Wye Valley NHS Trust

Trust Head Quarters
County Hospital
Union Walk
Hereford
HR1 2ER

[redacted]

15 August 2023

Dear Mr Bricknell,

Please consider this letter a formal response to the prevention of future deaths report received by Wye Valley NHS Trust on 30 June 2023 concerning the inquest into the death of Mr George Edward Griffiths. The Trust would like to offer the family of Mr Griffiths our sincerest condolences.

We have considered the concerns detailed in the Regulation 28 report with the utmost seriousness. Pressure area care is an area of clinical practice that is a high priority at the Trust and is subject to a quality improvement project. The concerns over Mr Griffiths care have been reviewed fully, alongside our existing improvement plans and we hope that this will provide reassurance of the actions being taken to improve practice in this area.

I will address the issues you have raised in turn:

1 **The patient appears to have been held in ED for 40+ hours during which time footwear was not removed. Necrotic Toe apparent without evidence of appropriate management or referral.**

At the time that Mr Griffiths was admitted to the ED the NHS was experiencing unprecedented demand and excessive waits in ED were a symptom of the pressure the NHS faced at that time.

That said it is unacceptable that Mr Griffiths was left in a position where his footwear was not removed, and therefore the pressure damage to his toe was not identified and managed in a timely way.

The ED has since recognised the need to implement new ways of working in response to the sustained pressures and patients spending far longer in the department than we would like. In response, we introduced a senior nurse care review, to meet the needs of those patients spending a long time in ED waiting for a bed. The care review is akin to the review ward based nurses would undertake and is intended to ensure that comprehensive care assessments and planning that would not ordinarily happen in an Emergency Department are undertaken.

A thematic review of pressure damage cases in ED has also identified further areas for improvement that will be formalised into a departmental improvement plan. This includes a review of our Trust policy, which currently focusses on pressure area care in inpatient areas. The policy is being updated and an

accompanying standard operating procedure will be added to clearly communicate a local plan for the emergency department to ensure pressure area care is provided in a timely systematic way.

Given the pressures across Emergency Departments in the NHS, we are also focussing on an urgent and emergency care transformation programme, which aims to reduce congestion in ED, improve patient flow and pathways and ensure sufficient bed capacity.

2 Skin inspection on admission confirmed that all areas were intact but there is no evidence of preventative care despite patients' time in ED (40 hours) and in AMU (5 days). Acknowledgement of pressure area damaged occurred on 8th February but no reassessment took place until 20th February with consequent failure to implement pressure-relieving measures.

The Serious Incident investigation into Mr Griffiths pressure area care clearly outlined our failure to assess and treat Mr Griffiths appropriately for his pressure damage. The report acknowledges that at this time, the Trust was experiencing significant staffing shortages and this undoubtedly played a part in our failure to appropriately assess, escalate and plan his care.

Having moved from a paper assessment and care planning system onto a digital platform we have recognised that senior nursing oversight (nurse in charge) of the status of all patient assessments is not as accessible and obvious as when documentation was kept at the end of the patients' bed. Part of our improvement plan is to develop an automated dashboard on the digital system, which will enable the nurse in charge to check the status of assessments and care plans for all patients in their charge. In addition, the assessment document itself is being reviewed to simplify the steps for completion and to add in prompts for accessing equipment/referring for specialist advice etc.

Regular audit of the quality of completion of assessments and care plans is undertaken and monitored by the matrons for all wards including AMU. The results of these audits are reported through our quality and performance monitoring forums. The Trust has included the national CQUIN for pressure area assessment as a priority into this year's contract and this forms part of our overall approach to improving practice in this area.

Early identification of the need for pressure relieving equipment is crucial to support better pressure area care. The Trust has modified the request process from the equipment library so that pressure relieving mattresses and chair cushions are provided routinely as part of the same request.

The ED department has recently invested in new mattress toppers for all ED trolleys to mitigate the risk of patients developing pressure damage in the event a patient has a longer than expected wait in the department and for those patients most at risk a bed and air mattress can be requested.

3 The Pressure Sore acquired in Hospital contributed to the death and it is noted that pressure area care training is not mandatory within Wye Valley NHS Trust

Whilst pressure area care training is not mandatory at the Trust, front line nurses and nursing associates do receive pressure area prevention, assessment and care planning education as part of their core pre-registration training and for health care support staff this is taught as part of their care certificate and clinical skills training on induction to the organisation. Given the Trusts improvement plan and desire to improve clinical practice the Chief Nursing Officer has also contacted the local university to check that the pre-registration curriculum remains fit for purpose in this regard.

In addition to core training, e-learning modules are available for all staff to refresh their skills and knowledge. A local competency package has been developed and has been piloted in areas where patients are most at risk (Frailty service). Once this has been evaluated, the competency programme will be rolled out more widely in the Medical Division, which will include the Emergency Department and Acute Medical Unit.

The Trust has Tissue Viability link nurse roles across the wards and relevant departments. This role has been refreshed as part of our overarching improvement plan and the individuals have received additional training. These members of staff are 'on the ground' experts and can provide timely advice and make recommendations for treatment plans. In addition, the Tissue Viability team are there to provide specialist advice if the ward based team feel specialist input is required and referral is necessary.

The Trust also holds a weekly Pressure Ulcer panel with subject matter experts (Tissue Viability/ Safeguarding/ Quality & Safety/ Therapies/ Matrons) where all incidences of pressure damage are discussed. Ward managers are invited to complete rapid reviews so that any omissions of care can be identified and rectified and to ensure learning takes place.

We are very sorry for the inadequate level of care that Mr Griffiths received. I trust that this response demonstrates how seriously we regard this and the changes we have taken and continue to take to improve practice in this area.

Please do not hesitate to get in touch if you have any further questions or need to seek clarity on any points in this letter.

Yours sincerely,

[redacted]

[redacted]
Managing Director

[redacted] [redacted]