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Ms Anna Loxton
Assistant Coroner
HM Coroner's Court
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Surrey
GU22 7AP

By recorded delivery and email:

6 July 2018

Dear Ms Loxton

Doris Ridgwell (Deceased)
Response to Regulation 28 Report to Prevent Future Deaths

This letter comprises the formal response of Epsom and St Helier University Hospitals NHS Trust 'the Trust' to the issues raised in the Regulation 28 Report to Prevent Future Deaths, dated 15 May 2018 'the Report', made subsequent to the inquest into the death of Doris Ridgwell, which adjourned part-heard for further evidence on 15 March 2017 and concluded on 15 May 2018. The Trust would like to again express our deepest sympathy and condolences towards the family.

Background

Mrs Ridgwell attended Epsom Hospital on 25 February 2017 with knee pain and swelling. Whilst she did not display symptoms of a high International Normalised Ratio 'INR', the blood tests ordered by her treating doctor included her INR level as she was receiving warfarin therapy. Her INR level was found to be 8.1 which is an abnormally high level requiring attention. Having been noted as abnormally high, the Biomedical Scientist in the Haematology Department attempted to telephone the result through to Epsom Hospital Emergency Department, in line with the Trust's Standard Operating Procedure. They advised him that Mrs Ridgwell had been transferred to the Ambulatory Care Unit 'ACU' awaiting discharge. Two attempts were made to telephone the results through to the ACU but there was no reply. The results were then made available on the Clinical Manager system and no further attempt was made to inform the ACU of this result.

The doctor who had requested the blood tests did not note the high INR level on the Clinical Manager system and stated this may be because this result was released onto the system after the other blood tests requested had been made available and checked, and he overlooked reviewing this result as his working diagnosis for Mrs Ridgwell did not include a high INR.

Mrs Ridgwell was discharged home to her daughter's address and no healthcare professionals followed up her high INR. Her over-anticoagulation was only noted and treated on 3rd March 2017, when she was readmitted to Epsom Hospital with a large subdural haematoma and intraventricular bleeds which were not suitable for active treatment, and further blood tests revealed her INR level was 15. She deteriorated until her death on the morning of 4 March 2017.

A narrative conclusion was delivered at the inquest as follows:

'At 10am on 4th March 2017, Mrs Ridgwell died at Epsom General Hospital. She had been admitted the previous day having suffered a large subdural haematoma and intraventricular bleed which was not suitable for active treatment. She was found to have an INR level of 15 and this over-anticoagulation was an important causative factor in her bleeds and therefore it is highly likely this contributed to her death. She had attended Epsom General Hospital with knee swelling and pain on 25th February 2017 when her INR level was tested and found to be 8.1. However this result was not successfully telephoned through to the ward or noted by the Healthcare Professionals who managed Mrs Ridgwell's care and therefore no action was taken to counter the high INR until her second hospital admission on 3rd March 2017.'

The medical cause of death was found to be:

1a) Large subdural haematoma and intraventricular bleed

1b) Warfarin therapy

2) Community Acquired Pneumonia

The Report raises the following concerns:

1. The Trust's Standard Operating Procedure for Telephoning of Coagulation Results is not sufficiently clear regarding what action should be taken by staff in the Blood Sciences Department to ensure abnormal coagulation results are made known to the treating Healthcare professionals;

2. A new Standard Operating Procedure has been prepared, but having had sight of this, I do not believe this clearly outlines for Laboratory staff the steps to be taken in telephoning through abnormal Coagulation Results;

3. Abnormal results are not authorised onto the Clinical Manager system to be viewed by Healthcare professionals by Laboratory staff until they have telephoned the results through to the ward, which can potentially cause a delay in these being available on the system;

4. The Discharge summaries provided to GPs following discharge from Hospital do not include blood tests results, meaning a potential safeguard to check these results is missed;

<u>First and Second Concerns</u>

The first Concern set out in the Report is as follows:

> *'The Trust's Standard Operating Procedure for Telephoning of Coagulation Results is not sufficiently clear regarding what action should be taken by staff in the Blood Sciences Department to ensure abnormal coagulation results are made known to the treating Healthcare professionals'*

The second concern is as follows:

> *'A new Standard Operating Procedure has been prepared, but having had sight of this, I do not believe this clearly outlines for Laboratory staff the steps to be taken in telephoning through abnormal Coagulation Results';*

Trust response:

The Root Cause Analysis investigation carried out following this incident identified the fact that the Trust's Standard Operating Procedure for the telephoning of clinically urgent abnormal coagulation results was not robust enough and that the procedure required strengthening. As a result of the investigation the Standard Operating Procedure was revised to make it clear that where it is not possible to get hold of a clinician who has requested a blood result which has been deemed clinically urgent, this needs to be handed over to those working the next shift in the Blood Sciences Department in order that continuous attempts to contact this clinician can be made. This strengthened the process but following the concerns raised at the inquest hearing we have strengthened the process even further.

The new process for biomedical scientists who need to alert clinical staff about abnormal results is set out at paragraph 15 of the revised Standard Operating Procedure 'Telephoning of Coagulation Results', see below:

Para 15.5 Obtaining contact details and communicating clinically urgent abnormal results

In-patient / A&E:

- Scanned image of the request form (press F7 whilst accessing record on Telepath)
- Lab telephone lists have most ward extensions

1. *Switchboard can assist with contacting requesting medics, bleep numbers, clinical teams, medical secretaries to communicate to requesting/relevant healthcare professional*
2. *If you have problems contacting A&E specifically - contact the Nurse in charge (Epsom 07975 232 344 St Helier 07812 119 011)*

If for any reason this is not possible:

3. *The appropriate site manager should be contacted if all attempts to contact the clinical team or ward are unsuccessful (Bleep 884 Epsom &*

443 St Helier). They should be asked to locate a responsible clinician and request they contact Blood Sciences to discuss an abnormal result.

Para 15.6 Telephoning results

- *Identify yourself clearly*
- *Clearly identify the patient using at least 2 identifiers (Name, DOB, Hospital / NHS number)*
- *Give the results, if necessary explaining why you are telephoning them*
- *Ask for the results to be read back to you & document (RCONF)*
- *If necessary explain that results need to be forwarded to the appropriate medic as soon as possible*
- *Advise that Haematology Clinical staff are available to advise 24Hrs a day*
- *Take the name of the person to whom you are giving the results*
- *Add the comments FCA & FCA1 "For clinical advice contact the Haematology Clinical team (out of hours contact the On Call Haematology Consultant)"*

Para 15.7 Documenting the Telephoning of results

It is essential that a clear record of the communication of clinically urgent abnormal results be made. Good information recorded at this stage will aid any future audit or investigation.

Using either specimen notepad or result comments record:

- *That the result was telephoned*
- *The date and time it was telephoned*
- *The name of the person who took the result*
- *Any other relevant details*

Third Concern

The third concern set out in the Report is as follows:

> *'Abnormal results are not authorised onto the Clinical Manager system to be viewed by Healthcare professionals by Laboratory staff until they have telephoned the results through to the ward, which can potentially cause a delay in these being available on the system';*

Trust Response:

The Standard Operating Procedure: 'Telephoning of Coagulation Results' has now been updated to include details which makes it very clear that as soon as a clinically urgent abnormal result is actioned by a biomedical scientist it should be released on to Clinical Manager). It is worth noting that in some instances there is a real clinical need to discuss the abnormal result to determine the clinical significance prior to authorising to ensure a correct interpretation of the result.

Para 15.8 In the event that a clinically urgent result cannot be telephoned

Under most circumstances it is possible to find an appropriate person to take abnormal results.

If, however all reasonable steps have been taken to telephone a result it is important to not unnecessarily delay authorising the result so that it is available to the requesting medical team as soon as possible:

- *Fully document the steps taken to telephone the result using either Telepath notepad or result comments*
- *Add the comments FCA & FCA1 "For clinical advice contact the Haematology Clinical team (out of hours contact the On-Call Haematology Consultant)"*
- ***Authorise the result*** *in a timely manner*
- *Utilise hand-over sheets / hand-over diary to record and hand over details of the patient / result to the next shift so that results can be telephoned later.*

Fourth Concern:

The fourth concern set out in the Report is as follows:

> *'The Discharge summaries provided to GPs following discharge from Hospital do not include blood tests results, meaning a potential safeguard to check these results is missed'*

Trust Response

The possibility of including blood results from hospitals within hospital discharge summaries was discussed with a GP representative from the local area at the Clinical Quality Review Group on 24 May 2018. They did not feel they would be able to review blood results within patient's discharge summaries. Moreover, it is not felt that it would be appropriate to rely on GP's to act as a potential safeguard for abnormal results. Blood results taken in hospital can be accessed by GP's via a computerised patient management system, Telepath.

We have issued new guidance for all staff to make it clear that if they are made aware of a patient's clinically urgent abnormal result from the Blood Sciences Department and that patient has left the hospital, it is the responsibility of that individual to ensure that appropriate action is taken. Appropriate action will be dependent on the significance of the abnormal result and will range from calling the patient back to hospital for urgent review to contacting the patient and their GP to make them aware of the abnormal result and asking them to arrange an appropriate outpatient appointment.

When the Emergency Department have been unable to communicate urgent results to patients who have been discharged from hospital in recent months the police have been contacted to ask them to attend the home address of the patient to ensure that the patient is brought back to hospital for urgent review.

Conclusion

As a result of the inquest and the concerns raised, the Trust has reviewed its procedures and has:

1. Revised its Standard Operating Procedure 'Telephoning Coagulation Results' for the Blood Sciences Department to make it clear that :

    a) In the event that a biomedical scientist is unable to get hold of a relevant healthcare professional by telephone to communicate a clinically urgent abnormal blood result they should contact the appropriate Site Manager. An abnormal blood result should be released on to Clinical Manager as soon as possible to avoid a delay in communicating the result to the requesting clinician;

    b) A biomedical scientist's responsibility to communicate a clinically urgent abnormal blood result to a relevant clinician does not cease once it has been released on to Clinical Manager and there needs to be a telephone communication of the abnormal result before it can be marked as completed. Where it has not been possible to telephone a clinically urgent abnormal blood result before the end of a shift, this must be handed over to the biomedical scientist taking over the next shift both orally and in a written handover document (handover diary).

2. Re-issued guidance to all clinical staff to make it clear that where a clinically urgent abnormal blood result is communicated to them it is their responsibility to ensure that this is communicated to the patient and that appropriate action is taken, even when that patient has left the hospital.

I hope that this letter has provided you with assurance that your concerns have been taken very seriously by the Trust and that our procedures and processes have been revised to address those concerns.

We will share this letter with the family of Mrs Ridgwell and hope that it provides them with some reassurance that the Trust now has safeguards in place to ensure that abnormal results are communicated to the relevant clinical staff and acted upon accordingly.

Yours sincerely,

Daniel Elkeles

Chief Executive Officer
Epsom and St. Helier University Hospitals NHS Trust