Surrey and Sussex NHS
Healthcare NHS Trust

Please reply to:
[redacted]
Chief Nurse
☎ : [redacted]
Fax : 01737 231769
Email: [redacted]

Our ref: [redacted]

Headquarters
East Surrey Hospital
Canada Avenue
Redhill
RH1 5RH

Tel: [redacted]
www.sash.nhs.uk

H M Assistant Coroner Anna Crawford
H M Coroner for Surrey
Station Approach
Woking, Surrey
GU22 7AP

23 February 2021

By recorded delivery

Dear Ms Crawford

I write in response to the Preventing Future Deaths Report addressed to Michael Wilson, Chief Executive, and received on 6 November 2020, following the Inquest into the death of Mrs Linda Doherty.

Please find attached the Trust's response to the Matters of Concern addressed in your report dated 5 November 2020. I am aware from from earlier communications with the family of Mrs Doherty that they do not wish to receive direct correspondences from the Trust, and I would therefore appreciate it if you could ensure a copy of the enclosed report is sent to them, via their legal representatives. A copy of the report has been sent to the CQC.

I am grateful to you for the additional time you have afforded the Trust to respond, and and I also appreciate the family's patience.

Yours sincerely

[redacted]

Chief Nurse

CONFIDENTIAL
Serious Incident Report **V18 17.2.21 post meeting**

Incident Number	[redacted]
Date of Incident	7th August 2017
Date reported on Steis	3rd November 2020
Grade	1
Date submitted to CCG for closure	
Closure due date	31st January 2021

Please confirm that the following detail is included in the report	
Root Cause identified	Yes
Being Open policy followed	Yes
Lessons Learned	Yes
Recommendations	Yes
Mechanism for shared learning	Yes
Report anonymised	Yes
Action Plan states accountability and date for completion of actions	Yes
Was a SVA alert raised? (if appropriate)	N/A
If applicable, was a SAAR taken forward? If not, please state reason why?	N/A
SAAR Outcome and Allegation	N/A
Any actions resulting from the SAAR process relating to SASH are included in the RCA Action Plan	N/A
Recommendations/Further information requested have been updated	

Report prepared by	Associate Medical Director	
Contact details	[redacted]	
Report reviewed by SIRG		Serious Incident Review Group (Chair signature)

Scrutiny Group Use Only

Full RCA provided	
Robust Root Causes	
Robust Action Plan	

Root Cause Analysis Investigation Report

Incident Reference: [redacted]

Incident Description:

The patient, a 69 year old lady, died in August 2017 at the end of a 3 month stay in hospital following emergency surgery for recurrent bowel obstruction due to adhesions and subsequently-diagnosed Crohn's disease. An inquest reported that for the last month of her life, it was not recognised that she was suffering from malnutrition, weight loss and intestinal failure.

Following the inquest a Regulation 28 Preventing Future Deaths report was issued and an SI investigation was opened at SASH to review the matters of concern raised by the Coroner and to provide the Trust's response.

Incident Date:	7th August 2017
Date Incident Reported:	4th November 2020
Incident Type:	Care implementation
Datix Reference Number:	[redacted]
Speciality:	General surgery
Actual Effect on Patient:	Patient experienced malnutrition on the ward and subsequently died.
Actual severity of the incident:	Severe
Level of Investigation:	Serious incident investigation
Involvement and support of patient and relatives (application of Duty of Candour legislation):	The chief nurse wrote to patient's husband following the inquest on 20th November 2020. In an email received from the family's solicitor, further direct contact was requested via the solicitor's office.
Detection of Incident:	Coroner's inquest conclusion
Immediate Actions Taken:	Review of dietitian provision in the Surgical division

Pre-investigation Risk Assessment:

A Potential Severity (1-5)	B Likelihood of Recurrence at that Severity (1-5)	C Risk Rating (C = A x B)
5	2	10

Terms of reference:

Purpose of investigation:

To consider the matters of concern raised by the Coroner in a Regulation 28 Preventing Future Deaths report following the inquest, and to use this information to ensure that future harm to patients has been significantly reduced since this patient's care, and to identify any further issues arising which the Trust needs to address.

Key issues to be addressed:

Extracted from the Coroner's Regulation 28 Preventing Future Deaths report:-

1. To ensure that the appropriate procedures are in place for recommendations stemming from MDT meetings to be actioned appropriately.

2. To ensure that staff are sufficiently trained in how to score MUST charts.

3. To ensure that procedures are in place to:-
   (i) Identify those patients who require food charts
   (ii) To ensure that they are properly completed.

4. To review whether any additional measures or training are required to prevent delays in acting on a patient's significant weight loss in the future.

5. To ensure that appropriate end of life policies and procedures are in place and that staff are sufficiently aware of them.

In addition to the concerns raised in the Regulation 28 report, the investigation also considered the following issues that had been highlighted during the inquest:-

- The missed opportunity to commence TPN feeding.

- A review of the current dietetics provision in the Trust in 2020.

Background and context:

The patient, a 69 year old lady suffered an acute colonic perforation whilst on a cruise near Honduras in September 2016. She underwent an emergency laparotomy and Hartmann's procedure at a local hospital. She was repatriated back to the UK for ongoing rehabilitation, and after returning home she developed a DVT and had ongoing abdominal pain. In November 2016, an ultrasound scan by her GP identified a suspicious abnormality in her gallbladder for which she was referred to the upper GI MDT, and after further investigation with CT and repeat ultrasound, she underwent a cholecystectomy and partial liver resection at the Royal Surrey hospital in February 2017. The final histology was benign. At around the same time, she had already been referred to the colorectal surgical team for consideration of stoma reversal, and was seen in the colorectal clinic in January 2017, when a colonoscopy was planned for May 2017, with a view to possible stoma reversal later in the year.

Following the cholecystectomy, the patient continued to experience episodes of abdominal pain, and was admitted to hospital in March with presumed adhesional small bowel

obstruction, confirmed on CT. In April, a colonoscopy was performed which was normal apart from diverticular disease, then on 8 May 2017, she was re-admitted to East Surrey hospital complaining of abdominal pain and poor stoma output. A diagnosis of subacute adhesional bowel obstruction was made and she underwent a laparotomy and reversal of the Hartmann's procedure with formation of loop ileostomy on 11 May 2017. At operation, she was noted to have dense adhesions throughout the abdomen, and a small bowel mass involving the terminal ileum, which was also resected. Her initial recovery was slow, with a prolonged ileus, and she was briefly discharged to the ward on 2 June, before returning to ITU on 3 June with urosepsis. On 9 June 2017, the histology report from her operation was released which diagnosed Crohn's disease, and medical treatment with steroids was commenced immediately.

By 23 June 2017, the patient was improving and was transferred to Copthorne Ward and in early July 2017 the various teams involved in her care were planning her discharge home. There were fluctuating signs of progress, but by 1 August 2017, she had begun to deteriorate again and there was inflammation in her small bowel, due to the Crohn's disease.

On 4 August 2017, she was diagnosed with intestinal failure due to Crohns disease and by 5 August 2017 an end of life pathway was commenced and she sadly died on 7 August 2017.

The inquest was opened on 10 August 2017 and took place on 21-22 May 2019 but did not conclude. The hearing resumed on 22–23 October 2020 and the conclusion from the Coroner was received on 27 October 2020.

Medical cause of death

The Coroner returned a medical cause of death as:

1a sepsis and acute kidney injury

1b malnutrition

1c Intestinal failure secondary to Crohn's disease and ileac resection, and inadequate nutritional intake from 23 June to 2 August 2017

The Coroner returned the following narrative conclusion:-

"On 2 December 2016, the patient underwent a CT scan in relation to a suspected mass in her bowel. On 20th December 2016 the results of a CT scan were discussed at an upper GI MDT meeting at East Surrey Hospital and it was agreed she would be referred to colorectal surgeons for follow up. On 8 May 2017 the patient was admitted with bowel adhesions and underwent a laparotomy. Thereafter the patient remained an inpatient.

On 9 June she was diagnosed with Crohn's disease for which she was begun on steroid. On 4 August there was a diagnosis of Intestinal Failure. On 5 August she was placed on end of life care.

There was no follow up which led to a delay with diagnosis and treatment for Crohn's disease

From 10 July to 23 July there was an omission to recognise she was receiving inadequate nutrition.

From 11 July to the beginning of August there was a failure on the part of the clinical team to realise she was suffering malnutrition, weight loss, and intestinal failure.

As a result they failed to feed her by TPN, but for which failure she would have survived. In relation to the failure to feed by TPN, her death was contributed to by neglect."

Following the inquest, the Coroner issued a Regulation 28 report – Action to Prevent Future Deaths which was sent to the Chief Executive at Surrey and Sussex Healthcare Trust.

The Coroner's matter of concerns raised are as follows:

1. There was no colorectal follow up in relation to the findings of the CT scan carried out on 2 December 2016 despite it being recommended by the Upper Gastro-Intestinal Multi-Disciplinary Team (MDT) meeting at East Surrey Hospital on 20 December 2016.

   Consideration should be given as to whether the appropriate procedures are in place to ensure that recommendations stemming from MDT meetings are actioned appropriately.

2. The Malnutrition Universal Scoring Tool (MUST) charts for the patient were inaccurately scored during the period from 3 to 23 July 2017.

   Consideration should be given as to whether staff are sufficiently trained in how to score MUST charts.

3. The food charts for the patient were not completed from 23 June to 12 July 2017 and again from 18 to 23 July 2017, despite the patient being at risk of malnutrition.

   Consideration should be given as to whether appropriate procedures are in place to:-
   (i) Identify those patients who require food charts
   (ii) To ensure that they are properly completed.

4. The MUST charts recorded that the patient's weight was 65kg in early June 2017 and had reduced to 57kg by 11 July 2017, yet the multi-disciplinary team caring for her did not recognize that she had lost a significant amount of weight until 1 August 2017.

   Consideration should be given as to whether any additional measures or training are required to prevent similar delays in the future.

5. The patient was placed on end of life care on 5 August 2017 by a Senior House Officer (SHO) following consultation with his Consultant, both of whom had had only limited prior involvement with her. The decision to place her on end of life care was made without any consultation with the Intensive Care team, to ascertain whether she would be suitable for intensive care, and without any consultation with the clinicians who had been treating her over the course of the preceding three months.

Consideration should be given as to whether appropriate end of life policies and procedures are in place and whether staff are sufficiently aware of them.

In addition to the Regulation 28 report, the investigation also considered the following issues that were highlighted during the inquest:-

- The missed opportunity to commence TPN feeding.
- A review of nutrition documentation.
- A review of the current dietitian provision in the Trust in 2020.

Information and evidence gathered:

The patient's clinical records

Statements provided for the Coroner's inquest

Discussions

ICU Dietitian - 10.11.20
Consultant Gastroenterologist – 17.11.20
Chief of Surgery and Consultant General Surgeon – 24.11.20
Ward manager and sister – 25.11.20
Head of Therapies – 2.12.20
Registered Dietitian – 8.12.20
Critical Care Outreach Lead Nurse – 10.12.20
Consultant Surgeons x 2

Policies and guidelines

SASH policy for oral nutrition and hydration (ratified July 2019)
SASH policy adult enteral feeding (ratified Sept 2020)
SASH policy for fluid balance monitoring in adults (reviewed Oct 2019)
SASH clinical guideline for risk feeding (ratified Aug 2018)
SASH clinical guideline for management of hydration and nutrition at the end of life (ratified Feb 2020)
SASH End of Life Care Strategy 2019-2023 (ratified December 2018)
SOP for Hospital Palliative Care Team Referral and Triage

Documentation

Patient Bedside Safety Booklet: Risk assessments and care plans (relevant pages appendix)
Escalation of Treatment form (appendix)

Terms of reference
Oral nutrition and hydration group
Deteriorating patient group
End of Life Steering group

Training Presentations

SASH Intranet – MaST Clinical topics renewed by staff annually:-
Nutrition and Malnutrition
End of Life Care at SASH

PowerPoint presentations to doctors:-
Palliative and End of Life Care FY2 – Sept 2020
Palliative Care – symptom management - medical registrars – Dec 2020
Palliative Medicine – internal medical trainees - Nov 2020
End of Life Care – year 5 medical students – Dec 2020

Findings:

The events leading up to the death of the patient have already been comprehensively covered by the statements from staff for the inquest and the report prepared by the Coroner's expert witness. The purpose of this investigation was to consider the matters of concern raised by the Coroner following the inquest and other issues arising that were a cause of concern for the Trust.

MDT meeting follow up review

The first consideration was to examine if the appropriate procedures were in place to ensure that the recommendations stemming from MDT meetings were actioned appropriately. The investigation focused on the Upper GI MDT meeting, which was the area of concern in December 2016.

The investigation found that following the December 2016 MDT meeting, the patient was seen by a colorectal surgeon five weeks later to explore the possibility of re-joining her bowel. The consultant explained that whilst he felt that a colostomy was possible, he did not want to do it so soon after her original surgery, so she was booked for a colonoscopy in May 2017 with a view to the reversal taking place in Autumn 2017. The colorectal consultant was not aware of the concerns raised by the Upper GI MDT regarding a possible thickening in her small bowel, and had not seen the CT report from December 2016.

After further investigation of the patient's suspicious gallbladder mass with a repeat ultrasound, she was admitted for a cholecystectomy and partial liver resection at Royal Surrey hospital in February 2017. The gallbladder histology showed chronic cholecystitis, with no malignancy.

The patient was admitted in March 2017 with small bowel obstruction, and a CT scan at that time did not report any intrinsic small bowel pathology. A colonoscopy was performed in April 2017 which identified diverticular disease and follow up in the clinic was scheduled, but the patient was readmitted to East Surrey hospital in May 2017 and underwent laparotomy for adhesiolysis, small bowel resection and reversal of Hartmann's with formation of loop ileostomy and remained in hospital until her death in August 2017.

The current arrangements for the follow up of the recommendations made at the Upper GI MDT meeting were reviewed. The outcome for all patients discussed at the MDT meeting, whether cancer patients or not, are recorded on the Somerset database (a digital platform designed for healthcare professionals to manage cancer patient care). This is monitored by cancer services trackers who are then able to escalate to the most appropriate person any concerns i.e. tests not being requested and will chase dates as needed.

The cancer nurse specialists (CNS) who attend the MDT meeting, action the meeting outcomes, where possible, such as requesting for any diagnostic tests or appointments and referring to specialist teams to prevent delays. The CNS will monitor the actions using their own spreadsheet management tool, as a backup to the Somerset database, and ensure comprehensive notes are kept in both places.

A letter is generated by the consultant who chairs the MDT meeting which is forwarded to the patient's GP within 24 hours detailing the outcome and plan. Patients are not copied into this letter at this point due to the nature/sensitivity of the information. The CNS ensures that the team who have referred the patient for MDT discussion are made aware of the outcome and plan on the same day as the meeting. The CNS will arrange for patients to be seen in clinic or contact them regarding the outcome and any recommendations. Where the CNS has been in contact with the patient, they ensure the patient has been given the CNS details as a point of contact.

Nutritional management

The inquest also raised concerns regarding the nutritional management of patients, in particular the use, accurate completion and training in relation to food charts and weight loss management whilst on the ward.

At the time of the patient's admission in 2017, the recording of food charts took place on loose sheets of paper. In August 2018 the 'Patient Bedside Safety Booklet: Risk assessments and care plans' was introduced and is now used for all in-patients. This booklet includes all the documentation for nursing assessments, for example falls management, skin integrity and cannula care.

Nutrition assessment and monitoring has now been combined into one section which includes a malnutrition universal screening tool (MUST) assessment, nutrition care plan and BMI score, fluid and nutrition chart (appendix 1).

The MUST screening tool documentation includes BMI chart and 'percent weight loss' table for ease of BMI and percentage weight loss calculation, improving the accuracy of recording. The 'Nutrition Care Pathway' directs staff on how to proceed with the MUST score identified (from surveillance to dietitian referral) and requires a nursing signature. A food record chart allows staff to accurately record type and quantity of food or nutritional supplements offered using a simple tick box record which has proved effective at assessing global nutritional intake.

Dietitians had identified deficiencies in ward based nutrition screening and in early 2018 reviewed the knowledge and understanding of ward based staff. Following this review, a new training package was developed based on its findings, which has now become a clinical core topic of the Mandatory and Statutory training (MaST) at SASH which staff complete annually. Compliance is monitored via the on-line Electronic Staff Record (e-ESR) and reminders are sent to staff 3 months in advance of expiry.

In the first 6 months of roll-out, over 1000 staff members were trained on the MUST tool, nutrition screening and assessment. This initial training provided by dietitians has now moved online along with other MaST training since the outbreak of COVID-19 in 2020. This online version is available at all times via the SASH Intranet. Live webinar sessions are also available to book, for those who prefer this format and includes the opportunity for questions and answers. On the ward refresher training is still given by ward dietitians to staff where a need is identified.

The training package was developed to coincide with the nutritional documentation in the 'Patient Bedside Safety Booklet: Risk assessments and care plans'. This presentation delivered by a dietitian is 37 minutes long. The PowerPoint slides describe in detail how to assess and calculate MUST scores giving examples. The management of a patient's weight includes how to measure arm circumference for those who are difficult to weigh.

An audit to assess the impact of this training and use of the documentation is due but has been delayed due to the pressures of the COVID-19 pandemic.

The incomplete food charts presented at the inquest hearing, reflect the omission by ward based staff to document nil oral intake whilst artificial feeding was being delivered. On review of the feeding routes given to the patient by a dietitian, it appears that the absence of food recording on most dates reflected periods of enteral, parenteral or combined feeding. This would not be expected for a patient managed with parenteral nutrition to have any food record charted as they would be made 'nil by mouth' or sips of fluid for oral comfort only.

It was clearly documented where the patient declined nutritional input, both on the food chart and in the patient's clinical notes where conversations with the patient and her family were recorded. The dietitians who reviewed the case felt that the weight loss experienced by the patient related not only to the disease process but also a fragmented nutrition delivery. There were episodes where parental nutrition was halted for suspected or proven line sepsis or improvements in oral/naso gastric (NG) tolerance. There were times when enteral feeding was halted or abandoned due to patient refusal, delayed NG placement and frequent removal of the NG tube. On occasions the surgical team stopped enteral feeding to allow for oral intake.

There were references in the nursing notes to the family bringing in food but this was not entered on the food charts so the amount consumed was unknown. The patient had a reported dislike of the oral nutritional supplement drinks and the additional food choices available from the hospital kitchen and she had the capacity to refuse these when they were offered, which made further input difficult.

All the wards now have "daily huddles", where the ward team come together to discuss nursing issues and MUST is part of the daily checks. Any problems or concerns are escalated to the nurse in charge.

There is a nutrition nurse specialist available at SASH 4 days a week but she also works in the community and only tends to get involved when there is a problem or complex issue. This is unusual as there is usually at least one full time separate community and hospital nutrition nurse available for inpatient nutritional support planning.

A need for a specialist multi professional Nutrition Support team was identified for the oversight of the provision of nutrition for patients with complex artificial feeding needs. This group is a national recommendation and aims to optimise the metabolic care of the sickest patients in hospital, by performing regular nutrition ward rounds with supporting members e.g. surgeons and feeding into the proposed complex nutrition MDT meeting. The team consists of a gastroenterology consultant, nutrition nurse specialist, senior nutrition support dietitian and a pharmacist. In October 2020, the Trust appointed a Consultant Gastroenterologist with a special interest in nutrition who has reviewed the current nutrition policies, procedures and service at SASH. Twice weekly nutritional ward rounds are now taking place, led by this Consultant Gastroenterologist, and a monthly complex nutrition MDT meeting will be operational by April 2021. This will be a forum for surgeons and dietitians to meet monthly to review nutritional needs of specific patients, any refusal of treatment and the use of parental nutrition.

An additional specialist dietitian and nutrition nurse specialist would allow more prompt assessment of parental nutrition and better support for the Nutrition Support team and wards to be able to see all patients referred for parental nutrition, monitor line care on the wards, provide training to wards and provide monitoring for patients.

The Trust Nutrition Steering Group, based on another national recommendation, was meeting every 2 months but was put on hold in 2019 when the previous lead consultant left the Trust. It was reinstated within SASH by the new consultant gastroenterologist. Its purpose is to set and audit standards, review education and training, agree equipment used and co-ordinate other governance issues, for example infection control and risk management. This group is responsible for its own sub-committees of Oral Nutrition and Hydration group, Complex Nutrition Group and Eating Disorders group and will report to the Trust's Clinical Effectiveness committee, chaired by the Medical Director.

The Oral Nutrition and Hydration group launched in October 2020 currently meet monthly, and was formed to contribute to the SASH food and drink strategy through ensuring the delivery of best practice nutrition standards in relation to the accessibility of appropriate food and drink 24/7 for all patients, taking into account individual medical requirements. It also

has oversight of the actions being taken to improve food and drink provision and to develop and monitor related audit programmes.

The Complex Nutrition group also meets monthly to discuss and evaluate complex nutrition needs and support which includes consultants and senior dietitians.

Nutrition was included as part of foundation training for FY1 and FY2 junior doctors from 2018 and continues to be provided on an annual basis by a specialist dietitian. The talks address the nutrition training needs of junior doctors relevant to the Foundation training curriculum 2016. Feedback has been overwhelmingly positive.

As part of the Trust's commitment to providing a more efficient nutrition service, it was identified that one potential delay to instituting total parental nutrition (TPN) was in having a PICC (intravenous) line inserted. Prior to April 2019, the service was completed on an ad-hoc basis and managed by Radiology with some PICC's being completed in Radiology and some on the CEPOD list. The service was reliant on skill mix availability on the day, and as a responsive organisation it was recognised that this service was not wholly conducive to patient care.

So with effect from April 2019, Theatres began the structured service provision for the PICC Line Service. This service is available Monday – Friday with the majority of PICC's being completed on a daily basis. There is also the capability to provide a PICC service on some Saturdays and Sundays dependant on skill mix, although primarily focused on a weekday service. The service is run by a small named team, standard operating procedures, a dedicated room set up, and bookings taken through a live database.

End of life policies and procedures

The patient was placed on end of life care on 5 August 2017 by a Senior House Officer (SHO) following consultation with his Consultant, both of whom had had only limited prior involvement with her. The decision to place her on end of life care was made without any consultation with the Intensive Care team, to ascertain whether she would be suitable for intensive care, and without any consultation with the clinicians who had been treating her over the course of the preceding three months.

It is acknowledged that the decision to put the patient on end of life care could have been more widely consulted upon; however this was unusual as processes are in place to facilitate the process.

The Coroner asked for consideration to be given to whether appropriate end of life policies and procedures were in place at SASH and whether staff were sufficiently aware of them. There are a number of policies and information to support patients and staff available on the SASH Intranet on the Policies and Palliative Care Workspaces (see information and evidence gathered).

A SASH End of Life Care Strategy 2019 – 2023 is available based on the Ambitions for Palliative and End of Life Care:- A national framework for local action 2015-2020 which was produced by the National Palliative and End of Life Care Partnership. This document identifies six ambitions for end of life care in the UK, and the eight foundations which are necessary to support their implementation and success, and which form the basis of the SASH strategy. This includes personalised care planning and education and training and identifies the current situation at SASH and next steps required for improvements.

An Escalation of Treatment form to aid clinical decision-making for patients with a DNACPR in place or who are at risk of deterioration is in place and was revised in 2020. (Appendix 2)

SASH has an End of Life Care Steering group who meet quarterly to facilitate improvements in the quality of end of life care for patients, and in the support provided to their relatives and carers. The group is multi-professional and has representation within SASH and the wider local health care economy.

The Deteriorating Patient group meets monthly to oversee aspects of care and treatment related to the acutely deteriorating patient at SASH. They promote collaboration between the Critical Care Service and other Speciality Services within the Trust, provide support to promote and advance expert clinical resuscitation practice whilst ensuring clear leadership of the resuscitation service. They are also responsible for the implementation of operational policies governing peri arrest, prevention and or management of cardiopulmonary resuscitation, practice and training.

End of Life Care is a clinical topic on the MaST programme and is available online in an 11 minute PowerPoint presentation that includes an introduction to the team and contact details for the 7 days a week 9am – 5pm service. The role of the team and the referral process is outlined, together with hydration and nutrition needs and planning with the patient and their family/carer.

There is also a training programme for palliative care which is delivered to foundation year 2, IMT (internal medicine trainees), registrars and medical students (see information and evidence gathered) and adapted accordingly to the group, but generally covers:-

- Recognising the patient with limited reversibility of their medical condition and the dying patient.
- Understanding palliative care service provision.
- Increasing confidence in managing physical symptoms in patients and psychosocial distress in patients and families.
- Increasing confidence in developing appropriate advance care plans, including DNA/CPR decisions.
- Managing patients in the last days of life.
- The doctor's role in supporting a rapid discharge home.

Dietetic provision at SASH

The investigation also included a review of the dietetic service within SASH. The management of the therapies service moved to SASH from the community provider in 2010. There have been problems identified with the resourcing of the dietetic service which has been on the risk register since June 2020 in the Surgical division for 'lack of adequate adult dietetic staffing to manage levels of referrals for both in and outpatient dietetic services'.

The current therapy structure is historical and the Head of Therapies would like this to change and it has previously been a part of business planning but has yet to be fulfilled. The proposal to appoint a lead dietitian was not approved, leaving no one in overall charge of the dietetics service. Funding is available for clinical but not management posts; it was felt that dietetics needed its own lead. There is currently a team leader who is a speech and language therapist who manages the dietitian's annual leave and vacancies.

To provide a flexible service within the resources of the dietetic team, it is not possible to always assign a dietitian to each ward, However, GI surgery, gastroenterology and critical care do have specialist named dietitians assigned to their areas.

There is presently no dietetic support available at weekends; the Trust has acknowledged that this needs to be part of the gastroenterologist review of policies and procedures and service provision. At present there are hospital agreed protocols for the clinical teams to be able to manage patients nutritionally at weekends in the SASH policy for adult enteral feeding

(ratified Sept 2020).

There has been an increase in the dietetic service and in comparison to four years ago the establishment has increased by 4 whole time equivalents and this does support the specialties of ITU, medicine and surgery teams.

There is a robust process for continuous professional development (CPD) in place. All the teams have a direct supervisor who they meet with monthly. The meetings are formal and notes are kept by the supervisee which may be audited as part of Health and Care Professions Council registration and forms the evidence for their fit to practice.

They also use audit afternoons for regular professional CPD teaching sessions and internal CPD sessions to build on what they want as a team. They attend regular staff meetings and specific band 7 meetings and overall therapy meetings. They have recently started a 'What's App' group to aid communication.

The outcome of the discussions was that everyone would like to have a closer working relationship and better communication between dietitians, gastroenterologists and surgeons. A dietitian being present at ward rounds would be welcome but it would mean taking them away from their duties and with current staffing levels, this was not considered to be practical.

The 'Early Recovery After Surgery' (ERAS) programme addresses nutrition in the pre- and post-op period. Moving forward, it would benefit surgical patients to have a more robust approach to their post-operative nutritional care, with dietetic concerns and recommendations noted and considered by the surgical team as part of the overall patient care process.

This serious incident investigation arose from a Regulation 28 prevention of future deaths notice issued by HMC after recording the death of a patient in whom malnutrition significantly contributed to the death. In conducting this investigation, the findings have made it possible to answer the specific concerns that the Coroner raised, in a positive way.

The investigation has also been an opportunity, to provide a general and detailed review of the nutritional service at East Surrey Hospital. The findings demonstrate that a step change in the nutritional service is underway, for example the introduction of a complex nutritional MDT meeting, a twice weekly consultant delivered nutritional ward round and resuming the nutritional steering group. Where deficiencies have been identified, recommendations have been made, for example a clinical lead post for dietetics.

Overall, the investigation has offered reassurance to the Trust that improvements are continually being made to the nutritional service and that it is in a better place than in 2017, but it has also highlighted that action still needs to be taken to implement further planned improvements to achieve the optimum service that it endeavours to provide.

Care Delivery Problems:

Patient lost a significant amount of weight during her 3 month post-operative stay at ESH that was not progressed.

Nursing food charts were not accurately completed.

Enteral feeding was not consistent.

Contributory Factors:

Task Factors

Nutritional decisions based on normal weight of 65kg.

MUST score was not always accurate.

Provision of nutritional care was fragmented due to parental nutrition being halted for suspected or proven line sepsis or improvements in oral/naso gastric (NG) tolerance.

Input from different healthcare professionals was not cohesive due to lack of dedicated time to discuss nutrition issues.

Team Factors

Dietitians not present at MDT meetings.

No nutritional specialist input on the ward rounds.

No professional lead for dietetics to provide clinical leadership and management of dietetic service.

No lead dietitian for complex nutrition at SASH.

Nutritional nurse specialist not on site full time.

Communication

Nutrition documentation was on separate pieces of A4 sheets in 2017.

No nutritional dedicated MDT meeting.

Work Environment

Provision of the dietitian service is challenging due to limited resources.

High dependency on agency and temporary staff to cover dietetics.

There is no means of electronic referral to the dietitians; however, there is a dedicated extension number for all referrals to the service with voicemail for 24 hour referrals.

Education and Training

Training for MUST tool was ad hoc prior to 2018

No monitoring of training results via audit.

Patient Factors

Patient unable to take in enough from an oral diet, and on occasions declined the supplements offered to her.

Patient was non-compliant with NG feeding.

Patient had capacity to make her own decisions.

Patient had episodes of sepsis so unable to put on weight.

Diagnosis of small bowel Crohn's disease, refractory to medical therapy.

Family anxious to get patient home, so emphasis was on her discharge.

Patient needed high salt diet.

Organisational Factors

The dietitian service had evolved over the years and at the time of the incident required further design and resources to reflect what at that time were the needs of the service.

Root Causes:

In 2017, the provision of nutritional care was fragmented and input from the various healthcare professionals was not cohesive as there was no opportunity for staff to come together at a dedicated nutrition multi-disciplinary team meeting.

Lessons Learned:

The investigation has found that whilst the provision of nutritional care at SASH has been consistently improving since the patient's care in 2017, it still requires some additional support and funding to be a totally comprehensive service.

The dietetic service has good governance structures in place. The service has recruited 4 whole time equivalents since 2017, and we are now focusing on the leadership needs of the service.

The appointment of two new consultant gastroenterologists has allowed the formation of a dedicated nutrition MDT meeting and specialist nutrition groups.

Post-investigation Risk Assessment

A Potential Severity (1-5)	B Likelihood of Recurrence at that Severity (1-5)	C Risk Rating (C = A x B)
5	1	5

Conclusions

Recommendations:

1. Review the current nutritional policies and procedures in operation at SASH to ensure that they reflect the needs of the service - complete
2. Introduce a formal complex nutrition MDT meeting and ensure that surgeons are active members - complete
3. Reinstate the Nutrition Steering Group and establish the reporting structure of the sub groups - complete
4. Undertake an audit to assess the impact of the MaST nutrition training on the completion of the MUST documentation.
5. Appoint a professional lead for dietetics to provide clinical leadership and management of dietetic service.
6. Appoint a lead dietitian for complex nutritional needs.
7. Secure the funding for an additional nutritional nurse specialist.

Arrangements for shared learning:

1. The investigation and its findings have been discussed at the divisional incident review group before internal closure to ensure that the investigation has been thorough and that the learning is shared within and across the Trust divisions.
2. Share investigation report and action plan at the Surgical Governance weekly meeting.
3. Share investigation report and action plan at the Patient Safety and Clinical Risk Committee.
4. Share investigation report and action plan at the Gastroenterology Governance forum.
5. Share investigation report and action plan at the Dietitian Governance forum.
6. Share investigation report and action plan at the End of Life Governance forum.

Distribution list:

1. The patient's family will receive a finalised copy of this report via their solicitor as requested.
2. All staff who contributed to this investigation will receive a copy of the report and action plan.
3. HM Coroner.

Author and Job Title:	Dr [redacted] Associate Medical Director

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST) ** FOR ADULTS

This tool should be completed for all patients within 24 hours of admission and repeated weekly It is designed to identify patients at risk from malnutrition.	Reported Usual Weight Kg	Height Metres

Step 1 - BMI Score1

BMI (kg/m²)	SCORE
> 20	= 0
18.5 – 20	= 1
< 18.5	= 2

N.B. Consider oedema & dehydration

+

Step 2 - Weight Loss Score 4

Unplanned weight loss in past 3- 6 months:

%	SCORE
< 5%	= 0
5–10%	= 1
>10%	= 2

+

Step 3 - Acute disease effect score5

If the patient is acutely ill and there has been or is likely to be no or little nutritional intake for >5 days.
For example:
- Nil by mouth >24hrs/ NG/ PEG/ Parenteral nutrition
- Major surgery / severe infection/ sepsis
- Gastrointestinal disease including severe diarrhoea/ vomiting/ malabsorption
- Decompensated liver disease/ acute pancreatitis
- Evidence of pressure ulcers and poor nutritional intake

SCORE 2

=

Step 1+2+3 = Step 4:

Total MUST score 6

1	2	3	4	5	6	7	8	9	10	11	12	13	14
Ward	Date	Current weight (kg) [1]	If unable to weigh calculate MUAC(cm)[2] and state reason for no weight	Oedema/ ascites present?	BMI (Kg/M²)[1,3]	BMI Score (0, 1 or 2)	Unplanned weight loss (%) [1,4]	Weight loss score (0,1 or 2)	Acute Disease effect [5]	Disease effect score (0 or 2)	Total MUST Score [6]	Print name	Signature

[1] Weight conversion charts and BMI charts available in ward Nutrition folder and/or attached to weighing scales. Tool also available online on NHS Choices, 'Tools'.
[2] If patient cannot be weighed via sitting, standing or hoist scales please state reason and record Mid Upper Arm Circumference (MUAC) instead.
[3] **A MUAC of less than 23.5cm indicates BMI less than 20kg/m² and greater than 32cm indicates a BMI greater than 30kg/m²**
[4] Please see over for percentage weight loss calculation chart
[5] Please state reason for Acute Disease effect score
[6] Add columns 7,9 and 11. Document MUST score in column 12.
See over for nutritional care plans based on total MUST Score; if MUST >2 sign & date care plan overleaf when referred to dietician.

NUTRITION CARE PATHWAY

MUST 0
No action required + rescreen weekly

Medical team to consider:
- Anti-emetics
- Laxatives
- Anti-diarrhoeals

Consider a RED tray

Could friends or family provide assistance?

Encourage hot puddings with meals and higher calorie ice-cream

Offer biscuits with AM and PM drink rounds

Order a dementia finger food box

Pick up a snack box from the kitchen

Nourishing Drinks:

- Full fat milk
- Malted drink (Horlicks)
- Hot chocolate
- Complan soup/Complan shake
- Fortified milk (7tsps milk powder with 200ml full fat milk)

MUST ≥ 1
To improve nutritional status at ward level

Could they be constipated, nauseous or having loose stools?

Could they benefit from encouragement, observation or assistance?

Encourage high calorie choices

Are they confused or have dementia and have poor oral intake?

Have they missed a meal?

Encourage nourishing drinks

MUST ≥ 2
To improve nutritional status at ward level + consider first line supplements

Medical team to consider **prescribing** Complan OD

Offer the patient the **snack list**

Refer to dietitian
(extension 6134)

Providing the following:
- Ward
- Name
- Date of Birth
- Hospital Number
- MUST Score
- Diagnosis / relevant medical conditions

Signature:

Date:

Snacks available:

- Ambrosia rice pudding pots
- Ambrosia custard pots
- Higher calorie ice-cream
- Madeira Cake
- Biscuits
- Cereal
- Slice of bread and butter /jam

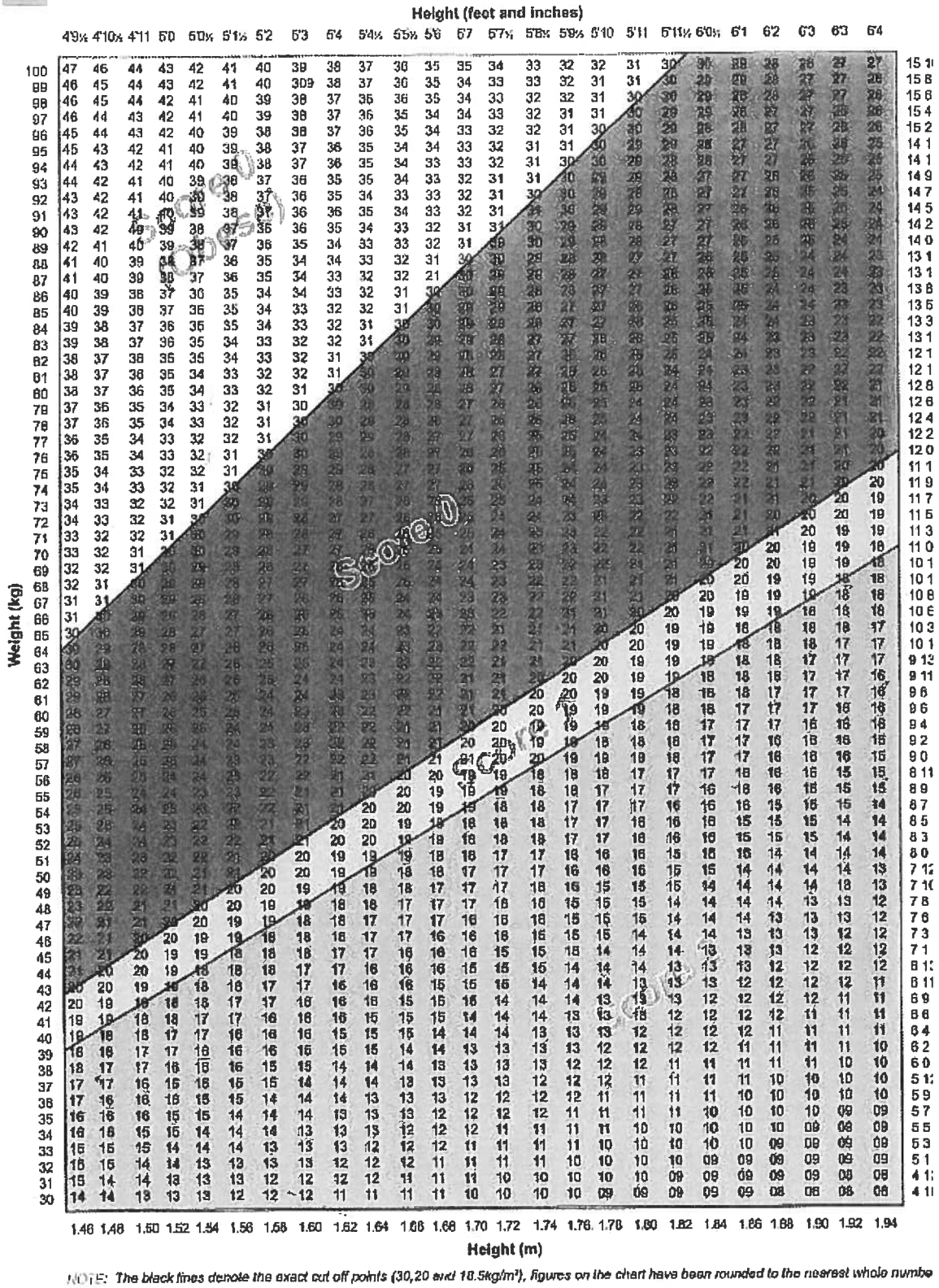
% WEIGHT LOSS SCORE

	Score 0 Wt loss <5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss >10%
	Weight loss in last 3 - 6 months		
kg	Less than (kg)	Between (kg)	More than (kg)
30	1.6	1.6 - 3.3	3.3
31	1.6	1.6 - 3.4	3.4
32	1.7	1.7 - 3.6	3.6
33	1.7	1.7 - 3.7	3.7
34	1.8	1.8 - 3.8	3.8
35	1.8	1.8 - 3.9	3.9
36	1.9	1.9 - 4.0	4.0
37	1.9	1.9 - 4.1	4.1
38	2.0	2.0 - 4.2	4.2
39	2.1	2.0 - 4.3	4.3
40	2.1	2.1 - 4.4	4.4
41	2.2	2.2 - 4.6	4.6
42	2.2	2.2 - 4.7	4.7
43	2.3	2.3 - 4.8	4.8
44	2.3	2.3 - 4.9	4.9
45	2.4	2.4 - 5.0	5.0
46	2.4	2.4 - 5.1	5.1
47	2.5	2.5 - 5.2	5.2
48	2.5	2.5 - 5.3	5.3
49	2.6	2.6 - 5.4	5.4
50	2.6	2.6 - 5.6	5.6
51	2.7	2.7 - 5.7	5.7
52	2.7	2.7 - 5.8	5.8
53	2.8	2.8 - 5.9	5.9
54	2.8	2.8 - 6.0	6.0
55	2.9	2.9 - 6.1	6.1
56	2.9	2.9 - 6.2	6.2
57	3.0	3.0 - 6.3	6.3
58	3.0	3.1 - 6.4	6.4
59	3.1	3.1 - 6.6	6.6
60	3.2	3.2 - 6.7	6.7
61	3.2	3.2 - 6.8	6.8
62	3.3	3.3 - 6.9	6.9
63	3.3	3.3 - 7.0	7.0
64	3.4	3.4 - 7.1	7.1

	Score 0 Wt loss <5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss >10%
	Weight loss in last 3 - 6 months		
kg	Less than (kg)	Between (kg)	More than (kg)
65	3.4	3.4 - 7.2	7.2
66	3.5	3.5 - 7.3	7.3
67	3.5	3.5 - 7.4	7.4
68	3.6	3.6 - 7.6	7.6
69	3.6	3.6 - 7.7	7.7
70	3.7	3.7 - 7.8	7.8
71	3.7	3.7 - 7.9	7.9
72	3.8	3.8 - 8.0	8.0
73	3.8	3.8 - 8.1	8.1
74	3.9	3.9 - 8.2	8.2
75	3.9	3.9 - 8.3	8.3
76	4.0	4.0 - 8.4	8.4
77	4.1	4.1 - 8.6	8.6
78	4.1	4.1 - 8.7	8.7
79	4.2	4.2 - 8.8	8.8
80	4.2	4.2 - 8.9	8.9
81	4.3	4.3 - 9.0	9.0
82	4.3	4.3 - 9.1	9.1
83	4.4	4.4 - 9.2	9.2
84	4.4	4.4 - 9.3	9.3
85	4.5	4.5 - 9.4	9.4
86	4.5	4.5 - 9.6	9.6
87	4.6	4.6 - 9.7	9.7
88	4.6	4.6 - 9.8	9.8
89	4.7	4.7 - 9.9	9.9
90	4.7	4.7 - 10.0	10.0
91	4.8	4.8 - 10.1	10.1
92	4.8	4.8 - 10.2	10.2
93	4.9	4.9 - 10.3	10.3
94	4.9	4.9 - 10.4	10.4
95	5.0	5.0 - 10.6	10.6
96	5.1	5.1 - 10.7	10.7
97	5.1	5.1 - 10.8	10.8
98	5.2	5.2 - 10.9	10.9
99	5.2	5.2 - 11.0	11.0

*Except when nutrition support will be of no benefit to the patient e.g. Patient on End of Life care plan
** Aspects of 'The Malnutrition Universal Screen Tool' (MUST) are reproduced here with the kind permission of BAPEN (British Association for Parenteral and Enteral Nutrition). For further information on 'MUST' see www.bapen.org.uk

BMI SCORE



NOTE: The black lines denote the exact cut off points (30,20 and 18.5kg/m²), figures on the chart have been rounded to the nearest whole numbe

FOOD RECORD CHART

	Day 1					Day 2					Day 3					Day 4					Day 5					Day 6					Day 7				
	Amount Eaten					Amount Eaten					Amount Eaten					Amount Eaten					Amount Eaten					Amount Eaten					Amount Eaten				
BREAKFAST	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¼	All	0	¼	½	¾	All	0	¼	½	¾	All
Fruit Juice																																		
Cereal / Porridge																																		
Bread 1 or 2 slices (circle)																																		
Marmalade / Jam																																		
Other																																		
MORNING	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¼	All	0	¼	½	¾	All	0	¼	½	¾	All
Drink																																		
Nutrition Supplement																																		
Snack																																		
LUNCH	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All
Drink																																		
Soup																																		
Bread																																		
Main course																																		
Potatoes / Rice (circle)																																		
Vegetables																																		
Dessert																																		
Custard / Sauce																																		
Other																																		
AFTERNOON	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All
Drink																																		
Nutrition Supplement																																		
Snack																																		
SUPPER	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All
Drink																																		
Soup																																		
Bread 1 or 2 slices (circle)																																		
Main Course																																		
Sandwich																																		
Dessert																																		
Other																																		
EVENING	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All
Drink																																		
Nutrition Supplement																																		
Snack																																		
EXTRAS	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All	0	¼	½	¾	All
Snack Box																																		
Please state if NBM status commenced or any special diets/diet related concerns	Additional information					Additional information					Additional information					Additional information					Additional information					Additional information					Additional information				

Escalation of Treatment form

Surrey and Sussex Healthcare NHS Trust NHS

Please complete for all patients with a DNACPR *or* at risk of deterioration

Name: _____

Date of birth: _____

NHS number: _____

Hospital: _____

Do not photocopy

This is a guide to aid clinical decision-making

In the event of deterioration, this patient should be:

For referral to Critical Care (bleep 830)..... **YES / NO**

For referral to Critical Care Outreach Team (bleep 766) for ward-based Non-Invasive Ventilation..... **YES / NO**
for AECOPD / obesity hypoventilation / neuromuscular syndromes only

For ward-based ceiling of treatment..... **YES / NO**

Should this patient be for MET calls? **YES / NO**
If not for MET calls and clinical concern, contact ward team or on-call doctor for review

Summary of reasons for above and discussions with patient and/or relatives:

For further information, see patient notes dated.....

If this escalation status is changed please clearly mark this form as cancelled, sign and date, and complete a new Escalation of Treatment form

Name/grade of doctor completing this form: _____

Signature:_____ Date: _____

Consultant endorsement of above decisions (within 24 hours):

Name:_____ Signature:_____ Date: _____

Putting people first
Delivering excellent, accessible healthcare

Draft v5 18.02.20
MR5286 - Oct 20

Action Plan

Reference:	[redacted]	**Datix number:**	[redacted]
Action Plan Lead:	[redacted], **Consultant Gastroenterologist**		

Surrey and Sussex NHS Healthcare NHS Trust

No:	Recommendation / Issue to be addressed:	Action(s) to be taken:		Action owner: *(job title)*	Deadline for Action:	Test of Effectiveness:	Monitoring committee:
		Action Category	Action *(SMART)*				
1.	Review the current nutritional policies and procedures in operation at SASH to ensure that they reflect the needs of the service.	Preventative	Review the current nutritional policies and procedures in operation at SASH to ensure that they reflect the needs of the service.	[redacted] Consultant Gastroenterologist	31.8.2021	Current nutritional policies and procedures in operation reviewed and updated for efficacy at CEC.	Clinical Effectiveness committee
2.	Introduce a formal complex nutrition MDT meeting and ensure that surgeons are active members.	Corrective	Implement a formal complex nutrition MDT meeting and ensure that surgeons are active members.	[redacted] Consultant Gastroenterologist	30.4.2021	Regular complex nutrition MDT meetings in operation.	Clinical Effectiveness committee
3.	Reinstate the Nutrition Steering Group and establish the reporting structure of the sub groups.	Corrective	Reinstate the Nutrition Steering Group and establish the reporting structure of the sub groups.	[redacted] Consultant Gastroenterologist	31.3.2021	Nutrition steering group meet monthly and minuted.	Clinical Effectiveness committee
4.	Undertake an audit to assess the impact of the MaST nutrition training on the completion of the	Detective	Nutrition Steering group to oversee an audit to assess the impact of the MaST nutrition training on the completion of the MUST documentation, when the	[redacted] Consultant Gastroenterologist	31.7.2021	Results of audit to provide assurance that current training programme is sufficient or deficiencies identified and	Clinical Effectiveness committee

No:	Recommendation / Issue to be addressed:	Action(s) to be taken:		Action owner: *(job title)*	Deadline for Action:	Test of Effectiveness:	Monitoring committee:
		Action Category	Action *(SMART)*				
	MUST documentation.		limitations of COVID-19 allow.			addressed with further training.	
5.	Appoint a professional lead for dietetics to provide clinical leadership and management of dietetic service.	Corrective	Appoint a professional lead for dietetics to provide clinical leadership and management of dietetic service.	[redacted] Medical Director	30.6.2021	Clinical lead for the dietetics service appointed SASH.	Clinical Effectiveness committee
6.	Appoint a lead dietitian for complex nutritional needs.	Corrective	Appoint a lead dietitian for complex nutritional needs.	[redacted] Head of Therapies	30.6.2021	Lead dietitian for complex nutritional needs appointed at SASH.	Clinical Effectiveness committee
7.	Agree the funding for an additional nutritional nurse specialist with the surgical division.	Corrective	Agree the funding for an additional nutritional nurse specialist with the surgical division.	[redacted] Chief Nurse	30.6.2021	Sufficient nutritional nurse specialist support in place.	Clinical Effectiveness committee