East Sussex Healthcare
NHS Trust

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 0300 131 4500
Website: www.esht.nhs.uk

Rachel Redman
Assistant Coroner for East Sussex
Innovation Centre
Highfield Drive
St. Leonards-on-Sea
East Sussex
TN38 9UH

8th July 2024

Dear Ms Redman,

East Sussex Healthcare Trust Response to Regulation 28 Report – Carol Ann Divall

Thank you for your letter of 14th May 2024, enclosing your formal report under Regulation 28 to Prevent Future Deaths you made at the conclusion of the Inquest into Mrs Carol Ann Divall's death on 29th October 2022 (Inquest concluded on 26th April 2024). I would like to convey my sincere condolences to Mrs Divall's family following her death and would like to assure them that we have considered all the recommendations in the report and have made changes to our systems as a result.

The Prevention of Future Deaths report identifies the following areas of concern, and we address each one in turn with our findings and actions that we have undertaken, or plan to undertake.

A. **That Mrs Divall developed severe oral thrush making it very difficult for her to eat and drink and take her oral medication. She was referred to the dietitians on 2.10.22 and triaged by an Assistant the following day. She was not prescribed Fortisip until 14.10.22 by which time she was becoming malnourished. The oral thrush continued until discharge. Nystatin appeared to be prescribed once on 12.10.22 and was not prescribed on discharge nor mentioned in the discharge summary. I heard evidence on PFD matters that software which requires a clinician to check oral care is being implemented. I remain of the opinion that this forms part of basic nursing care which was overlooked in Mrs Divall's case.**

   We recognise that the mouthcare received by Mrs Divall was not of a standard we expect. Since 2022 the Malnutrition Universal Screening Tool (MUST) and Mouthcare assessment have been a central element of basic documentation. At the end of last year both documents were transferred to an electronic system, to enable staff to record and monitor the care provided to patients, with a decreased risk of losing manual recording.

   High risk patients now receive daily mouthcare reviews, medium risk patients are reviewed every other day, and low risk patients are reviewed every third day ensuring that any oral concerns are picked up in a timely manner and managed until improvement is seen. All reviews are prompted on the electronic system and highlighted if not actioned.

   We have developed regular senior nurse-led audits to measure the quality of compliance with the treatment plan for MUST. Plans are also in place for a Trust wide audit of the quality MUST assessments, including evidence of treatments commenced.

The Trust has now established a role (the 'Mouth Care Matters' Lead) that is dedicated to the promotion of good standards of mouthcare for patients and targeted training is delivered as per requirements and individual patient need (for example, in the event of a patient who is distressed or failing to comply, additional support and training would be available to staff providing care).

We have revised the Planning Care Together Policy Respecting Patient Choice with Advised Treatment policy, which provides staff with guidance to manage discussions with patients when agreeing an appropriate treatment, and/or intervention. It encourages family, carers, and advocates to be involved in planning care. This is especially relevant if and when patients are unable to fully cooperate and/or are very resistant to receiving care, where there are concerns about capacity or impaired cognitive function. This policy is on the Trust extranet for all staff to access and it is referred to in training for mental health capacity and has been introduced to the Mouthcare training sessions with immediate effect.

Turning to the prescription of Fortisip, this is typically undertaken following a registered dietitian's assessment. We accept that doctors could have prescribed this prior to review by a dietitian in this case. On this occasion due to a coding error at the point of triage, the urgency of our response is not as it should have been. Dietetic Assistant (DA) competencies have now been updated and additional training and support are given to DAs regarding the importance of coding correctly at this point in the pathway, to minimise the potential for recurrence of this error.

Following the completion of the MUST or mouthcare assessment on admission, the dietitians will have base line information to work from to enable a full assessment of the patient. Any concerns are highlighted to dietitians via the referral process and from communication with the MDT, patient and family. As part of the learning implemented following Mrs Divall's experience, all ward staff have received escalated communications to remind them that they can offer nourishing drinks such as Complan shakes and thickened yoghurts prior to dietitian referral or review, as long as there are no concerns about swallowing difficulties/dysphagia. The Dietetic team additionally promote the availability of high calorie, high protein options on the wards to staff and patients.

We accept that the medical records show the prescription of Nystatin was not continued onto the next weekly paper medication chart when the previous one was full. We have recently introduced Electronic Prescribing & Medicines Administration (EPMA) system where the risk of a medication being missed is far reduced as the medication will stay on the system until the course is finished or stopped. We anticipate undertaking an audit of the new EPMA system within this financial year to review the impact on missed medication.

B. Mrs Divall was referred to the Physiotherapy Department 2 weeks after admission but was rarely assisted with mobilisation and left to sit out in her chair for long periods. Action should have been taken to encourage Mrs Divall to mobilise more often in an attempt to rehabilitate her after her surgery.

We recognise that further actions could have been taken to encourage Mrs Divall to mobilise more often to rehabilitate her after her surgery, noting the inherent risk of trying to mobilise a person if they do not wish to cooperate for any reason. Having reviewed the documentation, the Physiotherapy and Therapy Assisted Discharge Service (TADS) team visited Mrs Divall on 19 occasions during her time with us and she was able to actively participate to varying degrees in 15 of these sessions.

When Mrs Divall was an in-patient, we did not have a routine Physiotherapy weekend service and had experienced staff sickness as well. We have now made changes to the rota for this service and since mid-May we now have a Saturday service for new assessments of patients who have sustained a fractured Neck of Femur.

We have also increased staffing to include two full-time Physical Therapist Assistants (PTAs) in the period since this incident.

C. Mrs Divall developed a grade 4 sacral pressure sore. She was not referred to the Tissue Viability Nurse (TVN) until 1.10.22 who confirmed in her evidence that it would have taken 12-14 days to develop and would therefore have been available to be seen by the nursing staff caring for her. Contributing to the deterioration of her pressure sore was the deflating of her hybrid mattress on at least 2 occasions. Mr Divall noticed who visited for long periods every day noticed that his wife was never repositioned as she should have been on a 2 hourly basis at any time during his daily visits. I consider that Mrs Divall's immobility and malnourishment contributed to the development of her pressure sore the care of and severity were not mentioned in the discharge summary.

We acknowledge the unacceptable delay in dealing with the pressure sore. We note that category 2 pressure damage was first documented in Mrs Divall's health records on 20 September 2022, ten days before the referral to the TVN.

In order to strengthen the approach regarding managing pressure sores, the Tissue Viability Team are supporting the ward to undertake a quality improvement (QI) project in relation to the prevention and management of pressure ulcers including the recognition of potential skin damage likely to deteriorate. This is especially relevant to patients who have a history of trauma which often incorporates frailty, poor health and a long lie prior to their admission to the ward. The success of the interventions on this QI project to reduce pressure ulcers in the unit will be reviewed and recommendations extended across the organisation in all wards.

We also acknowledge that the communication and handover on discharge to the community nursing teams and with Mr Divall in relation to the extent of the wound and treatment required for the pressure damage was inadequate.

The Chief Nurse has proposed a new process called the '5P Process for Discharge' to improve the communication related to significant pressure damage on discharge. This has been presented and discussed at length with senior nurses across the organisation and is currently being developed and implemented. The process includes utilising our medical illustration team to take clear images of wounds for sharing with care partners with consent as required. We have included a copy of the process as Attachment A, and a copy of the 5P slide deck at Attachment B.

We note the failure of the hybrid mattress pump in this case. Even in the event of failure, we would anticipate that the mattress provides sufficient protection to patients at risk of pressure damage, however we note this did not happen in this case. We recently completed a Trust-wide audit of all inpatient beds to understand the current picture and are considering the findings in order to ensure effective next steps.

Additionally, as part of the QI project noted above, Benson Ward and Egerton Trauma Unit now complete daily checks on all hybrid mattress pumps and this is documented on a checklist (Attachment C). Actions are taken to supply pumps to those patients that need them (as all mattresses are hybrid) and address any issues with teams on the ward, who are

supported by ‘trouble-shooting’ sheets (see attachment D). It is our intention to take learnings from these pilot areas and share across the Trust.

D. The Discharge Summary was misleading to the District Nurses who were unaware of the severity of Mrs Divall's pressure sore until they saw it (down to the bone) and did not make clear that Mrs Divall had been discharged for end of life care.

It is acknowledged there was no mention of the pressure damage within the Doctor’s discharge letter. Although the District Nurse referral did state there was a pressure ulcer and the category, it is also acknowledged that it should have been more detailed to include a range of factors, including; the reason for admission/procedure, what is required from District Nurses, size, location, appearance (slough/black), treatment actions, dressing plan, when this should be started, how often, and other measures such compliance, aids used, air mattress and care needs.

To address these information concerns, we have developed a flow chart on how to refer to District Nurses and what information needs to be shared to support decision making and tasks related to fast track discharge, available on the extranet and in the discharge policy.

With regard to concerns around End-of-Life Care (EOL), from our documentation it was not recognised that Mrs Divall was EOL, and she was therefore not referred to the Specialist Palliative Care Team and this was not described on her discharge documentation. As a result, we have developed a pilot flow chart for recognising EOL. Once piloted, the intention is to share this throughout our hospitals, see Attachment E.

The flowchart prompts the recognition of factors such as frailty score, Nottingham Hip Fracture Score (30 day mortality), ongoing Orthogeriatrician input and several other details to be kept under review and monitored. On consideration of this, should a patient show signs of increased frailty or mortality, or decreased nutrition or rehabilitation, this will trigger immediate discussion with family and next of kin, a Multidisciplinary Team Discussion, and a best interests meeting. The discussions will support in identifying if a patient is either EOL or limited life expectancy (less than 24 months) so that we may refer them to a suitable/appropriate pathway consistent with their care needs.

Patients identified as limited life expectancy will receive input from the Frailty Team, and discussions with family to consider the most appropriate pathway such as fast-track for home support or involving the care home and other care agencies where appropriate. The EOL pathway will involve Palliative Care input and discussions with family regarding where the patient will spend their last days of life, including home support, nursing home, hospice or hospital environment.

E. The RCA was insufficient and did not address all of the issues surrounding Mrs Divall's care nor did it properly address those issues it did consider.

The report in question was a specific Pressure Ulcer Root Cause Analysis report and we accept that other issues and concerns in the care were not addressed as they were not noted as concerns at that time during Mrs Divall’s admission.

Under the NHS England’s Patient Safety Incident Response Framework (PSIRF) the Trust have developed a Pressure Ulcer After Action Review (AAR) template in collaboration with the TVN's and the Pressure Ulcer Review Group (PURG) – see Attachment F. The aim of PSIRF is to apply a broader approach to addressing patient safety issues, such as pressure ulcers, taking the focus away from investigation and individual incidents to instead focus on

quality improvement. The template has been trialled and on review is being used effectively, especially around learning and recommendations, it is an opportunity to review the care holistically and the look at the whole journey of the patient.

By applying this approach to the care delivered to Mrs Divall the Trust acknowledge and accept the concerns of the Coroner. We are aware we need to review and improve our communication with next of kin and, as above, between teams on discharge such as the District Nurses and ward to ensure important information is cascaded avoiding confusion and distress to families. We now have bimonthly Quality Summits which all the Ward Matrons will be attending in person to emphasise the importance of communication between families but also between staff in order to ensure that care provided is of the highest quality. We have also developed quality documentation audits and discharge checklist audits so that where we see a miscommunication we can put it right in the moment.

We recognise the need for a rapid escalation process that enables us to recognise very high risk/complex patients who may be resistant to care, which would have triggered a 'best interests' meeting and/or multidisciplinary meetings in real time to address the issues staff were experiencing in trying to deliver care. All of this should have been shared and discussed with her Next of Kin so they were aware and understood the extent of this and also the impact/risk(s) it posed. The Trust has developed a Standard Operating Procedure (SOP), currently being approved through our clinical governance process that will systematise the approach for teams who are caring for patients to whom this SOP applies.

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

Yours sincerely,

[redacted]

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Chief Executive