NHS
Central and
North West London
NHS Foundation Trust

Executive Office
Tel: 020 3214 5760

24 April 2019

Mr Edwin Buckett
Assistant Coroner Inner North London
Poplar Coroner's Court
127, Poplar High Street
London E14 0AE

Dear Mr Buckett,

RE: REGULATION 28: REPORT TO PREVENT FUTURE DEATHS FOLLOWING THE INQUEST OF MR JOHN WILLIAM PEARCE

I write in response to the Regulation 28 Report issued on 25 February 2019 following the inquest into the death of Mr John William Pearce.

Central and North West London NHS Foundation Trust (CNWL) deeply regret the death of Mr Pearce and apologise for any failings in the care we provided.

The Regulation 28 report identified four concerns which I have identified in bold below followed by the Trust response:

"There was no clear instruction, protocol or system which assists nursing staff in dealing with elderly patients who suffer from open wounds which worsen over time, as to when the emergency services should be contacted. It is clear that the staff were following a Tissue Viability Nurse care plan, but no-one appeared to recognise the severity of the injury and the fact that tendons and bone were exposed"

CNWL has a Lower Limb and Leg Ulcer Management Policy which was published in October 2018 and gives detailed instructions on the management of lower limb wounds, including traumatic non healing wounds as seen in this case. The purpose of the policy is to standardise lower limb and leg ulcer management strategies across the Trust in accordance with NICE (2016), Best Practice Statement (2016) and RCN (2006) guidance.

It is completely unacceptable that this policy was not consistently adhered to by the staff involved in Mr Pearce's care. In response to this, the Divisional Director of Nursing and the Inner London Lead Nurse met with the team involved in this gentleman's care on 19 March 2019 to discuss the findings of the PFD, reiterate the policy and assess any further support required in ensuring the above policy is followed in the future.

In the meeting on 19 March, the policy was discussed in detail alongside reinforcement of individual roles and responsibilities for escalating any deterioration in a patient's condition. This included reiteration of the role of emergency services and the need outlined in this policy which requires the attendance on every third visit by a qualified nurse or senior nurse; ensuring a thorough re-assessment is undertaken and any risk factors which may contribute to delayed healing are identified early and appropriately managed in line with the policy.

A further follow up meeting is planned with the team on 3 May 2019 to assess how the team have embedded learning from this incident to date including their local processes for ensuring that at handovers, deteriorating patients are identified in a systematic manner.

All of our district nurses complete annual refresher training on wound care management. There is a competency framework in place for health care assistants and district nurse team leaders are responsible for ensuring that their staff are competent. In light of these findings, the Lead Nurse will oversee a programme for reassessment of competence and this will be completed for all staff by 1 June 2019.

In addition, a Trust-wide clinical message will be cascaded out to all community nursing teams reminding them of the policy requirements, consent and capacity and escalation processes.

There were insufficient attendances on Mr. Pearce by the District nurse Team when it appeared to be decided that he would be visited at more frequent intervals"

Whittington NHS Trust currently provide the specialist tissue viability service for complex wounds to Camden residents and were directly involved in the care delivered to Mr Pearce. As the specialist service, they advise our district nursing teams on the wound care plan and frequency of visits. We are therefore sharing, and working together, with the Whittington NHS Trust in the learning from this case.

Where a patient is clinically assessed and the condition of any wound is noted to be significantly deteriorating, we fully acknowledge that the capacity and best interest of the patient must be clearly assessed on each occasion and the records must evidence that this has occurred.

Where the clinical advice indicates an enhanced level of visits, the decision to reduce the level of visits should only be taken following evidence that the potential consequences for the patients' well-being have been detailed in full to the patient and the risk to the patient discussed with those involved in the patients care.

Through the meetings already underway and being planned we have reinforced the requirement for all involved parties – in this case our district nursing service, the GP and the Whittington NHS Trust to consider better how to ensure the care continues to be delivered in the best interest of the patient and the required frequencies of attendances.

As above, the requirement of the policy that every third visit should be undertaken by a qualified nurse or senior nurse; ensuring a thorough re-assessment is undertaken and any risk factors which may contribute to delayed healing are identified has also been further reinforced with the team.

"Too much emphasis was placed on Mr Pearce's own view that he did not like hospitals and did not want to go there, even though he was noted to be an individual who had difficulty expressing himself"

This case has highlighted the difficulties of safely managing patients who decline care against clinical advice. In cases where health workers believe the patient is making unwise decisions against hospital admission and more frequent visits in his/her own home, we provide specific safeguarding advice and will now consider how best to adapt our existing Mental Capacity Act (MCA) training to support the application of the MCA, and best interests need to be made on each occasion when the patient is declining appropriate clinical care.

Where there is continued refusal but capacity is still observed and recorded, we will ensure there is further escalation. The requirement of the CNWL Lower Limb Policy referred to above that every third visit should be undertaken by a qualified nurse or senior nurse must be followed.

We are tightening our process for ensuring that there is formal and regular mental capacity assessment at the point that treatment decisions of consequence are being made and recorded accurately in our clinical records.

We already run regular peer reviews across community services. As part of this process, we will also now ensure that on each peer review, a sample of notes is audited to assess completeness and accuracy of documentation.

On 10 April, the CNWL Trust Deputy lead for safeguarding adults and MCA met with the team to follow up how community staff should be making their assessment of capacity and consideration of best interests when seeing patients in their home environment. The actions to be taken where the health of patients is observed to be deteriorating and how that risk should be effectively managed, has been reinforced.

During May our Safeguarding Adults lead will also be providing additional bespoke training for capacity and best interest in community settings including supporting clinicians with necessary documentation.

As identified above, the learning from this case will be shared across the Trust as part of our "clinical message of the week" process during the next month. The case will also be shared at a planned learning event with staff, GP and colleagues from Whittington Health on 9 May 2019.

CNWL operates a Trust-wide Pressure ulcer board and, during June, this forum will also be used to cascade learning around escalation of deteriorating wounds, capacity and best interest assessments.

"There was no clear evidence that photographs taken of the wound were shared with other agencies or the deceased's GP, such that another view could be taken of those wounds so as to consider whether the emergency services should become involved as a matter of urgency"

Photographic evidence was regularly taken and consent to photography was recorded with all photographs being uploaded to the clinical recording system (Systmone). The process already in place ensures that any photographs can be reviewed by the Whittington NHS Trust who currently provides the specialist tissue viability service to Camden residents and were involved in the care delivered. As mentioned above, we are working with the Whittington to address the learning from this case and are due to meet with them on 9th may as highlighted above.

Due to the GPs using a different recording system (EMIS), the GP would not automatically be able to access the photographs. We recognise that it is not practical or necessary to share all photographs of wounds automatically with every GP. As part of the escalation where a patient's condition is seen to be deteriorating, the requirement for sharing information, including photographs, is expected and would take place via secure email. This has been reinforced to our staff as part of the meeting in March and will be again reinforced at the follow up session in May.

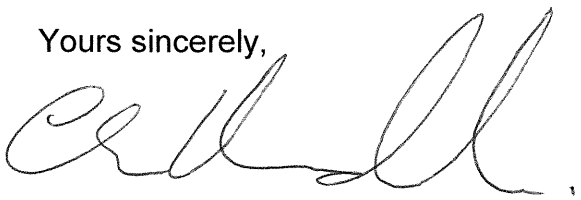
The ability to share photographs of deteriorating wounds with both the specialist service and the GP will provides a further level of scrutiny to decision making regarding the need or otherwise of involvement of emergency services.

CNWL has a deteriorating patient policy which identifies actions staff need to take to identify when patients clinical condition changes. The policy requires that staff in adult services use the National Early Warning Score (NEWS2) tool which directs staff to seek emergency help. CNWL will re-train members of the team in the use of this tool by the end of May 2019.

The Lead Nurse will oversee a 3 month action plan to ensure that the improvements required, as outlined above, are embedded in this team. She will be required to formally report back, at the end of the 3 month period to the Divisional Board as part of our assurance process.

I hope this provides you with sufficient assurance that the Trust is taking decisive action to improve care for patients in the community with this type of injury. If you have any questions or comments, please do contact me directly on the details above.

Yours sincerely,



Claire Murdoch
Chief Executive