Medway
NHS Foundation Trust

07 June 2022

Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY

Mid Kent and Medway Coroners
Cantium House
2nd Floor
Maidstone
Kent
ME14 1XD

Dear Mr Brownhill

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

**Re: Mrs Kathryn Millard**

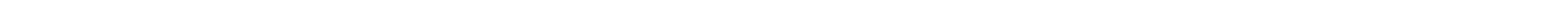
I am writing in response to your report dated 26 April 2022, concerning the care provided to Mrs Millard whilst at Medway NHS Foundation Trust. Your report highlighted three matters of concerns which are listed below. For clarity I will respond to each of your concerns in the order they are raised;

1. **The direction of the most senior clinician, the orthopaedic surgeon, was not documented in the medical records and was not implemented. It is concerning that this treatment plan was not recorded properly in the deceased's notes.**

   In relation to the concern of poor record keeping by the medical doctor, the Orthopaedic team have discussed the outcome of the Serious Incident Investigation report at the junior doctor's grand round.

   Medical doctors have been reminded of the importance and principles of effective healthcare record keeping, which is a minimum standard. The quality of records should meet the Generic Record Keeping Standard, General Medical Record keeping Standards (Royal Academy of Physicians) and Standards for the structure and content of patient records (Academy of Medical Royal Colleges).

   The adherence to national and Trust standards will be audited on a monthly basis and the results of the audit will be shared at local and divisional governance board meetings to ensure compliance and improvement in practice.



2. **The medical records indicated that at least one doctor had indicated that Mrs Millard should have anti-embolic stockings applied. However, the nursing staff gave evidence that they were not aware of this.**

The Trust has also taken action to ensure that Anti-Embolic Stocking (AES) are prescribed and applied when indicated by the medical team. Safety messages and local teaching have occurred to ensure that nurses escalate incidents where an appliance has been indicated, but not prescribed.

Since the recipient of this letter, the team has again sent out safety message to all nursing staff as a reminder of the expected standard. Compliance with expected practice will be audited monthly, and monitored during 'Ward Rounds' and 'Drug Rounds' and lessons identified will be shared at ward meetings.

3. **The nursing staff were concerned on the 12 May 2021 as to the presentation and prognosis of the deceased. Whomever attended (if anybody did in fact attend), did not make any entry into Mrs Millard's medical records. It is concerning that the Trust were not able to identify this individual and that they did not discuss the patient's presentation and prognosis with the nursing staff.**

As you highlighted, the Trust was unable to ascertain if Mrs Millard was indeed assessed by a clinician on 12 May 2021 when her condition deteriorated as there is no record of this care taken place. This does not meet the standards we would expect and all staff have been reminded that all patient contacts are to be recorded in the patient medical record in line with national and Trust guidelines.

An audit of healthcare record keeping (including compliance with relevant Trust policy) will take place on an annual basis Trust wide. In addition, compliance with the expected documentation standards are included in the Ward to Board Assurance and Accreditation Process, which will be rolling out from 27 June 2022.

The results of such audits will be reported via the Trust's Governance structures for Quality, including outcomes and exceptions. In addition, ongoing regular audits will be undertaken using the Trust 'Gather' reporting system by Care Groups to ensure that ongoing record keeping is of the required quality. This will help to inform local audit programmes and to measure the impact of actions taken, supporting improvement activity.

The Trust is committed to learning and improving the standards and quality of our services and care to ensure the best possible experience and outcomes for our patients, their families and carers. I hope that my response, in addition to the included action plan provides assurance that we have taken your concerns seriously and responded to them to ensure we implement lessons identified.

Yours sincerely

Interim Chief Executive Officer