Greater Manchester Integrated Care

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Date: 2nd April 2024

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Private & Confidential
Ms Alison Mutch
H M Senior Coroner
1 Mount Tabor Street
Stockport
SK1 3XE

Dear Ms Mutch

Inquest into the Death of Susan Wendy Bracegirdle - Date of Death 09 February 2023

I refer to the Regulation 28 Prevention of Future Deaths Report issued following the inquest into the death of the above named. I am sorry to learn of the circumstances of Mrs Bracegirdle's death and offer my sincere condolences to her family.

You seek assurance in response to the following causes for concern:-

The inquest heard evidence that because Mrs Bracegirdle was in a care home setting the District Nurses were responsible for management of her pressure ulcers. The care home was asked to ensure pressure relieving processes were followed. However, the District Nurses did not share care plans with the care team on the basis that they were digital documents and were care plans for the use of District Nurses. Consequently, the care home management were not fully sighted, and joint care was more difficult to deliver increasing the risk of the pressure ulcers deteriorating.

Whenever a District Nurse attends a resident at Stable Steps any advice in relation to the management of pressure ulcers is shared with the team via a Communication Book.

From a review of the Communication Book in the name of Mrs Bracegirdle, I am satisfied that on each occasion that a District Nurse attended, a note was added to the book, detailing the actions required to support the management of the pressure ulcers which included regular turning, the ordering of a specialist cushion and referral to the Tissue Viability Team.

Stockport NHS Foundation Trust have provided a timeline which includes details of frequent communication with the care home in relation to the management of Mrs Bracegirdle's pressure ulcers. Although patient records are electronic, verbal advice was given to the care home in relation to pressure relieving strategies. In circumstances where a carer had any concern in relation to pressure damage, it would be expected that this would be communicated directly to the District Nursing Team for their review.

Prior to being on the Victoria District Nursing caseload, Mrs Bracegirdle was under the care of Tame Valley District Nursing Team from 07 April 2022, where she was noted to have a pressure ulcer to her sacrum (present on admission to the caseload). She was provided with a Quattro mattress, had twice weekly visits and 2 hourly repositioning was instigated. The wound had healed by 21 April 2022; an entry in the notes dated 09 May 2022 confirms pressure area check identified the sacral wound was still healed and that a Quattro mattress and repose were in use.

Mrs Bracegirdle transferred to Stable Steps Care Home on 25 May 2022. On 10 June 2022, Victoria District Nurses received a referral from Stable Steps as Mrs Bracegirdle had no pressure relieving equipment in place and there was marking to her skin; at this point she was being cared for on a hospital bed with a foam mattress; she was being hoisted into a chair.

At the District Nurse first assessment (the same day) it was noted that Mrs Bracegirdle had a deep tissue injury (DTI) to her sacrum and a red heel; she was noted to have a history of pressure damage to her buttock area. The District Nurse assessed Mrs Bracegirdle of being at 'elevated' risk of further damage. The foam mattress was upgraded to a Tally Quattro and the nurse discussed the importance of repositioning every two hours, with the care home staff. The use of a slide sheet for moving in the bed and barrier products to keep her skin protected from moisture associated with incontinence were introduced. Mrs Bracegirdle was scheduled for weekly reviews of her DTI and four weekly full skin inspections and reassessment of her pressure ulcer risk using PURPOSE-T and MUST assessment.

On 15 June 2022, Mrs Bracegirdle scored a MUST of 1. There was a nutritional plan written up by the Care Home, who supported her with all of her meals; her appetite was variable, however, it was noted that she had gained some weight since her transfer to Stable Steps.

During a visit on 29 June 2022, Mrs Bracegirdle's wound was assessed as having evolved to an unstageable wound. The Wound Care Plan was updated to support wound debridement. The Care Home continued to support with two hourly turns. Following a senior review, the original DTI had evolved to a category 2 pressure ulcer.

During a MUST review on 26 July 2022, the nurse identified that Mrs Bracegirdle had lost weight since her last review; further weight loss was also recorded on 17 August 2022. Mrs Bracegirdle's nutritional plan had been updated to two Ensures a day, regular snacks and assistance with all feeding; she was also referred to the dietician. A continence reassessment was sent by Stable Steps on 18 August 2022, for improved continence products as the continence aids she was wearing were not managing her needs.

On 30 August 2022, the visiting support worker recognised there had been further deterioration in Mrs Bracegirdle's wound which was escalated to a senior nurse and she reassessed on the same day. This would be usual practice when staff identify any concerns for escalation to the nursing team. The nurse has documented that Mrs Bracegirdle's wound was again unstageable. From reviewing the photograph there is some evidence of an increased depth. Through conversation with the carers, it was brought to her attention that on 29 August 2022 there was a flood in Mrs Bracegirdle's room. The carers advised that they had removed her from the room and sat her upright on a pressure cushion, in a bucket chair for four hours. As the repairs had not been completed by bedtime, she was placed into another room overnight on a static foam mattress, with two hourly turns. A safeguarding concern was not raised following this incident. However, the nurse discussed that if a similar

incident was to occur then the District Nursing Team could support with obtaining another mattress. Mrs Bracegirdle was moved back into her own room and onto her Tally Quattro mattress the following day. District Nurse visits continued twice a week for wound care and four weekly PURPOSE-T.

On 07 October 2022, the visiting nurse has documented that Mrs Bracegirdle's sacral wound was now category 3, probing at 1cm in every direction, but not tracking. Advice was given to the carers about the importance of repositioning off the area of skin damage.

Following a visit on 14 October 2022, a referral was made to the Tissue Viability Service. The care home had reported that though they repositioned Mrs Bracegirdle every 2 hours, using the pillows to keep her off her side, she continued to reposition herself onto her back. The nurse swabbed the wound at this visit due to the deterioration and requested a fluidiser cushion to support with positioning via a TVN referral on 15 October 2022.

A remote TVN review took place on 20 October 2022. The photographs on EMS evidenced a deterioration from category 2 to category 3; a joint face to face visit was scheduled for 27 October 2022. During this visit the TVN verified the wound to be a category 3 pressure ulcer. The care home turning charts were checked and it appeared that no positional changes were documented on 25 October 2022 for 9-10 hours. Complete bedrest was advised to enable Mrs Bracegirdle to remain off the area of skin damage. A DATIX (incident report) was completed as this had not been done and a safeguarding alert was raised.

Mrs Bracegirdle continued to be seen by the Victoria Team for wound care twice a week, 4 weekly pressure area check using PURPOSE-T, and remained under the Tissue Viability Service for face to face and remote review. The category 3 pressure ulcer remained clean and appeared to be healing well. There is no evidence of any wound infection documented within the nursing notes and this is supported by wound photography which was uploaded to EMIS and reviewed by the TVN on 17 November 2022 and appeared stable on the photograph on 30 November 2022. There is also evidence within the documentation that Mrs Bracegirdlle was being nursed off the area of skin damage and the fluidiser offloading device provided by the TVN was being used to support this. Mrs Bracegirdle's wound care plan was updated following TVN review on 17 November 2022.

During a routine visit for wound care on 9 December 2022, the visiting nurse has documented that the category 3 pressure ulcer was now odourus and had an increased volume of exudate; there was evidence of a macerated peri wound with localised erythema on the photograph on EMIS uploaded following this visit. The nurse has documented that a wound swab had already been taken and sent by the care home but results were awaited. A routine PURPOSE-T was completed at this visit which evidenced that all other pressure points remained vulnerable but intact. The nurse has documented that infection was suspected which would be followed up with the GP. However, there is no evidence to confirm this was done and following review of the EMIS records the GP has documented during the ward round on the same day that Mrs Bracegirdle's wound was improving.

On 11 December 2022 the visiting nurse has documented that Mrs Bracegirdle had a rash on her body and she felt hot to touch; the carers had already contacted Mastercall and were awaiting GP review. The Mastercall out of hours report states that Mrs Bracegirdle was seen via video consultation. Clinical observations were Sp02 94%, temperature 36.6oc, blood pressure 126/60. The rash was visualised and diagnosed as being eczema related; Timodine

ointment was prescribed which the carers were going to collect.

On 13 December 2022 the nurse has documented that Mastercall had re-reviewed Mrs Bracegirdle following escalation by the care home team. Clinical observations were noted; temperature was 38 oc, heart rate was 102 beats per minute, and her blood pressure was 100/60. Ceilings of care were discussed and it was agreed by the GP, care home and family that ideally, Mrs Bracegirdle was not for hospital admission. A repeat swab of the wound was requested from the care home as the previous sample had been discarded. Mrs Bracegirdle was referred and accepted for intravenous antibiotics at home.

On 14 December 2022 a nurse from the Victoria team discussed Mrs Bracegirdle with the TVN; it was agreed that the current wound care plan was to continue. The nurse has also documented that Mrs Bracegirdle was being moved into a nursing bed within the care home as the residential unit was unable to meet her needs. Mrs Bracegirdle was discharged from the Victoria caseload following wound care on 14 December 2022. The GP also undertook a review on the same day noting that Mrs Bracegirdle appeared to be responding well to the intravenous antibiotics and that her observations had improved (temperature 37.5, heart rate 98, Spo2 97% and blood pressure 106/74). Mrs Bracegirdle remained on the nursing unit at Stepping Stones until 16 December 2022 when she was admitted to hospital by her GP as she was spiking a temperature and had raised inflammatory markers. It was during the ED attendance that the wound was categorized as a grade 4 pressure ulcer.

In undertaking this review there was evidence of verbal communication with the care home staff and written notes within the communication book at the care home. However, an information leaflet will be developed to promote communication.

There was no communication strategy in place as a consequence of an approach that did not promote team /joint working. The inquest heard that consequently the family were unsighted on the condition of Mrs Bracegirdle until shortly before her admission to hospital. This meant that the family could not support the work to reduce the risk of the pressure ulcers deteriorating further and were not able to be a proactive about the care she was receiving increasing the risk of her pressure ulcers deteriorating.

The care home provider would be expected to keep family members updated in relation to all aspects of a resident's health and wellbeing as a matter of course, using the information from the communications book, and from direct conversations with the attending district nurses. In the event of further questions from the family then it would be expected for the care home staff to liaise with the attending team to obtain information to address those questions. This would include information about pressure ulcer management and any advice from community colleagues (District Nursing Team) or the TVN Team.

From a review of the patient electronic record system, there is no documentation to suggest that family members were present at any of the nursing visits; nor is there any evidence of any phone call between a member of the district nursing or TVN teams and a family member regarding ongoing concerns regarding pressure damage. However, as stated above, the expectation would be for the care home staff to keep family members updated in all matters relating to the wellbeing of a resident.

The information leaflet being produced by Stockport NHS Foundation Trust (Stepping Hill Hospital) will include details of how family members can contact the District Nursing service with any questions or for advice in relation to pressure area care.

The GP was asked to provide input. Due to a lack of information sharing the GP who dealt with Mrs Bracegirdle does not seem to have appreciated the extent of the issue and consequently there was no face-to-face examination and antibiotics were not started.

Members of the District Nursing Team input their clinical notes onto the Emis clinical system; these notes are visible to a patient's GP as they use the same clinical system. This does ensure that the registered GP does have access to full details of all District Nurse visits and treatments. This would include confirmation of referral to Tissue Viability Service and access to any wound photographs which may have been taken as these are uploaded into Emis.

A GP attends Stable Steps on a weekly basis to undertake a 'ward round'; this is a review of patients by a GP supported by either the Care Home Manager or a nurse and carer to discuss all residents' clinical/medical needs.

Notes made by the District Nursing Team dated 9 December 2022 confirmed the pressure ulcer to be improving. Records reflect that on 11 December 2022, Dr Julia Gallagher, Out of Hours GP, was called and carried out a video consultation. This was due to concerns about a rash on Ms. Bracegirdle's back and abdomen which it was thought was likely due to dry skin. A cream, Timodine was prescribed with a plan for the regular GP to review at the next ward round.

On 13 December 2022, an out of hours GP, [redacted], was called due to concern that the pressure sore had become infected. The wound had become red and pus was present. A swab had been sent off for laboratory analysis the previous week but as the lab request form did not include details of the site of the pressure sore, the swab had not been processed. At this point, Ms Bracegirdle had a high temperature and an elevated heart rate; in addition, the pressure sore was noted to be grade 4 with lots of grey discharge. Hospital admission was considered but in view of Ms Bracegirdle's co-morbidities and general frailty, it was agreed that admission should if possible be avoided. Mrs Bracegirdle was seen on the same day by the IV at Home Team and given a loading dose of Teicoplanin (an antibiotic used for skin infections) and further blood tests were carried out.

The results were received the following day and were consistent with a severe infection; Mrs Bracegirdle had her second dose of IV antibiotics that day and she was also seen on the ward round that day, when it was noted that her observations had improved. It therefore appeared that improvement was being achieved by the administering of the IV antibiotics.

On 15 December 2022, Mrs Bracegirdle was seen again by the IV at Home Team for the third dose of the antibiotics; it was noted that she only received half of the dose as the cannula had tissued (this means that the cannula was putting the medication into the surrounding tissue rather than not the vein). Blood tests were also repeated on this day.

By the following day results were reviewed which at this point showed a high white cell count; other test results requested were not available due to the sample having haemolysed. The Care Home was therefore contacted and advised that Mrs Bracegirdle again had an elevated temperature (39.4) despite 3 days of antibiotics and her heart rate was 95. Since progress was not being made despite antibiotic therapy, hospital admission was indicated. The attending GP spoke directly with Mrs Bracegirdle's son who was in agreement with the admission on the basis that this was a potentially reversible condition. Admission to Stepping Hill Hospital was therefore arranged.

From the information available, I am satisfied that the GP did have access to current information from the District Nursing Team and that appropriate tests were undertaken to support prompt referral for intra venous antibiotics at home and that when improvement was not evident, Mrs Bracegirdle was admitted to hospital.

During the Trust review of the pressure ulcer review, an area of learning was identified in relation to communication with the GP and an action was taken: This was to discuss with the nursing team the importance of following up any concerns or actions with the GP and not to rely on carers to ensure this is done. Since this rapid review, there have been no further incidents in relation to contact with GP practices.

There had been a safeguarding review undertaken. However key people involved in her care had not provided input to the review which meant there was no clear holistic assessment of what lessons could be learnt to reduce the risk of deaths from pressure ulcers in the future. It was unclear why such an approach had been taken.

I can confirm that following initial review of Ms Bracegirdle's case it was confirmed that the circumstances of the case met the criteria for a Safeguarding Adult Review (SAR) as set out in Section 44 of The Care Act 2014.

The key lines of the enquiry were agreed as follows:-

(1) How were support and care needs communicated to the Care Home when Mrs Bracegirdle became a resident in May 2022?
(2) How were care needs and support plan communicated multi-agency, and how was it co-ordinated and reviewed?
(3) How did the professionals communicate with Mrs Bracegirdle's family?
(4) Explore the response and decision-making process with regard to the safeguarding referrals.
(5) How was information shared between the Care Home and the District Nurses and were there any barriers to communication?
(6) Identification of areas of good practice.
(7) What developments have been made to practice since the scoping period of this review?

The timeline for the process is as follows:-

Scoping Meeting/Panel 1	8.2.24
Engagement with family	Begin 12.2.24
Agency reports returned	7.3.24
Agencies to inform Jonathan Burrows of Learning Event Attendees	7.3.24
Learning Event	25.3.24 (face-to-face)
First draft of Report	11.4.24
Panel 2 (to discuss draft 0.1)	19.4.24 1.30pm – 4pm
Second draft of Report	3.5.24
Panel responses to second draft by email by	24.5.24
Third draft of Report	29.5.24
Panel 3	5.6.24 9:30am -11:30am
Final (potentially) draft of Report	ASAP
Email response to final draft	ASAP
Sub Group Presentation	? possibly 20.6.24

Whilst there was an initial meeting to discuss this case which was with limited personnel, that meeting was to determine whether the case met the criteria for Section 44 of the Care Act. I would like to assure you that the final stage of the SAR process is for a Practitioner Learning Event to take place. In this case, the attendees for that meeting will be as follows:-

- Adult Social Care (ASC)– Neighbourhoods Team
- ASC – Safeguarding Service
- Hospital Safeguarding Team
- District Nurses (including lead and staff who submitted safeguarding referral)
- Tissue Viability
- Care Home staff including senior health care assistant.
- GP Practice manager / safeguarding lead
- Hospital – staff from Ward E2 and Acute Medical Ward

Engagement with the family:

A key element of Safeguarding Adult Reviews is engagement with family members/close friends, to ensure their views are sought and integrated into the Review and the learning.

Family/friends will be initially notified of the review by the Safeguarding Adults Partnership and the independent reviewer will follow up by making contact (if agreed) and ensuring that they are invited to participate with the review process - either by a personal interview, email correspondence, or telephone conversation.

Contributions will be woven into the text of the Report and the family/close friends will be given feedback at the end of the process.

The partnership has contacted one of Ms Bracegirdle's sons and informed him of the process. It is agreed that Allison Sandiford would contact this son (initially by email) on Monday 12 February 2024 and I can confirm that this communication did take place as planned.

I hope you are satisfied that the process of review is such that it does enable a holistic view of the events and circumstances so that valuable lessons can be learnt.

Whilst I am satisfied that this case has been appropriately referred for detailed investigation and learning, I am sorry that this was not made clear to the family at an earlier stage and for any upset which may have been caused as a result of this process not having been fully explained in a timelier manner.

An earlier internal review by the District Nursing team when Mrs Bracegirdle's pressure ulcer became a category 3 was not shared or discussed with the family and they were unsighted on the issue.

The Division of Integrated Care at Stockport NHS Foundation Trust, carried out two rapid reviews in relation to Mrs Bracegirdle's pressure ulcers, one in October 2022 and one in December 2022. These were presented to the Serious Incident Review Group (SIRG), chaired by the Deputy Director of Governance and panel members. The panel agreed that there were no lapses in care by the District Nursing Team which directly contributed to the

acquired pressure ulcers. In this instance, it is not usual practice to share the rapid reviews with patients or their next of kin.

However, the Trust acknowledge that a 'Being Open' conversation should have taken place with Mrs Bracegirdle's next of kin to discuss the pressure ulcer damage and the outcome of the rapid review of the incident. Going forward the Trust will ensure that a 'Being Open' discussion does take place with patients or families for all raid reviews (which are deemed no lapses in care), and this will be monitored through the monthly Quality Assurance Meetings.

For rapid reviews (incidents) where there are lapses in care, these would be declared a Patient Safety Investigation and duty of candour would be opened with the patient or next of kin as per the usual process.

The Tissue Viability team had been asked by the District Nurses for input. This was provided remotely via access to photos taken by the District Nursing Team. Whilst it was clear that remote review could be effective it was not in this case because the review was based on an older image and an updated image showing a deteriorating picture in relation to the pressure ulcers was not uploaded. This was as a result of lack of joint working and effective communication. The impact was that what would have been helpful expert input from the TVN was not provided to a deteriorating picture.

All wounds are to be photographed and uploaded on to the patient's electronic record system once per week by the District Nursing Team.

When providing remote access, the TVN utilises the information shared by the referring service and by reviewing the medical notes (i.e. EMIS electronic shared record). This further in includes wound photography and documentation of the findings and treatments provided by the attending clinicians. If the information available is insufficient, incomplete, or not up to date, the TVN will contact the nursing service to discuss the patient's Care Plan and determine if further information can be provided to the TVN to then give the required advice or arrange an in person assessment.

The District Nursing Teams or nursing home nurses can also contact the Tissue Viability service and alert the TVN to changes or concerns and reference or provide updated wound photography. This can be completed via EMIS task or via e mail. The TVN can then triage this and action by providing further assessment and advice remotely or arrange a further in person visit (or both, providing first line remote advice and then a planned visit).

Wound photography is reviewed and interpreted within the context of the documentation from the clinician who took the photograph and the TVN also assesses the presentation in the photograph in comparison to previous photos taken. In some cases there may be a discrepancy between the photo and description or if the wound photo is of poor quality or difficult to interpret then the TVN will take alternative action, contacting the care provider to discuss the status of the patient and plan further input as clinically indicated.

I hope the information above is helpful to you and that you are satisfied that the events surrounding the care of Mrs Bracegirdle in the months leading up to her final admission to hospital, have been fully investigated.

Yours sincerely

[redacted]

[redacted]
Deputy Chief Nurse (Quality and Safety)
p.p. on behalf of

[redacted]
Interim Deputy Chief Executive
And Chief Nursing Officer
NHS GM Integrated Care

[redacted]

Placed Based Lead
Greater Manchester Integrated Care