Chief Medical Officer's Office
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[redacted]

24th March 2023

Andrew Cox
Senior Coroner for Cornwall and the Isles of Scilly
H.M Coroner's Office
Pydar House, Pydar Street
Truro, Cornwall
TR1 1XU

Dear Mr Cox

Re: Death of Felice Eileen Grace Banfield - R28 PFD Report & letter [redacted]

I write in response to the Regulation 28 Report to Prevent Future Deaths, dated and received on the 30th of January 2023, issued as a result of the inquest into the death of Ms Felice Banfield.

I would like to take this opportunity to express my sincerest condolences to the family of Ms Banfield for their loss.

During the course of the inquest, the evidence revealed matters giving rise to concern. These are as follows:

- A lack of clarity about if and when NIV can be offered to admitted patients.
- A patient admitted into RCHT with a respiratory element to her underlying condition was not brought to the attention of the respiratory team. The presenting complaint was not of a respiratory nature and so the challenge appears to be to identify those patients with multiple co-morbidities, one of which has a respiratory component, particularly where the patient is not on a respiratory ward.

- A failure to recognise a deterioration in the presentation of a patient which could have triggered a request for repeat bloods and revealed the worsening acidosis before an AKI developed. There appear at least two elements to this:

  i) the use of food and fluid charts to make sure a patient is not becoming dehydrated and is having adequate calorific intake;

  ii) for patients who stay on AMU longer than usual, ensuring there is some continuity in medical or nursing care, so a deterioration in presentation can be recognised promptly. Would there be value, for example, in requiring a patient who is on AMU for longer than say, 48 hours, to become the responsibility of a single, named consultant who will be responsible for regular review starting at the 48 hour mark?

Please find below the response from the Trust and the detail of the actions being taken in relation to each concern.

A lack of clarity about if and when NIV can be offered to admitted patients

During the COVID-19 pandemic, the guidance of when and where NIV could be delivered was regularly changing as more was learnt nationally about the virus.

If a patient is admitted to RCHT now, usually on home NIV and stable, and can manage their own mask and ventilator as they would at home, they can be managed on any medical ward. There would only be a concern if the patient is positive for COVID-19 or flu and then they would need to be accommodated in a side room. However, if patients on long term domiciliary NIV are admitted acutely and are ventilator dependent (i.e. requiring treatment >15 hours per day), they would be managed in Wellington D Bay or Critical Care irrespective of their presenting complaint.

The Non-Invasive Ventilation Use in Patients with Acute Hypercapnic Respiratory Failure Standard Operating Policy (SOP) is currently in the process of being reviewed, however the above detail is also in the current live version. The current version of the SOP has been shared with staff on AMU which gives clarity of when and where NIV can be offered to patients, both those who are stable and those admitted acutely. Once the revised SOP has been signed off, this will be shared with key staff and wards and a communication circulated Trustwide to ensure that staff know about the revised SOP, the key changes and how to access it.

A copy of the approved SOP can be provided on request once this has been signed off.

A patient admitted into RCHT with a respiratory element to her underlying condition was not brought to the attention of the respiratory team. The presenting complaint was not of a respiratory nature and so the challenge appears to be to identify those patients with multiple co-morbidities, one of which has a respiratory component, particularly where the patient is not on a respiratory ward.

Not every patient presenting to the hospital with known co-morbidities will need to be cared for on the speciality ward for their known co-morbidity. If there are no concerns related to their underlying condition, they would be cared for on the appropriate ward for their primary presenting issue. If during the admission the underlying condition did give cause for concern, the patient would be referred to the appropriate speciality via the Maxims system. There is a space on the referral to leave your contact details and if for any reason the referral is rejected, the rejecting clinician can notify the referrer if these details have been completed.

It is the opinion of the respiratory expert that in this case the provision of the NIV would have made no difference to the outcome for the patient, as there was no evidence of decompensated respiratory failure or respiratory acidosis. Blood results showed that the patient had an Acute Kidney Injury which had led to a metabolic acidosis. Metabolic acidosis occurs when the kidneys cannot remove enough acid from the body, it will often cause tachycardia, rapid breathing, confusion or feeling very tired. Severe metabolic acidosis can lead to shock or sadly as in this case death.

Based on the learning from this case, where patients whose primary reason for admission is not a respiratory element, but because of the specialist care some respiratory patients may require, for example, as in this case NIV; it was decided that it would be useful to have a way of quickly identifying these patients to the respiratory clinical nurse specialist team when the patients are not accommodated on a respiratory ward.

The patient information services have added an alert to all patients currently in receipt of NIV on the patient administration system (PAS). The alert triggers when a known NIV user patient is admitted and the detail feeds into an electronic report in our RADAR system called Patients in Hospital with Alerts. RADAR is a live system that updates every two minutes and can send automated reports to specific individuals as well as being a visible live record of the hospital's current status and specific patient detail. Having this alert and visibility of the NIV report will provide an accurate way of identifying patients on NIV who are not on a respiratory ward which will update as new people are admitted or discharged.

The report in RADAR has been shared with the Respiratory Matron and Respiratory Clinical Nurse Specialists (CNS). The expectation of the Respiratory CNS team is that they will review the RADAR page daily, contact the ward where the patient has been identified as admitted and offer any support that may be required, they will also ensure the ward has the contact details of the CNS so that they can be contacted if there is any need for their input.

A failure to recognise a deterioration in the presentation of a patient which could have triggered a request for repeat bloods and revealed the worsening acidosis before an AKI developed. There appear at least two elements to this:

i) the use of food and fluid charts to make sure a patient is not becoming dehydrated and is having adequate calorific intake;

Following the local investigation completed by the Trust, AMU cascaded a safety briefing to all relevant staff regarding the appropriate use of fluid and food charts in vulnerable patients, highlighting the learning identified in the investigation.

In addition to the safety briefing, in March 2023 the Matron commenced an audit of all nursing risk assessments on Nerve centre (the Trust's electronic documentation platform) with the aim of ensuring all assessments are completed in a timely manner and that any missing assessments are highlighted in real time for completion by the nurse caring for the patient. The risk assessments include the malnutrition screening tool (MUST) which on completion ensures patients are managed appropriately according to their risk. This will ensure that the care is planned appropriately and provide a learning opportunity for staff. Through the continuous audit process, it will help to provide assurance that learning has been embedded from the delivery of the safety briefing and highlight individuals who may require further education to support their practice.

Trust wide compliance with MUST scoring, Food and Hydration Charts is monitored monthly on the Audit Management and Tracking (AMaT) system. The AMaT system highlights any hotspots for needing additional support with training and learning that can be supported by the Lead for Quality, Safety and Innovation and Corporate Nursing Team. AMU has not triggered as a hotspot of concern which would suggest the action being taken by the Matron and the sharing of the safety briefing has been effective.

AMU have also implemented a band 6 link nurse for nutrition and hydration on the ward. This individual liaises with the dietitians and therapists as part of quality improvement. There is a study session on the ward booked for the 4th of June 2023 where nutrition and hydration will be covered.

ii) for patients who stay on AMU longer than usual, ensuring there is some continuity in medical or nursing care, so a deterioration in presentation can be recognised promptly. Would there be value, for example, in requiring a patient who is on AMU for longer than say, 48 hours, to become the responsibility of a single, named consultant who will be responsible for regular review starting at the 48 hour mark?

The Trust's aim is to ensure that speciality patients are reviewed and then moved to the appropriate area as soon as possible. Therefore, the focus is on the flow out of AMU, rather than normalising a lengthy admission in that area. If AMU were to have a single named consultant responsible for those over 48 hours, those patients would no longer receive the speciality care they do now from the speciality visiting consultant.

To address the flow out of AMU the Executive team, in conjunction with the (ICB) Integrated Care Board, have commissioned an external consultancy service (PRISM) to support flow

through the hospital and establish a programme of improvement on AMU. The main focus is supporting AMU processes and the patients who have been on the ward for over 48 hours. This is a 12-week rapid improvement project based on the successes of North Bristol Trust.

The improvements are expected to see the board round and huddles display the live data and involve full MDT engagement, to ensure rapid movement through AMU to speciality areas. This will not just be those patients on AMU for longer than 48 hours but wider as this project, like Bristol, is also expected to assist in supporting the ED overcrowding and ambulance hold delays.

The improvements also include ensuring that all AMU patients are reviewed early each morning at the bedside, identifying patients who are deteriorating and referring them to the correct clinical teams. In addition the project team will also review and update existing policies and standard operating procedures (SOPs) for all admitting areas to ensure they are up to date and support the principle of the right patient in the right bed at the right time.

Currently all patients on AMU are referred to individual specialities for review however this can often be delayed due to internal demands on wards and hospital pressures. The improvement project in support with the wider hospital teams will focus on bringing that review forward.

There is a daily review of the length of stay of patients in AMU and where this does exceed the 48 hours, this is escalated via the site team to ensure rapid referral to the speciality teams. There are regular audits of all patient's length of stay, and plans are put into place to reduce these stays.

The aim is that this model will ensure continuity in medical and nursing care and support the early identification of any deterioration in presentation.

To summarise the above, the Trust are taking the following actions

1. Share the Non-Invasive Ventilation Use in Patients with Acute Hypercapnic Respiratory Failure Standard Operating Policy v4 with all of AMU once finally approved.
2. Embed the use of the RADAR report with the Respiratory CNS team which will identify patients on NIV who are not on a respiratory ward.
3. Continue the monitoring of compliance with MUST scoring, food and hydration charts via the AMaT system and address hotspots as needed.
4. Continue with the 12-week rapid improvement project and embed the positive changes made.

I hope that this letter provides both you and Ms Banfield's family with assurance that the Trust has taken seriously the matter of concerns you raised in your report and that the Trust has taken appropriate action to prevent future deaths.

Yours Sincerely

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Chief Medical Officer