Milton Keynes University Hospital NHS
NHS Foundation Trust

Fractured Neck of Femur 01/12/14 – 30/11/2015 (TBC)

SURGERY DIVISION – MUSCULOSKELETAL

Project team		
Name of project lead	**Title/grade**	
Debbie Bandey	Patient Safety Lead for Surgery	01/12/14 - 30/11/15 02/03/16
Name	Title/grade	
Name	Title/grade	

Specialty/service/operational area (locality)

TRAUMA AND ORTHOPAEDICS

Disciplines involved

Trauma and Orthopaedic Surgeons, Fragility Nurses

Contents

Background/rationale

This is audit has been completed following request from Mortality Review Group – triggers on Dr Foster data shows a higher than expected incidence of hospital deaths in patients who have been admitted to Milton Keynes University Hospital NHS Foundation Trust (MKUH) with Fractured Neck of femur (22 reported, expected 18.37).
This issue has been previously audited where there were no highlighted concerns about the patients care. The time frame for this audit is 1st December 2014 – 30th November 2015. Any findings, recommendations and actions will be shared with the Trauma and Orthopaedic Team, and any other relevant areas.

Aim

- The audit will highlight any issues with patient care in relation to fractured neck of femurs and will help us identify any changes to practice to ensure a safe service.
- To establish if any of the deaths reported could have been avoided.

Objectives

To ensure that all subsequent fractured neck of femur patients are managed correctly and in accordance with NICE guidance.

To identify any gaps in the medical management of patients presenting with fractured neck of femur.

Standards

NICE Guidance – CG124 Fracture Neck of Femur Management
MKUH National Hip Fracture Database
MKUH Planned Joint Replacement Surgery

Method/Sample

All retrospective medical records review of all patients admitted to MKUH with fractured neck of femur that died in the year between 1st December 2014 and 30th November 2015. There were 241 #NOF patients admitted to MKUH in total during this period however 8 of these patients were treated non-operatively.

The original sample size was identified by the data provided by Dr Foster (22 patients – 17 MRNs provided when requested). On beginning audit and review of medical notes, it was found that one patient had # Nof Surgery in 2013 (013072 IG) and therefore has been excluded from this study.

In additional to reviewing the medical records of the 16 patients, a review of the data held by the Fragility Nurse Team was also undertaken to ensure all patients had been included it was established that there was 29 patients data held by them. On further investigation one patient (263329 DC) had been discharged from hospital and therefore has been excluded from this audit.

As the final figure is 28 and this does not correlate to the original intended audit, the decision was made to review all 28 records.

Data source

Data obtained from Dr Foster, Fragility Nurse Team and the patients' health records.

Results/Conclusion:

The audit involved a sample size of 28 patients who had been admitted with fracture neck of femur and who had died in hospital.

Summary of Results:

- Of the 28 patients, 21 were women (75%).
- 18 patients (67%) were over the age 80, with the highest percentage (37%) being between 80 and 90 years of age.
- 7 of the patients had been admitted on a Saturday (25%).
- 19 (68%) had fallen at home as opposed to nursing home etc, none were inpatients at the time of the fall. 1 had fallen whilst out with family. 1 patient had a subsequent fall whilst in the Emergency Department ((ED) - investigated).
- 19 (68%) of the patients had 4 or more co-morbidities and 3 were known cancer patients.
- 6 (22%) were documented as being known to have dementia. A lower figure than suspected.
- 6 (22%) of the patients died on a Thursday. 5 on a Monday (18%) and 5 (18%) on a Saturday.
- The majority of patients (16, 57%) died whilst an inpatient on Ward 21 – the designated ward for T&O patients. unexpectedly 8 patients (29%) died on a medical ward. 2 died on DoCC and 2 it was not possible to identify the ward from the medical notes.
- Operation to death in number of days; 39% (11) had died within 7 days of their operation. 3 patients within the audit did not have surgery as they were not fit for surgery.
    - 90+ female died 11 days after admission, significant PMH – MI.
    - 100+ female died 2 days after admission, significant PMH – Intracerebral Haemorrhage.
    - 60+ male died 5 days after admission – significant PMH – severe sepsis.
- Cause of death given on Referral to Coroner Form – 1a Sepsis/Pneumonia/RTI – 17 patients (61%)
- 100% of patients received care as recommended by NICE Guideline – CG124 Key priorities.
- All patients received appropriate care medical care, and nursing care. The Personalised care plan for the dying patient appears to improve documentation between staff and the family members.
- Two patient's care was investigated as a Serious incident
    - HW, 90+, F, fell at home and fell in ED. ED investigation - **Pneumonia**
    - DB, 80+,M,Fall whilst out with family - **Hypoxic Brain Injury**

- When adjusting the figures (28) to remove the 3 cancer patients and the 3 patients who did not have surgery gives the number identified by Dr Foster – 22 patients

- T&O surgeons have held regular Mortality and Morbidity meetings, in collaboration with the Orthogeriatrician.
- However there was only 50% evidence that patients were discussed at these M&M meetings.

Areas of good practice:

- All patients were assessed and managed as recommended by NICE guidance CG124 – National Hip Fracture Management.
- Documentation for these patients is clearly demonstrated in the fracture neck of femur pathway.
- Early involvement with the Orthogeriatrician Team.
- Documentation for patients on the personalised Care Plan for the Dying appears to improve communication with families

Areas for improvement:

- Evidence for M&Ms should be more robust
- Minutes of M&M meetings should follow trust standard templates
- Minutes and presentations should be stored centrally

Recommendations for improvement:

Development of a Standard Operational Policy for T&O M&M meetings to include:-

- Collection of Mortality Review Forms from the Bereavement Office monthly.
- M&M lead will be advised by the Patient Safety Lead of the Mortality cases for discussion at the next meeting
- Patient details will be added to the database prior to the next meeting, as a means of tracking.
- Attendance at M&M meeting must be signed by all and will be removed at the end of the meeting for scanning and saving to the Governance shared drive. Attendees will also be documented in the minutes.
- Mortality Review forms must be completed during meeting.
- M&M minutes - once written will be sent to the lead for approval (marked DRAFT). Once agreed they will be returned (marked APPROVED).
- Morbidity cases will be minuted.
- Future audit - Database will be updated, including any morbidity cases discussed, lessons learned and actions.
- Presentations at the end of the meeting will be collected and stored.
- A pdf copy of all of the above will be sent to the audit lead to store in the Consultants shared drive – if they wish to.

Incorporate SMART (Specific Measurable Achievable Realistic Timely) principles in all recommendations.

1. By 31st July 2016 the T&O M&M meetings will be minuted using Trust standard, Form A will be completed for each patient, and once completed will be stored centrally on the Clinical Governance Shared drive.
2. By 31st July 2016 Supporting documentation will be on the Clinical Governance Shared Drive in the M&M folder
    a. Database for cases discussed

b. Signed attendance sheets
c. Minutes
d. A Forms
e. Presentations including actions plans

Learning points

A robust system (Spreadsheet) is required for tracking cases for discussion.

Action plan

All recommendations in the clinical audit report should be numbered and mirrored in the action plan. Actions will be captured as evidence of Quality Improvement initiatives.

Project Number:

KEY (Change status)
1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented
4 Recommendation never actioned (please state reasons)
5 Other (please provide supporting information)

Clinical Audit Action Plan

Project title	Fractured Neck of Femur Audit 01/12/14 – 30/11/5

Action plan lead	Name: Debbie Bandey	Title: Patient Safety Lead for Surgery	Contact: Bleep 1320 ext 86213

Ensure that the recommendations detailed in the action plan mirror those recorded in the "Recommendations" section of the report. The "Actions required" should specifically state what needs to be done to achieve the recommendation. All updates to the action plan should be included in the "Comments" section.

Recommendation	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Comments/action status** *(Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)*	**Change stage** (see Key)
1. T&O M&M meetings will be minuted using Trust standard, Form A will be completed for each patient, and will be stored centrally on the Clinical Governance Shared Drive.	Development of appropriate minutes and SOP for M&M meetings.	31st July 2016	Debbie Bandey Patient Safety Lead for Surgery	Attendance Register and Minute template has been developed for use at first M&M meeting following this audit. Admin support provided for M&M meeting	*3*
2. Supporting documentation will be stored on the Clinical Governance Shared Drive in the M&M folder a. Database for cases discussed b. Signed attendance	A robust storage and system will be developed.	31st July 2016.	Lee Bonner, Clinical Governance Admin Support	New SOP will be presented with Audit	*2*

sheets c. Minutes d. A Forms e. Presentations including actions plans					