University Hospital of South Manchester NHS
NHS Foundation Trust

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Mr J S Pollard
Senior Coroner
HM Coroner – Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

13 May 2016

Dear Mr Pollard,

Re: Regulation 28: Prevention of Future Deaths report – Mr. Patrick McGagh (Deceased)

I am responding to the Regulation 28 – Prevention of Future Deaths Report Issued to University Hospitals of South Manchester (UHSM) on 6 May 2016.

*The **MATTERS OF CONCERN** are as follows:-*

On the 5th November he was seen by his GP and he had just been discharged from Wythenshawe Hospital three days previously. No discharge letter of note had been provided to the GP nor had the patient been sent home with any of the antibiotics which had been prescribed to him by the hospital doctor. Neither the care staff nor the GP was aware that he should have been taking these antibiotics.

We have reviewed Mr McGagh's attendance at UHSM on 2nd November 2015. We can confirm he attended the Emergency Department on this date presenting with scrotal swelling and accompanied by his carer. Mr McGagh was reviewed by both the on call medical and the urology teams. Following assessment at approximately 23:30 hour it was felt that Mr McGagh did not require formal admission and could be discharged back to his nursing home. Mr McGagh was then transferred to a bed within the Clinical Decisions Unit (CDU) to be made more comfortable and to await ambulance transport.

Thank you for raising these concerns, UHSM recognize the importance of effective documentation and communication with patients' GP's and care staff providing ongoing support for patients. The concerns you have raised will be responded to in turn with an outline of the actions we are taking to address them.

1. Concern: *No discharge letter or note had been provided to the GP.*

The Trust does not send notification of attendance to the Emergency Department. This decision was made following consultation with local GP's, where it was agreed that the ED would no longer issue a notification of attendance on discharge from the ED. Formal discharge letters are produced only following an in-patient stay.

However a review of the clinical records indicate that the urology doctor completed an outpatient discharge prescription with a 14 day course of oral ciprofloxacin (antibiotics) to treat a suspected epididymo-orchitis (inflammation or the epididymis and /or testis). A copy of the prescription is retained within the medical records. Medical staff also included on the prescription notes for the GP.

In this case the prescription notes to the GP request that Mr McGagh's scrotum is monitored for any skin change and requested that the GP also chased up the results of swabs taken during his ED attendance to confirm the antibiotics prescribed would treat any organisms identified.

It would be normal practice for the prescription documentation to be given to the patient or carer after the medication had been dispensed. However in this case it was not. The Trust apologises unreservedly for this omission and poor standard of care.

2. Concern: *Antibiotics prescribed were not dispensed.*

The Medicines Policy guides staff to supply pre-packed medication for patients in the Emergency department when Pharmacy is closed. The supply must be recorded in the patient's Emergency Department notes.

> *5.25.3 Supply from Emergency Department Outside Pharmacy Opening Hours*
> *Nurses or doctors in the Emergency Department may issue pre-packs that have been labelled and supplied by pharmacy, in accordance with a prescriber's outpatient prescription.*

On review of Mr McGagh's records the ED staff did not dispense Mr McGagh with the antibiotics he was prescribed or provide him or his carer with a copy of the prescription. The Trust apologises unreservedly for this sub- standard care.

3. Concern: *Communication with carers.*

It is documented within the clinical records that Mr McGagh's carer was advised regarding using a scrotal support and also to monitor for any skin changes and for Mr McGagh to return to hospital urgently if any concerns or his symptoms deteriorate. It is not explicit within the records if the carer in attendance was advised regarding the antibiotics. We again apologise for this omission, all clinical ED staff have been reminded of the importance of supplying verbal and written instruction as required and this interaction must then be documented in the clinical health records.

Actions taken:

To establish whether this is common practice UHSM has undertaken a retrospective audit within the ED of the discharge prescriptions and the documentary evidence that these medications were communicated and dispensed in line with policy.

The findings of the audit demonstrated that 9% of prescriptions in this category the guidelines were not followed and there was no documentary evidence that the patients had received the medications as required. This is clearly unacceptable.

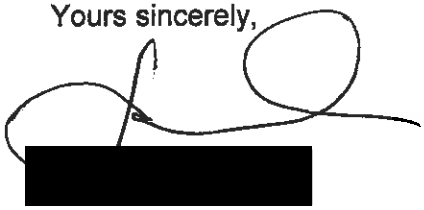
[redacted] has reiterated to all the staff within the ED and CDU the importance of ensuring that patients requiring medication and prescriptions with specific instructions for the GP should be supplied and this then must be clearly communicated and documented within the clinical health records.

To support ongoing improvements a regular audit program within the ED to monitor compliance with the policy and documentation has been commenced. Any individual staff identified that are not adhering to the required processes will be managed accordingly.

The Trust accepts that Mr McGagh should have been provided with antibiotics prior to his discharge along with a copy of the prescription for his GP. This should have also been clearly discussed with the carer who accompanied Mr McGagh when he attended the department [redacted] has highlighted this to the staff within both ED and CDU. The Trust has also reiterated the importance of comprehensive documentation relating to any discussions had with patient, families and carers regarding treatment and management plans to all clinical staff across the organisation.

The Trust would wish to thank you for raising this issue with us to enable us to put in measures to improve the standard of care delivered to our patients. The [redacted] and the Trust wish to apologise unreservedly for the omissions in care and will extend an offer to the patient's family to come into the Trust to discuss this incident.

Yours sincerely,



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Medical Director