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Royal Cornwall Hospitals NHS Trust

Chief Medical Officers for CFT and RCHT
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16th August 2024

Mr Stephen Covell
Assistant Coroner for Cornwall and the Isles of Scilly
H.M Coroner's Office
Pydar House, Pydar Street
Truro, Cornwall
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Dear Mr Covell

Re: Death of Paul Byron Holmes - R28 PFD Report and letter (ref: 10871060)

We write in response to the Regulation 28 Report to Prevent Future Deaths, dated the 13th June 2024 and received on the 27th of June 2024, by both the Cornwall Partnership NHS Foundation Trust (CFT) and the Royal Cornwall Hospitals NHS Trust (RCHT), issued as a result of the inquest into the death of Mr Paul Byron Holmes, which concluded on 22nd of February 2024.

We would like to take this opportunity to express our sincerest condolences to the family of Mr Holmes for their loss.

During the course of the inquest, the evidence revealed matters giving rise to concern. These are as follows:

On Paul's transfer from The Royal Cornwall Hospital to Liskeard Community Hospital on 18 April 2022

1) There was no clear, detailed and direct handover between doctors of the two hospitals.

2) A treatment plan including the need to continue to treat Paul for dehydration and what to do in the event of deterioration was not agreed and recorded clearly between clinical staff of both hospitals.

3) Any handover which did take place was not properly recorded in Paul's medical notes.

4) An error in the writing out of a prescription for intravenous fluids at the Royal Cornwall meant that the administration of hydrating fluids at Liskeard Community Hospital was delayed.

Please find below a response from the Trusts in relation to each concern you have raised:

1) There was no clear, detailed and direct handover between doctors of the two hospitals.

Whilst in the Emergency Department at Treliske, there was a detailed management plan in place for Mr Holmes including the administration of intravenous fluids, oral antibiotics, regular laxatives and restarting his regular diabetic medication. A sputum sample was sent for cultures and a note made to review Mr Holmes' pain relief. The advice was to continue with ongoing rehabilitation inputs and monitor electrolytes, inflammatory markers and renal parameters. Further to satisfactory improvement, the Consultant who reviewed Mr Holmes on the post-take ward round on the 18th of April 2022, deemed him appropriate to complete his recovery in a community hospital, after stabilising the acute medical illness that Mr Holmes had presented with. The rationale for the transfer was acknowledged as clear at the inquest.

There is no documentation of a handover from the discharging Consultant to the accepting team at Liskeard, however this is in-line with expected practice.

The expected practice within CFT for admissions to community hospitals would not ordinarily include a doctor-to-doctor handover. Following the decision by the Consultant in RCHT that the patient was appropriate for admission to a community hospital and once a bed was identified, it is expected that a nurse-to-nurse handover would take place. In the case of Mr Holmes, this nurse-to-nurse handover did occur as expected and confirmed that Mr Holmes' presentation and condition at the point of admission was appropriate to the capacity and remit of the ward.

There are some additional safeguards in place for more complex presentations. In the scenario where a patient has needs which cannot safely be met by the nurse-led community hospital, an admission can be refused. There have also been cases, where the patient's needs are complex, where a doctor-to-doctor handover does take place.

Given that there is very limited medical cover available at CFT community hospitals, it is not feasible to change practice to insist on doctor-to-doctor handovers for all admissions to nurse-led wards.

2) A treatment plan including the need to continue to treat Paul for dehydration and what to do in the event of deterioration was not agreed and recorded clearly between clinical staff of both hospitals.

The handover from the frailty nurse at Treliske was that they did not feel Mr Holmes was septic or had an infection but that he was dehydrated. Intravenous fluids were prescribed. The nursing documentation on the morning of transfer to Liskeard details an update to Mr Holmes' son, an update on an attempt to administer medication to Mr Holmes and also that a sputum sample and CSU had been sent.

There is no documentation of the detail of the handover from the discharging nurse at RCHT.

The patient handover form was completed by the receiving nurse at CFT, however, this did not detail the need to continue to treat the patient for dehydration and what to do in the event of a deterioration. Although specific actions in the event of a deterioration were not documented on the handover form, there was a Treatment Escalation Plan (TEP) dated 4th of April 2022 recorded in Mr Holmes' paper notes, which did detail that Mr Holmes was for escalation back to the acute hospital in the event he deteriorated. The TEP was followed.

The response to concern number 3, below, describes that a nurse-to-nurse handover is expected practice and both Trusts propose some actions to strengthen this process.

3) Any handover which did take place was not properly recorded in Paul's medical notes.

Within CFT, the verbal nurse-to-nurse handover is documented on a paper record, which is then added to the patient's paper notes on arrival at the ward. Due to limited communication between the electronic patient records of both Trusts, it is not practicable to produce a shared handover which is apparent on both systems.

Both Trusts acknowledge that this poses a risk of there not being a shared understanding about when to escalate the patient for further treatment.

Both Trusts propose to review the inter-hospital transfer form used by both the discharging and receiving wards to ensure an escalation plan is documented and to ensure that the handover record in both Trusts is consistent. Any revisions to the handover documentation would need to include a prompt for the discharging and receiving nurse to share any relevant details from the medical management plan.

Both Trusts commit to establishing a task and finish group to review the design of the inter-hospital transfer forms and take forward any developments. This group will be established by the start of October 2024.

4) An error in the writing out of a prescription for intravenous fluids at the Royal Cornwall meant that the administration of hydrating fluids at Liskeard Community Hospital was delayed.

It is recognised that there was a delay in administering IV fluids to Mr Holmes as a result of the prescription provided by RCHT having an invalid date. Because CFT and RCHT do not use the same electronic prescribing system, there are inherent challenges when trying to rectify a prescription which is invalid. As detailed in the statements to inquest, efforts were undertaken within CFT to seek a new prescription through the out of hours medical service, which is the only option for medical cover in evenings and weekends.

CFT recognise that an additional option in such circumstances would be for the receiving ward to return to the original prescriber to rectify any prescription issues. Upon review with ward managers, this course of action is routinely taken when prescription errors are detected in normal operating hours, however this is not a safeguard which would apply in the out-of-hours scenario which impacted Mr Holmes.

RCHT recognise the human error made in the writing of the prescription. The science of human factors (and ergonomics) seeks to understand human interactions with systems of work to identify, prevent and where possible design-out the opportunity for error. In relation to medication incidents, the Trust continually explores how the electronic prescribing system can build-in prompts and highlight where there may be risks to safety such as allergies and drug interactions. We also have processes such as medicine reconciliation which ensure the medicines prescribed to a patient prior to admission are continued. However, errors do sometimes occur for a number of reasons, and we are using education to create a culture of learning, understand error types and ensure the appropriate corrective actions are taken to reduce risk.

Whilst training regarding human factors and medication has previously been delivered on an ad hoc basis to all professional groups in the Trust, it is also now part of the revised LEAD programme aimed at all leaders, supervisors, and managers in RCHT. Specific reference to medication errors is made to ensure learning in personal awareness but also that the conditions we create for ourselves (and others) can contribute to slip and lapse errors which can be seen in tasks such as transcription and completing care related tasks.

The LEAD programme went live in August 2024 and completion is monitored via electronic staff records.

We hope that this letter provides both you and Mr Holmes' family with assurance that both Trusts have taken seriously the matter of concerns you raised in your report.

Yours Sincerely

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[redacted] and [redacted]

Chief Medical Officers

CFT and RCHT