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Milton Keynes University Hospital
NHS Foundation Trust

Our ref: 20191203JH
Date: 03 December 2019

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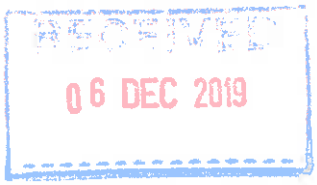

Mr Tom R Osborne
HM Senior Coroner
HM Coroner's Office
Civic Offices
1 Saxon Gate East
Central Milton Keynes
MK9 3EJ

Dear Mr Osborne

REGULATION 28 REPORT TO PREVENT DEATHS – Mr Thomas Henry Smyth

Dear Mr Osbourne,

I am writing in response to a Regulation 28 Report, issued to me as Chief Executive of Milton Keynes University Hospital NHS Foundation Trust on 28 October 2019. The report requires a formal response by 16 December 2019 and this letter is intended as that formal response.

The inquest that the Regulation 28 Report followed was into the death of Thomas Henry Smyth, aged 86. You reached a narrative conclusion which read: *The deceased was admitted to Milton Keynes University Hospital on 12th July 2019 following a fall at his nursing home. A CT scan revealed a subdural haematoma and the neurosurgeons advised that his anticoagulation medication should be stopped. It was inappropriately restarted on 13th July 2019 and this resulted in his clinical deterioration and he died from the subdural haematoma on 3rd August 2019 at Mallard House Milton Keynes.*

Following the conclusion, you stated matters of concern that form the basis of the Regulation 28 Report. Those concerns read: *During the course of the evidence I heard from consultants and more junior staff that they were unaware of certain facts relating to Mr. Smyth at the time that they were dealing with him and making decisions relating to his care, and yet the information was recorded in the electronic notes and records. It appears to me that staff are having difficulty accessing vital information that should be clearly available to them. I would ask that you carry out a review of the notes system to see whether or not it is being used correctly, whether staff members have been adequately trained with regard to its use and whether changes should be made as to how information is recorded and*

retrieved. Unless the system is working effectively I anticipate that further lives will be put at risk.

I would like to address those concerns and set out what we have done and are continuing to do to ensure that our electronic notes system is safe and effective.

You may recall that we introduced an inpatient Electronic Patient Record (which we refer to as eCARE) in May 2018. The supplier of the system, Cerner, is used in more than 20 hospitals across the UK as well as in hospitals and health systems globally.

To ensure the system was introduced safely, and with the minimum of disruption to patients and patient care, we undertook an extensive programme of staff training in the lead up to the eCARE system going live across hospital inpatient areas (including the Emergency Department and Maternity – some areas, including Critical Care and Paediatrics, are in the next phase of the roll-out). This programme included individual and team training; dedicated staff to support wards and departments on the use of the system after go-live; training for all temporary staff; and training materials, including videos, as well as individual and team support remaining readily available.

The Trust also appointed a Chief Clinical Information Officer (a consultant vascular surgeon) and a Chief Nursing Information Officer (an experienced senior nurse), to ensure appropriate clinical oversight and input into all aspects of eCARE – from its introduction to ongoing training and future developments.

We have a robust governance process and structure in place to oversee the development, implementation and continued performance of eCARE, including staff training and use of the system. This structure reports to a main board (the Health Informatics Programme Board) which I chair as Chief Executive. This board has oversight of risks and issues and works to ensure that these are mitigated and managed appropriately.

In the care of Mr Smyth, the Emergency Department Doctor notes Mr Smyth was on Apixiban in the free text area of the eCARE record. It would be optimal if this were recorded in the medication history section of the eCARE record. The Pharmacist subsequently reviews and inputs an accurate medication history. By the time Mr Smyth is clerked by the Trauma and Orthopaedics Senior House Officer, the Apixiban is clearly in the medication history and this is included in the SHO's note.

Mr Smyth had a Venous Thrombolytic Embolism (VTE) assessment to assess whether prophylaxis was required to prevent Deep Vein Thrombosis/ Pulmonary Embolus. The Doctor who completed this recognised that Mr Smyth should not have VTE prohylaxis due to his intracranial bleeding; however they do not check the box on the electronic form that says 'concomitant use of anticoagulants'. If they had checked this box the Doctor may have thought to stop the Apixaban.

Apixaban is given to Mr Smyth twice a day on 14 and 15 July, and one dose is given on 16 July. A VTE assessment is completed by a different Doctor on 16 July but 'concomitant use of anticoagulants' is again not identified.

Apixaban was then stopped on 16 July as Mr Smyth's condition deteriorated; and Apixaban was not administered again during admission.

Although documentation in the free text area of the eCARE record is appropriate, it is not best practice, as there are more secure designated (and specifically designed and included) sections of eCARE in which to include issues that may raise a medication alert or other safety alert in the care and management of individual patients.

In this particular case, it is clear that important and relevant information was indeed recorded in the clinical record. Members of staff did not consistently review key elements of the record when assessing Mr Smyth; for example, the medication chart does not seem to have been reviewed daily when clinicians assessed Mr Smyth's condition. Review of the medication chart and observations is a key element of routine rounding and this will be reinforced with staff. This will be addressed in training – with additional training in ED and Trauma and Orthopaedics. This specific case will be used for learning in plenary sessions during the year to reach a wide medical and multidisciplinary audience.

It should be noted that the electronic system used by the Trust to communicate with neurosurgical colleagues in Oxford (OARS) offers huge advantages over the informal paper-based system which came before it. There is now a thorough audit trail of all communication between local doctors and those in the tertiary centre, with automated alerts to the lead clinician when an individual patient's record is updated.

It is important to recognise that electronic health records – whether within a hospital (such as eCARE) or within a clinical network (such as OARS) – offer very significant benefits in relation to accessibility, governance and patient safety. Electronic prescribing in particular

has major advantages. Where care does not go according to plan and deficiencies in note keeping and communication are identified, it is imperative that we do not persuade ourselves that the medical records of old were better: lost records, illegible entries, medication charts in pharmacy, two different perspectives on the same conversation between centres with no written record of either.

I am satisfied that with the actions proposed, and the governance structure in place to manage the use of and risks associated with eCARE, the risk of future recurrence is appropriately mitigated.

If you require any further information or evidence, please do contact my office without hesitation.

With kind regards

Yours sincerely

Professor Joe Harrison
Chief Executive

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[redacted] Medical Director