Portsmouth Hospitals University
NHS Trust

Trust Headquarters
F Level, Queen Alexandra Hospital
Southwick Hill Road
Cosham
PORTSMOUTH, PO6 3LY
[redacted]
21st February 2023

[redacted]

Mr R Simpson
Assistant Coroner
HM Coroner's Office
Coroner's Court
1 Guildhall Square
Portsmouth
PO1 2AJ

Dear Mr Simpson

Response to Regulation 28 report to prevent future deaths following the inquest into the death of Anthony Blower

I write to provide the Trust's response to the regulation 28 report issued following the inquest into the death of Anthony Blower. For ease of reference the matters of concern identified by you during the inquest, as described in the report, are set out below in italics with the Trust's response underneath each concern.

1) *Evidence at inquest revealed that none of the nursing care plan risk assessments, which had been completed on Mr Blower's arrival on the ward, had been updated during his stay. I heard evidence that there were changes to his clinical presentation that were recorded in the nursing notes and that these should have been reflected in updated risk assessments. The multi factorial falls risk assessment had not been fully completed on admission nor fully updated after an in-patient fall by Mr Blower.*

The evidence I heard from the nursing staff was that they are potentially missing opportunities for nursing interventions when risk assessments are not updated and that they do not always have the time to review the nursing notes.

I note that the hospital is carrying out audits of documentation completion and updating some systems. However, some 2 years after the death of Mr Blower, the ward manager stated in evidence that her reviews of care plans showed a huge variety in the level of completion and that concordance with documentation remained poor. The hospital witnesses noted that staff were under significant time pressure and completing documentation is not seen as a priority.

[redacted]

Trust Response

Good documentation is vital to the provision of good quality clinical care as you acknowledge above, and as is explained in the letter of 20th December 2022, (attached) the Trust does audit documentation and is in the process of updating its systems.

The importance of good documentation is reflected in our training for both medical and nursing staff. With regard to medical staff this is reinforced through ward-based scrutiny.

With regard to nursing staff, the trust has recently reviewed its preceptorship programme for all newly registered nursing staff and for the new HCSW workforce. This includes a comprehensive overview of documentation as part of a fundamentals of care education package.

The current hybrid between paper and electronic records on the wards creates greater complexity and inefficiency for our staff in terms of recording information. It also leads to there being a more fragmented overall record which makes it harder for members of the multidisciplinary team to be aware of all the information that has been recorded for any given patient. The ambition of PHU and similar NHS Trusts who have not already done so, is to move to a true paper free Electronic Patient Record (EPR). We are working with the Integrated Care Board (ICB) and other Acute Trusts in Hampshire and Isle of Wight to achieve that goal over time.

***2)** Mr Blower was found to be dehydrated and he required IV fluids during his admission. The hospital nutrition policy (section entitled hydration) states that it is the responsibility of the registered nurse and medical practitioner to ensure patients receive adequate fluids and that a minimum of 7 drinks should be provided daily.*

In evidence I was informed that the nurses monitor fluid intake by keeping an eye on water levels in patients' jugs (for those not deemed to require fluid intake charts). There is no one on a ward with overall responsibility for ensuring that the trust policy on hydration is adhered to. Representations from the hospital state that other members of staff also keep an eye on nutrition. This was not sufficient to prevent Mr Blower from becoming seriously dehydrated.

Trust Response

Inpatients are routinely offered a drink at 7 scheduled beverage rounds a day, 6 of these are carried out by housekeeping staff with the final nighttime round being carried out by ward nursing staff. In addition, water jugs are provided for all patients which are refreshed throughout the day as required and should be checked/topped up by housekeeping staff at mealtimes. Additional beverages are also available throughout the day via ward staff, who will contact a housekeeper or access the beverage trolley overnight.

We do not routinely keep a fluid balance record for patients who are drinking well and not receiving supplementary fluids.

Where there is a clinical need, for example in patients with sepsis, acute kidney injury, diarrhoea and vomiting, patients will receive intravenous fluids, and for those patients fluid balance charts will be kept.

The Trust recognises the importance of having a Nutrition and Hydration strategy to support clearer guidance on decision making around which risk factors should lead to a patient being placed on a fluid balance chart. We have just re-established the Trust's Nutrition and Hydration Steering Group which has been tasked with updating that strategy.

I do hope the contents of this letter provide the assurance required to demonstrate that the Trust is aware of, and responding to, those issues of concern raised in the regulation 28 report. If you, or any of your Coronial colleagues, would like to visit Queen Alexandra Hospital to see how documentation is completed and audited, and how hydration is administered and monitored, we would be delighted to facilitate that.

Yours sincerely

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Chief Executive