NHS
Portsmouth Hospitals University
NHS Trust

Trust Headquarters
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[redacted]

Dear Mr Pegg,

Response to Regulation 28 report to prevent future deaths following the inquest into the death of Beatrice Dawkins

I write to provide the Trust's response to your regulation 28 report issued following the inquest into the death of Beatrice Dawkins. For ease of reference the matters of concern identified by you during the inquest as described in the report are as follows:

The deceased's medical records contained at least seven entries indicating the deceased had a sensitivity to chloramphenicol, the first such entry being recorded in 1997.

Those medical notes included notes made by the Queen Alexandra Hospital, Portsmouth in which the deceased's recorded allergies included chloramphenicol.

Evidence was adduced that had the clinicians involved in the care and treatment of the deceased in September 2020 had knowledge of those notes and/or the deceased's sensitivity to chloramphenicol had been flagged in the medical records during the deceased's September 2020 admission, chloramphenicol would not have been prescribed to the deceased.

My concern is that relevant, critical information relating to the care and treatment of the deceased was in existence but was not accessible nor flagged up to those involved in the care and treatment of the deceased.

In the absence of a process where relevant, critical information is accessible or flagged up to clinicians, there continues to be a future risk to life.

Trust Response

The risk of mis-transcription of allergies and drug sensitivities is increased by the manual completion of drug charts, requiring the prescriber to identify historical allergies from [redacted]

available records, including GP referral letters, and document them accurately on the new drug chart. The records from which this information is obtained for all non-elective admissions are held electronically, either in the form of historical outpatient correspondence and discharge summaries, or through the Care and Health Information Exchange (CHIE). CHIE is populated by primary care held information and accessible to the hospital clinical teams where a patient has given consent for their records to be included on the system. CHIE is probably the most reliable resource for allergy identification available to admitting clinicians who are normally working under significant time pressure, followed by previous discharge summaries. The pharmacy team also have access to the Summary Care Record (SCR) which provides an additional resource for reviewing community records. It is not possible for doctors, other prescribers, or the pharmacy team to go through every historical electronic and paper record available for each patient due to the realistic time constraints present for all practitioners in a modern acute healthcare system. Thus, where an allergy has not been transcribed into CHIE or SCR and is not mentioned within recent hospital derived medical correspondence, risk arises of the sort demonstrated in this case.

As was described in the evidence adduced at the inquest, an Electronic Prescribing and Medicines Administration (EPMA) system is currently being rolled out to every inpatient ward across the Trust and the Emergency Department. It has already been rolled out across medicine and will be extended to all wards across the Trust by the end of 2022. This system will retain information regarding any previous documented allergies or drug sensitivities and will provide that detail automatically when any new prescription is commenced to support future admissions. There is also a requirement to specify the nature of the allergy at the point it is documented. The data on drug allergies and sensitivities are flagged up prominently whenever the electronic drug chart is being reviewed, when new medicines are being prescribed, and when medicines are being administered by the nursing team. If the prescriber overrides an allergy or interaction, they will need to state a reason for why this has been done, which is logged and fully auditable. This will significantly reduce the risk of drug allergies not being identified going forwards.

Inpatient discharge summaries are sent electronically to GP practices. With the introduction of EPMA the medicines component of those summaries will now be populated by the EPMA system to improve their accuracy. For medicines this will require the prescriber to select the medication to appear on the discharge summary, for allergies this will pull through automatically. It is already recommended to our teams that any new allergies should be flagged in the GP Actions section of the discharge summary to ensure that they are translated effectively into the primary care patient records. To further reinforce this, we will be making a change to the discharge summary template with the support of the DigiMeds team (the team supporting the introduction of EPMA into the Trust), to include this as an option. We will also be looking to remove the 'no action' option to promote clear recording.

Identification of allergies and adverse drug reactions (ADR) is a national focus for the NHS with NICE guidance on drug allergies aiming to improve the sharing of allergy and medication intolerance data across the health service in England. An NHS Commissioning

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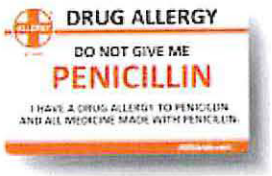
for Quality and Innovation incentive (CQUIN) for 2022-23 is currently being deployed to promote the Transfer of Care Around Medicines (TCAM). TCAM requires the pharmacy team within Acute Hospital Trusts to communicate any high-risk patients to their community pharmacy, for example if a new drug allergy has been identified. This information will be transmitted electronically and stored on the records of the community pharmacy for that patient. The presence of this information held within the database of the community pharmacy will increase the opportunity for the GP practice to obtain that information and record it on their own systems. PHU Trust will be supporting this transfer of information using the PharmOutcomes platform.

A key requirement to prevent further cases of this type, is to work with primary care to ensure that the GP records can be as complete as possible in relation to Adverse Drug Reactions (ADR) including allergies. To support that in Portsmouth and Southeast Hampshire (PSEH), we will share the learning from this case with local GP practices to reinforce the need for allergies reported by the hospital to be cross referenced with Primary Care records when patients are discharged. In the case of Mrs Dawkins, the allergy reported by the patient during previous hospital appointments was included within written correspondence to the GP but was still not added to the GP record. If this had been done, then the Chloramphenicol sensitivity would have been available on the GP record and thus would have been transcribed over to the drug chart either by the admitting doctor or through medicines reconciliation by the pharmacy team.

Handheld severe allergy cards will also be developed and made available within PHU for patients who have difficulties remembering their allergies or who have multiple significant allergies. Upon development, these cards will be shared with the Hampshire and Isle of Wight Medication Safety Group as recommended best practice for wider adoption.



In addition to the actions taken locally, there is a national Information Standard being developed by NHS Digital looking specifically at medicine and allergy/intolerance data transfer between care settings.

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The initiatives described will significantly reduce the risk of a recurrence of Mrs Dawkins case, both immediately and into the future. Given the number of patients that the hospital cares for each year, the complexity of the information pertaining to them and the fact that the accuracy of its recording is subject to human error on occasions, unfortunately it will not be possible to completely eradicate the possibility of an episode of this type occurring again.

However, I hope that the information contained within this response provides you with the assurance you need that PHU is taking all reasonable steps to minimise that possibility.

Yours Sincerely

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Chief Executive