NHS
Worcestershire
Acute Hospitals
NHS Trust

[redacted]
Chief Executive
Worcester Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

08 November 2024

[redacted]

Mr David Reid
HM Senior Coroner
Worcestershire Coroners Court
The Civic
Martin's Way
Stourport on Severn
Worcestershire

Sent via email: [redacted]

Dear Mr Reid

Re Regulation 28 Report to Prevent Future Deaths

Please accept this letter in response to your Regulation 28 Report to Prevent Future Deaths received on the 16th October 2024, following the Inquest touching on the death of Kelly Stevens.

In your Regulation 28 report, you identified the following matters of concern relating to the Worcestershire Acute Hospitals NHS Trust (WAHT).

> ***1) Despite being under the care of the medical team, Ms. Stevens did also receive input from the surgical team. Her situation was further complicated by the fact that for most of her admission she was placed as a medical outlier on a surgical ward. In the event, no one consultant was in overall charge of her care, which meant that the issues identified in this case were not picked up on. I heard evidence that there was no policy in place at the Trust to give guidance as to how this sort of situation should be resolved, but instead that it was expected that consultants would liaise with each other in order to do so.***
>
> ***That did not happen in this case;***
>
> ***2) No doctor providing care for Ms. Stevens followed the established principle that the prescription of intravenous fluids for a patient must be accompanied by regular testing of electrolytes. In Ms. Stevens' case, this was particularly important because her baseline sodium level was low***

anyway, so the overprescription of fluids put her at greater risk of hyponatraemia;

3) There was no proper recording of Ms. Stevens' fluid intake and output on fluid balance charts for most of her hospital admission. For the reasons set out at 2- above, this was vitally important in her case;

4) Ms. Stevens' hospital notes revealed evidence of the routine "copying and pasting" of out-of-date care plans by previous doctors. This meant that the next person reading her notes would be left with an erroneous view of her current care plan.

RESPONSE:

1) At the time of the incident, there was no policy in place for the management of medical outliers. In the action plan of the report the Chief Medical Officer (CMO) has an action relating to the review of a patient outlier policy and to taking over patient care. These actions are almost completed. Meetings were held between the senior clinical leaders and the Chief Medical Officer on 11th October 2024 and the 4th November to review the policy. The policy has been agreed and will be shared through the Improving Safety Actions Group (ISAG) on 14th November 2024 and approved through Trust Management Board on 20th November 2024 with immediate implementation thereafter.

   Any issues with outliers are escalated via the capacity meetings/the flow WhatsApp group which is monitored on a daily basis by the bed lead for the Division. This process is followed Monday to Friday and ensures any issues with either review or management of outlier patients are picked up in a timely manner.

2) Blood monitoring training is included as part of the core medical curriculum covered within medical training.

3) There have been multiple actions to improve fluid balance records:

   - A Trust wide "Lesson of the Week" was shared on 5th August 2024 to share learning and actions required to support immediate improvements in Fluid Balance documentation in EPR.
   - Additional opportunities for education around nutrition and hydration are included throughout the ward:
     - Local induction to the ward for Healthcare Assistants (HCA) covers MUST and fluid balance; this is an informal local training and is completed with the Band 6.
     - Fluid balance training provided by the Acute Kidney Injury nurse.
     - Rolling HCA study day programme which includes MUST and nutritional risk.
     - Due to changes with fluid balance and the introduction of EPR, the Division recognise there is a gap in training; the Division are currently formulating a training package to be delivered locally.

- Training compliance will be monitored through the Nutrition and Hydration steering group, a trajectory has been submitted to improve compliance with training over the next 3 months to provide assurance around learning

4) The copy forward function on EPR was removed from 3 documents on 14th May 2024: Medical Clerking, Ward Round and Specialty Review. Copy forward was then removed from all documents within the EPR system on 4th September 2024.

I hope that the above addresses the concerns which you raised. I have no representations in respect of publication of the Regulation 28 or this response by the Chief Coroner.

I shall be grateful if you could kindly send a copy of my response to anyone to whom you copied your Regulation 28 report.

Yours sincerely

[redacted]

Chief Executive