Brighton and Sussex University Hospitals NHS
NHS Trust

Your ref: [redacted]
Our Ref: [redacted]

Miss V Hamilton-Deeley, HM Senior Coroner
Coroner's Office, Woodvale
Lewes Road
BRIGHTON
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Headquarters
The Royal Sussex County Hospital
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Tel: [redacted]

12 January 2015

Dear Miss Hamilton-Deeley

The Late Maureen Ellett, date of birth: 07 January 1948
NHS No: [redacted]

Thank you for your letter and enclosure of 31 October 2014, and for drawing your concerns to our attention in detail. As you know, we are always willing to review our practices, in order to identify improvements which can be made in the light of experience. Thank you also for agreeing an extension of time for provision of this detailed response. We have chosen to respond jointly to the issues you have raised, reflecting the way we work closely together within this Trust to address concerns.

Using the same numbering as in your letter, we would make the following comments on the issues you have raised:

1. We agree that there were shortcomings in the record keeping when Mrs Ellett first arrived in the Emergency Dept. Since then, several changes have been made. Agreement has been reached with the South East Coast Ambulance NHS foundation Trust (SECAMB) that they will start calculating National Early Warning Scores (NEWS) and the triage nurse will note this when the patient arrives. We agree that the term Acopia is inappropriate and misleading, and should not be used to describe the condition of a patient on arrival to the Emergency department. We are continuing to educate staff about avoiding this term, while recognizing that it may be used by other people outside this Trust. We are aware that it may be repeated by junior medical staff on occasion, as in this instance, to describe what has been reported to this Trust as the condition ascribed to the patient by other people before arrival to the hospital.

   We do not believe it is appropriate for any decision about whether or not blood is to be taken to be based on the mode of transport by which they arrive (ambulance, own transport etc). We agree that Mrs Ellett's blood should have been taken for testing, and confirm that while blood may be taken by medical or nursing staff, it is the responsibility of the doctor to ensure that appropriate blood has been taken and appropriate blood tests ordered. The doctors' induction programme has

been amended to emphasize to the new doctors in the department that it is their responsibility to ensure appropriate blood tests have indeed been taken.

2. We believe the A&E consultant's failure to date and time his signature on the transfer documentation, while not best practice, is not relevant to the clinical care of Mrs Ellett. However, we agree that she should not have been transferred until an appropriately detailed plan for her management had been agreed and summarized in a series of bullet points in the documentation, and the clinical shift leader had confirmed his agreement by signing the proforma. All the consultants and the relevant shift leaders have been reminded of the importance of this aspect of their duties.

3. We agree that it is particularly important for senior staff to be vigilant when working with less experienced agency junior staff. All the Emergency Department consultants and other senior doctors in the department have been asked, in the light of these events, to reflect upon their current approach, practice and vigilance. These clinicians have been strongly reminded that extreme caution should be taken if a patient is not being seen in person by them, after assessment by any locum staff who are not familiar with the department or any locum not previously known to the senior clinician.

4. We have established that the triage nurse to whom you refer handed over to her colleague starting the next shift that there were several outstanding assessments to be completed and documented for Mrs Ellett. We deeply regret that this next member of staff, who had newly come on duty, did not complete these tasks as he should have done. We have not been able to take this up with him in the light of your comments as he had already left the Trust before Mrs Ellett's inquest took place. Arrangements have been made for further training on documentation to be included in both the departmental nurse induction programme and also in the nurse development training days held in the department.

   We do not believe the failure to complete and document these outstanding assessments arose from the length of shifts being worked by the staff. While we acknowledge that there are recognized risks associated with staff working these long shifts, the Trust's Chief Nurse agrees with the national view that these risks are counter-balanced by the benefits associated with such shifts. In particular, the continuity of care for individual patients is preferred by most patients and many staff. Such continuity makes it easier to detect what may be subtle changes in a patient's condition, as the same clinical member of staff has direct contact with the patient over a longer period. We are also aware that it is at handovers between staff that there is a particular risk of miscommunication, and by reducing the numbers of handovers in a 24 hour period, there is a reduction in this risk.

5. The Emergency Department has 5 electrocardiograph (ECG) machines. One of these is allocated for sharing between the Clinical Decisions

Unit (CDU) and the neighbouring Short Stay Ward (SSW) - effectively the small adjacent male and female ward areas within the Emergency Department for patients who are asked to stay in the department for a longer period. We believe this provides sufficient access for ECGs to be requested and performed safely in both areas, and that it is not necessary to have a dedicated ECG solely for the 7 female patients in the SSW.

6. A stamp has been devised for use in the Emergency Department on ECG print outs so that doctors can document, sign and date on it their interpretation of the ECG and any associated plan for the patient's management.

7. While we do not accept that it is necessarily clinically appropriate for every patient to be reviewed in person by a doctor if a decision is taken that a further ECG should be taken after an interval, we do agree that continuity of care is desirable (see 4, above). However, we are not convinced that it is always safest to insist that a particular doctor reviews a second ECG, especially in a busy Emergency Department. This reflects both the risks inherent in interrupting a doctor who may be in the middle of some other complex patient assessment, and also the recognized advantage of using fresh eyes to assess a new heart trace.

8. The agency staff nurse who worked that shift in the SSW is a very experienced nurse, with plenty of experience of working on different types of wards as well as undertaking regular part time NHS employment in an endoscopy unit. We have no reason to doubt her clinical skills in caring for patients in a setting such as the SSW, while acknowledging the difficulties which will always be associated with working in any unfamiliar ward or department, for example, locating equipment or completing local documentation which may be in an unfamiliar format.

   This nurse was closely supported by the senior charge nurse in the Emergency Department who was responsible for the SSW and other areas on the night shift. He had been fully involved in the decision-making for Mrs Ellett to be moved to the SSW, had discussed the management plan for her with the consultant and had assured himself that she met the criteria for such a move before it took place. He also made sure that the agency nurse received a formal induction to the department and the SSW at the start of her shift. He himself visited the agency nurse several times on the shift to ensure she was not experiencing difficulties, and he offered her an earlier break during the shift. She chose initially to have some refreshment without leaving the unit, and to carry on working until later in the shift. On reflection, we agree that it would have been preferable for her to have been encouraged more strongly to take an earlier break, even though we have no reason to think that the clinical care of any patient was compromised by her commitment to continuing their care without taking a formal break for several hours.

9. We agree that a hands on approach to patients is important, and believe that the experienced nurse caring for her did interact with Mrs Ellett on several occasions, for example when helping her to reposition to make sure that she was comfortable, and when helping her to have a drink. This provided her with opportunities to take into account what the policy you refer to describes as the "look, listen and feel" of Mrs Ellett. These interactions did not initially give her cause for concern, and she described a sudden change in Mrs Ellett's condition later in the night.
10. The observations policy requires trained staff to review and countersign the findings, if taking the observations has been delegated to a health care assistant, however experienced that health care assistant may be. The agency staff nurse gave evidence to you that she had reviewed the first set of observations taken on the CDU and satisfied herself that the NEWS score was zero. What she failed to do, and acknowledged she should have done, was to countersign to indicate that she had carried out this check. We do not believe this documentation oversight at 21.55 had any adverse effect on Mrs Ellett's clinical assessment, but we appreciate - as does the agency nurse herself - that detailed documentation of this kind is nevertheless important.

The nursing and medical staff in the Emergency Department, as well as the locum staff involved in the care of Mrs Ellett, and we ourselves have taken very seriously all the issues you have raised, and changes have been made to improve different aspects of the quality of care. As an over-arching step, individual named emergency consultants have recently been given responsibility for each of the Short Stay Ward and Clinical Decisions Unit, in order to provide visible senior medical leadership in each area and to seek ways of improving the quality of care. This will include regular audit to ensure proformas are being used correctly.

Thank you once again for raising your concerns. Finally, please pass on our condolences to the family and friends of Mrs Ellett on their sad loss.

Yours sincerely

[redacted]

Matthew Kershaw
Chief Executive

[redacted] Governance Lead
on behalf of [redacted],
Lead Consultant,
Emergency Dept

[redacted]

[redacted]
Matron,
Emergency Dept

* [redacted] is currently away, but has been actively involved in investigation of the issues raised and has contributed information contained in this letter. [redacted] has confirmed the accuracy of the finalized text in relation to the Emergency Dept

* ELECTRONICALLY