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Northern Care Alliance
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Salford I Oldham I Bury I Rochdale I North Manchester

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Ref: CB

Date: 9.12.19

The Coroners Office
Paderborn House
Howell Croft N
Bolton
BL1 1QY

Via email only

Dear Ms Syed

Re: Victor Hall (Deceased)

I write following the conclusion of this inquest on 16th October 2019. At the outset please accept my sincere condolences to the family of Victor Hall. I am sorry that they have been given cause for concern at such a difficult time.

Thank you for bringing the concerns raised to my 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 into the concerns raised.

I have set the concern to The Chief Executive, Salford Royal Hospital, NHS Trust Hospital, Stott Lane, Salford, M6 8HD out in bold below:

i. **Guidance and procedures in relation to the dispensing and transfer of medications from the Pharmacy Department to a ward, to include a system of checking medications against the packaging, labelling and prescription chart at the time of receipt by the ward. Furthermore, to consider documentary evidence of the fact that the medication packaging has been checked against the prescription chart and an acknowledgment of receipt of the correct medication by the pharmacy and ward staff, evidenced by a signature of the recipient.**

In response to the issues raised a full review of the dispensary environment at Salford Royal Hospital will be undertaken. This review will look at the workspace design and the processes involved in the dispensing and checking of medication in the pharmacy department with the aim of reducing noise and distractions. I have set out the Trust's action plan to achieve this below:

Action	Action Lead	Completion By
Preventing staff entering the dispensary unless they have a relevant reason to be in there and so minimise the risk of interruption. This will be enforced with signage and staff awareness at daily huddles.	[redacted]	31st January 2020
Introducing library conditions within the dispensary.	[redacted]	Commencing with immediate effect.
Changing the exit route (after 5pm) from the department which is currently located next to the accuracy checking area. Staff will exit the department via the pharmacy reception exit, preventing staff using the dispensary as a thoroughfare.	[redacted]	31st January 2020
Arranging feedback sessions for all staff to highlight elements of the clinical check, dispensing and accuracy check processes that need to be improved. Staff will be made aware of this at daily huddles.	[redacted]	31st January 2020
Reviewing the layout of the dispensary with the aim of separating the areas used for different parts of the dispensing process and improving the flow of work.	[redacted]	29th February 2020
Implementing "closed loop dispensing" (linking the electronic prescribing system to the pharmacy dispensing system and robot) with the aim of reducing dispensing errors and improving efficiency and therefore reducing the number of staff needed in the dispensary.	[redacted]	30th June 2020

Changes will be made to the processes involved in administering medication by both the nursing and pharmacy staff to inpatients at Salford Royal NHS Foundation Trust by:

Action	Action Lead	Completion By
Implementing "closed loop medication administration" (electronic barcode scanning of patients and medications) to ensure that patient's receive the right drug at the correct dose by the right route at the intended time. This will indicate to nursing staff (at the point of administration rather than the point of receipt) that the prescribed medication has been correctly sourced.	Digital Team	30th June 2020

i. **Training, Auditing, Supervision and monitoring of all staff, particularly nursing and pharmacy staff, in relation to the above issues.**

We acknowledge as a learning organisation that we need to review our training and supervision for both our nursing and pharmacy staff. The pharmacy department will ensure the following actions will be taken:

Action	Action Lead	Completion By
Updating the accuracy checking procedure which will incorporate a second check for all intravenous fluids.	[redacted]	31st December 2019
Introducing an electronic sign off to indicate that key procedures have been read and understood by relevant staff.	[redacted]	31st December 2019
Reviewing the number of items required to complete dispensing and accuracy checking logs during induction.	[redacted]	31st December 2019
Introducing a formal revalidation procedure for staff involved in dispensing errors	[redacted]	29th February 2020
Introducing a recurrent accuracy checking log for all accuracy checkers to ensure competence.	[redacted]	29th February 2020
Identifying formal supervisory duties and responsibilities in the dispensary.	[redacted]	29th February 2020
Analysing near miss data to identify common dispensing errors and introducing on-going communication of this to staff.	[redacted]	29th February 2020
Reviewing the accuracy checking test to incorporate a wider range of medications.	[redacted]	29th February 2020
Monitoring of compliance of medicines safety training completed by nursing staff on Ward H2.	[redacted]	Commenced
Monitoring of medicine safety incidents on ward H2	[redacted]	Commenced
Policy to be published about the process to follow when involved in a medicines safety incident.	[redacted]	29th February 2020
All nursing staff to be made aware that there are many different types of Polyfusor products. In order	[redacted]	29th Feb 2020

to prevent errors all details must be checked in full as per any medication.		
Implementation by the Learning and Development team learning from this incident within the medicines learning package.	[redacted]	31st December 2019

In addition the nursing staff recognise that there are lessons to learn and will ensure that the following actions are taken:

- Deborah Hindle, Deputy Director of Nursing for the Integrated Care Division will ensure that all nursing staff on ward H2 are compliant with their medicines safety mandatory training. Deborah Hindle will monitor medicines safety mandatory training and ensure all staff are compliant. Weekly senior nurse walkabouts will include ward H2, where observations will be undertaken of nursing medication/fluids dispensary checking procedure.
- A policy will be published to provide guidance about the process to follow if a member of staff is involved in a medicine safety incident. This will provide instruction to clinical staff about the framework of processes for all aspects of medicines management including the administration of medication. It will also provide guidance on whether staff need to repeat their medicines management workbook.
- The senior nursing staff will be responsible for the dissemination of the policy, monitoring the implementation and adherence to the policy.

I do hope the above gives assurance that the concern raised the Trust has recognised and taken the concerns raised seriously and taken prompt steps to ensure lessons have been learnt.

I would like to conclude by offering my personal apologies to Victor Hall's family for their sad loss and would like to reiterate that we are committed to embedding the learning from this case to ensure ongoing improvements to patient care at the Trust

Yours sincerely

Chris Brookes.

[redacted]
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)

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