Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

Ms M A Jones
Her Majesty's Assistant Coroner
Stoke-on-Trent & North Staffordshire Coroner`s Office
Stoke Town Hall
Kingsway
Stoke-on-Trent
ST4 1HH

25th November 2020

Dear Ms Jones

Re: Mavis May Lawrence (deceased)
Report to prevent Future Deaths

Thank you for your letter dated 1st October 2020, reporting matters to us, in accordance with Regulation 28 and 29 of the Coroner's (Investigations) Regulations 2013.

Following discussions within the teams involved, I am now in a position to respond to your specific concerns, whereby you stated you heard at the inquest during the course of the evidence:

I am sorry that a complete set of records was not made available to you at the point of the inquest. We note, as part of your inquest conclusion and subsequent concerns outlined in your Regulation 28 report, that unfortunately you did not have access to the My Care File, which contains the records held at a patient's home or place of residence. Our response is made on the basis of our review of the relevant MPFT care records.

We have responded to each of the concerns raised and identified some actions, which are in the action plan below for your information.

(1) Nursing notes evidence that pressure areas (sacrum/ buttock/hips) were not checked between 3.12.18 and 11.12.18. Wounds to the sacrum and left hip were documented on the 16.12.18 in nursing notes.

We have identified a number of actions aimed at improving completeness of our documentation; including the provision of additional training and a programme of audits, to ensure improvements are made. (Please see action plan below actions 1 & 2 & 4c).

(2) No wound treatment assessment charts after the 18.12.18 to document deterioration of pressure areas.

There is evidence in the deceased's records that wound assessments were undertaken after the 18.12.2018. Wound assessments were completed on the 01.01.2019 and on the 27.01.2019 clearly documenting the condition and anatomical location of the wounds. The MPFT guidance is that wound assessments need to be carried out and documented on a fortnightly basis. If the wounds deteriorate before the next fortnightly review, a wound assessment will be completed prior to that date. Records show that in between the regular wound assessments there were regular summaries of the condition of the wounds. Up until the date of admission to hospital the records

state that the wounds to the sacral and right hip area were improving, granulating (healing) or that there were no concerns to raise. The assistant practitioner (band 4 nurse from the district nursing team) has documented that there may be a new non blanching area to the right hip. The assistant practitioner (band 4 nurse from the district nursing team) recorded in the nursing notes that "the family has been advised of Mavis's presentation and requirements" on the last wound assessment on the 27.01.2019.

(3) Nursing notes in December 2018 did not portray a clear story of positioning and changes to the ulcers.

Please see response above.

(4) The pressure mattress had been turned off on the 22.1.19

The Residential Home is responsible for ensuring appropriate use of the equipment. Our records show that during a routine visit on 22.1.19 the district nurse noticed that the pressure mattress had been turned off, and took immediate action and turned it back on.

(5) No record of last visit by district nurses on the 27.1.19

When the patient is cared for in a residential home, the carers are expected to carry out regular skin checks as they are tending to the patient, on a regular basis. The process in place requires that the care staff raise concerns to the district nurses as and when required. There is evidence in the care records that MPFT staff did request the Residential Home staff contact MPFT district nursing staff if they had any concerns. There is evidence of a wound assessment table having been completed by the assistant practitioner (band 4 nurse from the district nursing team) on 27.1.19, in the My Care File when the assistant practitioner (band 4 nurse from the district nursing team) was requested by the Residential home care staff to complete an assessment.

(6) There was no evidence that band 4 nurse escalated the seriousness of the situation.

There is evidence in the records that the band 4 nurse escalated this appropriately and notified the nurse in charge of the district nurse team, as well as the tissue viability team, on Sunday 27th January 2019.

(7) There was no evidence that the deceased had been provided with any pain relief and the GP had not been sufficiently involved.

Records show that pain assessments were done at each wound assessment but they do not document pain management in a way that we would expect. It is expected practice that any deterioration in the patient's condition would be addressed with the appropriate intervention by the relevant practitioner, for example, the General Practitioner. We have identified an action to improve our processes to ensure that GPs are sufficiently involved and in addition to strengthen documentation associated with pain management (Please see action plan below - actions 3 & 4a, 4b, 4c & 7.)

(8) District nurses had not involved Tissue Viability Nurses.

The district nurses and assistant practitioner band 4 assistant practitioners are skilled in managing wounds; including pressure ulcers.

The wounds were documented to be healing prior to the 27th January 2019. The assistant practitioner (band 4 nurse from the district nursing team) was at the Residential Home reviewing other patients when the Residential Home staff requested an assessment be completed by her on that day.

In line with our Trust policy for pressure ulcer prevention and management, the practice is that the district nurses will refer to the tissue viability team when there is deterioration in a wound. Once the assistant practitioner (band 4 nurse from the district nursing team) identified (on assessment) that the wounds were deteriorating they followed the correct process of incident reporting, and notified

the nurse in charge of the district nurse team, as well as the tissue viability team, on Sunday 27th January 2019.

MPFT has identified the following actions to improve processes.

Action	**Lead**	**Leek District nursing Team Completion Date**	**District nursing teams and Home First Teams**	**Trust Wide Completion Date**
Point 1 – 1.Provision of additional training in wound care documentation utilising the YouTube training link developed by MPFT Tissue Viability Team (Wound assessment training)	Operational Lead for Leek district nursing team	31.01.2021	Each operational lead to check training register and to ensure all staff have undertaken the update training	31.01.2021
Point 1 – 2.An audit of nursing documentation including pressure ulcer management	Operational Leads Professional Lead & Tissue Viability Lead	30.11.2020 Check audit and compile report for senior management	Develop an audit tool for all community/district nursing teams and a pressure ulcer audit will take place Trust wide	28.02.2021
Point 7 – 3.To raise awareness of the need to involve the GP in the ongoing management of patient care as part of the multidisciplinary team	Clinical Lead & District Nursing	Commenced by 30.11.2020	To raise awareness of the need to involve the GP in the ongoing management of patient care as part of the multidisciplinary team	Commenced by 30.11.2020
Point 7 – 4a. Documentation will be improved. The pain assessment tool has been reviewed and updated; a relaunch with all clinical staff took place in August 2020. 4b. The patient care plan template to be updated to incorporate the pain assessment tool.	Professional Lead for Community Nursing Tissue Viability Clinical Lead Professional Lead for Community	31.10.2020	The audit tool will identify if this process has been embedded	31.10.2020 31.12.2020 28.02.2021

4c. An audit will take place to ensure the pain assessment process is embedded in clinical practice	Nursing Tissue Viability Clinical Lead			
Point 1 & Point 7 5. A new Community Nursing Assessment document has been introduced to document a holistic assessment for patients referred into the District Nursing service to identify needs based on the activities of daily living model.				Completed
6. Multidisciplinary team to share best practice and learning from incidents across all clinical teams via a monthly newsletter following each Pressure Ulcer Review Group and Tissue Viability Steering Group meeting for discussion at team huddles	Tissue Viability Clinical Lead	04.11.2020	Multidisciplinary team sharing best practice and learning from incidents Across all clinical teams A monthly newsletter following each Pressure Ulcer Review Group and Tissue Viability Steering Group meeting	04.11.2020

In line with our governance processes we will share the learning from the Regulation 28 and the actions identified will be monitored, to ensure the action plan is fully completed.

I hope this response helps to address your concerns. However if you require any further information please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]
Chief Executive