St Andrews Health Centre

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02-Jul-2017

Coroner ME Hassell
Senior Coroner
Inner north London
St Pancras Coroners court
Camley Street
London
NC1 4PP

Response to the Prevention of future deaths report following the death of Nasar Ahmed

I am writing to you on behalf of Bromley by Bow health partnership in response to the matters of concerns raised by the coroner's inquest in the 'prevention of future deaths report' following the death of Nasar Ahmed.

We have been deeply saddened by the events and death of this child and the impact it will have had on the family- our thoughts are with them.

Following the events that have occurred, these are just some of the steps we have taken:
- We have discussed the case multiple times as a team and taken steps as a team to identify areas of good practice and areas for learning.
- We have discussed the case individually with all those involved in Nasar's care (nurses, GPs, clinical pharmacist) and each consultation has been thoroughly reviewed.
- We have contacted the pharmacy he collected medication from to discuss the matter and improve our understanding.
- We have been in contact with the borough safeguarding team to provide information in order to support discussion at the serious case review panel for further learning.
- We have also been in contact with the hospital paediatric respiratory team to arrange a meeting for further learning.

I will now specifically respond to the 4 main points raised in turn.

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Point 1 states that Nasar's report of symptoms to his consultant didn't correlate with the GPs findings, that his lung function tests were good, that GP prescribed 30 inhalers which is a recognised risk factor for death and that he should have been seen by the consultant again. The point queries whether an automatic flag could be raised if excess medication is prescribed.

There is already a mechanism in place via our Emis patient records system which flags a pop up alert anytime excess short acting beta agonist inhaler prescriptions are given- this is if more than 12 are issued in the last 12 months. The patient is flagged as high risk and if we haven't already, we would contact the patient/parent to book in for an asthma review.

These patients also get flagged up on our recall list for 'enhanced asthma review'. We currently run searches for those deemed as high risk patients (i.e. those that have a high use of SABA inhalers more than 6 per year, more than 2 asthma exacerbations per year, recent hospital or A&E attendance or high dose inhaled steroid therapy) and proactively invite these patients for review as a priority for enhanced asthma reviews.

Nasar was proactively invited for an enhanced review as he was flagged up in such a way demonstrating that the flag does pick up such patients. This review took place on 15th Feb 2016 and this is where he was discovered to have poor inhaler technique. Time was spent teaching him the correct technique for his preventer and reliever medication. The report suggests he should have been seen by the consultant again. He did indeed get seen 5 days after this consultation in a consultant clinic. On 19th Feb he was seen by a specialist registrar. We believe that the registrar did not flag him up as a high risk patient because following the correction of his inhaler technique by our team, his symptoms and lung function tests were much better. He had further follow up appointments organised by us after this in March and it did in fact show that his asthma control score had improved to 24/25. Nasar was invited again in August 2016 proactively for another enhanced asthma review. Our notes indicate that our recall team called the family and reminded Dad the day before that Nasar had an appointment for the on 31st august. The clinician conducting the consultation also called prior to the appointment to remind family to bring in inhalers so that inhaler technique could be checked again, unfortunately, these were forgotten by the family and so a note was made by the clinician that the inhaler technique needs to be checked again at next follow up. At this point, the Asthma test score was again 14/25. There was no specified time period for follow up or review. However, there was a further entry on 14th

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October 2016 in the notes where we contacted the parents to come in for a medication review with a GP.

On review of the literature, there is no specified guidance about what actions should be taken with different levels of asthma test scores- just that a score less than 20 may indicate poorly controlled asthma. Further national level guidance on this may be useful to avoid variations in action. At a clinical team meeting on 27th June 2017, we reflected on the point that at Nasar's August 2016 asthma review, there was no follow up specified for the patient on finding that his asthma test score was 14/25. It was agreed that all clinicians must document specified follow up if the asthma test score is found to be suboptimal (i.e. <20/25). Who this review should be with and how soon it should take place would be agreed with the patient/parent on a case-by-case basis. This will be implemented immediately i.e. from June/July 2017.
We hope this addresses all the queries raised in point 1. Whilst we believe our processes work well, following the event we have taken steps to tighten these even further.

Point 2 states that the asthma pump in Nasar's medication box was an accuhaler which is inappropriate for an emergency situation and that the appropriate inhaler should have been prescribed with a spacer. You wonder whether there is a wide spread lack of understanding about this.

As a team, we have reviewed national and local guidance around appropriate prescriptions of inhaler devices. We have discussed this with nurses, specialist pharmacists and the rest of our clinical team. The guidance suggests, and widespread practice is, to prescribe the inhaler type that best suits the child. In Nasar's case this was an accuhaler. We could not find any guidance that those prescribed an accuhaler for preventer use should also be prescribed a metered dose inhaler with an aerochamber to be kept at home/school for emergencies. Furthermore, throughout all his specialist hospital reviews, this was not a suggestion made by our paediatric respiratory specialists.

We reviewed BTS/Sign guidelines 2016 and the national review of asthma deaths audit 2014. BTS/SIGN (2016) stated:

Specific evidence about the pharmacological management of adolescents with asthma is limited and is usually extrapolated from paediatric and adult studies. Specific evidence about inhaler device use and choice in adolescents is also limited.

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INHALER DEVICES- Adolescent preference for inhaler device should be taken into consideration as a factor in improving adherence to treatment. As well as checking inhaler technique it is important to enquire about factors that may affect inhaler device use in real life settings, such as school. Consider prescribing a more portable device (as an alternative to a pMDI with spacer) for delivering bronchodilators when away from home.

On discussion we felt that it may be an expert opinion to additionally prescribe another inhaler with an aerochamber for emergency situations such as this but there isn't any broader local or national guidance that recommends this and if this is the most appropriate action, this needs to be highlighted at national level to feature in guidance so that systemic change can take place both within general practice but also at hospital level.
We agree that an accuhaler is not suitable for an emergency situation where a patient may not have enough respiratory effort to take in the medication appropriately so as a practice we agreed that for patients using accuhalers, we would issue an MDI with spacer for use in emergencies and make it clear what this is for in the asthma review. This will be implemented from July 2017.

Point 3 suggests that there must be a way of ensuring that a school care plan is accurate, up to date and that there are identical copies stored at home, school, GP surgery and within hospital records.

We are currently in contact with our borough children's safeguarding team to determine whether School nurses have access to the community version of our patient record system so that information about care plans can be input into this and this can be shared between us and the school nurses. Some hospital departments also have limited access to our patient record system- this may be a good way to share information. There needs to be borough wide (and national consideration around this). From a practice level, our clinical teams are checking for up to date and accurate care plans during asthma reviews- however, this case has further highlighted the importance of this.

As a practice, we have agreed that our nursing team (who conduct the majority of our asthma reviews) will post/email a copy of the asthma action plan to the child's school health team and/or a copy will be given to parents to hand into the school. This change will be implemented from July 2017.

Point 4 asks if there is a way of disseminating info more widely around the appropriate indications and use of IM adrenaline.

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All our staff receives yearly BLS training and training around anaphylaxis. During this training the points above may or may not be emphasised by the trainer. We would share our learning around this at borough wide level with the safeguarding children team and discuss whether change can be implemented such that trainers organised to deliver this training emphasise the points highlighted if they also agree with these. By the end of September 2017, our nursing team will investigate whether there are anaphylaxis care plans that are already in place and being used by secondary care. We will then be incorporating these into care plans when seeing patients with asthma and allergies who have adrenaline prescriptions.

I hope all your points have been addressed. We are keen to work with all willing partners to improve the care of patients with asthma and will be happy to provide any further information as required.

Regards

[redacted]
GP Partner – Bromley by Bow health partnership