Tameside and Glossop
Integrated Care
NHS Foundation Trust

Chief Executive Officer
Tameside and Glossop Integrated Care NHS Foundation Trust
Silver Springs
Fountain Street
Ashton under Lyne
Lancashire OL6 9RW

7 September 2023

Strictly Private and Confidential

FAO Ms Mutch
HM Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
Cheshire
SK1 3AG

Private and confidential
To be opened by the addressee only

Dear Ms Mutch,

I am writing further to the inquest touching upon the death of Mrs Jane Wadsworth, who died on 31st December 2022 which concluded 12th June 2023 and the subsequent Regulation 28 Notice issued to the Trust.

You raised 6 questions of concerns which are set out below and I will respond and answer these questions as succinctly as possible to provide you with additional information and assurance.

1. **Mrs Wadsworth missed three doses of antibiotics prescribed to treat her infection according to the evidence given to the inquest. This did not appear to have been escalated and there was no clear explanation regarding this occurring other than that her cannula may not have been in place and there was a delay in a doctor being available to reinsert one;**

The Trust acknowledge that in Mrs Wadsworth's case she missed a number of doses of intravenous antibiotics on 26/12/2023 as her cannula had become dislodged. The medical records document the steps taken by the Registered Nurse to attempt to re-site the cannula without success. This also included escalation to both the Night Nurse Practitioner and the doctor. The doctor was eventually successful in gaining intravenous access.

During Trust induction all registered members of staff undergo clinical induction training which includes intravenous (IV) cannulation. Registered members of staff is asked to complete an e-learning package and present evidence of the completion of training by way of a certificate to the Trust Training team. On receipt of the certificate the Trust training team support simulated practice on an artificial arm to illustrate and reinforce practice under direct supervision. Once completed the registered member of staff is provided with a competency document which is taken into clinical practice. Competency is completed following assessment in the clinical setting by another competent colleague. This skill is essential to role for all Registered Nurses working within Acute Care and the IV therapy Team.

The Trust continue to focus on improvement in relation to missed doses of medication. There is an established program of medication audits which are reported to the Trust's Medication Safety Group. The Medication Group meet bi-monthly and has a multidisciplinary membership. At present the Pharmacy Department perform an annual snapshot retrospective audit which focusses on omitted/unsigned doses. The audit covers inpatient areas and looks at any medication doses which are not administered as prescribed and the documented reasons for this. The most recent audit was presented to Trust Medicines Safety Group on 28/04/23.

The Trust recognise that there is an overall percentage of medication doses which are omitted for a 'non-valid clinical reason'. This means that unsigned doses would be recorded under this category (along with any medication doses omitted due to lack of availability). In the last completed audit the percentage of medication doses omitted for a 'non-valid clinical reason' averaged 4% of all prescribed doses. This audit is part of the Trust's standard audit cycle and the results are fed back to the multidisciplinary Medicines Safety Group. One of the actions from the last audit was to issue a new poster which highlights to all staff how to avoid missions in medication- this includes information of how to access medication if unavailable within the clinical area.

In addition to the annual pharmacy led audit, Ward Managers perform their own documentation audits and complete electronic incident reports as appropriate. An incident would then evoke further local investigation and individual competency assessment using the medication management assessment tool. Any learning from this is shared at the daily huddles within each ward setting to ensure all staff appreciate the importance of accurate medication management. Medication incident numbers are monitored through the Trust Medicines Safety Group and the Medicines Safety Officer also provides a summary document of any emergent themes and trends.

In addition to documentation audits the ward managers also complete a monthly Quality Assurance audit. This includes an assessment of whether medications have been administered as prescribed, each audit involves the review of three patient's medical records which includes the medication kardex.

The Trust has an embedded ward accreditation process, where each ward is accredited on an at least 32 weekly basis and more regularly if required. The ward accreditation process includes a review of omitted doses of medication. The

accreditation team is led by a Head of Nursing or Midwifery and is supported by four senior health professionals. The results are shared with the ward managers and leadership team with Executive oversight. This enables areas for improvement to be identified and appropriate action to be taken.

The Trust medication kardex has been redesigned to place greater emphasis on time critical medications. Pharmacy systems for ordering medications to the ward have been streamlined and the Trust also has an emergency medication cupboard and an on-call pharmacy for obtaining medications out of hours. I attach a copy of the template of the updated medicines kardex and the PowerPoint slides to support the new medicine chart for your consideration and information.

To provide further support for inpatient areas each ward has a Ward based Pharmacy Team. Each ward area has an allocated ward pharmacist and pharmacy technician who evaluate individual treatment sheets on a daily basis. They form a key element of the multidisciplinary team caring for our patients. Pharmacy presence on the wards supports the accurate prescribing and administration of medication. They also ensure timely ordering of medications which do not form part of the routine medication stocked within the ward area.

Out of hours, in the event of a medication being unavailable on the ward, nursing colleagues have access to an Emergency Drug Cupboard, a list of where medications are stocked across the site ("Location of Stock on Wards" list available on the Trust's intranet site). This is further supported with access to an on-call Pharmacist who can offer further support if necessary.

The issue of omitted doses is covered in the nursing induction training that the Pharmacist delivers. Every nurse receives this training at the point of joining the Trust. This training can also be accessed as a refresher course. Every nurse new to the Trust also receives a medication management assessment undertaken by the Ward Manager which evidences safer practice in keeping with Trust policy. This is recorded in the individual's personnel file and a copy sent to the learning and development department.

2. **The evidence before the inquest was that on her admission over Christmas/New Year there was no effective consultant input into her care;**

The Trust operates a Consultant on-call rota which includes all weekends and bank holidays throughout the year. The on-call Consultant's remit is one of assisting their Urgent Care consultant colleagues in the review of new patients who have been admitted to the Acute Medical Unit and also to perform the review and care planning of any acutely unwell medical patients located in the medical wards across the Hospital if required.

This Consultant rota is planned 6 weeks in advance and managed by the Trusts medical staffing department. The medical staffing department have confirmed that the Consultant on-call rota identified no deficit for the period of Mrs Wadworth's admission.

Alongside the Consultant on call rota the Trust operate a Consultant ward round which includes weekends and bank holidays, which focusses upon patients who are deemed medically optimised and fit for discharge. This ward round takes place on every medical ward between the hours of 9am – 1pm and despite the focus being dischargeable patients, the Consultant would be a point of escalation should any of the ward team identify that a patient required urgent review.

In terms of staffing areas of the Trust there is a robust mechanism of oversight of staffing both medical and nursing which takes place several times per day to ensure safe staffing across the organisation. This is monitored at least 5 times per day during the Trust capacity meetings, where operational / clinical /site and senior managers attend. Any potential shortfalls in medical cover are addressed and actioned by operational and clinical colleagues to mitigate risk. Should any further escalations relating to staffing shortfalls be required then the onsite team are supported by a first on call senior manager rota and a Executive on – call rota.

3. **The junior doctor involved in her care felt that ICU involvement/input would be beneficial. The evidence was that there did not seem to be any doctor to doctor discussion of this. The inquest heard evidence that this was one way a patient could be transferred to ICU. It was unclear why there had not been such a discussion and whether in periods such as Christmas/ New Year where there were fewer consultants available the system worked effectively. This was not a situation where there had been a ward based ceiling of care put in place and ultimately Mrs Wadsworth was treated by ICU but was extremely unwell at that point and did not respond to that intervention at that point;**

From a review of Mrs Wadsworth care and medical records there is evidence that she was reviewed by the medical team on a daily basis. Mrs Wadworth was also reviewed by a Renal Consultant (30/12/2022) and a Microbiology Consultant. On 28/12, 29/12, 30/12 and 31/12/22 Mrs Wadsworth was reviewed by a Medical Registrar. On 31/12/22 at 08:50am Mrs Wadsworth was reviewed by the Medical Registrar following appropriate escalation by the nursing team, who contacted the Critical Care Team to request a higher level of care for her. Following this Mrs Wadsworth was admitted to the Critical Care Unit. Further information regarding Critical Care and MERIT team provision is provided as part of the response to point 4.

4. **The alternative support available to ward based staff and possible route into ICU according to the evidence given at inquest was via the Critical Care Outreach team. That team is staffed primarily by nurses and its key focus is on presentation linked to NEWS2 scores according to the evidence given to the inquest. Mrs Wadsworth's case was a complex one involving issues relating to her liver function and kidney function rather**

4. **The alternative support available to ward based staff and possible route into ICU according to the evidence given at inquest was via the Critical Care Outreach team. That team is staffed primarily by nurses and its key focus is on presentation linked to NEWS2 scores according to the evidence given to the inquest. Mrs Wadsworth's case was a complex one involving issues relating to her liver function and kidney function rather than just her NEWS2 scores and it was unclear if the Critical Care Outreach Team were best placed to assess her need for ICU support;**

The Trust has an established Critical Care Outreach Team which is comprised of a number of highly skilled and experienced critical care nursing colleagues. The service is available on a 24 hour, seven day a week basis. In addition to this the Trust also implemented a MERIT (Medical Emergency and Rapid Intubation Team) team as part of its response to the Covid-19 pandemic. Although the Trust, like others nationally have stood down many of the supportive measures implemented in response to the pandemic, the organisation has continued with the MERIT Team. The MERIT Team is staffed by senior anaesthetic colleagues, including Consultant level from 08:30 to 18:00, and from 18:00 to 08:30 this is staffed by a middle grade anaesthetist. The MERIT team is available on a 24 hour seven day per week service and this is in addition to the medical staff who support the Critical Care Unit who would also provide support / advice and guidance. At the time of Mrs Wadsworth's admission there were no deficits within the staffing of the MERIT team or the Critical care Medical team.

The Admission and Discharge Policy for Critical Care clearly sets out referral pathways for those patients who may require a higher level of care including critical care due to their current clinical condition. The referral pathway is in line with national guidance (National Confidential Enquiry into Perioperative Deaths- NCEPOD, The National Institute for Health and Care Excellence- NICE, National Patient Safety Agency-NPSA, and Royal College Physicians) that the optimal referral pathway is consultant to consultant. However the policy describes that in more critical instances where any delay may be detrimental to the patient then a referral may come from training grade doctors. It is expected that this be a medical registrar (i.e. the medical middle grade either on-call or responsible for the patient). It is not expected that F1/F2 trainees are to refer directly to Critical Care unless directed to do so whilst the registrar is in attendance.

5. **The inquest heard that on the date of one referral that team was not in any event available to the ward and the nurse who should have undertaken the role had been redeployed elsewhere in the trust and there was no capacity to fill that role;**

The outreach team at Tameside Hospital are a team of 7 clinical practitioners, the service is run on a 24 hour a day, 7 day per week basis and this was first launched January 2018. On 29/12/2022 when nursing staff contacted the Outreach Practitioner to review Mrs Wadsworth, she had already been reviewed and been seen by the medical doctor who had prescribed Albumin to be given intravenously. The Outreach Practitioner had advised the ward nurse that they could not attend so therefore the nurse correctly re contacted the ward doctor to review Mrs Wadsworth again and for

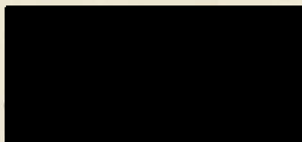
the appropriate medical plan to be put in place. At the time of Mrs Wadsworth's admission the Outreach Practitioner had been allocated to an inpatient area to mitigate risk following a short notice staff absence. However despite this the ward team could have also considered contacting the MERIT team for advice and guidance for Mrs Wadsworth.

There is a Standard Operating procedure to manage short notice absence from within the outreach team which includes a number of proactive steps to cover the shift. In terms of staffing other areas of the Trust there is a robust mechanism of oversight of staffing which takes place several times per day to ensure safe staffing across the organisation. This is monitored at least 5 times per day during the Trust capacity meetings, where operational / clinical /site and senior managers attend.

6. **Following her first admission to ICU there was a note that Mrs Wadsworth's case should be discussed with a specialist Liver team. There was no evidence available to the inquest that such a discussion had taken place. It was not entirely clear on the evidence precisely which clinician was to take ownership of the action.**

The Critical Care Team have regular team huddles during each day to overview and discuss patient's in their care. The huddles which take place several times per day involve Advanced Care Practitioners, Medical Staff, Physiotherapists, Nurses and support workers. The huddles involve diagnostic tests, results, current condition, specialist team involvement and can also include resuscitation status of the patient. In addition to the huddles the medical team also have a formal handover of care between shifts, these are recorded electronically.

The Trust acknowledge that the clinical documentation recorded within the Critical Unit was not clear with regards to who and when Mrs Wadsworth was referred to the Liver Unit. In response to this the Critical Care Unit have amended their daily review chart to provide additional clarity on this point and that this is documented in a more comprehensive way.



Medical Director
On behalf of Karen James
Chief Executive Officer
Tameside and Glossop Integrated Care NHS Foundation Trust