Barking, Havering and Redbridge
University Hospitals
NHS Trust

Private & Confidential

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HM Senior Coroner
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Legal Services
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11 April 2023

Dear Sir,

Regulation 28 Report on the death of George Kearsey

Thank you for your Regulation 28 Report of 09 February 2023. The Trust has carefully considered the concerns raised by HM Senior Coroner in his Regulation 28 Report and guidance has been sought from various specialists within the Trust as to the concerns raised by the Learned Coroner in his Regulation 28 Report.

The matters of concern identified in the Regulation 28 report are:

- IV fluids were not administered consistently. The longest period in which fluids were not administered was 17 hours and 45 minutes.
- Contrary to Trust policy, fluid balance charts were not in place to assess Mr Kearsey's fluid intake and output.
- Clinical records were poorly maintained, resulting in an unclear picture of fluid administration.
- Consultant led ward rounds did not adequately review fluid monitoring.

Trust's Response:

In order to address the concerns you have identified, the Trust have carried out / are implementing the following:

- Cross site audits have been completed on COTE (Care of the Elderly) wards on a random basis to understand a cross section of compliance with fluid management with no notice given to the ward in advance of the audit. The audits capture patients who are on fluid restriction, patients requiring oral and intravenous hydration, parenteral nutrition and output monitoring, whether the intake and output is entered on Careflow Vitals and appropriate action taken as necessary. The audits were completed by senior nursing teams (Matrons, Ward Managers, Practice Development Nurses).

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The division will continue to monitor this (three times a week for the next 6 months on every COTE ward) to ensure that fluids are recorded on Careflow Vitals and that the fluid balance is maintained appropriately. Learning and findings from the audit are shared verbally with the teams.

- Peer audits are being undertaken - The first phase of the audits has been completed. The nursing staff on all wards have been informed of the expectation for fluid monitoring and recording this on Careflow Vitals. We have also introduced peer audits where ward teams will conduct random audits on other COTE wards for the next 6 months. The format of these audits will mirror those conducted by the wards. The feedback from these audits will be shared with the matron and ward manager of that area and relevant action taken, if required. An example is if a patient is on fluid restriction and their fluid intake has not been recorded on careflow vitals. This can have an adverse effect on the patient's treatment. The ward manager will discuss the importance of fluid management and monitoring with staff. The peer audits will commence in April 2023 and will run concurrently with the 3 times a week audits. The results of these audits will also be presented at divisional weekly (tracker) governance meetings. Ward Managers and Matrons will also share the results of these audits during daily huddles.

- The findings and the learning from the audits will be presented in the monthly divisional QGSG (Quality Governance Steering Group) meeting which is well attended by both medical and nursing teams. This will be completed by 30 June 2023.

- Nursing staff have received additional training on Careflow vitals to reinforce the importance of staff compliance with the Trust policy on the completion of fluid monitoring. In addition, nursing staff have had 1:1 sessions with matrons and practice development nurses. Since the implementation of the audits, an improvement has been noted in fluid balance monitoring. For example, on 15 February 2023, Clementine A only scored 70% compliance. The gaps were discussed and addressed immediately with the nursing teams. This improved the compliance on Clementine A, with audits now showing 100% compliance.

- We identified that some medical staff were not familiar with using Careflow Vitals to access patients' fluid balance. Face to face training, by the Careflow team has now been provided for all medical staff, to ensure they are all aware of how to access the fluid balance on Careflow Vitals. Medical staff were all made aware that paper fluid charts will not be completed in the future.

- Following the inquest, it was highlighted, during the Divisional Quality and Safety Meeting in March 2023, that consultants should review patient fluid monitoring information on Careflow vitals. This was followed up by an email sent by the Quality and Safety team on 30 March 2023 to all of the COTE medical staff to ensure that all medical staff are aware that fluid monitoring will be recorded on Careflow Vitals and that assistance should be sought from the nurse in charge, Ward Manager or Matron if they were unable to access that information. This will be discussed again at the April 2023 Divisional Quality and Safety meeting. The Matrons will be giving feedback about the audits they have completed, and any issues identified as part of the ongoing monitoring.

- Fluid monitoring is now consistently reviewed at Consultant Led Ward Rounds. Following Mr Kearsey's inquest hearing, clinical leads from the geriatric's division worked with IT colleagues to ensure a comprehensive understanding of VitalPack as well as ensuring there was clarity in knowing how to access fluid charts. This was shared with all medical staff in the division via the divisional governance meeting. The same information was

shared at board rounds which are the Trust's multidisciplinary patient review meetings. They take place twice a day and all doctors on every ward are now familiar with electronic fluid charts on VitalPack.

- The Trust's Careflow vitals lead will be responsible for the teaching presentation on the use of careflow for fluid management at the next clinical review group (CRG) (date to be confirmed). Information about use of Careflow for fluid management was shared via the CMO (chief medical officer) newsletter. In the March edition of the CMO newsletter, Dr Daniels wrote: *We need to ensure we review fluids in all patients receiving IV fluids daily, we need to ensure we write up fluids in a timely manner. We need to ensure that we always review fluid balance in a patient on IV fluids on the ward round*. CMO newsletters are monthly newsletters posted on 'workspace' - an online platform for all staff, including nursing and medical staff, which has been designed to replace the Trust's intranet.

- Training material has been produced on BEST for all aspects of Careflow vitals including fluid management which can be accessed by all staff. BEST is an online application available on the TRUST intranet where staff are able to access training and to record the training they have completed. A quick 'how to' video targeting doctors has been developed and was published on workspace on 29 March 2023. These videos show where to find fluid management information and all staff are able to access.

In addition to the above a Clinical Safety Assessment is to be carried out by the end of April 2023. The purpose of the assessment is to identify any hazards, risks or issues to mitigate any issues of not being able to enter data or view fluid balance records. Thirteen staff completed the clinical safety (CS) officer training on the 29th /30th March. The CS role is in the recruitment process and will be interviewed for on the 18th April 2023.

The Trust have taken the issues identified by the Learned Coroner very seriously and have taken positive action to address those issues. Further steps are still being taken as we have detailed in this letter and we hope that this allays any concerns the Coroner has regarding the issues identified in the PFD report.

I would be happy to meet to discuss this response if that would be helpful to the Coroner.

Yours sincerely,

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Chief Medical Officer