

EXECUTIVE SUMMARY

Report to	Trust Board
Date	Tuesday 1 December 2015
Agenda Number	2.7
Agenda Item	Mortality Review Report in response to the CQC Regulation 17 Request letter dated 30.09.15
Sponsor	George Thomson, Medical Director
Prepared by	Julie Poyner, Senior Governance Manager (Compliance)
Presented by	George Thomson, Medical Director

1 Purpose and Key Issues

The purpose of this paper is to present the Trust Board with the report in response to the Regulation 17 Letter received from the Care Quality Commission re: Imperial College Dr Foster mortality outlier alert for acute bronchitis at Northern Devon Healthcare NHS Trust.

- 40 deaths were identified in this outlier alert and a full review of all the notes for the 40 cases was undertaken by a senior clinical team.
- The 40 case studies were scored against the Hogan Scale, NCEPOD and Hogan Quality Scale as requested by the Care Quality Commission.

2 Supporting Information

The report is attached.

3 Controls and Assurance

The Trust has a Mortality Review Group in place which monitors all Mortality issues and reports to the Quality Assurance Committee.

4 Legal and Regulatory Implications

The Trust is required to be compliant with the Health and Social Care Act 2008 as Regulated by the Care Quality Commission.

5 Equality and Diversity Implications

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. No adverse or positive impacts have been identified from this report.

6 Patient, Public and Staff Engagement

The Trust ensures that patients, the public and staff are involved in the decision-making process when appropriate.

7 Cost Implications

Failure to return services to compliance could lead to a fine from the Care Quality Commission.

8 Potential Risk to the Organisation

There is a risk of failing to reach the Care Quality Commission Standards of Quality and Health which could lead to discontinuing services.

9 Board Prompts

- Is the Board assured that the Management of the Care Quality Commission report and Action Plan development by the Trust to meet the compliance actions and recommendations made in the Report is sufficiently robust?
- Does the Board need any additional information?

10 Recommendations

The Board is asked to **RECEIVE** the report.

11 References

- The Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)
- Health and social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended)

12 Strategic Objectives

The Trust's strategic objectives are reviewed by the Board on an annual basis. This paper supports the achievement of the following strategic objectives:

X	Highest quality		Flexible & multi-skilled workforce
	Sustainable services		Efficient & effective
	Integrated health & social care		Local provider of choice

13 Principal Risks

The Trust's principal risks have been identified through the Trust's risk management processes. They are updated as they are identified by the Risk Management Committee. This paper supports the mitigation of the following principal risks:

X	Financial planning & management	X	Clinical records management
X	Strategic & business planning	X	Leadership & management
X	Workforce numbers	X	Unsafe behaviour
X	Workforce skills	X	External demands
X	Procedural management	X	Partnership arrangements
X	Equipment & facilities arrangements	X	Communication

Northern Devon Healthcare NHS Trust

Review of mortality outlier alert for “acute bronchitis” Report

In response to the Care Quality Commission letter received 30 September 2015

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Review of mortality outlier alert for “acute bronchitis”

1.0 Outline

This report is in response to Care Quality Commission (CQC) following notification from the Dr Foster Unit at Imperial College of a mortality outlier alert for “acute bronchitis”.

2.0 Action taken

A comprehensive retrospective audit of notes, discharge summaries, death certificates was undertaken. A separate clinical coding review was undertaken on the records of each patient identified.

3.0 Method

The 40 deaths causing the alert were identified for review by using the Dr Foster Quality Investigator tool to find the patient identifiers for the patients in the “acute bronchitis” diagnosis group between 1st June 2014 and 31st May 2015. These details were then used to identify the patients on PAS. All notes were pulled and have contributed to the analysis shown below.

The CQC proforma which accompanied the letter requesting the review was used as the tool for reviewing the case notes as it included Hogan Scores not currently included in the Trust’s existing audit form. This tool will be adapted to use as part of the Trust’s Mortality Review Panel process when all in-hospital deaths are reviewed.

The review team consisted of:

- Dr John Coop – General Practitioner
- Tina Naldrett – Head of Professional Practice/Assistant Director of Nursing.
- Dr Chris Bowman – General Practitioner and Clinical Director for Community Services
- Dr George Thomson – Medical Director
- Dr Alison Diamond – Chief Executive

The reviews carried out by the team contributed approximately 30 hours of clinical time. This was supported by a further 150 hours of senior management involvement.

Patient summaries are included in Appendix C on pages 15 to 29 of this report.

4.0 Results

See appendix 1 (Page 7) for explanation of finished consultant episodes (FCEs,) Spells and Superspells.

Breakdown of the 40 deaths

All deaths were recorded with the Lower Respiratory Tract Infection (LRTI) unspecified code J22X.

- **Average age and range and age groups**

- Mean – 88 years
- Median – 83 years
- Range 64 – 102 years

- **Age Group and site of death**

Age Group	Acute	Community
60 - 69	1	0
70 - 79	2	2
80 - 89	7	11
90 - 99	5	8
100 - 109	0	4
Average Age	85.9	89.9

- **Sex**

- Female – 24
- Male – 16

Admissions from nursing and residential home information obtained from the patient's address held on PAS.

- **Admissions from nursing homes**

- 2 NDDH
 - Swimbridge Nursing Home, Swimbridge, EX32 0QT
 - The Warren Nursing Home, Bideford, EX39 3QF

- **Admissions from residential homes**

- 2 NDDH
- 2 RD&E (both transferred to Sidmouth Community Hospital)
- 1 Sidmouth Community Hospital
- 1 Seaton Community Hospital

All Admissions were felt to be appropriate excluding one patient (No. 8) who it was considered could have received palliative care at the nursing home.

- **Readmissions within 30 days**

- 4 patients who had been sent home were readmitted within 30 days
 - 3 from North Devon District Hospital (NDDH)
 - Patient No.19 had 3 admissions in previous 3 mths with ulcerative colitis. 30 days from previous spell to readmission. Cause of death: pulmonary embolism and bronchopneumonia.
 - Patient No.9 had a previous admission to the NDDH for dyspnoea with abnormal finding on chest x-ray. When readmitted 23 days later lung metastases were recorded in the clinical coding. Cause of death pneumonia.

- **Single spell hospital stays**

- Nos: 5, 8, 9, 13, 14, 18, 19, 20, 21, 24, 29, 32, 34, 36, 37, 38, 39, 40.

Site	Number of patients
BIDEFORD HOSP COM SERVICES	1
EXMOUTH HOSPITAL	1
HOLSWORTHY HOSP COM SERVICES	2
HONITON HOSPITAL	2
NORTH DEVON DISTRICT HOSPITAL	12
OTTERY ST MARY HOSPITAL	1
Total	19

- **2 spells in superspell**

- 8 patients started in Royal Devon & Exeter (RD&E) and had second spells where LRTI was recorded in primary position in central and eastern community hospitals.
 - 4 of these had LRTI recorded as the primary diagnosis in both spells. No. 15, 23, 30, 35.
 - 2 fractures – acetabulum and neck of femur in the RD&E spell. No. 11, 27.
 - 1 gastro intestinal haemorrhage. No. 6.
 - 1 unspecified injury to hip. No. 33.
- 3 patients started their superspell at NDDH:
 - 2 patients had LRTI recorded in primary position in NDDH. Both of these patients were transferred to Stratton where they went on to be coded with cancer of the prostate and lobar pneumonia. No. 25, 31.
 - 1 patient coded with disorientation at NDDH who was transferred to South Molton Community Hospital with LRTI. No. 3.
- 1 Okehampton Community Hospital patient with LRTI transferred to RD&E where they were coded with a urinary tract infection (UTI). No. 4.

- **3 spells in superspell**

- 1 Northern patient:
 - Holsworthy Community Hospital– UTI, NDDH – UTI, **Holsworthy – LRTI** No. 28.
- 3 RD&E and central and eastern community patients:
 - RD&E – gastroenteritis, Honiton – gastroenteritis, **Seaton – LRTI** No.2.
 - Seaton Community Hospital – UTI, RD&E – tendency to fall, **Seaton – LRTI** No.10.
 - Sidmouth Community Hospital – cellulitis, RD&E – pneumonia, **Sidmouth - LRTI** No.26.

- **4 spells in superspell**

- 1 Northern patient:
 - NDDH – Stroke, Bideford – Stroke, NDDH – LRTI, Bideford – Vascular dementia. No.1
- 2 RD&E and central and eastern community patients:
 - RD&E – LVF, Tiverton – LRTI, RD&E – calculus of gall bladder, Tiverton – bronchopneumonia. No.16
 - RD&E – Pertrochanteric #, Exmouth - # Neck of Femur (NoF), RD&E – complications of genitourinary device, Exmouth – LRTI. No.22

- **5 spells in superspell**
 - 1 RD&E and central and eastern community patient
 - RD&E – acute renal failure, Tiverton – UTI, RD&E – LVF, Tiverton LRTI, RD&E – acute renal failure. No. 17
- **9 spells in superspell**
 - 1 Northern patient
 - NDDH – Ulcer lower limb then osteomyelitis, Bideford – osteomyelitis, NDDH – osteomyelitis, Bideford – osteomyelitis, NDDH – UTI, Bideford – UTI, NDDH – sepsis then LRTI, Bideford – LRTI, NDDH – bronchopneumonia. No.12.
- **Transfers from RD&E Acute to NDHT**
 - There were 12 Patients who started their admissions under RD&E that were transferred out to NDHT sites. Patient Nos. 2,6,11,15,16,17,22,23,27,30,33,35.
- **Transfers from RD&E Acute for Palliative care admission**
 - There were 2 patients that should have had a palliative care code recorded as they were specifically admitted for palliative care. Patient Nos. 27, 35.

From the audit all patients 1-35 had a DNAR form inserted in notes.

There were 5 Community patients where the death certificate was not available due to being under GP care and these had been issued by the GP Surgery.

The correlation between day of admission and date of death, whether this was a weekday or weekend, was excluded due to the cross-Trust uses and variations between admitting Trust and Trust where the death occurred.

Initial assessment carried out by the following grades

Grades at initial assessment	Number of patients seen
Foundation Doctor Year 1	2
Core Trainees Year 1	2
Core Trainees Year 2	2
Core Medical Trainees Year 2	1
Specialty Training Officer 1	2
Senior House Officer	2
Specialty Registrar	2
Consultant	1
GP	24
GP associate specialist	1
Not recorded	1

Average time to first review –

Community setting	
Range	0 - 96 hours
Average	26 hours 45 mins
Most frequent	24 hours
Mid point	48 hours

Acute setting	1st review	1st review by consultant
Range	45 min - 22 hours	1 - 77 hours
Average	5 hours 40 min	19 hours 30 min
Most frequent	none	none
Mid point	11 hours 22 min	39 hours

Procedures and Interventions

Procedures based on clinical coding	Number of patients	Case numbers
Diagnostic Scans and or Xrays	3	1, 19, 40
Urinary Catheterisation	3	13, 33, 37
Primary prosthetic replacement head of femur	1	34

EWS scores

These were observed in 37 cases of 40 reviews; the details of the patients without scores are given below.

- Patient 14 – due to palliative care team involvement and no concerns recorded regarding the preventability or quality of care were identified.
- Patient 22 – concern re identifying end of life.
- Patient 35 – patient was admitted in a moribund state for end of life care and no concerns with the preventability or quality of care were identified.

Hogan Scale

This was completed for all but 1 patient of the 40 viewed. This patient was transferred to the Royal Devon and Exeter (RD&E) hospital where they died. The auditor comments state “No evidence that the death was preventable as they died in RD&E”.

The average score was 1.075.

36 patients received a score of 1 (definitely not preventable).

2 patients received a score of 2 (slight evidence of preventability).

- Reasons and patient id:
 - 1 lack of clinical record in notes – patient 17.
 - 1 possible delayed diagnosis – patient 19.

1 patient received a score of 3 (possibly preventable but not very likely, less than 50-50 but close call).

- Reasons and patient id:
 - Deterioration not recognised, patient found dead in bed. No Documentation of the Death Certificate in the notes – patient 11.

NCEPOD

This was completed for all but 3 patients of the 40 viewed: The average score was 1.3.

28 patients received a score of 1 – Good practice

- 8 patients received 2 – Room for improvement
 - o Aspects of clinical care that could have been better.
 - o Patient ids – 8, 11, 17, 22, 24, 28, 29, 37.
- 1 patient received 4 – Room for improvement
 - o Patient id 39. The patient was seen by multiple specialties and reviewer was unclear who had overall responsibility.

Hogan Quality Scale

This was completed for all but 6 patients of the 40 reviewed:
The average score was 1.94

- 7 patients rated as receiving - Excellent care
- 22 patients rated as receiving – Good care
- 5 patients rated as receiving – Adequate care

Changes to Clinical coding following audit of 36 of the 40 sets of notes

23 patients coding was found to be correct
5 patients coding has been amended to pneumonia
8 patients coding has been amended to

- Fractured neck of femur
- Unspecified injury to thorax
- Myocardial infarction
- Acute renal failure
- Problem related to life management difficulties
- Other complication of urinary device
- Atrial fibrillation
- Chest pain

64% percentage of the 36 patients whose coding audit papers were available at the time this report was compiled were correctly coded as lower respiratory tract infection.

6.0 Summary

This audit has identified no cases where the deaths were preventable. There were cases identified where the quality of care could be improved, and an action has been identified to re-review these cases to ensure learning is captured and shared.

Fourteen patients' records were incorrectly coded and external support has been sourced to assist the coding department in addressing these issues and establishing best practice. However, it has also been recognised that in some cases the coding was affected by the poor quality of record keeping and information in discharge summaries. There are on-going processes in place to improve the quality of documentation through the use of a monthly clinical effectiveness tool, results of which are reviewed at the Safer Care Delivery Committee with actions taken to address identified shortfalls.

Of the 40 patients reviewed, it has been identified that 5 should have been coded as pneumonia not LRTI and 9 other reasons not LRTI, leaving 26 cases which were correctly coded. 12 of these started their superspell in other trusts and were transferred to community hospitals managed by this Trust for end of life/palliative care. Also, of the 40 patients reviewed, 4 died in other Trusts (2 at the RD&E and 2 at Stratton Hospital).

The Trust already have ongoing actions in place to manage the following areas identified through this review:

- Recognising and managing the deteriorating patient
 - Patient at Risk of Deterioration Policy
 - EWS scores and escalation process
 - Resuscitation Team teaching sessions on EWS escalations (which continues to see a reduction in the number of cardiac arrests which occur outside the ED)
 - Community Hospital escalation process to GP and out of hours services
 - Patient case reviews at divisional governance days
 - Grand rounds
 - Teaching sessions based on case studies
- Avoiding drug errors
 - Incident reporting process
 - Medicines Management Policy
 - Individual patient drug charts checked by ward pharmacists on a daily basis
 - Drug and Therapeutics Committee review drug errors and identify themes and trends which are then acted upon
 - Internal patient safety alerts
 - Formulary published on the website and available as an app
- Identifying palliative care
 - Medical Director's directive to all admitting staff raising awareness of palliative / end of life care admissions
 - Palliative care stamp used in patient notes
 - Palliative care caseload lists
 - Hospice links
 - End of life care training
 - End of life care lead
 - Palliative care team
- Clinical coding quality checks
 - Raising awareness in the clinical coding department of the need to appropriately code end of life care and palliative care
 - Continuing hospital project on discharge summaries and end of life care
 - Resourcing external expert support for the clinical coding team to enable improved quality and best practice

Coding Audits have already been introduced and the first two presentations were recently made to the Trust Board. The following are the results of the first two audits.

Projected HSMR Following Coding Audit 1

CCS diagnosis Groups	Current deaths	Post audit	Move ment	Relative risk now	Projected change
Acute Bronchitis	40	26	-14	183.19	122.18
Acute Myocardial Infarction	25	26	+1	115.92	121.12
Cardiac Dysrhythmias	8	9	+1	127.92	143.41
Pneumonia	125	130	+5	98.09	101.30
Acute & unspec renal failure	25	26	+1	105.31	108.79
Urinary Tract Infection	47	48	+1	139.34	142.16
Fracture NOF (Hip)	34	35	+1	108.49	111.48
Other fractures	10	12	+2	104.09	123.89
Complication of device implant or graft	6	7	+1	154.36	179.08
Residual Codes unclassified	8	9	+1	216.85	242.27
All shown diagnosis groups				115.86	115.60

12 month view - The projected effect overall indicates a small drop in the relative risk, the effect of 2 missed palliative care spells hasn't been calculated into the projected change.

Projected HSMR Following Coding Audit 2

	Current deaths	Post audit	Move ment	Relative risk now	Projected change
Acute Bronchitis	10	7	-3	259.30	186.81
Acute Myocardial Infarction	8	8	0	132.71	132.71
Cardiac Dysrhythmias	4	4	0	328.04	328.04
Pneumonia	31	33	+2	95.88	100.98
Acute & unspec renal failure	12	12	0	162.72	162.72
Urinary Tract Infection	2	3	+1	25.84	38.56
Fracture NOF (Hip)	10	10	0	153.49	153.49
Other fractures	3	3	0	128.25	128.25
Complication of device implant or graft	1	1	0	100.27	100.27
Residual Codes unclassified	5	5	0	394.31	394.31
All shown diagnosis groups				123.44	122.95

Because of the HES data freeze we can't go back and change our data pre 1st April so this table shows the projected changes for Q1 2015/16, 2 extra palliative care spell were also picked up which will bring the projected figure down

Appendix 1

Explanation of Full Consultant Episodes (FCE's or Episodes), Spells and Continuous Inpatient Spells or Super Spells											
		Admission to hospital A								Discharge to hospital A	
Patient 1		Consultant X									
		One FCE									
		One spell									
		One Continuous Inpatient Spell/Superspell									
		Admission to hospital A								Discharge to hospital A	
Patient 2		Consultant X				Consultant Z					
		1st FCE				2nd FCE					
		One spell									
		One Continuous Inpatient Spell/Superspell									
		Admission to hospital A								Transfer from Hospital A to B different Trust	
		Consultant X				Consultant Z				Consultant Y	
		1st FCE				2nd FCE				One FCE	
		One spell								One spell	
Patient 3		One Continuous Inpatient Spell/Superspell									
										Discharge to hospital B	
<p>Each FCE will be individually coded by the clinical coders using ICD10 and OPCS coding HRG's are based on each spell and are based on all the coding and are used by finance for billing purposes</p>											

Appendix 2

ACTION PLAN		IR Number (s)	N/A			Risk ID	
Risk Lead	Name	Julie Poyner			Job title	Senior Governance Manager (Compliance)	
Description of hazard/ risk	Identify a process of review of all in-patient deaths to be reported through the Mortality Review Group						
Risk score <i>(Initial risk score)</i>	What was the consequence of the incident, and what is the likelihood of it happening again?				Target risk score once actions have been implemented		
	Consequence	4	Likelihood	4	Consequence	4	Likelihood
Risk Matrix	1	2		3		4	5
Consequence	Insignificant	Minor		Moderate		Major	Catastrophic
Likelihood	Rare	Unlikely		Possible		Likely	Almost certain

	Actions	Ref	Actions	Person responsible	Action due date	Action Taken	Report / monitoring arrangements / Evidence	Status
1.0	Identify the 40 patients referred to in the letter received from the CQC 30 September 2015 re: Imperial College Dr Foster Mortality Outlier alert for acute bronchitis at NDDH.	1.1	Identify the patients from Dr Foster	BS	31.09.15	Patients collated onto spread sheet		G
		1.2	Prepare the audit sheet to be used to review the patients notes from the examples the CQC have supplied		31.09.15	Audit form prepared and mail merged with PAS information		G
2.0	Identify Consultants who will review the notes and write up audit forms	2.1	Request from Consultants time to review notes	GT	02.10.15	Chris Bowman/John Coop identified for Southern notes		G

	Actions	Ref	Actions	Person responsible	Action due date	Action Taken	Report / monitoring arrangements / Evidence	Status
		2.2	Arrange 'pulling and collating' notes from records and delivery to Exeter offices	AC	02.10.15	Notes requested and delivered to Exeter offices. Office booked for storage and review		G
		2.3	Karen Ricketts, Dave Williams identified for NDDH	GT		KR/JW unable to review due to sickness and annual leave. John Coop requested and agreed to review NDDH notes		G
		2.4	Audit forms to be returned to NDDH Governance Dept/Performance to be collated into spread sheet and report	JP/BS		Audit forms received and collated		G
3.0	Review forms independently peer reviewed	3.1	Audit forms to be reviewed by the Medical Director or Chief Executive	GT/AD	19.10.15	Audit forms reviewed		G
4.0	Review audit form proforma to include Hogan methodology	4.1	Review audit form proforma against DOH pilot and include Hogan methodology. Present draft to Nov15 Mortality Committee for approval	GT	31.12.15			B
		4.2	Trial over 6 weeks and present results to Mortality Review Committee for approval.	GT	31.01.16			B
5.0	Put in place mortality structured case reviews of all in-hospital deaths	5.1	Identify process and medical staff to undertake the structured case reviews	GT	31.01.16			B

	Actions	Ref	Actions	Person responsible	Action due date	Action Taken	Report / monitoring arrangements / Evidence	Status
6.0	Develop and implement process for investigation where Hogan scores identify potential concerns.	6.1	Develop a process for ensuring investigation takes place on all reviews where lower Hogan scores are marked. Results to be presented to the Quality Assurance Committee.	GT/MK	31.01.16			B
7.0	Ensure mortality review audit is part of the Clinical Audit and Effectiveness programme for the Trust for 2015/2016 to ensure on-going discipline	7.1	List the Clinical Audit/Review of notes as a mandatory part of the Clinical Audit and effectiveness programme	GT	31.01.16			B
8.0	Review the processes and methodology of the Clinical Coding department	8.1	Assess competency of clinical coding team and take actions on any shortfalls.	KH/MS	31.01.16			B
		8.2	Ensure on-going audit of all in-patient death notes to ensure accuracy of coding. Take actions to amend any shortfalls.	KH	31.01.16			B
9.0	Raise awareness of record keeping accuracy and quality with medical staff to ensure in line with trust and professional standards	9.1	Develop a clinical effectiveness tool to monitor medical record-keeping standards through regular audits	HJ	31.01.16			B

Person responsible	
Name	Job Title
Alison Diamond	Chief Executive
George Thompson	Medical Director
Bridget Stephens	Performance Analyst
Julie Poyner	Senior Governance Manager (Compliance)
Mandy Kilby	Head of Corporate Governance
John Coop	General Practitioner
Chris Bowman	Medical Director for Community Services
Tina Naldrett	Assistant Director of Nursing, (Community) Clinical Lead Dementia
Kat Howarth	Clinical Coding Manager
Martin Scrace	Head of Informatics, Information and Technology
Hannah Jones	Clinical Audit & Effectiveness Manager

Status tracking		
Complete	Green	G
On plan	Blue	B
Slippage	Amber	A
Not achieved	Red	R

Appendix 3

Case 1

72 yr old male admitted from home on 29 November 14 at 9.14pm. He was admitted with recent CVE, Type 2 Diabetes, on Insulin, vascular dementia, PVD, AF, on warfarin, CCGF, COPD, hypertension, suffered brain stem CVE. He died peacefully on Willow Ward in Bideford Hospital on 12 January 2015. The patient had a DNAR form in place dated 31 December 2014 and was on an End of Life Care Pathway. The patient was reviewed 4.5 hours after admission and had a clear diagnosis and management plan. A Consultant reviewed within 36 hours and there was no change to management/care plan. The care was appropriate and there was nothing to be handled differently.

There was an issue regarding coding:

108 –E11.9 Non-Insulin dependent Diabetes Mellitus without complications. The patient was on Insulin. Vascular dementia, AF, CCF.

Hogan Scale:	Definitely not preventable.
NCEPOD:	Good Practice.
Hogan Quality Scale:	Good.

Case 2

85 yr old female admitted to RD&E from home, transferred to Seaton Hospital on 4 June 2014. She was transferred from RD&E post rehydration following D&V. Advanced vascular dementia, Insulin dependent type 2 Diabetes Mellitus, PH, CVE & Hemiballismus. She died due to a cerebrovascular episode on 29 June 2014. The patient had a DNAR form in place dated 5 June 2014, she was not on an End of Life pathway. A GP reviewed 24 hours following admission and a diagnosis of a chest infection was made R+ commenced. Obs were ceased as patient was put onto End of Life care on Syringe Driver. The care was appropriate and there was nothing to be handled differently.

There was an issue regarding coding:

147 –E11.9 Non-Insulin dependent Diabetes Mellitus without complications. The patient was on Insulin with complications, Diabetic Retinopathy and CVE.

Hogan Scale:	Definitely not preventable.
NCEPOD:	Good Practice.
Hogan Quality Scale:	Good.

Case 3

101 yr old female admitted to North Devon District Hospital and transferred to South Molton Hospital on 19 December 2014 at 3.30pm. She was admitted with a chest infection from which she died along with mid ventricular failure and old age. The patient had a DNAR form in place dated 23 December 2014. A GP reviewed her at initial clerking into South Molton Hospital and again 26 hours following admission. The patient was not given resus as she had a TEP form. The care was appropriate and there was nothing to be handled differently.

There were no clinical coding issues.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Good

Case 4.

88 yr old male admitted to Okehampton Community Hospital on 11 March 2015 at 10.31 with confusion & disorientation, UTI, LREI, diabetes type 2, because non-compliant with medication and aggressive with staff and was transferred to RD&E hospital where he died on 27 March 2015. He was clerked in by a GP and was reviewed 12 hours following admission. He had a DNAR form in place dated 11 March 2015 and was not on an End of Life care pathway. There were no aspects of his management that could have been handled better.

There were no clinical coding issues.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Good

Case 5

101 yr old female admitted to Honiton Hospital on 29 November 2014 at 6.00 pm. She was admitted with a chest infection/bronchopneumonia. She was previously being treated for malignant neoplasm of mandible. She died of pneumonia and old age. The patient had a DNAR form in place dated 29 November 2014. A GP initially clerked her in and reviewed her after admission. There was evidence of good end of life care and management of the patient.

There were no clinical coding issues.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Good

Case 6

102 yr old female admitted to Okehampton Community Hospital on 13 November 2014 at 2.30pm from a residential nursing home having been treated for GI Bleed AF and died of Bronchopneumonia on 22 November 2014. The patient was clerked in by a GP and reviewed by an OOH GP 24 hours following admission. The patient had a DNAR form in place dated 17 November 2014 and was on an End of Life Care Pathway. There was nothing that could have been done differently.

There were no clinical coding issues.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Excellent

Case 7

89 yr old male admitted to Honiton Hospital after failed discharge as he was unable to cope at home on 7 October 2014 at 3.00pm. He was frail, dysphagia and on antibiotics and had type 2 Diabetes and essential hypertension. He died of a chest infection. The death was reported to the coroner in view of the 4 falls he had. The patient had a DNAR form in place dated 16 October 2014. He was initially clerked in by GP and reviewed 24 hours after admission. The patient was not transferred to acute as after discussions with patient and relatives they decided transfer was not appropriate.

There were no clinical coding issues.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Good.

Case 8

85 yr old female with history of CVE admitted from a Residential Nursing Home to North Devon District Hospital after treatment for Intracranial Bleed/ + Peg Feed, admitted with Aspiration Pneumonia & CCF. She was reviewed on clerking by CT² and again 6 hours after admission. The decision was made to treat palliatively, no more bloods, wean O₂, 12 hourly Obs, no BP, Palliative R+. Condition deteriorated & R+ palliatively with syringe driver. She died of Aspiration Pneumonia and Congestive Cardiac Failure. A management plan was developed after first review. The death was referred to the coroner. A DNAR form was in placed dated 31 December 2014. Resuscitation was inappropriate due to a Treatment Escalation Plan (TEP) put in place.

There were no clinical coding issues.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice
Hogan Quality Scale: Good.

Case 9

97 yr old female was admitted from home to North Devon District Hospital on 19 April 2015 at 11.00pm. She was being treated for Metastatic breast cancer and Ischaemic Heart Disease. She presented with multiple pulmonary metastases + CA and requested no further intervention/obs. She had capacity and appropriately received palliative R+. She had a DNAR form in place dated 19 April 2015 and was on an End of Life Care pathway. She was initially clerked in by a CMT 2 and reviewed 10 hours following admission. A Consultant reviewed her 16 hours following admission. There was nothing that should have been handled differently.

There were no clinical coding issues.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Excellent.

Case 10

99 yr old female admitted from home to Seaton Hospital. She was being treated for a UTI and a chesty cough which did not clear with antibiotics. She died of old age. She was initially clerked in by a GP and reviewed after 9 hours following admission. She was transferred to RD&E. She was transferred to Seaton Hospital on 17 October 2014 at 3.00pm. She had a DNAR form in place dated 15 October 2014 which was updated on 20 October 2014. She was on End of Life Care Pathway. The patient did not receive resus and was on a Syringe Driver.

There were no clinical coding issues.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Good.

Case 11

86 yr old female was transferred from RD&E with a Fracture NOF (R) having been treated for R+ (R) Hemiarthroplasty, PH pulmonary fibrosis, NSTEM1, Vasovagal episodes having been admitted from a residential nursing home. She was transferred to Sidmouth Hospital on 27 January 2015 at 4.00pm. She had been initially clerked in by a GP and reviewed 24 hours following admission. No clinical deterioration was recognised and a EWS Score of 2 was taken at 23.35 on 5 March 2015. She was found dead in bed on 5 March 2015. The patient vomited x 3 21.20, 22.00, 22.50. P109, BP 220/110 (was 140/80). There were aspects of the patient's management that could have been handled differently.

There is an issue with the clinical coding.
No mention of Pulmonary fibrosis, Asthma, 1HD (PH NSTEM1).

Hogan Scale: Possibly preventable but not very likely, less than 50-50 but close call.
NCEPOD: Room for Improvement.
Hogan Quality Scale: Adequate.

Case 12

81 yr old female admitted from home to NDDH and transferred to Bideford Community Hospital with recurrent urosepsis, HAP, History of Type 2 Diabetes Mellitus, 1HD raised BP – (L) BK amputation, CKD Stage 4 Asthma, AF, Deteriorated despite R+. She was initially clerked in by a GP and reviewed 72 hours after admission where she was referred back to NDDH. The Consultant review took place 18 hours after clinical deterioration was recognised. No resuscitation was given as patient was at usual baseline. The patient had a DNAR form in place dated 2 August 2014. She was not on an End of Life care pathway. There were no aspects of the patient's management that could have been managed differently.

There were issues with clinical coding.
Codes should have been Ischaemic Heart Disease, Anaemia 2⁰ to chronic disease, transfusion dependent, Asthma, AF.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Excellent.

Case 13

92 yr old female admitted to North Devon District Hospital a residential nursing homes on 9 March 2015 at 11.40pm with 4 days of raised confusion and generally unwell. Seen by GP Diagnosis LRTI & R+ antibiotics. 2 Falls and complaining of left chest pain. Recent NSTEMI. She was clerked in by CT1 in A&E and seen by a doctor 1.25 hours following admission. She was assessed by the surgical team and transferred to care of the medical team. The patient had a DNAR form in place dated 9 March 15. TEP and NFT completed.

There were no issues with clinical coding.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Good.

Case 14

100 yr old female admitted to Ottery St Mary Hospital at end stage heart failure for palliative care. She was initially clerked in by a GP who reviewed her after 24 hours. GP recorded in notes 'not for EWS'. The palliative care team were involved in her care plan. She had a DNAR form in place dated 21 May 2014. Nothing could have been handled differently with her treatment.

There were no issues with clinical coding.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Excellent.

Case 15

84 yr old male admitted to RD&E from home. Transferred to Tiverton & District Hospital on 23 February 2015 at 3.00pm. He had been seen by a consultant one day prior to transfer and TEP completed having discussed with patient. This patient had significant comorbidities and the coroner has agreed the cause of death as Acute cardiac failure, Myocardial Infarction and type 2 diabetes mellitus. He was reviewed by a GP 1.5 hours after admission and agreed appropriate R+ of cardiac failure. This patient had a DNAR Form in place dated 23 February 2015. A consultant reviewed the patient 40 minutes from time of recognition of deterioration. Ambulance was called for transfer to RD&E, son asked doctor to stop active treatment.

There were no issues with clinical coding.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Good.

Case 16

94 yr old male was admitted to RD&E on 1 March 2015 and transferred to Tiverton & District Hospital on 23 March 2015 at 20.30pm. This patient was known to have end stage heart failure secondary to Ischaemic heart disease and essential hypertension. The patient died of bronchopneumonia, end stage heart failure, ischaemic heart disease. The patient was initially clerked in by a doctor and was reviewed by GP after 48 hours. The patient had a DNAR form in place dated 2 March 2015 and updated on 10 April 2015. The patient was not on an End of Life care pathway. There was nothing that could have been done differently for this patient, treatment after EWS score was taken was entirely appropriate.

There were no issues with clinical coding.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Good.

Case 17

95 year old female admitted to RD&E from home, transferred to Tiverton & District Hospital on 17 December 2014 and transferred again to RD&E where she died on 19 December 2014 from Urosepsis, heart failure, acute kidney injury, hyperalbuminemia, CKD, CA breast, osteoporosis. The notes identify GP clerked her in but no evidence of examination. She was reviewed after 24 hours and chest and CVS examined and documented. EWS showed evidence of deterioration but no notes documented. The patient had a DNAR form in place dated 5 December 2014. There could be improvements in documentation.

We have not yet identified whether there were any issues with coding, we are awaiting notes from RD&E.

Hogan Scale: Slight evidence of preventability (Lack of clinical notes).
NCEPOD: Room for improvement.
Hogan Quality Scale: Adequate.

Case 18

83 yr old male was admitted to Bideford Community Hospital on 10 February 2015 at 1.30pm due to increasingly difficult social situation. He had Type 2 Diabetes, CKD, and died unexpectedly. CKD, 1 HD, Parkinson's disease & ↑ frailty. He developed a chest infection but after 1st dose antibiotic, O2 Sats ↓ & became cyanosed & subsequently died. He was clerked in by a GP and reviewed 96 hours after admission by an OOH GP, requested by the nursing staff. The patient had a DNAR form dated 10 February 2015. There was nothing that could have been managed any better. The coroner should have been informed of this death.

There were clinical coding issues.
No mention of type 2 Diabetes, CKD and ?MI.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Good.

Case 19

78 yr old male admitted from home to North Devon District Hospital on 8 February 2015 at 11.05 am with the sudden onset of SOB, treated as RTI but subsequently found to have PE. The patient was clerked in by the SHO and reviewed 3 hours following admission. Consultant review 4 hours following admission. PE added to differential diagnosis as sudden onset SOB + 2/7 history of calf tenderness. The patient had a DNAR form in place dated 27 February 2015. First consultant review clearly states CxR demonstrates heart failure but queries PE in view of pain. Complex readmission following pneumonia. Admitted with bronchopneumonia and died as a result of hospital acquired pneumonia following complicated course in hospital including PE and LVF (appropriately managed).

There were no clinical coding issues.

The audit outcome of this case was independently reviewed by the Medical Director, whose opinion was that the Hogan Scale should be amended as the outcome for the patient was unlikely to have been different.

Hogan Scale:	Slight evidence for preventability.
NCEPOD:	Room for Improvement.
Hogan Quality Scale:	Good.

Case 20

88 yr old female admitted from home to Exmouth Hospital on 1 May 2015 at 1.00 pm with Type 2 Diabetes, visual impairment, ↑BP, CVD, PMR, Diverticular Disease with Colostomy, Leg Ulcers, frequent falls, expressed a wish to die. R+.

The patient had a DNAR form in place dated 1 May 2015 and was not on an End of Life Care pathway. The patient was clerked in by a GP but there is no documented evidence of the first review. There was a medication error which is unlikely to be relevant to the outcome - given long acting rather than short acting oxycodone. The care was appropriate and there was nothing to be handled differently.

There were clinical coding issues.

No mention of Polymyalgia rheumatica, Visual impairment and Hypertension.

Hogan Scale:	Slight evidence for preventability
NCEPOD:	Room for Improvement.
Hogan Quality Scale:	Good.

Case 21

64 year old female admitted from home to North Devon District Hospital with known non-alcoholic steato hepatitis cirrhosis, chronic kidney disease, Parkinson's disease, cerebrovascular disease, IBS paraprotein. The patient was admitted with pneumonia which was treated with antibiotics, BIPAP but continued to deteriorate and died from bronchopneumonia on 09 October 2014 with non-alcoholic steato hepatitis liver cirrhosis listed as a contributing condition. There was documentation of DNAR dated 08 October 2014. The initial clerking was completed by an FY1 with a further review 2 ½ hours after admission by an SpR. There was also a Consultant review 7 hours after admission. The care was appropriate and there was nothing to be handled differently.

There was an issue with coding:
No mention of cerebrovascular disease, PH TIA and hypocalcaemia.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Not recorded on form.

Case 22

87 year old male admitted from home to Exmouth Hospital on 03 January 2015 at 17:00 with hypoxia, cancer, cerebrovascular event, epilepsy, fall and multiple comorbidities. There was documentation of DNAR in the case notes dated 26 February 2014 and he died peacefully on 18th February 2015 (awaiting death certificate information). The initial clerking was completed by a GP and FY1 with a further review 13.5 hours after admission by a GP. It was noted that there were aspects of the patient's care that could / should have been managed differently and a Datix incident report and SEA were completed as a result.

There was an issue with coding.
End of life care not coded.

Hogan Scale: Definitely not preventable.
NCEPOD: Room for improvement (Aspects of clinical care that could have been better).
Hogan Quality Score: Good.

Case 23

98 year old female admitted from home to Seaton hospital on 06 October 2015 at 20:00 H/O 1 HD PPM, Syncope, Polymyalgia rheumatica, chronic kidney disease, congestive cardiac failure, peripheral vascular disease. She was transferred from Royal Devon and Exeter Hospital with a resolving lower respiratory tract infection. She gradually deteriorated and commenced a syringe driver on 05 May 2015 as unable to take oral medication for pain relief. There was documentation of DNAR in her case notes dated 27 April 2015. The clerking was completed by a GP with another review by a GP 48 hours after admission. The care was appropriate and there was nothing to be handled differently.

There was an issue with coding.
Peripheral vascular disease not included.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Score: Good.

Case 24

94 year old female admitted from home to Holsworthy Hospital on 27 November 2014 at 21:00 recorded as being "off legs" and with a chest infection. She was treated with antibiotics but gradually deteriorated and a decision was made to give palliative care. The patient was on an end of

life care pathway and there was documentation for DNAR in the case notes dated 12 December 2014. The patient died from bronchopneumonia on 31 December 2014 with old age and hypertension recorded as being contributing conditions. The clerking was completed by a GP with a review 24 hours after admission by another GP. Appropriate care given but it was noted that medical record keeping could be improved. There was also a note about bloods being taken on 28/11/14 Macrocytic anaemia, raised WCC, raised urea, Creatinine, urea & urate with a repeat found from 08/12 no change.

There were no issues regarding coding.

Hogan scale: Unpreventable.
NCEPOD: Good Practice.
Hogan Quality Score: Good.

Case 25

87 year old female admitted to North Devon District Hospital on 04 March 2015 at 21:10 with a chest infection. Treatment administered 4/0 gradual cognitive and mobility deterioration over the past 6 months. She was transferred to Stratton Hospital with an early warning score of 0 where she later died. DNAR documented in clerking after discussing with family. Patient says she would like resus. The clerking was completed by a CT1 with a review 22 hours after admission (no grade recorded) and a consultant review 22 hours after admission. The care was appropriate and there was nothing to be handled differently.

There were no issues regarding coding.

Hogan scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Score: Good.

Case 26

93 year old female admitted from home to Sidmouth Hospital on 23 February 2015 at 16:00. Decision that lower respiratory tract infection was not responding to oral antibiotics taken only 24 hours after transfer back from the Royal Devon & Exeter Hospital. The was possibly preventable but the clinician queried if IV antibiotics would be appropriate in a 93 year old with dementia, registered blind and with bullous pemphigoid. There was documentation of DNAR in the case notes dated 24 February 2015. The initial clerking was carried out by a GP with a further review from a GP 27 hours after admission.

There was an issue regarding coding:
No mention of the patient being registered blind.

The audit outcome of this case was independently reviewed by the Medical Director, whose opinion was that the Hogan Scale should be amended as the outcome for the patient was unlikely to have been different.

Hogan Scale: Definitely not Preventable.
NCEPOD: Not recorded on form.

Hogan Quality Score: Adequate.

Case 27

90 year old female transferred from Royal Devon and Exeter Hospital to Tiverton Hospital on 13 January 2015 for palliative care following a broken left acetabulum. On arrival the patient was unresponsive and kept comfortable with a syringe driver and sub-cut fluids as she was unable to take medication orally. She died from bronchopneumonia with ischaemic heart disease listed as a contributing condition. Death certificate information not available as referred to the coroner. The patient was on an end of life care pathway with documentation of a DNAR in the case notes dated 13 January 2015. The initial clerking was carried out by a GP with a further review from a GP 7 hours after admission. The care was appropriate and there was nothing to be handled differently.

There were no issues regarding coding.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Score: Good.

Case 28

78 year old female transferred from North Devon District Hospital to Holsworthy Hospital on 18 September 2014 at 14:45 with confusion and acute kidney injury. Pituitary haemorrhage of pituitary tumour, cerebral meningioma, type 2 diabetes, cerebrovascular event and asthma. Gradual deterioration and strongly declined acute hospital admission. The patient was on an end of life pathway and documentation of DNAR was present in the case notes dated 06 October 2014. She died from bronchopneumonia on 08 November 2014 with acute kidney injury, type 2 diabetes and cerebral meningioma listed as contributing conditions. The initial clerking was completed by a GP with a further review by a GP 175 hours following admission. Aspects of this patient's management that could have been handled differently identified as being more frequent medical reviews, however the nursing notes do not suggest this advertently affected the outcome.

There was an issue regarding coding.

Some conditions not coded: Acute kidney injury, Type 2 diabetes, Pituitary Tumour treatment, cerebrovascular event and cerebral meningioma.

Hogan Scale: Definitely not preventable.
NCEPOD: Room for improvement (Aspects of clinical care that could have been better).
Hogan Quality Scale: Adequate.

Case 29

89 year old male admitted from a Residential Nursing Home to North Devon District Hospital on 22 December 2014 at 17:39. The patient was admitted by GP with H/O confusion, restlessness and hypoxia. Query respiratory tract infection, query pulmonary embolism. Could he have had a pulmonary embolism in retrospect? The patient was clerked by an SpR then reviewed 19 hours following admission by an FY1 and a further consultant review 23 hours after admission. The patient died on 25 December 2014 from pneumonia and there was documentation of DNAR in his case

notes dated 23 September 2014. Areas of patient's management which could / should have been managed differently were: X ray and ECG requested 25/12. X Ray – R moderate pleural effusion and small to moderate pleural effusion, L no comment on either. Query facial weakness.

There was an issue regarding coding.
No mention of mixed aortic valve disease.

The audit outcome of this case was independently reviewed by the Medical Director, whose opinion was that the Hogan Scale should be amended as the outcome for the patient was unlikely to have been different.

Hogan Scale:	Definitely not preventable.
NCEPOD:	Room for improvement (aspects of clinical care that could have been better.
Hogan Quality Scale:	Not recorded on form.

Case 30

85 year old male admitted from home to Exmouth Hospital on 11 July 2014. The patient died on 24 August 2014 due to a lower respiratory chest infection. There was documentation of the DNAR in his case notes dated 11 July 2014. On 29 July 2014 the Nursing notes recorded "Now for palliative care". The patient was clerked by a GP with a further review by a GP 48 hours following admission. Patient's notes were misfiled and this was highlighted as an aspect of the patient's care that could / should have been handled differently.

There were no issues regarding coding.

Hogan Scale:	Definitely not preventable
NCEPOD:	good practice
Hogan Quality Scale:	Not recorded on form

Case 31

82 year old male admitted to North Devon District Hospital on 03 June 2014 at 16:37 with raised shortness of breath and Cachexi (Pulmonary hypertension, peripheral vascular disease (?Abdominal aortic aneurysm & amputation) with fast atrial flutter and prostate cancer. INR above 10 and a CT scan showed multiple metastases (not from prostate). The patient was transferred to Stratton Hospital for palliative care to be near his family. He was reviewed and clerked by an Emergency Department Consultant on admission with a further review 2 hour later. There was documentation for DNAR in his case notes. Management of this case was appropriate.

There was an issue regarding coding.
Specialist palliative care on E-discharge and in clinical notes, Prostate cancer, multiple malignant deposits – not prostate, Adeno carcinoma.

Hogan Scale:	Definitely not preventable.
NCEPOD:	Good Practice.
Hogan Quality Scale:	Excellent.

Case 32

92 year old male admitted to Holsworthy Hospital on 02 March 2015 at 14:00 with community acquired pneumonia which fails to respond to oral treatment. Patient also has type 2 diabetes, dementia, epilepsy, hypertension and is on the end of life register and known to the hospice team. The patient died from bronchopneumonia on 17 March 2015. On admission the patient was clerked by a GP with a further GP review 24 hours after admission. There were no aspects of the patient's care that could / should have been handled differently. He was on an end of life care pathway and documentation of DNAR was held within his case notes.

There was an issue regarding coding.

Conditions not coded: Type 2 diabetes, epilepsy, hypertension, Hospice team involved in care plan.

Hogan Scale: Definitely not preventable.

NCEPOD: Good practice.

Hogan Quality Scale: Good.

Case 33

88 year old female admitted to Okehampton Community Hospital on 07 October 2015 at 16:00. She was transferred from Royal Devon and Exeter Hospital with an ovarian mass, atrial fibrillation, congestive cardiac failure, osteoarthritis, PH breast cancer and was increasingly frail with sudden deterioration. Old age and congestive cardiac failure have been listed as the conditions leading to her death on 17 November 2014. The initial clerking was completed by a GP with a further GP review 24 hours after admission. There was documentation of DNAR in the case notes and the care was appropriate with no aspects of the patient management being identified as needing to be handled differently.

There was an issue regarding coding.

No mention of PH breast cancer.

Hogan Scale: Definitely not preventable.

NCEPOD: Good Practice.

Hogan Quality Scale: Good.

Case 34

93 year old male admitted from a Residential Nursing Home to North Devon District Hospital on 09 November 2014 at 09:22. The patient had severe dementia and fell causing him to sustain a broken neck of the left femur. He then developed pneumonia (Hospital Acquired Pneumonia) which was resistant to treatment. The patient was unfit for operation and developed acute kidney injury. S/B palliative care and commenced on end of life pathway. The condition directly leading to the patient's death was chest sepsis. Documentation of a DNAR was present in the case notes and was dated 11 November 2014 and the patient was placed on an end of life care pathway. The initial clerking of the patient was undertaken by a CT2 with a review 3 ¼ hours after admission completed by an F2, followed by a Consultant review 22 hours after admission. There were no aspects of the patient's management that could have been handled differently and the care was appropriate.

There was an issue regarding coding.

Specialist palliative care input, hip operation coded but not undertaken as patient was deemed unfit.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Good.

Case 35

92 year old female admitted from a Residential Nursing Home to Sidmouth Hospital on 11 March 2015 at 16:00. She was transferred from RD&E unrousable with a chest infection not responding to treatment. Known to specialist palliative care team, transferred for palliative care on a syringe driver. The patient died due to bronchopneumonia and had documentation of DNAR in her case notes dated 11 March 2015 and was on an end of life care pathway. The initial clerking was completed by a GP and the patient was reviewed again 25 hours following admission by a GP. The care was appropriate and there was nothing to be handled differently.

There was an issue regarding coding.
Not coded for Palliative Care or Carcinoma of bowel

Hogan Scale: Definitely not preventable.
NCEPOD: Good practice.
Hogan Quality Scale: Good.

Case 36

86 year old male admitted from home to North Devon District Hospital on 10 March 2015 at 04:30. Patient with long standing H/O coronary artery bypass graft, angina, valve replacement and pacemaker. Admitted as an emergency from home with UTI diagnosed as septic and was treated aggressively with antibiotics. Unfortunately the patient deteriorated and was provided with good end of life care. The patient died of a UTI on 14 March 2015. The patient was on an end of life care pathway and there was documentation of DNAR in their case notes dated 11 March 2015. The initial clerking was carried out by an SpR, followed by a review with an SHO 1 ½ hours after admission and a consultant review 3:20 hours after admission. The care was appropriate and there was nothing to be handled differently.

There was an issue with coding.
Cause of death UTI.

Hogan Scale: Definitely not preventable.
NCEPOD: Good Practice.
Hogan Quality Scale: Excellent.

Case 37

87 year old male admitted from home to North Devon District Hospital on 31 March 2015 at 23:25 feeling weak in legs and the provisional diagnosis was a lower respiratory tract infection. There was

an episode of epigastric pain post lunch and collapsed on the way to the bathroom, CPR was initiated but unsuccessful. The patient died on 02 April 2015 from acute myocardial infarction. The patient was not on an end of life care pathway and there was no documentation of DNAR in his case notes. The initial clerking was carried out by a middle grade doctor with a review 4 hours after admission from an ST1 and a consultant review 8 hours after admission. It was documented that there were aspects of the patient's management that could have been managed differently such as possible test for undiagnosed epigastric pain. EWS Score = 1 (Heart rate 100).

There were no issues regarding coding.

The audit outcome of this case was independently reviewed by the Medical Director, whose opinion was that the Hogan Scale should be amended as the outcome for the patient was unlikely to have been different.

Hogan Scale:	Definitely not preventable.
NCEPOD:	Room for improvement (aspects of clinical care that could have been better).
Hogan Quality Scale:	Good.

Case 38

88 year old female admitted from home to North Devon District Hospital on 13 January 2015 at 18:47 with ischaemic heart disease, atrial fibrillation, hypertension, transient ischaemic attack and chronic kidney disease stage 3. The patient was on an end of life care pathway and had documentation of DNAR in the case notes dated 14 January 2015. The patient died of pneumonia on 17 January 2015 after expected deterioration. An FY1 completed the clerking of the patient and then a follow up review was completed by a SpR 4½ hours after admission with a consultant review 14 hours after admission. The care was appropriate and there was nothing to be handled differently.

There was an issue regarding coding.

No mention of pressure ulcer.

Hogan Scale:	Definitely not preventable.
NCEPOD:	Good Practice.
Hogan Quality Score:	Excellent.

Case 39

92 year old female admitted from home to North Devon District Hospital on 14 August 2014 at 01:45 with chest pain. X Ray completed and showed displaced # of sternum. There was no documentation of DNAR in the case notes and the patient was not on an end of life care pathway. The patient died of pneumonia on 18 August 2014. There was a review by an ST2 3 hours after admission followed by a Consultant review 77 hours after admission. It was identified that some aspects of the patient's care could have been handled differently such as earlier identification of the broken sternum and TEP for discussion with patient. ICU consultant noted that CPR would be futile.

There was an issue regarding coding.

No mention of RBBB, cardiomegaly, or # sternum and pneumonia .

Hogan Scale:	Slight evidence for preventability.
NCRPOD:	Room for improvement (aspects of clinical and organisational care that could have been better).
Hogan Quality Scale:	Adequate.

Case 40

75 year old male admitted from home to North Devon District Hospital on 12 May 2015 at 10:15. Patient had small cell lung cancer and sudden shortness of breath at home, pulmonary embolism or chest infection, treated for both. The patient deteriorated and was provided with good end of life care. There was documentation of DNAR in the case notes dated 10 December 2014. The patient died on 13 May 2015 due to a lower respiratory tract infection with pulmonary embolism, small cell lung cancer and pulmonary fibrosis all listed as contributing factors. The clerking was completed by an SHO followed by another review 9 ½ hours after admission completed by an SHO and registrar. The consultant review was completed 11 ½ hours after admission. The care was appropriate and there was nothing to be handled differently.

There was an issue regarding coding.

No mention of neutropenic sepsis, consolidation on CXR.

Hogan Scale:	Definitely not preventable.
NCEPOD:	Good practice.
Hogan Quality Scale:	Good.