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NHS Foundation Trust

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Our Ref: MG/CS/KLG/PRIOR

28 July 2014

Mr M Kendall
Assistant Coroner for West Sussex
County Record Office
Orchard Street
Chichester
West Sussex
PO19 1DD

Dear Mr Kendall

RE: Inquest into the death of Denise PRIOR – Regulation 28 response

Thank you for your letter dated 3 June 2014.

The Trust has undertaken a thorough investigation and review into the areas in which you raised concern and is pleased to enclose an action log setting out the action taken.

I hope that you will be reassured by the actions taken by the Trust and please do not hesitate to contact me should you require any further information or clarification.

Yours sincerely

[redacted]

Marianne Griffiths
Chief Executive

Enc

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Matter of concern	Action taken	Timeframe	Overall Responsibility	Monitoring process
(1) Application of the NEWS System and apparent inconsistencies between the actual score and what had been recorded on the chart and why scores were re-interpreted and effectively 'down graded'.	**Matrons/ outreach to do update sessions on the wards to ensure all know the escalation process whether using Patientrack or paper version. Use of ward meetings or 'drop in' update sessions.**	**3 Months**	[redacted]	**Clinical Audit programme to monitor effectiveness**
	Monthly agenda item at Sisters meetings across both sites to highlight and review the NEWs process, escalation and incidents.	**Ongoing**	[redacted]	**Review of Sister's meeting Agenda's and minutes**
	NEWs is discussed at resuscitation training annual updates – ensure that scoring and escalation is reinforced at these sessions on both sites.	**Ongoing**	[redacted] **and resuscitation training team**	**Register of resuscitation trainees and programme agenda and notes.**
	Continue to ensure NEWs section on AIMs and ALERT course are given adequate emphasis.	**Ongoing**	**AIMS and ALERT course programme leaders and** [redacted]	**Register of attendees, course programme and notes.**
	Review of paper observation chart – there is already a space at the bottom to			

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	document whether increasing NEWS has been escalated but needs revising to allow better documentation on chart itself	**3 months**	[redacted]	**Review of paper charts**
	Cardiac arrest cases – all are currently reviewed, including frequency of observations. This will be fed back to teams if not appropriate as part of RCA	**Ongoing**	[redacted] **with matrons and ward managers**	**Review of RCA's at clinical governance meetings**
	Ensure all wards have: **a. the laminated escalation sheets which clearly indicate when to escalate to medical team and when to be increasing observations. To be displayed clearly and attached to front of patient's nursing notes folder** **b. the ward computer screen open at the nursing station to see clearly those who are scoring highly and when observations are due**	**3 months**	[redacted] **with matrons and ward managers**	**Audit of where laminated sheets are displayed on each ward.** **Observational audit by managers and matrons on walk**

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				abouts and frontline Fridays.
(2) Lack of recording of Oxygen prescription and concentration and ability to record on patient rack.	**There is a current and very robust Trust Policy regarding prescribing and monitoring of Oxygen – with a requirement to be followed in all settings.**  oxygen-in-adults-poli cy-for-the-prescriptio **There was Rapid response alert issued by NPSA in 2009; we completed a self-assessment and did implement the issues identified but there is a case for refreshing the message five years on.**  NRLS-1124-RRR-Oxy gen-safety-2009.09.: **Re-audit the use and**	**Review Date November 15** **Expiry Date March 2016** **6/52**	Consultant Respiratory Physician Consultant Anaesthetist Team Manager, Clinical Pharmacy Services [redacted]	**Audit of adherence to policy by Audit Committee and Medical Gases Group. (Chair [redacted]** **Redistribute Rapid Response Report with update from Chair of Medical Gases Group**

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	compliance of the current drug chart, which was developed in line with the oxygen prescribing policy and directs towards identification of device and O2 saturation target.	**Six Months**	[redacted] with Audit Group.	**Presentation of Audit Outcomes to Clinical Governance Groups.**  Copy of Oxygen May 13.xls
	We are going to have access to an on-line training package (via HEKSS) for F1s – with a respiratory section which should include use of oxygen. This should become part of Junior Doctors mandatory training for completion during the first year	**1 Year**	[redacted] and DME	Review of mandatory training modules completion.
	We do have access to on-line training packages for nurses in relation to medical gases including oxygen and should explore further their usefulness and a method to implement their completion	**1 Year**	[redacted] and Matrons	Review of nurse training curriculum.

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(3) Problems with intermittent working of patientrack and use of paper record as an alternative.	**In contradiction to the evidence given to the Assistant Coroner at the Inquest, Patientrack & Wifi were working well on the days in question and this has been confirmed electronically.** **The issue appears to be that the android handheld devices were not charged, though Patientrack can also be accessed at all times by desktop computers at the nurses station.** **We will be performing another Wifi survey of WSHFT for the Electronic Prescribing Medicine Administration (EPMA)**	**Ongoing review ensuring devices are charged, working and utilized.** **6 Months**	**[redacted] – Zen Mobile** **Matrons and ward managers** **[redacted] and [redacted]**	**Patientrack electronic reports** **Walkabouts and frontline Fridays.** **Ongoing presentation to EPMA project Group and**

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	project & [redacted] (Director of IT) has requested that Middleton Ward is given priority again for this survey.			**Patientrack team.**
	The use of paper charts should be seen now as exceptional and for contingency, only when there is a significant IT problem.	**1 Year**	**[redacted]**	**Disappearance of paper charts from ward areas.**
	Patientrack data reporting – We are planning to roll out and continue the work of the outreach team on the Worthing site, across both sites – reviewing individual ward data and feeding back to the sisters. This looks at timeliness of observations in relation to NEWs scores which is part of the escalation process. This will highlight wards who may need support and more education.	**Ongoing**	**[redacted] and Matrons**	**Patientrack regular reports**
	Spot checks by matrons of Patientrack i.e reviewing ward patients in a.m on Patientrack, identifying	**Ongoing**	**[redacted] and Matrons**	**Observational audit**

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	those scoring higher than expected and visiting wards to check responses and timeliness of observations, as appropriate **Introduction of Patientrack 'auto-alerting', (either to medical bleeps or outreach teams) and senior ward nurse in charge if a patient's NEWs deteriorates beyond an agreed threshold**	**Not yet known**	**[redacted] and Patientrack implementation Team**	**Patientrack reports**
(4) Record of inspired Oxygen concentration on Patientrack.	**In contradiction to the evidence given to the Assistant Coroner at the Inquest, Patientrack does have the facility to record the inspired oxygen concentration (FiO2) delivered to the patient and this is used widely throughout the Trust. (The <u>prescription</u> of oxygen currently takes place on the drug chart , but will move onto the electronic prescription– Patientrack is for recording and not prescribing). The link opposite gives a realtime, assessment of the inspired**	http://ryras042/reportserver/pages/reportviewer.aspx?/Assessments/FI02+Launch 1 Year	**EPMA project Board for electronic prescribing of Oxygen**	**EPMA audit review**

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	oxygen concentration for each ward patient monitored. **The team at WSHFT are also in the process of upgrading this facility so that the actual oxygen device (eg nasal prongs, venturi, non-invasive ventilation) can also be recorded in Patientrack, & this facility will also be shared with other hospitals in the UK using Patientrack.**	1 Year	[redacted] **and** [redacted]	**Patientrack Audit**

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