University Hospitals Birmingham
NHS Foundation Trust

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27th December 2024

Mrs Louise Hunt
HM Senior Coroner for Birmingham and Solihull

By way of email only:

Dear Mrs Hunt

Inquest touching the death of Mrs Phyllis Tromans
Response to Regulation 28 Report to prevent future deaths

I am writing in response to the Regulation 28 notice issued following the conclusion of the inquest on 31 October 2024, into the death of Mrs Tromans at Queen Elizabeth Hospital Birmingham.

We have carefully considered the concerns raised within your report to prevent future deaths and our response is set out below.

1.It is likely that Mrs Tromans' tissue damage was exacerbated during her period in the Emergency Department. On admission, her Waterlow score indicated a high risk of pressure sores. That score was underestimated and the correct score would have indicated a very high risk. She spent almost 18 hours in ED, during which time she was positioned on a trolley without pressure area care.

It is probable that Mrs Tromans' tissue damage accelerated during her prolonged stay in the Emergency Department. Her Waterlow score upon admission indicated a high risk of pressure sores, but the actual score should have indicated a very high risk i.e. the tissue substrate was poor. She was positioned on a trolley for nearly 18 hours in the ED without adequate heightened levels of pressure area care, which likely contributed to the development of her pressure sores.

In response to this, several measures are being taken to prevent future occurrences. Due to the increasing demand on the ED, which has led to patients spending longer than desirable periods in the department, the Tissue Viability team has collaborated with ED Matrons to implement a project aimed at reducing pressure ulcers in the ED. This includes:

- **Education**: A targeted training program for ED staff covering topics such as pressure ulcer categorization, reporting mechanisms, skin inspections, and repositioning techniques.
- **Equipment**: The introduction of new trolley mattresses with deeper pressure-relieving foam and the use of pillows to offload pressure from patients' heels. This equipment is not conventionally used in ED but will now be available in this setting.

- **Documentation**: A booklet supporting accurate completion of Waterlow scores is being updated and will soon be relaunched to ensure proper documentation across the Trust.

Furthermore, skin champions have been introduced in the ED, with staff undergoing comprehensive training. The department is also working on auditing trolley mattresses to ensure they provide effective pressure reduction, with plans for a trolley audit program in place.

Assurance: The implementation of these measures will be monitored through regular audits of pressure ulcer data in the ED to assess effectiveness and identify areas requiring further intervention.

2.Mrs Tromans had a repositioning schedule in place when she was admitted to the Acute Medical Unit and subsequently to ward East Ground B. This required repositioning at no greater intervals of four hours to mitigate the risk of pressure sores. On a total of 22 occasions during her inpatient stay, the schedule was not adhered to. This led to occasions where Mrs Tromans was left in the same position for up to 14 hours.

Mrs Tromans was admitted to the Acute Medical Unit (AMU) and subsequently to Ward East Ground B, where she had a repositioning schedule that required her to be repositioned every four hours to prevent pressure sores. However, the schedule was not adhered to on 22 occasions, resulting in her remaining in the same position for up to 14 hours, likely contributing to the deterioration of her condition.

In response, several actions are being taken:

- **Training**: In December, two Tissue Viability Link Worker events focused on repositioning were held, with support from therapy teams using pressure mapping devices to identify pressure points and promote effective repositioning. The sessions also provided education on anatomy and physiology, with an emphasis on safe side-lying techniques to relieve pressure.
- **Compliance Monitoring**: A weekly audit of repositioning practices in the AMU is now being conducted, with real-time feedback provided to staff. The AMU also receives regular communications emphasizing the importance of following the repositioning schedule and completing daily care plans.
- **Response Assessment Tool (RAT)**: The Tissue Viability team has implemented the RAT to scope trust-acquired pressure ulcer events. This tool, which will be used by senior staff to ensure repositioning strategies are being followed, will be audited for compliance and quality.

Assurance: The implementation of regular audits and ongoing educational efforts will be monitored, with results reviewed in the spring of 2025 to assess improvements in repositioning practices and a reduction in pressure ulcer incidence.

3.East Ground B ward had a paper version of a wound care plan which was designed to provide detailed monitoring of her skin condition and a treatment plan for pressure sore care. This was not completed at any stage.

On Ward East Ground B, there was a paper-based wound care plan designed to monitor Mrs Tromans' skin condition and provide a treatment plan for her pressure sores. However, this plan was not completed at any point during her stay, which hindered the timely and effective management of her pressure sores.

The Trust has responded by updating its wound care tools and processes:

- **Updated Wound Assessment Chart**: The Wound Assessment Chart has been recently updated as part of the Wound Product Formulary review. This document is now available to staff, who are being trained in its use during patient reviews. The chart will be used to document skin assessments and treatment plans.
- **Education and Training**: The clinical educator for the Healthcare of Older Patients (HCOP) service is delivering additional training across ward areas, with senior staff leading bi-monthly sessions to reinforce pressure ulcer prevention and care.

Assurance: The use of the updated wound assessment chart will be monitored through patient assessments and quarterly audits to ensure proper documentation and adherence to care plans.

4. The Matron's investigation into these gaps in care did not seek to establish why they had occurred. This raises a concern about the quality and efficacy of the Trust's post-death investigations which in turn raises a concern for future deaths.

The Matron's investigation into the gaps in care did not thoroughly explore why these failures occurred, which raises concerns about the effectiveness of post-death investigations within the Trust. A more comprehensive investigation would involve speaking directly with staff involved in care delivery to understand the root causes of care failures.

In response to this, the leadership team has reflected on the investigation process and acknowledged the need for individual fact-finding interviews with staff involved in care delivery. Moving forward:

- **Improved Investigation Process**: The investigation process will be revised to include individual statements from staff involved in care, ensuring that all aspects of care delivery are fully explored. These findings will be embedded into roundtable reports to provide greater assurance that all contributing factors are understood and addressed.
- **Learning Dissemination**: The findings from the investigation will be shared across all relevant clinical teams, with regular updates and action plans to ensure that lessons are learned and improvements are made.

Assurance: The Trust will continue to focus on improving its investigation process to ensure that the causes of care gaps are thoroughly examined and that appropriate corrective actions are taken. Regular reports will be presented to senior leadership to track progress.

Wider Learning and Improvement

The issues identified in Mrs Tromans' care have prompted widespread changes across the Emergency Medicine, Acute Medicine, and Healthcare of Older People (HCOP) services. The case has been shared at the QEHB Care Quality Meeting to disseminate learning, and actions are being reported through clinical delivery groups' Quality and Safety meetings. Additionally, improvements in care delivery, monitoring compliance with standards, and preventing future incidents of pressure ulcers will continue to be a focus for ongoing staff education, audits, and process improvements across the Trust.

These actions aim to enhance patient safety, improve pressure ulcer prevention, and ensure that staff are equipped with the necessary knowledge and resources to provide high-quality care.

I would like to assure you that the concerns raised within the Regulation 28 Report have been taken extremely seriously, which I hope is demonstrated in the steps that have been taken following Mrs Tromans' death.

Yours sincerely

[redacted]

[redacted]
Chief Executive