East Lancashire Hospitals
NHS Trust
A University Teaching Trust

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Mr Christopher Long
HM Area Coroner
Lancashire and Blackburn with Darwen
2 Faraday Drive
Preston
PR2 9NB

Dear Mr Long

Regulation 28 Report – Response by East Lancashire NHS Trust
Inquest relating to the death of Margaret Clement

This letter comprises the formal response of East Lancashire Hospitals NHS Trust ("the Trust") pursuant to section 7(2) to Schedule 5 of the Coroners and Justice Act 2009 and Regulation 29 Coroners (Investigations) Regulations 2013, to the issues raised in the Regulation 28 Report to Prevent Future Deaths, dated 14 May 2024, made following the inquest into the death of Margaret Clement, which concluded on 8 May 2024.

I would like to start the response by offering our sincere condolences to Margaret's family for their loss. The Trust fully accepts the findings of HM Coroner and are truly sorry that Margaret did not receive the treatment and care we would expect her to receive.

The Prevention of Future Deaths report identifies a number of areas of concern, and I will address these in this response, with details of the actions we have undertaken and those that we plan to undertake in the near future, along with details of the improvements made to date.

Matters of Concern

(1) Evidence was heard that nursing records on Reedyford ward were inadequate in a number of respects including recording the wrong medication, requesting a medical review for the wrong patient and not recording when an urgent review was needed in the doctor's task book.

Response

The Trust undertook a Patient Safety Incident Investigation (PSII) into the treatment and care provided to Margaret during her admission to Royal Blackburn Hospital in May and June 2022. The investigation found a reliance on written documentation to escalate and communicate Margaret's condition by staff at Reedyford ward, and that nurses at Reedyford Ward did not have an opportunity to escalate to a doctor in person.

Since the conclusion of the inquest the Trust has undertaken a significant amount of work on Reedyford ward to ensure these concerns have been addressed.

Firstly, since 21 June 2024, the doctors' tasks book on Reedyford has been removed. I can confirm that now all doctors' tasks (non-urgent) are requested via the Whiteboard on Cerner (the Trust's Clinical Electronic Record system) during core hours. Urgent actions are communicated verbally and escalated directly to medical staff during core hours and to the Acute Care Team out of hours.

Secondly, the SOP091 Pendle Community Hospital Ward Escalation Plan which was referred to at the inquest, includes a nurse escalation process, outlines the Early Warning Score, the frequency of observations and an escalation protocol, and has been printed/laminated and attached to the clinical observation equipment, so it is visibly available on the ward. A hard copy of the SOP is also available on the ward and all staff are aware of the escalation pathway which contains the staged process, outlining what action needs to be taken and by when. I have received assurance from the Ward Manager that all staff are now compliant with the awareness and training of the nurse escalation process on the ward.

I can also confirm that all medications are now administered and updated via Cerner. All Reedyford Ward computers have scanners attached to them to administer medications and these are now being used by the Registered Nurses during the medicine rounds. To provide assurance that this action is being taken, the use of wrist bands and the administration of correct medication will be routinely monitored through senior nurse observations and reported back to the Division if any concerns are identified. I am pleased to advise that following an audit undertaken on 24 June 2024 no concerning medication incidents were identified and we will continue to monitor this through the appropriate governance forums, including the Trust's Quality and Safety Committee.

In addition to the above, the doctors' guidance documents have been updated to include these updated processes so that clinicians on the ward are familiar with the updated ways of working.

(2) Evidence was heard that nursing handovers were inadequate and did not ensure appropriate risks were managed and prioritised.

Response

During the inquest I am aware that evidence was heard that the signs of gastrointestinal bleeding, and plans made to manage Margaret's condition, had not been verbally handed over between nursing staff on Reedyford Ward.

Since the conclusion of the inquest work has been undertaken to ensure that there is a standardised approach for the measurement and management, and communication, of clinical risks between shifts.

As indicated above, doctors task books are no longer in use and all tasks are updated, monitored and completed on Cerner which all staff have access to. Nursing and Medical staff are responsible for ensuring these tasks have been completed and nurses are embedding the use of the Patient e-Obs at handover which provides an overview of the clinical observations over a period rather than the last set of observations taken. This enables trends in clinical observations to be identified in a timely manner and I have received assurance from observation of practice by Senior Nurses that this is now happening.

(3) Evidence was heard that doctors on the ward did not effectively prioritise work by reviewing the task book in order to identify more urgent tasks.

Response

The Trust's investigation found that the task book entry relating to Margaret's condition, and the signs of gastrointestinal bleeding, were not reviewed by a doctor whilst at Reedyford ward. Therefore, as indicated above, in order to address this concern, the task books have been removed from the wards at Pendle Community Hospital.

There is now a daily MDT (multidisciplinary team meeting) and a twice daily planned handover from the medical team to the Acute Care Team (ACT) to ensure seamless handovers to ensure that any patients who are of concern are identified. The ACT are highly experienced with the skills needed to provide timely interventions to stabilise patients whose clinical condition deteriorates unexpectedly. This level of advanced clinical decision making and problem solving enables a more comprehensive and encompassing package of care and increases support for the workload of the medical teams, particularly if needed in the out of hours period. All doctors' tasks (non-urgent) are requested via the Whiteboard on Cerner during core hours. Urgent actions are now communicated verbally and escalated directly to medical staff during core hours and to the Acute Care Team out of hours.

In order to provide assurance around the new process a review of all incidents and medication errors has been undertaken which I am pleased to confirm has not identified any concerns.

(4) Nursing staff failed to request medical review verbally where it was appropriate to do so, relying on a task book.

Response

With regards to the above concern, I am aware that nursing staff on the ward relied heavily on the doctor's task book to escalate actions. In addition to the removal of the task books, nursing staff now accompany the doctors on their ward rounds and make use of the daily MDT to escalate concerns and immediate actions where necessary.

A review of this new MDT process was undertaken on 17 June 2024 which confirmed that all notes and actions are now being documented in Cerner, which includes actions for the medical, nursing and therapy teams.

The SOP046 MDT will be updated to reflect the requirement that both medical and nursing staff check that the doctor's tasks have been completed before they leave the ward. An audit of this SOP has been undertaken and was presented at the Clinical Effectiveness Group in July 2024, which identified recommendations. These have been transferred to a SMART action plan which will be monitored by the Clinical Audit team within the Trust.

(5) Nursing staff failed to seek urgent clinical assistance when presented with a significant per rectum bleed.

Response

I am aware that as part of the Trust's investigation it was identified that staff failed to escalate Margaret's condition when it was deteriorating. Therefore, as a Trust we needed to ensure that there was a clear process in place for recognition and escalation of deteriorating patients,

particularly in our community hospital.

Firstly, the Trust has arranged simulation training for all staff on the community wards. The staff are presented with a history of the patient and are asked to detail how they would assess that individual; this is repeated a number of times looking at the appropriate and most effective ways to identify any concerns or deteriorations in a patient. The staff are expected to complete full assessments of clinical observations, a physical examination of the patient, discuss handover and who they would escalate to. Detailed documentation is also discussed, including Incident reporting and the importance of accurate timely documentation.

Another element of training is a practical simulation-based assessment, which includes an assessment of patients with varying medical complaints, each training session also simulates a patient with a GI bleed, with a history similar to that of Margaret.

Secondly as indicated above, the SOP091 Pendle Community Hospital Ward Escalation Plan which includes a nurse escalation process, including the frequency of observations and an escalation protocol is now visibly available on the ward and all staff are aware of the Plan which contains the staged process, outlining what action needs to be taken and by when.

(6) Inadequate measures have been taken to assess compliance with procedural changes and expectations that have been set following the Trust investigation into this matter.

Response

Since the conclusion of Margaret's inquest, the Trust has updated its central process around monitoring of actions by adding assurance regarding completion of action plans to the PSG [Patient Safety Group] TOR (Terms of Reference) and agenda and all divisions have been informed that they must ensure that they have PSII action plans assurance monitoring included within the governance meetings. On agreement of all actions being completed, evidence will then be uploaded on the Trusts Incident Management System DATIX.

To support the change to PSG agenda and TOR a new divisional report template has been designed and approved. The report includes a section on PSII action plans, and these will be governed by the Corporate PSG. Any delays or issues with actions plans not being completed within timescales will be escalated within the report to PSG for discussion and support.

I hope that I have provided reassurances around the steps that we have taken to address the issues of concern contained within your report. I would like to assure you that the Trust takes your concerns extremely seriously, and, as a learning organisation, constantly strives to improve the clinical services it delivers to patients.

Our thoughts remain with Margaret's family.

Yours sincerely,

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Chief Executive Officer