EXCELLENCE STARTS HERE

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NHS Foundation Trust

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17 April 2024

Yvonne K Blake
Area Coroner for Norfolk
County Hall
Martineau Lane
Norwich
NR1 2DH

Dear Ms Blake

Kim Stroud – Trust's Response to Regulation 28

We write further to the Report for the Prevention of Future Deaths made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 22 February 2024.

We will respond to Ms Blake's areas of concern as set out below, and explain the actions being taken in response, as follows:

> *"Mrs Stroud's care appears to have been non-compliant with both hospital policies and the Nursing and Midwifery Council regulations for the administration of medication. Mrs Stroud's relatives found pots with tablets in on several occasions just left on their mother's bedside table. These had been signed for as given. On one occasion Mrs Stroud had concealed 9 tablets inside her incontinence pads because she thought she was being poisoned, clearly not supervised in taking those either. It was extremely unsafe to leave tablets in this way. Mrs Stroud had delirium and could not be left to take them herself. There were other confused and mobile patients on the same ward who could have picked them up. On several occasions Mrs Stroud was found in her bed so soaked in urine (I have seen photographs of this) that the urine was dripping off the edge of the bed and the family had to wash and change her themselves. Also wash faeces from her body".*

Prior to Mrs Stroud's death, we had been informed by her family that they were unhappy with the standard of care she was receiving, noting that they had found her in a wet bed on multiple occasions, and a meeting was held with the senior sister on Necton ward on 28 August 2022, where we were able to apologise to the family directly for these incidents. We completely agree this is unacceptable and does not meet the standard of care we strive to provide for our patients, which they are entitled to receive. We understand that on each occasion this was dealt with appropriately after being brought to our attention. We know there will unfortunately be occasions where a family is aware of their relative having wet their bed, or needing to be changed, before a member of the nursing team is aware. We would of course expect this situation to be managed wherever possible to try to reduce occurrences, and to protect patients' skin integrity and of course their dignity.

We are very sorry if Mrs Stroud's family feel there was more we could have done to prevent Mrs Stroud from wetting the bed. Our records show that Mrs Stroud was being supported to use the commode where possible. However, she was having a lot of anxiety around using the commode, and was experiencing panic attacks even though she was reassured on several occasions that she could keep her oxygen mask on whilst using the commode. It is not clear whether Mrs Stroud's family witnessed this during their visits to her, or whether these issues had been discussed with the family, either before or after the meeting on 28 August 2022 (which was not minuted). We sincerely apologise for Mrs Stroud's poor experience, and that Mrs Stroud's family had cause to bring this to our attention on more than one occasion.

We have been provided with a photograph which appears to show two nebuliser vials on a bedside cabinet, next to a mobile phone. The vials contain a solution of 250 micrograms of Ipratropium Bromide in a 1ml dose. This would be used with a nebuliser - a small machine which turns liquid medicine into a mist which can be easily inhaled through a connected face mask. Mrs Stroud had several factors which would have caused difficulty breathing, including her pre-existing Interstitial Lung Disease, as well as Covid Pneumonia, and likely would have benefited from the use of a nebuliser to increase the flow of air in and out of her lungs.

At the time this photograph was taken, which we believe to be on or around 18:15 on 18 August 2022 based on the mobile phone screen visible in the photograph, this was Mrs Stroud's first day on Necton ward, which is the Trust's respiratory ward. She was documented as being on 15 litres of oxygen with a venturi mask, and was still only reaching 91% saturation of oxygen in her blood. Every time the mask was removed, she desaturated. Our investigation of this concern has identified two potential reasons which may have led to those nebuliser vials being on Mrs Stroud's bedside unit:

- The nebuliser vials would be dispensed as part of the medication round, which is where prescribed medications are dispensed to the patients. These vials would be dispensed together with any other medications the patient may require, but whereas the patient would be supervised to take their medications in liquid or tablet form at the time they are dispensed, the nebuliser vials need to be given via nebuliser, which takes approximately 6-7 minutes. The medication rounds are timed to coincide with meals, so the nebuliser vials would be placed to one side so that the patient can enjoy their meal hot. This can then be given after the mealtime is over, so as to protect patients' mealtimes. As the photograph was taken at 18:15, it is possible this coincided with the time when the vials had been dispensed, but not yet given to Mrs Stroud.

- Alternatively, it may be that the vials had been dispensed as described above, however attempts to use the nebuliser with Mrs Stroud were unsuccessful due to her desaturating when her oxygen mask was removed. Her NEWS2 score on this day was documented as 5, which indicates that there were clinical signs of her condition deteriorating. Although in Mrs Stroud's case, her score remained elevated for much of her admission due to her symptoms but was not increasing beyond that point, it may have been felt that attempting to use the nebuliser would be too much of a risk. In this case, it would be reasonable for the vials to be left in the hope that her condition would stabilise, and the nebuliser could be used before the next medication round. We can confirm that the vials could only have been there since that morning at the earliest, because Mrs Stroud was only transferred to Necton around 21:59 on the evening before, 17 August 2022.

If it was not possible to give Mrs Stroud her nebuliser immediately, it may have been understandable for these vials to have been on her bedside table. For example, postponing the use of a nebuliser so that a patient can enjoy a hot meal is beneficial for patient experience, and also aligns with the Trust's focus on nutrition and hydration, which is one of the Trust's three priorities under the new Patient Safety Incident Response Framework (PSIRF). Equally, it may have been an appropriate clinical decision not to use the nebuliser when Mrs Stroud was consistently desaturating, but to leave these available in case her condition stabilised overnight and she was able to have the benefit of the nebuliser at a later time. We would have expected that if this was brought to the attention of the ward staff, the reason for the vials being there could have been explained to her family, to reassure them and to explain the reasoning behind the decision. There is no documentation within Mrs Stroud's records regarding the nebuliser vials, or a conversation with the family to this effect.

Having reviewed Mrs Stroud's medical records and our incident reporting system (Datix), as well as all correspondence with the family, we have not been able to trace any reference within our records or other documentation that the family had been concerned that Mrs Stroud had not been supervised to take her medication, or that her medication had been found unattended. We were in contact with Mrs Stroud's family both before and after her death. Sadly, the first time we became aware of this being a concern of the family was on 20 November 2023, when we were provided with their statement during the inquest process. This was, unfortunately, over a year after Mrs Stroud died, so we have not been able to investigate this aspect of your concerns to the level of detail we would like. We apologise for any inadequacies in this aspect of our response.

The photograph described above was very helpful in assisting us to understand the circumstances of the nebuliser vials being left on her bedside unit, and we are grateful to the family for providing this. However, when addressing this aspect of the Coroner's concern we did not have the benefit of similar photographs having been provided, showing the instances of pots of tablets being left unattended, or tablets having been found concealed in Mrs Stroud's incontinence pad. This may have assisted us with identifying when and/or where this happened, and who would have been responsible for supervising Mrs Stroud with her medication on these occasions.

We have reviewed records from our Electronic Medicines Prescribing and Administration system (ePMA) to see whether we are able to identify a particular period where Mrs Stroud may have been dispensed nine tablets at once, as were reportedly concealed in her incontinence pad. However, we have not been able to confirm when this may have happened. With ePMA, medications are not "signed for as given" in a traditional sense, on a paper drug chart. Instead, the person dispensing the medication would be logged into the ePMA system, and would confirm that a particular dose had been given, and when. The system then records that person's identity against that dose.

We believe a copy of these ePMA records were provided to the family on or around 23 November 2022, together with the rest of Mrs Stroud's medical records from this admission. This may have enabled the family to check their own records of specific dates and times when they witnessed medication being left unattended, against the ePMA records. This would have been after Mrs Stroud's death, and a couple of weeks or months after the events occurred. Unfortunately, as these dates and times were not passed on to us, we have not been able to check this against our own records. We are very sorry that we have not been able to identify the specific occasions when this happened, despite our best efforts.

If we were aware that Mrs Stroud was either not taking her medications or spitting these out, and concealing these missed doses about her person, we would absolutely expect that additional support be put in place to try to identify the cause of this. This could have been via extra supervision both before and after Mrs Stroud was given medication to take. If there was a physical difficulty with her

swallowing the tablets, we could have explored whether any of the medications could have been given in another manner, or if not, whether an alternative medication could have been prescribed instead.

We know that for some periods of her admission Mrs Stroud was on Level 4 1:1 care, meaning that she had a member of staff with her at all times. This would have allowed us to ensure she kept her oxygen mask on, but would also have ensured she was supervised taking her medication, as well as afterwards, which should have mitigated any risk of her concealing the tablets or spitting them out. We do however appreciate that the events described could have happened when Mrs Stroud was not supervised to this degree.

We would not expect that pots of medication would be left unattended on a patient's bedside cabinet. If we had been aware of such an occurrence, we would expect that this would be documented within the patient's medical records, and also documented as an incident on Datix so this can be reviewed by the Patient Safety Team. If there was harm caused, or the potential for harm, the incident would have been discussed at our Safety Incident Review Forum. This is a multidisciplinary meeting attended by senior representatives across all areas of the Trust, where incidents can be debated, and next steps agreed.

Under the new Patient Safety Incident Response Framework (PSIRF), if an incident is brought to our attention, we now consider whether there is any learning to be taken from the incident, and review this in a number of different ways, rather than our investigation being guided by the level of harm or potential harm. If a patient safety risk is identified, under PSIRF we now look to identify wider themes to prevent future patient safety incidents, rather than focusing on an incident as an isolated event. If an incident such as this had been reported on Datix, depending on the issues identified at our initial review, we might look to review our medication round processes across the Trust. We might have identified an issue within a specific area, e.g. the ward itself, or we may be able to identify another root cause requiring a different approach. Having this greater flexibility to respond to patient safety incidents will mean that if a similar situation is brought to our attention in the future, we can ensure this is investigated and managed in the best way to protect patient safety. This is of course our priority at all times.

We note your concern regarding patients being able to gain access to, and take, the medications which Mrs Stroud's family reported being left unattended. We hope we can offer reassurance by saying that we have reviewed the past two years' worth of Datix entries, spanning the period before and after Mrs Stroud's admission, and were not able to identify any instances where this has happened.

We fully recognise that the experience reported by Mrs Stroud's family both during her admission and as part of the inquest process, was not what we would want for our patients and their families, and we deeply regret that this is the impression they have been left with when remembering Mrs Stroud's last weeks. We sincerely apologise for this. The Trust is always looking for opportunities to improve the service we provide, and we are committed to continuous improvement in this respect, in line with the Trust's core values of kindness, wellness and fairness. Since the incidents highlighted, many of the staff that would have been involved in Mrs Stroud's care have left the Trust and new staff are in place on the wards where we know Mrs Stroud's care did not meet our expectations.

These new members of staff have already undertaken a Caring with Kindness course or are booked to attend. This is a two-day course which has been running on a monthly basis over the past two years, and is generally attended by a combination of Registered Nurses, Healthcare Assistants, Allied Health Professionals, Trainee Nursing Associates and some student nurses. It has accreditation from the Royal College of Nursing to count towards participants' CPD requirements. Where appropriate, some

sessions have been attended by patients and/or their carers or family, giving them the opportunity to share their stories, which we find to be very powerful. This is a commitment on the Trust's part which supports the governance process around patient experience and safety, and also links with our Patient Experience Workplan. We believe this investment will pay dividends.

Since the time of Mrs Stroud's admission, Stanhoe Ward also has an entire new leadership team including the Band 7 Ward Manager and her four Band 6 Junior Sisters. We have seen a significant decrease in the number of concerns and complaints reported to our Patient Advice and Liaison Service for both Necton and Stanhoe Ward since these measures including staffing changes and the emphasis on Caring with Kindness have been implemented.

The Matrons' Ward Assurance Toolkit has also been reintroduced across the Trust, providing guidance around what to look out for and audit tools to confirm compliance. This includes a Medicines Management audit which specifically asks the auditor to document whether medications have been stored safely, and in particular, whether any have been left on patient bedside cabinets or tables. A copy of this Toolkit is attached for your information.

Finally, we would reiterate our earlier note that we deeply regret that we did not have the opportunity to investigate some of the concerns raised closed to the time of the incident, and that as a result we are not able to provide a definitive answer on these points.

We offered a Local Resolution Meeting to Mrs Stroud's family during a telephone call on 18 October 2022, however although Mrs Stroud's daughter wished to take part, she did not feel able to engage with this process at that particular time due to the recent death of her mother, which is of course entirely understandable. She was going to let us know when she felt able to meet with us to discuss the family's experience and care of her mother. This was the last documented communication with the family regarding their PALS concern, and it is always a difficult balance deciding whether to reach out to a family member who has said they prefer to be the one initiating further contact. On reflection, we should have considered making contact with the family again, after an appropriate amount of time had passed; to see whether they wanted us to close their enquiry, or schedule an LRM. We recognise they may have had additional questions after receiving the copies of Mrs Stroud's medical records, and may have benefitted from the opportunity to discuss the contents, or other aspects of theirs and Mrs Stroud's experience, with appropriate members of the clinical team.

We recognise how distressing it can be when patients or their families have unanswered questions, and we wanted to address the wider issue of improving access to raising complaints and concerns. This will help ensure we retain this opportunity wherever possible, for the benefit of both our patients and their families. To ensure that patients and relatives are able to raise concerns much more easily, we now have a matron or senior nurse on site until 21.30 every day and during 08.00-16.30 on weekends and bank holidays, who visit every ward and department to ensure that standards are maintained and that any concerns are dealt with promptly.

We would be happy to provide you with further information if required.

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Chief Nurse