University Hospitals Sussex
NHS Foundation Trust

HM Area Coroner Ms Joanne Andrews
Parkside Chart Way
Horsham
RH12 1XH

Letter by email only

University Hospitals Sussex NHS Foundation Trust
Trust Headquarters
Royal Sussex County Hospital
Eastern Road
Brighton
BN2 5BE
[redacted]

15 November 2023

[redacted]

Dear Ms Andrews

Inquest into the death of Alison Mary Ross

Thank you for your letter of 21 September 2023, enclosing your formal report under Regulation 28 to Prevent Future Deaths.

First, I wish to convey my sincere condolences to Mrs Ross' family. I am truly sorry that Mrs Ross died in our care.

Our new Divisional Director of Nursing for the Medicine Division has reviewed your concerns in relation to medication administration in conjunction with the safety, quality and governance team in her Division, and is confident that there is not an ongoing risk to patient safety in this respect. We have made significant improvements to the systems and processes in place following Mrs Ross' sad death, and I will summarise these below.

We have introduced a Safety Huddle on Balcombe Ward at 10:30am everyday with the multidisciplinary team (MDT) to highlight any concerns in relation to staffing, patient concerns, or planned procedures.

The Trust Medicines Management policy is being updated to specifically include advice about medications at the patient bedside.

The Medicines Management competency assessment documentaiton is also being updated.

A Medicines Governance Notice is being issued to remind all clincial staff of the importance of not leaving medication at a patient's bedside.

Work is underway to re-establish funding for a specific Medicine Division Ward Medicines Management Programme. The Principal Pharmacist for Medicines Safety, Quality and Governance is in discussions with the Chief Pharmacist to take this forward.

Refresher education and training regarding medication administration has been completed and this education programme is ongoing. This training is being delivered to the ward team by the Practice Development Nurses.

A reflective discussion with the nursing staff who cared for Mrs Ross has been undertaken to reinforce the learning.

Audits are undertaken to check that medication is not left at patient bedsides. A medicine management audit is on our safety software (Tendable) and this is being increased to a weekly item (from monthly). Furthermore, an extra question targetting this specific topic is being added to the audit to increase our assurance in this respect.

The learning from Mrs Ross' case will be shared (anonymously) at the Medical Grand Round on 24 November 2023.

We have drafted a Patient Story which incorporates the learning and feedback from Mrs Ross' family. This is to be shared at the Patient Safety Group meeting on 4 December 2023 and it will be cascaded to all Divisions to ensure there is widespread and far reaching safety learning.

The learning will also be shared at the Mortality and Morbidity meeting on 29 November 2023.

I am pleased that you were assured by the oral evidence from [redacted] about the actions in the SI in relation to the Ascitic Drain Proforma. By way of an update, the Proforma incorporating revised anti-coagulant guidance, was reviewed by the Gastroenterology team on 3 November 2023, and is to be discussed at the Trust Thrombosis Committee. Following the feedback from these specialist groups, it will be submitted to the Medicines Governance Group for approval, and it's use will be part of our audit programme in the New Year to ensure correct usage and efficacy. The Trust Anticoagulant Bridging Guidance is scheduled to be ratified at the Trust Thrombosis Committee. This is to be shared at the Patient Safety Group and it will be available to our staff on the intranet.

I hope this letter provides you and Mrs Ross' family with assurance that we have taken the learning extremely seriously and have made significant improvements. Once again, my sincere condolences to Mrs Ross' family.

Yours sincerely,

[redacted]

[redacted]

Chief Executive