University Hospitals of Leicester NHS

NHS Trust

HM Coroner for Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester
LE1 9BG

7th December 2015

Dear Mrs Mason

Re: Alan Henry Tear

Thank you for the Regulation 28 Report sent by your Assistant Coroner on 14th October 2015 I am now in a position to respond.

As indicated Mr Tear died from post-procedure complications on the 1st May 2015 following the insertion of a biliary drain by the interventional radiology team and transfer to a surgical base ward.

The Regulation 28 Report raises three matters of concern:-

1. Post-Operative instructions were not followed by nursing staff.

2. Post-operative observations were not reported to medical staff as required when the EWS was rising.

3. It was not clear that the Interventional Radiology team knew or understood what observations the nursing staff would carry out and the communication between the teams needs to be reconsidered.

At the point of transfer of Mr Tear from the interventional radiology team to the surgical ward there should have been an effective handover between nursing staff which should have been implemented on the surgical ward. This did not happen in this occasion. Handover is effected orally and supported by a sheet documenting the required frequency of nursing observations for the patient. This sheet follows the patient and documents the care needed. Regrettably the frequency of nursing observations was not undertaken in accordance with the patient's requirements as documented on the handover sheet.

As an immediate action after the inquest the matron met with all nursing staff on the ward to discuss what had occurred in this case. In particular ward staff

were required to consider and be aware of the required frequency of observations as set out in the handover sheet.

Additionally, as part of our wider learning, our Clinical Director for the Clinical Management Group (CMG) will, along with the Medical Lead for Imaging ensure that there is a continuous teaching session for CMG staff on the issue of Interventional Radiology for Surgical patients ; describing the techniques, complications, frequency of observation for each different procedure, identification of complications and escalation. This will have occurred before the end of December 2015.

Furthermore our Head of Nursing for the CMG will ensure that there is an audit undertaken to monitor the compliance with nursing instructions following radiology procedures. This audit will have been completed by the end of November 2015 and repeated thereafter according to its findings. The findings will be reported to the CMG Board.

With a view to strengthening our systems and processes generally the Trust intends to introduce a system for electronically recording nursing observations. This system (E-obs) is expected to be in place by the end of March 2016 and is led jointly by our Interim Deputy Medical Director and Assistant Chief Nurse. Once implemented, this system will issue alerts when required highlighting when observations have not been undertaken.

As a result of this inquest we will be redesigning the sheet which documents the required frequency of observations to be undertaken on the receiving ward. The sheet and required frequency will vary according to the type of the procedure performed. To optimise the hand over the sheet will be signed by the Interventional radiology nurse and receiving ward at the radiology theatre. Our Medical Lead for Imaging, in consultation with surgical colleagues, will have completed this work by the end of December 2015.

It is said that the post-operative observations were not reported to medical staff when EWS was rising. I understand that this was because you heard evidence that where there were conflicting EWS scores taken within a very short period it is always appropriate to act as if the more worrying score is the more accurate score.

As you will be aware EWS is a tool to assist clinicians to identify deteriorating patients. It relies on various parameters (including blood pressure) being measured and scored. However it does not replace clinical judgement and its usefulness depends on the reliability of the scores identified. Where there is genuine and immediate doubt as to the reliability of any particular reading our practice is to repeat that reading and place reliance on the score which is considered to be valid. We do not consider that it would sensible to change this practice and will not be doing so.

In this case, for a particular EWS score, there were two measurements of blood pressure, one undertaken on the patient's arm with another

measurement taken very shortly thereafter on the patient's leg. In some cases a patient's habitus can cause the blood pressure arm-cuff to be ill-fitting which can render a result unreliable. This would explain the need for the observation to be repeated on the patient's leg.

However we remain committed to improving our on-going education at the Trust on the EWS scoring tool. Our Interim Deputy Medical Director and Assistant Chief Nurse are currently rewriting the EWS training package and will use what occurred in this case to ensure that clinical staff are given clarity on the actions that they must take when there is either doubt as to the reliability of any particular EWS score or the EWS score is considered to require escalation. This work is due to be completed by the end of March 2016.

I trust that this provides you with the assurance that you seek that we take these matters seriously.

If you wish for any further information please feel free to write to me again.

Yours sincerely

[redacted]

[redacted]
Chief Executive

Cc: [redacted], Assistant Director (Head of Legal Services)
[redacted], Interim Medical Director
[redacted], Chief Nurse