Great Western Hospitals NHS
NHS Foundation Trust

Private and confidential

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David Ridley
HM Senior Coroner for Wiltshire and Swindon
Wiltshire and Swindon Coroner's Office
26 Endless Street
Salisbury
Wiltshire
SP1 1DP

By email only: [redacted]

26 August 2020

Dear Mr Ridley

Re: Coroner's Regulation 28 Report

Thank you for your letter dated 25 June 2020, which included a Regulation 28 Prevention of Future Deaths Report, raising concerns about the circumstances which led to the death of Mrs Winifred Mary Redfearn.

We take these reports extremely seriously and I am writing to share our response to your report, which aims to provide assurance that your concerns have been addressed and includes details of the actions taken or planned to reduce the risk of similar deaths.

As an organisation, we have also conducted our own internal investigation into the care provided to Mrs Redfearn, which will be shared with you once it has been through our governance process, this is scheduled to be completed by October 2020. This investigation identified a number of areas where improvements are needed to ensure all patients receive safe and high quality care

Details of action taken or action planned, in response to the matters giving rise to concern within your report and our own internal investigation, are outlined below.

Overview

There was a delay of two and half days, which included a weekend, in resuming Mrs Redfearn's medication 'Dalteparin' (an anticoagulant that helps prevent the formation of blood clots), after it was suspended pending the result of a CT scan.

You have acknowledged that there is no evidence to suggest that this omission caused or contributed to Mrs Redfearn's death, however believe that there is a risk of similar incidents occurring, posing a potential risk to other patients.

This has led to your concern about treatment being delayed, and the safety and quality of care given to patients potentially being of a different standard during weekends.

The Trust has therefore taken the following actions.

Matters of concern and actions taken

Raising awareness

We know that openly recognising mistakes leads to improved patient safety and we encourage staff to speak up so we can learn and make improvements.

Action

Mrs Redfearn's case has been discussed internally within the speciality, supporting our culture of openness and transparency.

Openly discussing where omissions in care were identified will raise awareness of potential risks to patient safety, actions we need to take to reduce these risks and ultimately inform changes which will lead to improved patient care.

IT based system for weekend review of patients

It was identified that there is no robust system for medical reviews of patients during weekends.

Currently, patients who require medical review over the weekend are added to a paper handover, which is not shared between wards. This system contributed to Mrs Redfearn not being reviewed by a doctor over the weekend.

Action

By mid-September a new electronic review system will be available at weekends. This will clearly identify which treatment is required, and which doctor and speciality the patient has been allocated.

Importantly, the information will be accessible from any location for review during weekends. The information will also be retained.

Venous Thromboembolism (VTE)

There are two areas of improvement to be made around VTE care.

1) The VTE risk assessment is completed on an electronic prescribing system called EPMA, while nursing handover information is stored on a different electronic system called Nervecentre.

   The fact that Mrs Redfearn's medication was suspended pending the result of a CT scan, was not documented on either system.

   Had this been documented, it may have acted as a prompt for nursing staff to escalate this information to medical staff.

2) Ward staff lacked sufficient knowledge regarding the increased risk of VTE from not having Dalteparin, **alongside the patient's immobility and not wearing** electronic regular compression boots.

   Had the ward staff been aware of the importance of Dalteparin, the absence of this medication may have been escalated.

Action

A training plan is being developed to raise awareness of the importance of methods to mitigate the risk of VTE and the importance of clear documentation. The training will commence in September 2020.

The admission of patients to the appropriate speciality

The Trust's current criteria is that any patient over the age of 65, admitted with a trauma, should be placed under the care of the trauma and orthopaedic speciality, with further input where required.

Mrs Redfearn was admitted from the Emergency Department (ED), to a medical ward called the Treatment for Older Persons Short Stay Unit (TOPSSU).

Had Mrs Redfearn been under the care of the trauma and orthopaedic speciality, they would have been more aware of the necessity for review of patients after CT scanning and the need for VTE prophylaxis.

Mrs Redfearn was on TOPSSU when her spinal fracture was diagnosed. This should have triggered a referral to the Spinal Team via the Oxford Acute Referral System (OARS), which enables the spinal team to review CT images and advise on treatment. There was a delay in this happening.

Action

In August 2020, the criteria regarding patients over the age of 65, admitted with a trauma, having care delivered by the trauma and orthopaedic speciality was shared widely throughout the unscheduled care and planned care divisions to increase awareness. The criteria will also be displayed in all patient

admission areas of the hospital. An audit will be undertaken in September to ensure that there is compliance with the criteria.

The protocol for referrals to the Spinal Team via OARS will also be reviewed. The Trauma and Orthopaedic clinical lead/spinal consultant will be leading the OAR review and will be working with OUH. This is expected to take at least 3 months.

Trauma alerts

Pre-alerts are made by the ambulance service and enable the Trauma Team to be called prior to the patient arriving, and the relevant specialties to be involved from the time the patient arrives in ED.

Silver trauma is a way of acknowledging that older people are at a higher risk of significant injury with lower impact mechanisms of injury. In circumstances where the ambulance service has not made a pre-alert call, ED staff can raise this alert.

During Mrs Redfearn's care this process was not followed. This meant that the Orthopaedic Team was not involved at the earliest opportunity and that imaging could have been done sooner in ED.

Action

Further training will be provided to staff to increase their knowledge of pre-alert calls for silver trauma cases. Training will be provided to ED nursing and medical groups by 30 September 2020. The training will be provided by the ED clinical nurse educator and senior medical staff.

The case will also be highlighted to the ambulance service so that they can ensure training is delivered to their staff.

I hope that this letter provides you with assurance that action has been taken in response to your report and that further actions are planned to address the concerns raised and improve the standard of care patients receive.

If you require any further information, please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]
Chief Executive

Copy to : CQC

Our Values
Service Teamwork Ambition Respect