Stockport NHS
NHS Foundation Trust

Our ref. AB/CM/PR-letter to HM Coroner- M Hutchence
Your ref. JSP/HC/00272-2016

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26 AUG 2016
HC

18 August 2016

Dear Ms Kearsley,

Re: Michael Guy Hutchence (Deceased)

I am writing in reply to the letter of 20 June 2016 from Mr Pollard, 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.

Your concerns are as follows:

1) **For no other reason, other than the convenience of hospital bed managers, Mr. Hutchence was moved at least four times from ward to ward within the hospital.**

The Trauma Nurse Team manage the Trauma and Orthopaedic beds in the hospital and when a patient needs admission from the Emergency Department (ED) we aim to put them on the correct ward, based on their orthopaedic injury, although this is always dependent upon bed availability. Mr Hutchence was admitted to Ward D1 (our Trauma Admissions Unit) from ED. He then had further moves to Ward D4 and the Short Stay Surgical Unit (SSSU).

Unfortunately it is often necessary to move Orthopaedic patients between wards within the Trauma and Orthopaedic Unit (Wards D1, D2, D4, and M4) and our SSSU (Surgical Short Stay Unit) to create bed capacity for admitting patients from ED in order to comply with the 4 hour wait in ED target. Moves are undertaken out of hours following discussion with the Senior Manager on call and Senior Nurse on Site Cover. We often move patients to SSSU to ensure we have enough acute beds for more complex trauma.

2) **The quality and accuracy of the nursing and medical notes left much to be desired and it was noted that Mr Hutchence was cared for by non-specialist nurses on a number of occasions and even when he was in the I.T.U. he was looked after by a trainee nurse.**

The Trust is currently in the process of installing an electronic patient record (EPR) system, which is a computerised version of the entire healthcare record. Instead of hospital staff using a mixture of paper and electronic records, information will be available to them online in one place. We already use a variety of electronic systems to help staff look after our patients, but the EPR will bring all this information together.

The EPR will improve patient safety and outcomes by standardising pathways underpinned by best practice, it will remove issues relating to the illegibility of written records and will also assist with the completion of important documents, as the system will employ a 'force function', meaning the record cannot be left incomplete. The roll out for the system will be completed in 2017. In the meantime we will continue to try to improve our written records by undertaking monthly 'live' spot audits of 30 inpatient records across the wards.

All nurses caring for patients in critical care are registered nurses; however, there are many trainee critical care nurses, all at varying points within their training. All new starters to the area have a 6- 8 week induction package, which includes being supernumerary and working alongside a trained critical care mentor. All staff new to the area undergo a National Step 1 Competency Programme taking 12 to 18 months to complete; they

then go on to complete a further 12 months of training to become a fully qualified and accredited critical care nurses. All staff undertaking critical care training are supervised by the co-ordinator and Mr Hutchence was at no time solely looked after by a nurse not qualified to do so.

3) **Mr Hutchence was administered his anti-coagulant simply on the basis of his body weight. He weighed 99.8 Kg and the difference between a daily dose of 40 mg. of Clexane and a twice daily dose of 40mg of Clexane is arbitrarily set at a body weight of 100 Kg. Should there not be a rather more refined way of assessing the dose required?**

I have referred this to our Haematology Lead Consultant, [redacted], who has advised:
"There is limited evidence to guide thromboprophylaxis in a patient who is overweight; this can also be said for those with low body weight, renal impairment with low creatinine clearance levels, patients in pregnancy and infants. The American College of Chest Physicians (ACCP) advises clinicians to follow manufacturer recommendations for antithrombotic dosing. Manufacturer's information for Enoxaparin (Clexane) and other Low Molecular Weigh Heparins do not recommend dosage adjustments for extremes of body weight; however there are 'off-licence' doses of 40 mg S/C BD and 60 mg BD in patients with weights of 100-150 Kg and those greater than 150 Kg respectively. VTE prophylaxis regimens are not 100% effective in any group of patients and there will be occasional failures of antithrombotic therapy. On the basis of an individualised patient risk and benefit assessment, a clinician may feel compelled to prescribe a more aggressive dose than what is advocated in national guidelines. This practice is not recommended without clinical evidence of efficacy and safety".

4) **In addition to the above problem, the body weight was recorded on some occasions in metric and others in imperial weights. This can and does lead to confusion. On one page the predicted weight was 15 stone 10 lbs which was in fact the actual weight and not the predicted weight. For the purpose of the accurate delivery of many drugs, including anticoagulants, accurate weight recording is essential.**

There is currently an ongoing awareness drive to ensure all staff are recording weight and height in the metric format.

5) **There was a shortage of trained nurses in the hospital and this may have led to at least one of the 'ward moves' and D2 was closed due to lack of staff.**

D2 (an elective inpatient ward) was closed following NHS England advice for us not to undertake any elective work, apart from day case work, due to winter bed pressures throughout the NHS at that time. As a result of this we merged the staff from D2 with SSSU which was open 7 days a week and increased to 32 patients at a weekend, giving us extra capacity for emergencies. Any spare staff were utilised to support gaps in staffing on other areas.

6) **I was told the ideal way of elevating a patient's leg is by using a Braun's frame. There was (and apparently still is) a shortage of these within the hospital such that Mr Hutchence's leg was at all times elevated by using pillows. This was a potential for causing or contributing to the formation of D.V.T.'s**

I have referred this to [redacted] Consultant Orthopaedic Surgeon, who has advised; "There is no direct evidence that elevation of an injured lower limb has any effect on the incidence of venous thromboembolism; elevation of the injured limb is employed to reduce swelling. The method of elevation does not impact on the risk of venous thromboembolism; however the advantage of the Braun frame is that the leg is better supported in the elevated position, as the leg tends to fall off pillows or the pillows compress and the degree of elevation is lost".

I can advise that four new Braun frames have since been purchased and were delivered to Ward D1 on 25 July 2016; we now have 8 in total. There is still a potential that outlying trauma patients, in the very busy winter period, may still have pillows utilised as an elevation method.

7) **Mr Hutchence was taken to theatre for the operation and this could not be started as the kit for the operation was found to have a non-sterile status as the outer wrapping had been breached. The operation was delayed whilst another kit was obtained but this was also found to be defective. The**

operation was then aborted and put off for a further two days, during which time Mr Hutchence was immobile and the risk of D.V.T. and P.E. was inevitably increased.

Mr. Hutchence was scheduled for surgery on the trauma list for open reduction and internal fixation of fractured left tibia and fibula on 19th January 2016. It has not been possible to identify a particular cause for the breaches in the wrappings. Great care and attention is given to maintaining the integrity and sterility of the instrument tray wrappings. It is standard theatre practice that careful and thorough checking of every instrument tray wrapping is undertaken by the theatre practitioner prior to use. In this case, the routine checking identified the breaches and appropriate action was taken to re-sterilise the instrument trays.

On discussion with HSDU it was determined that, as the instrument trays were heavy, the trays would require additional cooling time and would therefore not be available until approximately 16:30 hrs. Discussion then took place between [redacted] and the Anaesthetist [redacted] advised that the procedure was likely to take at least two hours and it was agreed that there would be insufficient time to undertake Mr. Hutchence's surgery on that day. [redacted] informed the team that he would make arrangements to reschedule Mr. Hutchence for surgery on 21st January 2016, when he had a scheduled operating session. [redacted] spoke to Mr. Hutchence in the theatre reception to inform him of the issue with the instrument trays and that his surgery would have to be postponed until 21st January 2016. It is very unfortunate that Mr Hutchence experienced these delays; however to have proceeded when the integrity/sterility of the trays was in question would have been unacceptable.

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