharged to community hospital.

Jan 2023 to March 2023

PRH

There were nine patients who died within 30 days of discharge who presented to the ED.

8 patients were under the care of the medical team.

1 patient was under the care of the ED.

- Evidence of infection and decreased mobility. Discharged home on oral Abx. Re-presented 2 days later in multi-organ failure.

RSH

There were ten patients who died within 30 days of discharge who presented to the ED.

7 patients were under the care of the medical team.

3 patients were under the care the ED.

- Patient 1 – Unrelated attendance.
- Patient 2 – Treated for cellulitis. Represented 9/7 later.
- Patient 3 – Presented with chest pain. Trop –ve and bloods nil significant. Cardiac arrest the following day.

APPENDIX C: Case reviews of patients referred to a medical specialty, surgical specialty and patients under an ED Consultant

(Removed for Public Board due to the risk of patient identification)

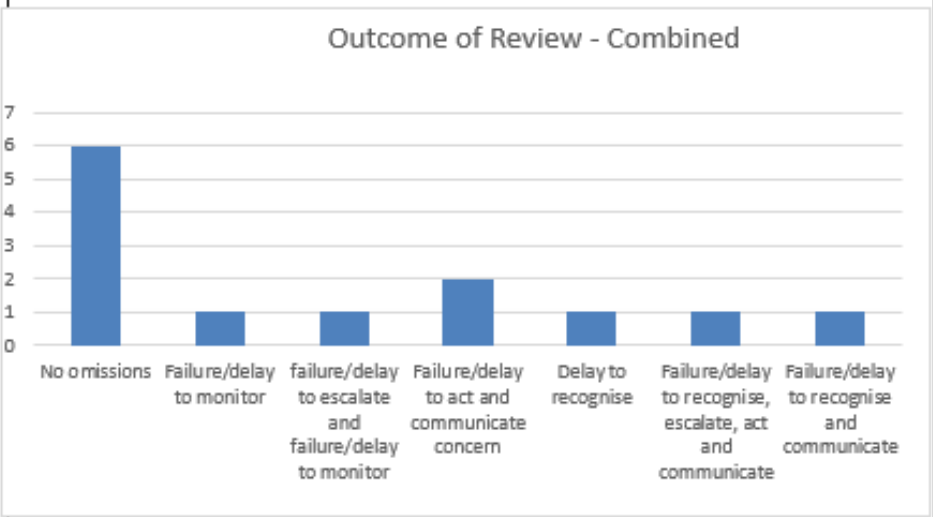
APPENDIX D: Summary of learning identified for SJRs completed within the review

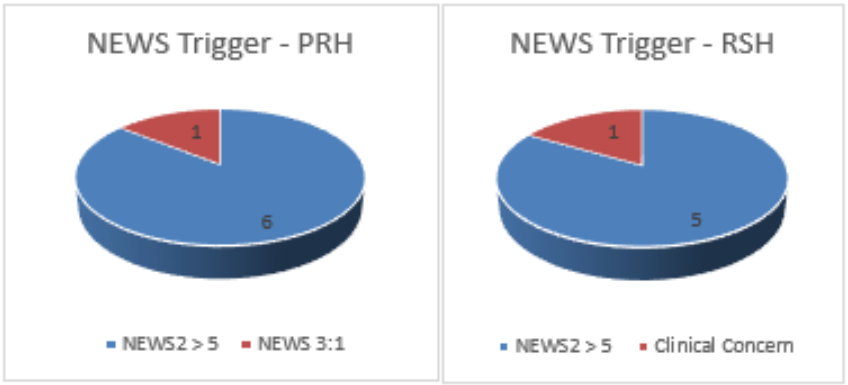
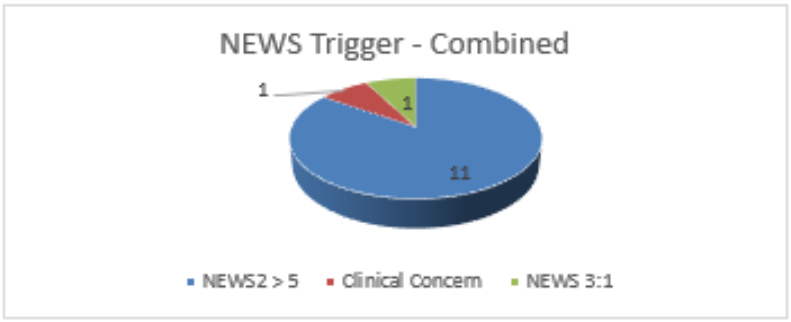
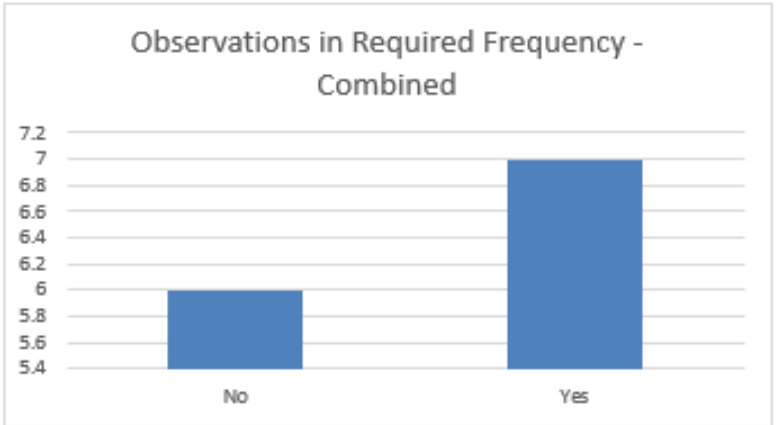
(Removed for Public Board due to the risk of patient identification)

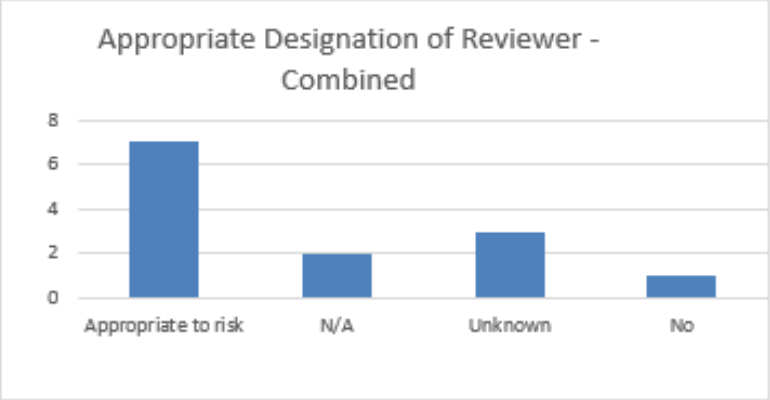
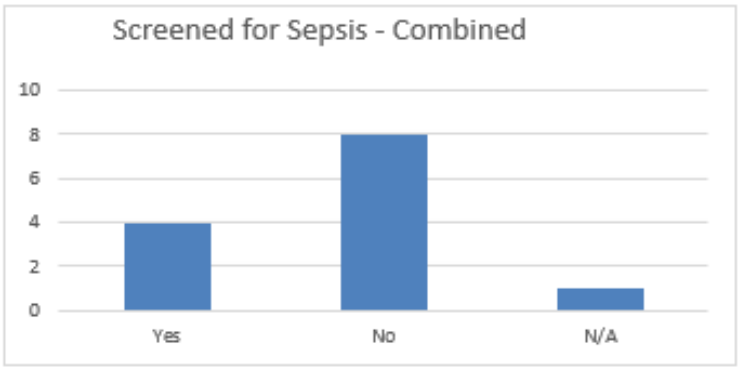
APPENDIX E: Specialist review Of 13 patients identified with sepsis from the cohort of 32 patients by Deteriorating Patient Specialist Leads

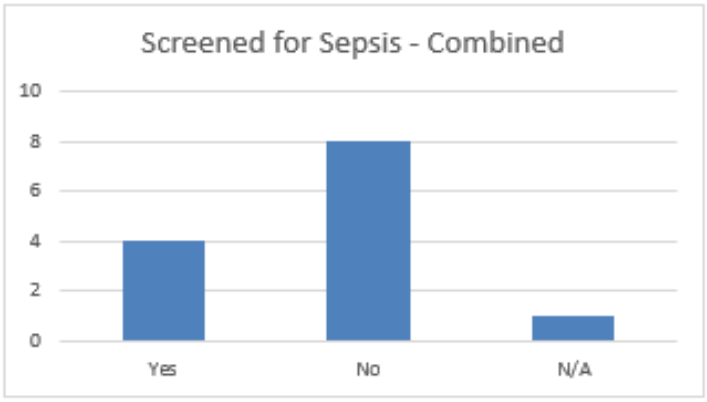
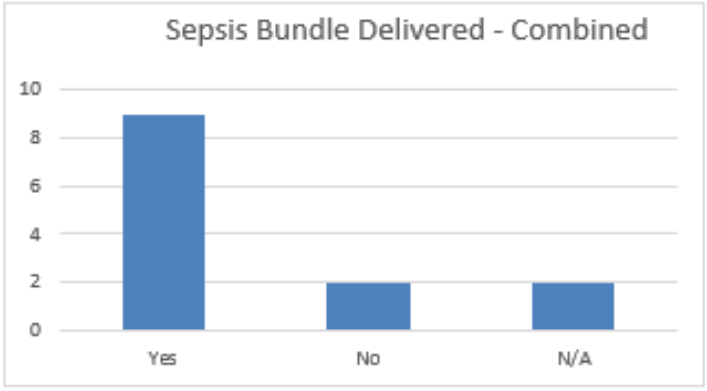
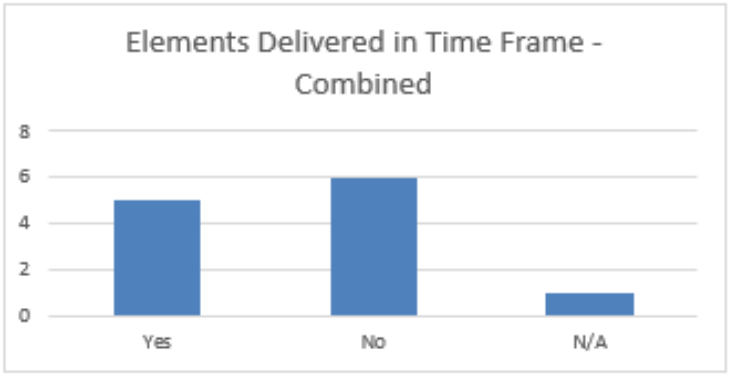
DETERIORATING PATIENT & SEPSIS

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Deteriorating Patient and Sepsis - Mortality Validation Report		
Report Date: 13/11/2023		**Report of:** Mortality ED Validations undertaken by the Deteriorating Patient and Sepsis Specialist Nurses
Requested by:		Learning From Deaths Committee (LFD) and ED Governance Committee
1	**Overview**	The team reviewed the patient medical notes and cas-cards for 13 patients across the two sites (RSH 6 / PRH 7) to review the processes for patient deterioration and Sepsis. The review was evaluated based on patient: **Recognition** – observations within recommended frequency, **Escalation** – documented timely escalation in keeping with deteriorating patient / Sepsis risk and **Response** - response time, designation of reviewer and associated action in keeping with level of risk Deterioration / Sepsis. This was informed and underpinned by the following policies, • Deteriorating patient policy Microsoft Word - 608001183_2610.doc (sath.nhs.uk) • Adult (non-pregnant Sepsis Recognition and Management ViewPDFDocument.asp (sath.nhs.uk) From examining the patient notes we then ascertained if there were any omissions along this process and categorised them as follows  Reassuringly nearly 50% of those reviewed had no omissions in care around sepsis or deterioration. The remaining 7 comprised a combination of omissions across recognitions escalation, monitoring and communication. Whilst there is learning to be gleaned from this review which would benefit the departments and division the thematic findings are consistent and representative of the wider system issues along the deteriorating patient pathway –it would therefore be greatly appreciated the teams and division would share any learning from their experiences in this process.
2a		Most of the patients triggered an aggregate score of ≥5 • With 11/13 = NEWS2 ≥5

	NEWS triggered by	• 1 patient triggered on a 3:1 parameter. • 1 patient triggered on clinical concern.  
2b	**Observations in Required Frequency** *As indicated by NEWS2 RCPH / Sepsis Guidance*	• We monitor completion of next observations in the desired frequency as timely monitoring is widely acknowledged as key to recognition and timely intervention in the deteriorating patient. • In total 7 of the 13 patients were reported in line with guidance time frames relative to the identified risk (risk of deterioration / risk of sepsis) this was broken down by site as: • PRH 5/7 patients had their next ob's in the desired timeframe for the risk, in RSH the ratio was inverted with only 2 of the 6 meeting this metric. 
2c	**Response** *Were these patients reviewed in the correct time frame according to risk .*	• In line with guidance and depending on the risk (Deterioration / Sepsis) we monitor the timeframes from the point of the patient triggering, to being reviewed. • 12/13 patient were reviewed in the correct timeframe according to identified risk with only 1 of the patients not fulfilling this timeframe this patient was located at PRH.

		
2d	**Response** *Designation of Reviewer*	• Similarly, the designation of the reviewer was observed as this varies depending on the level of risk, so we looked at whether in the cases identified the clinician reviewing was in keeping with that recommended for the level of risk (Deterioration / Sepsis) 
3	**Sepsis** *Overview*	• For this element the cases were assessed for evidence that (irrespective of NEWS2 score) patients were assessed for risk of Sepsis and screened where appropriate. • As per the organisation standards for those screened with an outcome of high-risk, we reviewed for evidence of delivering the Sepsis bundle (antibiotics within 60 mins) and if this was not deemed necessary that documentation provided sufficient detail of clinical judgement allowing for deviation from this process.
3a	**Sepsis** *Screening*	• A total of 4 /12 of those that should have been screened were screened. • Broken down by site shows, PRH 2/7 RSH 2/4 that should have been screened were screened (one was exempt on the basis of having and Palliative / end of life care pathway in place 

3b	**Sepsis** *High risk of Sepsis outcome management*	• Of the 13 audited 11 had high risk indicators of Sepsis (4 of these were screened)  • 9/11 received elements of the Sepsis bundle – the documented evidence does not give sufficient reasons for the two which did not receive the bundle. In one case there appeared a failure to recognise, in the second whilst there was evidence of escalation to higher levels of care, documentary evidence around treatment planning is lacking.  • For those that received the bundle we looked at how many received them in the desired time frame – the focus here is receipt of antibiotics within 60 mins. In RSH 3/3 were delivered in the desired time frame In PRH 2/6 were delivered in the desired time frame 
4	**Incidental Findings**	• In 5/13 cases the initial obs were not inputted onto vitals and so the elevated NEWS2 score did not prompt sepsis screening • In some cases, the documentation did not indicate the seniority of doctor undertaking the review. Where the seniority of doctor reviewing did not meet the desired seniority there was nothing documented to explain why.

		• There were absences of nursing documentation around escalation of deterioration / Sepsis risk and also medical documentation around response to identified risk, treatment plan and discussions with higher levels of care. • In some cases, the identification of expected death was delayed and as such there were missed opportunities to support the patient and family experience of dignified death.	
5	**Notable Practice**	• PRH demonstrated excellent recognition and management of Sepsis risk in 3 occasions meeting the 60-minute timescale and delivering all elements of the bundle. • RSH demonstrated excellence along the deteriorating patient pathway with timely delivery of the Sepsis bundle even when Screening wasn't undertaken, fluid balance monitoring and serial lactate monitoring was also highlighted as excellent in one case. Evidence of escalation to higher levels of care and determining ceilings of treatment was also considered to be well demonstrated.	
6	**How this learning will be disseminated**	• If the teams could feed back to us on the findings within this report and how this will be shared, and learning taken forward into the clinical areas we can share this at the DPG.	
Report compiled by		*Angela Windsor*	*Deteriorating Patient Nurse Specialist*

APPENDIX F: CHKS Peer Group

The SaTH Trust Peer 2020 comprises the following trusts:

Bedfordshire Hospitals NHS Foundation Trust

County Durham & Darlington NHS Foundation Trust

East & North Hertfordshire NHS Trust

East Lancashire Hospitals NHS Trust

Gloucestershire Hospitals NHS Foundation Trust

Northern Care Alliance NHS Foundation Trust

Royal Cornwall Hospitals NHS Trust

United Lincolnshire Hospitals NHS Trust

Wirral University Teaching Hospital NHS Foundation Trust

Worcestershire Acute Hospitals NHS Trust