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Royal Cornwall Hospitals NHS Trust

Chief Medical Officer's Office
Royal Cornwall Hospital
Truro
Cornwall
TR1 3LJ
[redacted]

12th October 2023

Mr Guy Davies
Assistant Coroner for Cornwall and the Isles of Scilly
H.M Coroner's Office
Pydar House, Pydar Street
Truro, Cornwall
TR1 1XU

Dear Mr Davies

Re: Death of Audrey Joan King – Response to Regulation 28 Report to Prevent Future Deaths

I write in response to the Regulation 28 Report to Prevent Future Deaths, dated 22nd August 2023 and received on the 24th August 2023, which was issued at the end of the inquest into the death of Mrs Audrey Joan King on 7th August 2023.

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

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

- Inconsistencies in record keeping by specialities.
- The process for entering an alert in the digital system that clinical notes have been handwritten in the written notes.
- The absence of an alert on the EPMA requiring review of the ongoing suspension of prescribed medication.

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

Inconsistences in record keeping by specialities:

I note that the Inquest conclusion was that '*Audrey died from complications following necessary surgery contributed to by not re-starting anti-coagulant medication after the operation.'*

The clinical context that may have led to Mrs King's death was discussed with [redacted], Stroke Consultant. Mrs King was known to have atrial fibrillation (AF) and there is a known increased risk of stroke post-operatively. There were clear recommendations which were underlined in Mrs King's notes by the care of the elderly consultant to re-start apixaban as soon as possible post-operatively. Unfortunately, these recommendations were not followed and could have been one of the factors leading to ischaemic stroke.

The Trust is moving towards having all clinical records available electronically and Oracle Health have been awarded the contract for our Electronic Patient Record (EPR) programme. The new EPR will integrate many of our digital and paper-based systems into a single platform, providing a more joined up way of working across our hospitals, improving safety and transforming the way we care. This system is expected to be operational from Spring 2025.

Until this is underway, the Trust has taken the decision to advise all specialities to only record inpatient clinical entries in the written paper notes with the exception of EPMA (which is our electronic prescribing system). The only ward exceptions to this are ITU /EPOC (Intensive care and Enhanced peri-operative care unit) which have an electronic record and high staff to patient ratio, there is no duplication and a paper copy is transferred with the patient when they leave ITU/EPOC. This will ensure all specialities undertaking ward rounds will have one set of written notes to review, along with the drugs chart (ePMA) The decision to revert to recording in the written notes was communication to staff and took effect from 08:00 hours on 13 September 2023.

The process for entering an alert in the clinical system that clinical notes have been handwritten in the written notes:

Please see above, as all specialities have been mandated to only record entries in the written notes, there is no requirement to set up an alert in a clinical system that a written entry has been made in the notes.

The absence of an alert on the EPMA requiring review of the ongoing suspension of prescribed medication:

The Trust currently uses Careflow Medicines Management systems to support electronic prescribing across most clinical areas. This system does not have the capability to set up an alert if medications are suspended. However, even if this was an option, it would not be

considered of benefit due to prescriber alert fatigue which could lead to prescribers ignoring the alert. To put this into context, for example, on 4th September 2023, 9% of medications prescribed for inpatients in the hospital were suspended across the Trust. This equates to 636 suspended items out of a total of 7,010 prescribed medicines for 706 patients.

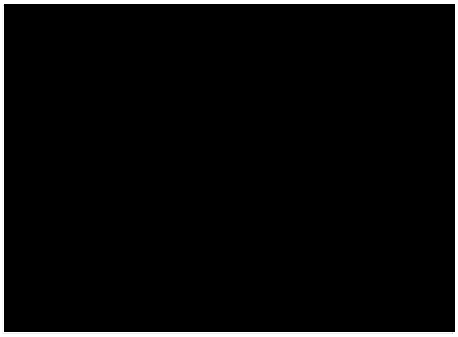
When a drug is suspended it remains on the inpatient chart, with an overlay showing that the drug is suspended (see chart below). When opening the drug chart, the ePMA system gives a clear visual prompt during wards rounds that a current medicine is suspended and this can be re-started if appropriate. Suspended drugs should be reviewed as part of the ward round drug chart review process.

As advised above, the system does not have the ability to create a separate alert; however there is a clear visual prompt to alert clinicians that a drug has been suspended and this was in place and in force at the time of Mrs King's admission.

All doctors have a professional responsibility to check written entries, drugs charts and test results on a ward round to ensure they have the full facts before making any clinical decisions. The importance of this is clear in the GMC Guidance, 'Good Medical Practice' - Duties of a Doctor and provided over extensive teaching and education with Foundation Year 1 and 2 doctors and IMG induction. The Trust will also run Snapcoms about the importance of checking ePMA along with written entries which will be aimed all staff working within the Trust.

I hope that this letter provides both you and Mrs King's family with assurance that the Trust has taken seriously the matter of concerns you raised in your report.

Yours Sincerely



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Chief Medical Officer