Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Salford I Oldham I Bury I Rochdale I North Manchester

Chris Brookes
Chief Medical Officer
Group Headquarters
3rd Floor
Mayo Building
Stott Lane
Salford
M6 8HD
Telephone: 0161 206 4657

Ref: CB/at

Date: 7 May 2019

Dear Ms McKenna

Inquest touching the death of Marjorie Gartside

I am writing to you, in response to your Regulation 28 Report sent on 11 March 2019 regarding the death of Mrs Marjorie Gartside, who sadly died following an admission at the Royal Oldham Hospital. At the outset please accept my sincere condolences to the family of Mrs Gartside.

Thank you for bringing the concerns raised in the Regulation 28 report to our attention. The Trust is dedicated to ensuring patient safety is maintained throughout all services. I would like to take this opportunity to provide assurance to both you and the family that the Trust takes the concerns raised very seriously and have conducted a thorough review.

Your matters of concern were as follows:

- *The information provided by the Royal Oldham Hospital to the Home on 10 October 2018 was inaccurate in suggesting that Mrs Gartside was able to mobilise. Had that information been relied upon by the Home it would have resulted in Mrs Gartside not having suitable or appropriate equipment in place for her return.*

- *Mrs Gartside's discharge from the Royal Oldham Hospital on 12 October 2018 appears to have been unsafe and raises a concern about the robustness of discharge processes.*

- *There appears to have been no handover of care and a lack of clarity as to whether Mrs Gartside was for palliative care when she was discharged from the Royal Oldham Hospital on 12 October 2018.*

- *The prescribed anticipatory medication was not sent with Mrs Gartside when she was discharged on 17 October 2018.*

A Rapid Review has been completed to ensure all lessons to be learned from this incident have been identified and to ensure the learning can be embedded. In order to address each concern you have raised I have responded to each point below:

The information provided by the Royal Oldham Hospital to the Home on 10 October 2018 was inaccurate in suggesting that Mrs Gartside was able to mobilise. Had that information been

relied upon by the Home it would have resulted in Mrs Gartside not having suitable or appropriate equipment in place for her return.

During Mrs Gartside's first admission, she was documented to have been "mobile with one" (requiring support from one person) and "a frame over short distances with assistance of one". This was in line with Mrs Gartside's pre-admission mobilisation needs according to the risk assessment completed by the Residential Home.

A telephone handover took place with the Home on the 10 October 2018 in line with Trust policy. The Rapid Review also identified that Royal Oldham Hospital delayed Mrs Gartside's discharge to ensure the right equipment (profile bed, mattress and cushion) was in place for her discharge to the Home. The equipment was ordered on 10 October, but not delivered until 11 October. Transfer took place on 12 October.

Unfortunately, our review has discovered that no written documentation of the conversation with the Home was recorded and this is not in line with the Trust's Standard Operating Procedure ("SOP") for Discharge, which states which states that *"Discharges into nursing or residential care will require the named nurse to give a handover summary over the phone to facilitate effective communication to detail the patient's care needs at the time of transfer, followed up by a comprehensive written communication document on behalf of the Trust to the receiving care facility.* I apologise to the family of Mrs Gartside that this fell below the expected standard that I would expect to see and would like to reassure them that in order to ensure learning from experience the Divisional Director of Nursing has shared this with response with all the teams to highlight the importance of adhering to the SOP for discharge. In addition, the Divisional Director of Nursing will also include this on the safety huddle to ensure all ward staff are aware of the learning around this very sad death.

Mrs Gartside's discharge from the Royal Oldham Hospital on 12 October 2018 appears to have been unsafe and raises a concern about the robustness of discharge processes

In order to ensure safe discharge, the ward team is ultimately responsible for getting the patient home safely. This includes nursing staff, medical staff and the discharge co-ordinator all supporting with facilitating safe transfer.

On review I can confirm that Mrs Gartside's discharge was delayed until the appropriate equipment was available at the Home to ensure that she was safe on her arrival and this was an appropriate measure. On 12 October 2018 (the day of transfer), Mrs Gartside's observations were checked, which were stable and two blood sugar readings were taken during the morning. Both of these were within normal range. It is documented that Mrs Gartside was provided with breakfast, however took a minimal amount and was discharged prior to lunch being served. All of the above would indicate that Mrs Gartside was safe for discharge and there was nothing that would suggest she needed to be kept in hospital. However, as part of our review is it recognised that the timing of the discharge could have been improved to ensure Mrs Gartside had eaten prior to leaving and this will be discussed with the ward staff to reiterate the importance of hydration and nutrient before a patient is due to leave the hospital.

As a Trust we are working with the British Red Cross to provide an Enhanced Discharge Service for those patients who have a lack of support at home and to assist with people regaining confidence. The Support at Home Service is for those patients who are discharged to their own home and links with other services, for example community connect and mobility services.

As you aware [redacted] Consultant in Geriatrics and General Internal Medicine gave evidence at the inquest and he has reviewed Mrs Gartside's care with [redacted] Medical Director for Royal Oldham Care Organisation to ensure any learning points are appropriately acted on. Having reviewed Mrs Gartside's discharge and medications, I would like to reassure the family that [redacted] and Jawad Husain do not consider that this was an unsafe discharge and I apologise if this was not reflected in evidence during the inquest and for any unintentional distress this has caused the family. The Trust would be happy to meet with the family if this is something they would find useful, please do not hesitate to contact me on the details at the top of this letter.

There appears to have been no handover of care and a lack of clarity as to whether Mrs Gartside was for palliative care when she was discharged from the Royal Oldham Hospital on 12 October 2018

I am sorry that it was perceived in this way during the inquest and most importantly that the family were given cause to concern. On review it is documented on 12 October 2018 that the Handover of Care Communication was completed. On the documentation it states for the GP to consider putting Mrs Gartside on the palliative register, consider Vitamin D and the ongoing need for analgesia and laxatives.

It documents that bisoprolol (medication to treat high blood pressure) had been commenced and that insulin had been increased to 22 units at breakfast and 12 units at tea time. The insulin was appropriate due to the fact Mrs Gartside's BMs (glucose measure) pre-discharge had been stable. Two blood sugar readings were taken and showed to be within normal range.

I hope the above reassures the family that the discharge plan was explicit with regard to palliation and the GP's letter back to the Emergency Department would indicate the GP had a copy of the plan.

The prescribed anticipatory medication was not sent with Mrs Gartside when she was discharged on 17 October 2018

On 17 October 2018, Mrs Gartside was prescribed anticipatory medications 'to take home' which were dispensed by the pharmacy. She was discharged and arrived back at the home at 3pm. Mrs Gartside did not arrive at the home with the anticipatory medications and unfortunately, her grandson did have to come back to the hospital to collect the anticipatory medication from F9 ward, which is not acceptable. Mrs Gartside should have had her medication sent home with her and in order to ensure that staff members understand the importance of patients getting their medication, the NCME022 Pennine Acute Hospitals NHS Trust Standard Operating Procedure for Discharge from Hospital and Supporting Choice has been re circulated to all staff: including those on the discharge ward.

It is unacceptable that Mrs Gartside had a cannula in her foot, which was removed by a District Nurse and this is not the standard we expect to see within our hospital. Please be assured that staff involved have been informed of this incident and reminded to check for cannulas pre discharge. I sincerely apologise for this omission and assure you that this issue has been raised within the division to ensure learning. This response will also be circulated to all staff across the NCA to ensure group learning from experience.

I do hope that this response provides assurance to you and Mrs Gartside family that Northern Care Alliance has worked hard and continues to focus on ensuring that lessons have been learned and improvements have been made.

Please do not hesitate to contact me if you require any further information in relation to our response.

Yours sincerely

Chris Brookes.

Chris Brookes
Consultant Emergency Medicine
Executive Medical Director, Salford Royal NHS Foundation Trust
Chief Medical Officer and Deputy Chief Executive Northern Care Alliance
(Incorporating Salford Royal NHS Foundation Trust and Pennine Acute NHS Trust)