NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

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[redacted]

1 March 2019

Ms. Mutch OBE
HM Coroner's Office
The Coroner's Court
1 Mount Tabor
Stockport
SK1 3AG

Dear Ms. Mutch

Regulation 28: Report to prevent future deaths, following the Inquest touching upon the death of Michael Flynn

I am writing in respect of your letter dated 10 January 2019, and enclosure in the form of a Regulation 28 Report issued following the Inquest touching upon the death of Michael Flynn, which concluded on 8 January 2019. I hope to be able to address the concerns raised in Section 5 of your report and set out below my response.

You stated that 'you were concerned that there was no monitoring of Mr. Flynn's NEWS in the post-operative recovery area. Observations were taken randomly but not incorporated into a NEWS score. Trust Policy was that this should have happened. Staff dealing with Mr. Flynn therefore, were unaware of his NEWS score. On arrival to the ward, Mr. Flynn's initial score was 11 under the NEWS system. Mr. Flynn arrived with a standard care plan'.

I understand from the Trust investigation into Mr. Flynn's care and management, that Mr. Flynn was monitored in the recovery area for approximately two hours and the decision to transfer him to the ward area was made with anaesthetic agreement, as his condition was stable.

The Matron for Theatres has confirmed that when a patient is in the recovery area post operatively, vital signs are continuously monitored using electronic monitoring systems that are set to record measurements electronically. The expectation is that observations are initially recorded and documented at 5-minute intervals. If a patient remains in recovery for longer than one hour, and observations are stable, the frequency is reduced to 15-minute intervals; however, the patient continues to be monitored with one to one nursing continuously during this time.

These observations should be recorded in the post-operative recovery chart, which is incorporated into the anaesthetic record. Post-operative recovery does not follow the Trust NEWS escalation process as the patients are continually monitored and the associated anaesthetist is

immediately available if required. However, there is an expectation that documentation is completed. I am disappointed to hear that this did not occur in the case of Mr. Flynn.

Additionally, I understand the recovery discharge document was not completed prior to the transfer. This should include the NEWS score before transfer from recovery to the ward, and in this case, the final NEWS score was not recorded. I acknowledge that this is unacceptable and am sorry that on this occasion documentation fell below the expected standard. I am advised the Matron for theatres has met with and provided feedback to the individual staff members involved in the post-operative recovery period with respect to completing the appropriate documentation.

For your further assurance, your concerns were raised and discussed directly with clinical teams at the Theatre team meeting on 29 January 2019. I am informed that the Matron for Theatres subsequently issued a memo to all theatre nursing staff detailing the concerns raised and the expectations on staff of ensuring recovery documentation is comprehensive and complete and that optimal NEWS scores are achieved prior to transfer of patients to the ward, or increased NEWS scores escalated appropriately to the anaesthetist prior to transfer.

The Matron for Theatres has also provided assurances that an audit of recovery documentation has been commissioned to provide evidence of compliance and continuous monitoring.

With respect to your concern regarding staff on the ward being unaware of Mr. Flynn's NEWS score on his transfer from recovery, I am advised the Matron for theatres has taken measures to improve communication with ward staff, by introducing a formal telephone handover for patients identified as 'high risk' detailing the current NEWS score and management plan in place. I understand that High-risk patients in this context are those who fall into categories 3-5 using the American Society of Anaesthesiologists physical status classification system.

Additionally, I understand when patients who fall into categories 3-5 using the American Society of Anaesthesiologists physical status classification system are now transferred from the recovery area to the ward, the provisional set of observations and assessment is undertaken with the transferring nurse in attendance, to provide further assurance of the patient's condition and wellbeing, and to provide additional support if any deterioration in the patient's condition is identified. The Matron for Theatres has advised she is closely monitoring compliance with this change in practice.

You raised a number of concerns that whilst Mr. Flynn was a patient on the orthopaedic unit, the Trust policy regarding monitoring and trigger points for regularity and escalation in relation to NEWS was not adhered to. In addition, you were concerned regarding the level of communication and documentation between the medical and nursing staff in relation to Mr. Flynn's clinical condition.

The Matron for the Orthopaedic Unit has provided assurances that formal discussions have taken place with the nursing staff identified through our investigation as failing to comply with Trust Policy in respect to the regularity, recording and appropriate escalation of NEWS observations, and consideration given to identified support or training needs. Additionally, I understand the ward manager has circulated a newsletter to all staff reiterating their responsibilities and accountability with regards to the appropriate recording and escalation of NEWS, including -

- Any increase in NEWS score must be escalated as per Trust Policy.
- Always evidence the name of the doctor/outreach staff member spoken to within the patient records.

- Always follow up with the medical team if the patient continues to have increased NEWS. If necessary, escalate to the senior doctors, or senior nurse bleep holder/site manager.
- Do not assume the doctor is aware of a patient's increased NEWS, and escalate personally.
- Ensure all sections of the patients NEWS are completed – do not leave any gaps.
- Ensure the NEWS is scored correctly.
- Every time a doctor reviews a patient, remind them to document in the medical notes.
- Always evidence why a complete set of observations have not been undertaken and inform the medical team.

The Matron for the Orthopaedic Unit has advised that the learning from our investigation into the care provided to Mr. Flynn was shared and discussed at the Divisional Senior Nurses meeting and subsequently, has been raised again on receipt of your concerns. [redacted] the Consultant Orthopaedic Surgeon who led the Trust investigation, has provided his assurances that the case has also been raised and discussed at the Orthopaedic Speciality meeting, which is attended by all grades of Orthopaedic medical staff. [redacted] has advised that the importance of documentation was highlighted as a particular focus for discussion at this time.

To provide assurances that the learning from this case is shared Trust wide I am aware that the Trust Patient Safety Team have drafted and distributed a 'Time out for Learning' bulletin focusing on the importance of completing, recording and escalating NEWS observations appropriately.

The Trust recognises, as does the wider NHS, that identifying and responding to the acute deterioration of patients is a significant patient safety issue across the NHS and has a dedicated patient safety workstream as part of the Trust's Patient Safety Programme, which is concerned with ensuring the Trust has clinical and operational processes to adequately support the effective management of the deteriorating patient. This workstream reports through to Trust Board via the Patient Safety Programme Board, which is chaired by my Medical Director.

Ensuring appropriate implementation of NEWS, with prompt escalation and clinical response is a primary purpose of this workstream. As part of the Trust mandatory training requirements, clinical staff receive annual updates on the management of the deteriorating patient as part of their basic life support or immediate life support resuscitation updates and the Trust is currently considering the benefits of introducing further focused mandatory training.

For nursing staff new to the Trust, training is provided on the use of the NEWS tool, including the thresholds for escalation and clinical response guides. In respect to medical staff, the Medical Education Manager has advised that the topic of NEWS is covered during the junior doctors' induction, at which time written information is also provided. All foundation doctors complete AIMS training as soon as they start at the Trust, which includes training relating to NEWS.

Although not directly relevant in the context of this Regulation 28 Report, I would like to advise you of a change made within the Trust relating to the National Early Warning Score tool (NEWS). At the time of Mr. Flynn's episode of care, the Trust were using a modified/adapted NEWS tool, which had been in use since 2014. In 2018, a Patient Safety Alert was published requiring Trusts to adopt a revised National Early Warning Score (NEWS2) drafted by the Royal College of Physicians. The alert resulted from the recognition that healthcare providers used a variety of adapted NEWS or locally devised early warning scores, increasing the risk of harm resulting from having different scoring systems in use across the NHS when patients or staff move between services. NEWS2 standardises how adult patients who are acutely deteriorating are identified and responded to, and will streamline communication across the NHS.

The alert requires acute hospital trusts and ambulance trusts to fully adopt NEWS2 for adult patients by March 2019. I am advised that within the Trust, training in the use of the NEWS2 tool commenced in October 2018, with the revised observation tool and escalation process being implemented in December 2018. I understand face-to-face training has been provided to senior clinical staff, with wider training subsequently cascaded through wards and departments by ward managers through either face-to-face training or via an online training tool provided by the Royal College of Physicians. Following implementation of NEWS2, we have continued focused work and awareness-raising.

With regards to your concerns that a Consultant did not see Mr. Flynn on the day after his operation, the Trauma and Orthopaedic Directorate Managers have advised that a Consultant team job planning session has taken place within the Speciality to discuss the availability of Consultants to undertake ward rounds. The team have agreed to job plans being reviewed and revised and individual Consultant job planning meetings are progressing. I understand the team aim to have completed all job planning meetings including senior management review and approval by mid-April 2019.

In addition, I am informed that discussions have taken place with the Directorate of Medicine to implement a triggered referral process to the Orthogeriatricians in cases where patients are identified as requiring a senior level orthogeriatric review. I have gained assurances from the Deputy Directorate Manager for Trauma and Orthopaedics that she is currently working with the Directorate Manager for Medicine to develop the process. The Speciality anticipates that these measures will provide additional support to the clinical teams and patients, ensuring senior medical reviews take place appropriately. To obtain some assurance in this matter, I understand a review of case notes is scheduled to commence in March 2019 on both the Planned and Emergency Orthopaedic wards to evaluate the medical documentation in relation to daily entries in the medical notes, the grade of doctor reviewing the patient, and whether an orthogeriatric review has taken place where indicated.

For further assurance, I understand the Speciality has also reviewed the handover arrangements between junior Orthopaedic medical staff and are in the process of designing a new handover document that will be located electronically and accessible from any computer. The Speciality anticipate this will support medical staff in identifying those patients requiring review and there is an aim for this to be implemented in March 2019.

You were concerned that the Trust has a Critical Care Outreach team whose role is to support units such as the orthopaedic unit. However, the team was not available when contacted, due to staffing issues. At the time of Mr. Flynn's case, the Trust Critical Care Outreach team were not established to provide cover 24/7. However, following a Trust 'Hospital at Night' consultation the establishment for the Outreach team has increased and new staff came into post in August 2018, providing establishment for 24/7 cover to be provided. Unfortunately, the ability to achieve 24/7 cover has continued to prove difficult, resulting in the Trust recently creating an additional temporary post within the Critical Care Outreach team. This has been appointed to and currently enables the team to provide support 24/7. However, the Trust NEWS Escalation and Response Guide provides clear guidance for staff regarding the process for escalating to the next response level if attempts to obtain reviews are not successful.

You were concerned that whilst a fluid balance chart was requested and fluids prescribed, the fluid balance chart was not completed fully and in particular, the necessary calculations to understand Mr. Flynn's fluid position were not made, thereby not following Trust policy regarding completion. Additionally, you were concerned that the doctor who saw Mr. Flynn on the morning of 16 July 2018 prescribed further fluids without reference to the fluid balance charts.

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With regards to your concerns that fluids were prescribed for Mr. Flynn without reference to the fluid balance chart, I understand from [redacted] that following the ward round conducted on the morning of 16 July 2018, and based on the clinical assessment and blood parameters noted at that time, it was clinically appropriate for fluids to continue intravenously, and to be re-prescribed. I understand from [redacted] that once an improvement in Mr. Flynn's renal function was noted on the afternoon of 16 July 2018, the correct decision was taken to discontinue the intravenous fluids.

In regard to the fluid balance chart, I have been assured by the Matron for the Orthopaedic Unit that formal discussions have taken place with the nursing staff identified as failing to comply with Trust Policy in respect to the completion of the fluid balance chart and consideration given to identify support or training needs. In addition, the newsletter previously referred to, circulated to all staff in the department, reiterates staff responsibilities and accountability regarding completion of the fluid balance chart. As an additional measure, I understand the ward manager has recently introduced new signage placed at the bedside to further support staff in recognizing which patients have a fluid balance chart in place.

I am aware that an audit of fluid balance charts has recently been completed, as part of a wider audit of the Trust's Acute Kidney Injury care pathway. The results identify 100% compliance in completion of the fluid balance chart. Whilst this provides a level of assurance, the Head of Clinical Audit and Effectiveness has indicated that a trust wide audit of fluid balance chart compliance has been added to the Trust Audit Programme for 2019/2020.

The Medical Education Manager has advised that fluid balance management is included in the AIMS training that is provided to junior doctors commencing at the Trust and the Patient Safety Team have drafted and distributed a 'Time out for Learning' bulletin focusing on the importance of monitoring and completing fluid balance charts.

I am very sorry that you had cause to issue this Regulation 28 Report. I hope I have responded to your concerns and wish to assure you that the Trust takes our responsibility in respect of management of the deteriorating patient seriously, and the Medical Director and Director of Nursing and Integrated Governance have established systematic oversight of this from a safety perspective.

Should you have any queries arising from the content of this letter or require further information or clarification, please do not hesitate to contact me.

Yours sincerely

Karen James
Chief Executive Officer