Response to Regulation 28: Report to Prevent Future Deaths

Re: Inquest of Karen Day (deceased) – 30.8.63 to 14.7.22

NHS Number [redacted] – Case No. 2024-0682

Meanwood Group Practice received a Regulation 28: Report to Prevent Future Deaths from Emma Mather, Assistant Coroner for West Yorkshire (East) on 10 December 2024.

The Inquest related to Karen Day who died on 14 July 2022.

The matters of concern raised in your report were:

1. *During the course of the inquest I heard evidence that the GP practice did not follow the lower limb framework, failed to refer to tissue viability appropriately, and failed to escalate concerns around the deteriorating wound or consider appropriate measures to support the deceased to either self-manage her wound with an at home compression bandaging kit, or to support her to attend appointments on a more regular basis. I am concerned that the practice was unable to provide assurance that the same situation could not occur again.*
2. *During the inquest I received evidence that the practice had not carried out any internal investigation in relation to this death and the practice accepted it should have done. I am concerned that the practice does not have adequate systems in place to ensure that patient safety incidents are reviewed in a timely way to allow lessons to be drawn from the findings*.

Practice response:

Meanwood Group Practice was deeply concerned about this case and to receive this report. We would like to thank you for bringing these matters to our attention. We have carefully considered and discussed the concerns you've raised and their implications for the practice.

The case had previously been discussed at a practice meeting on 25th July 2022 following the death of Ms Day. This is done for all patient deaths, and includes GPs, practice manager, practice pharmacist, and lead practice nurse. As with other case reviews it provided an opportunity to review and learn from the case.

Following the inquest the case was discussed again at a practice meeting on 2nd December 2024 with all partners, salaried GPs and GP registrars, practice manager and deputy, practice nurse lead and reception manager and a full significant event analysis was presented and discussed. This led to the use of a detailed wound care template for all relevant wound management consultations, a review of the use of Tissue Viability Team referral process to ensure no other referrals are rejected, and GPs and the practice nursing team updating their knowledge, training and processes for wound care, in line with Leeds guidelines.

As a result of the significant event analysis and practice team discussion the following action plan was agreed and implemented:

- [redacted], GP partner, has been appointed the Wound Care Lead for the practice, with [redacted] the practice nurse lead.

- To ensure the wound care template is used in full at the first consultation and then every 4 weeks in line with Leeds guidelines, to confirm that all the information needed is recorded for each patient contact. This will include regular use of photography, with images retained with the record, to document a wound and enhance continuity of care.

- To review all current patients in a practice meeting with all clinicians present in the first instance, using a large screen monitor to enable full review of the patient's clinical record.

- To audit all patients receiving regular wound care within the practice every month, and once the system is assured every 3 months.

- Datix Incident reports will be filed in the event of risks being identified. A Datix incident form has been filed because of this inquest regarding the risk associated with the withdrawal of funding for the community wound care clinic and the pressures being placed on General Practice nursing services because of this.

- Wound management training to be organised for the practice nursing team and GPs with the Lead Vascular Nurse Specialist, LGI, on 24th February 2025.

- Home 2-layer hosiery kits or Velcro-based adjustable compression kits to be offered to all appropriate patients by the community wound care team, in line with local clinical guidelines.

- The practice will adopt a process that all foot wounds that have shown no improvement or are static within four weeks would trigger a review and referral to podiatry and all leg wounds that have shown no improvement should be reviewed and considered for referral to the Tissue Viability service.

- Systems will be improved within the daily duty doctor arrangements to ensure all clinical contact related to a patient is appropriately recorded. As part of this whenever a GP is asked to review a patient by a nurse the patient's name should be added to the duty-list as a prompt for the duty GP to record their review, in addition to the practice nurse's consultation, in the notes.

- We have reviewed our clinical management of dependent oedema to ensure in all cases a clear plan for investigating heart failure and other causes is documented in the clinical record, in line with Leeds guidelines.

- Wound care and management will be made a standing item as part of the weekly practice meeting agenda with contributions from partners/GP Registrars/Nursing/ Pharmacy teams.

- We will hold regular multi-disciplinary team discussions for patients with complex or wounds that are failing to heal. The lead nurse to bring forward patients the nurses are concerned about. The result of the MDT will be record in the patient's record.

- We have invited a District Nurse representative to attend a practice meeting once every three months to review cases they are dealing with and facilitate a closer working relationship with our Leeds Community Healthcare colleagues.

- To discuss the case with other practices within our Primary Care Network at the next meeting on 28 January 2025, to share learning and improve quality of care across the area.

- The practice will have a lower threshold to complete a full significant event analysis. These will be discussed in the weekly practice clinical meeting and any lessons learnt recorded and acted on.

- To request legal representation at any subsequent inquests. In this case, MPS supported the preparation of an initial statement but advised that legal representation wasn't necessary. However, Leeds Community Healthcare and Leeds Teaching Hospital Trust had legal representation present. The inquest caused significant distress for those attending and the practice has a duty of care to support them.

- To write to the ICB, LCH, LTHT and CQC, sharing the Section 28 report, and to request an urgent meeting to learn lessons from this case and seek improvement to the community wound service. Other areas within West Yorkshire and elsewhere in the country have greater access to specialist wound care services and yet in Leeds the limited wound clinics have recently been discontinued. The practice should not be expected to care for patients with chronic wounds that are not healing and will work to ensure all relevant patients are referred.

- The practice will inform the ICB in Leeds of its intention to no longer provide long-term wound care management and would refer all relevant patients to a specialist service for wound care management. The practice would expect the ICB to commission the necessary service.

Summary

The practice has responded to the two matters of concern raised by the assistant coroner.

1. The practice has reviewed in detail how patients with wound care needs are managed, has made significant changes to our systems to ensure all wound care is done following Leeds clinical guidelines and delivered to the highest standards. A lead clinician has been appointed, and a process of monthly audit of consultations and referrals is now in place.
2. The practice has strengthened its arrangements to review and learn from all deaths and significant events as part of its weekly multi-disciplinary team meetings.

In closing we acknowledge that your concerns arose out of your investigation into the death of Karen Day and on behalf of the Practice, I would like to take this opportunity to offer our sincere condolences once again to her family in relation to her death and the impact it has had on them.

[redacted]

Senior Partner
Meanwood Group Practice
Leeds LS6 4JN