Stockport NHS
NHS Foundation Trust

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Our ref. AB/AF/CM/PR_letter To HM Coroner John Matthews
Your ref. JSP/KN/01936-2014

24 March 2015

H. M. Coroner
Greater Manchester South District
Coroner's Court
Mount Tabor
Mottram Street
Stockport
SK1 3PA

Dear Mr Pollard

Re: John Michael Matthews (Deceased)

Thank you for your letter, of 29 January 2015, concerning the inquest of the above named patient. As always, I am grateful to you for highlighting your concerns on the Regulation 28 'Report to prevent future deaths' and for providing me with an opportunity to respond. I shall respond to each of your concerns as you have detailed them:

Whilst in the Emergency Department (ED) at Stepping Hill Hospital, he was triaged without the triage nurse having seen the ambulance Patient Report Form.

The following system is in place for all patients arriving by ambulance to Stockport NHS Foundation Trust: the ambulance personnel will deliver a verbal handover to the triage nurse whilst a hard copy of the ambulance Patient Report Form (PRF) is left with the reception staff. This is then scanned by reception staff into the ED electronic system (therefore accessible to all) and the hard copy is taken to the main base in the ED clinical area. The ED electronic system is known as Advantis ED and instructions for obtaining access as well as training is part of induction training, this is for all staff including locums. This training includes instruction on how to access scanned documents.

In his statement to you, [redacted] states that *"Paramedic notes were not available to me."* What is clear on review of the events is that the triage nurse received a verbal handover as per usual practice. A review of the electronic system has been undertaken which shows that the ambulance document (PRF) was scanned and was added to the system within 13 minutes of arrival and ten minutes prior to the doctor seeing the patient so it is apparent that the system in place to link the paper document with the electronic document worked. I am unable to explain why the locum doctor did not review this information but am assured that he was given the training to enable him to do so.

To prevent a future occurrence of a similar situation, we have reviewed the induction training pack and amended the written information given to staff; this was launched in November 2014. We also

work closely with locum agencies to get this information to the locum doctor as quickly as possible prior to their shifts so they have time to review and digest it before commencing their shift.

This document clearly states:

> *The ambulance sheet is scanned on arrival – please access it electronically whilst assessing your patient. The hardcopy can also be found in the tray at main base.*

The document also very clearly states:

> *There is a Registrar in the department 24 hours a day and a consultant for 8-13 hours per day, therefore if there is any doubt about the clinical management of a patient within the Emergency Department, staff should seek this senior help at all times.*

At the start of a shift, the locum is asked if they have read and understood the induction document, they are asked to sign page 2 of the document which confirms this and they are asked if they have any questions. I hope this clarifies for you the Emergency department's recognition of the importance of robust induction for all locum staff.

The doctor having care of him in the ED was a locum doctor working his first (and only) shift at the hospital. That doctor told me that he could not find the PRF nor could he access the completed computerised system.

As in the response to your first concern, I can confirm that the locum doctor completed the local induction which includes access to Advantis ED (our paperless IT system in ED).

This eLearning includes all the aspects of our paperless system and takes up to 1 hour to complete. Once completed the doctor has to confirm that they have understand the system before a username and password are issued.

All junior staff, including locums, are aware to request support or advice if necessary from the 'ED floor lead'. Unfortunately, I cannot explain why this doctor did not ask for assistance when he found he was unable to see the ambulance information given the wealth of advice he was given regarding asking for assistance.

It was agreed by the ED consultant giving evidence that neurological observations ought to have been instituted, but they were not.

The ED record for this attendance state that at triage, neurological observations were not immediately required as the patient's issues had resolved. Following a review by the clinicians in the department the ED Clinical Director agrees that as the patient had suffered a collapse and had been unresponsive for approximately 20 minutes, that a minimum of one set of neurological observations should have been done (and then followed up as per protocol if appropriate).

The ED Matron has re-iterated to all nursing staff that vital information must be passed on to the doctors. This has formally been discussed in the sisters' meeting and at safety huddles. Safety Huddles are times when nurses and doctors meet for handover at the beginning or end of each shift. At these times information is shared about current patients along with any specific department information or to highlight any learning identified following investigations into incidents or complaints. Neurological observation needs have been discussed during these safety huddles, at Sisters' meetings and shared within the ED Quality Newsletter which is sent to all ED staff.

There was an unnecessary and to some extent unexplained delay in sending him for a CT of his head.

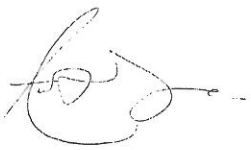
Unfortunately when reviewing the case we have seen that although a scan was booked for this patient it was done incorrectly by a permanent FY2 doctor on behalf of the locum. 'Out of hours', all scans should be booked electronically but then also verbally communicated to radiology. On review it would appear that this did not happen. This process is clearly stated within the locum induction pack.

CT requests should also be communicated to the co-ordinating nurse again on review it appears that this also did not happen so the senior nurse wasn't aware of the need.

For the future, to avoid a reoccurrence of this incident, we have instituted a system of checklists whereby a patient cannot leave the ED without all the investigations and treatments being completed. The investigations requested are clearly shown on Advantis ED therefore the nurse caring for the patient and the shift co-ordinator will be aware of investigations requested.

I hope that this response answers your concerns and provides you with the assurance that the Trust is committed to improving the quality of care we give to all our patients. Please do not hesitate to contact me if you have any further questions regarding this matter.

Yours sincerely



Ann Barnes
Chief Executive