Somerset NHS Foundation Trust was created from the merger with Yeovil District Hospital NHS Foundation Trust

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31 March 2025

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Taunton
TA1 5DA

[redacted]

Mrs Samantha Marsh
c/o Taunton Coroners Court

Sent via email to
[redacted]

Dear Mrs Marsh

REGULATION 28 REPORT – PREVENTION OF FUTURE DEATHS – Cynthia GILBERT

I am writing in response to your correspondence dated 24 January 2025 regarding the Regulation 28 of the Coroner's (investigations) Regulations 2013 following the inquest regarding the death of Cynthia Gilbert which concluded on 23 January 2025.

We have set out the matters of concern as raised in the report and our response to them.

MATTERS OF CONCERN

1. Adherence to the repositioning guidance and documentation in our Intentional Rounding (IR) chart

At Somerset NHS Foundation Trust it became clear that there was a lack of clarity around the purpose and process associated with the meaningful delivery of Intentional Rounding (IR) across the Trust. Some staff reported that they felt it had become a 'tick box' exercise and another theme was that with capacity and workforce issues on the ward, it was not always possible to complete it correctly. A staff survey was completed across both acute hospitals and the data showed that not all staff had a full enough understanding of the 5 elements of patient care that make up Intentional Rounding (pain, position, personal needs, patient wellbeing and prevention). There are many factors for this, including a lack of consistency in its application with varying versions of the documentation used, and the lack of knowledge and experience/training of new nursing and Healthcare assistant (HCA) staff.

In response to this, a Quality Improvement (QI) project was commenced in September 2024 with an aim to address these variances and improve the overall understanding, application and staff culture, leading to increased patient safety, a reduction in harm and ultimately better outcomes for patients. Since testing the specific role modelling approach for IR across 5 pilot wards, there has been an improved awareness and understanding from colleagues, a reduced number of reported incidences and / or concerns, with fewer patients suffering harm through the adverse effects of pressures leading to pressure damage. A new tool was developed which will capture more accurately the care delivery

'in real time' and be patient centred to reflect the needs of the individual patient. We aim to have the tool and training package rolled out across the organisation by June 2025.

2. **How we are addressing training around management of vulnerable patients**

   Our Head of Tissue Viability, [redacted], and her team have led a range of improvements over the last year, including:

   - Introduction of a mandatory eLearning module for Pressure Ulcer Prevention – which notes the importance of repositioning patients and highlights immobility as a key risk factor for developing pressure ulcers. Most recent figures demonstrate 93% compliance with substantive staff mapped to the training.

   - They are using the national recognised framework "aSSKINg" to support pressure ulcer prevention processes and education – with the K being "keep moving". This is around mobility and supporting repositioning to aid prevention/management of pressure ulcers.

   - They now have a Tissue Viability Education and QI Co-ordinator whose key function is to drive the development of the learning frameworks and competencies around tissue viability; the first framework they are looking at is pressure ulcers. They have developed further resources to add to LEAP (learning platform) to support this plus a How to complete Waterlow (risk assessment) and eAssessment to support the above eLearning module.

   - Education project 2023-24 – which saw 1251 education contacts, pre (1161) and post (481) knowledge questionnaires and audits that saw approximately 500 patient records reviewed within inpatient settings across the project. Further QI projects (with 6 ward areas with higher pressure ulcer rates) were commenced on the back of the results.

   - [redacted] has been a key stakeholder in the group reviewing the quality metrics tools across both the acutes. This set of metrics is a monthly audit which looks at the quality of care delivered across 9 domains, one of which is pressure ulcer prevention. The results of the audit are reviewed monthly by the senior ward managers and matrons, they look for areas of concern, share ideas and learning and plan improvement programmes.

In addition to this, there is further planned work to:

   - Align the selection of pressure relieving equipment (PRE) guide across the organisation.

   - Review and alignment of care plan templates/documents across the inpatient settings, which will incorporate the aSSKINg framework as a basis.

   - further align the PRE across the inpatient areas; working with procurement, medical electronic/equipment library and other key stakeholders to ensure to appropriate options are procured. This includes standardising the standard foam mattresses, air mattresses, heel protection devices and cushions across settings with either awarded contracts or preferred products lists. In addition, industry supported equipment audits to be scheduled within the tissue viability and infection prevention & control services work programmes to appropriate equipment is available, clean and fit for purpose.

- There is work, as a national safety alert (cot sides and bed accessories), to review the use of lateral turning devices (integral to mattress or separate support device to aid lateral turning/repositioning. This will include what devices are available to ensure equity of access, risk assessment tools for their use and developing a Standard Operational Procedure (SOP) document.

- Following engagement with the Executive Team, Non-Executive Directors, Governors, senior leadership team and the Associate Directors of Patient Care (ADPC's), a clearer programme of Board and Service Group reporting is under development relating to this topic. This is to improve Ward to Board understanding of challenges, assurance and actions/learning at all levels, with co-ordination through the Pressure Ulcer Steering Group. In addition, there has been agreement to develop a reduction/improvement programme across key settings within the Trust.

3. Are we encouraging use of a positioning chart? The IR form is where we record position changes

The Head of Tissue Viability, and her team have been instrumental in helping to develop the new IR tool. The document reports the patient's position, frequency of required position change to promote skin integrity, and, if a patient declines, prompts the nursing staff to have a conversation with the patient around the benefits of position changes and the consequences of the adverse effects of pressure.

4. Engagement with families from all members of the MDT –

The ADPC is carrying out patient and relative engagement walk rounds across all of our wards, during visiting hours, this have been very positive and allows us to hear about areas of notable good practice and areas of concerns that need to be addressed. A plan has been put in place to carry out a 15 steps challenge on several wards across the trust. Night walk rounds are ongoing by the ADPC across both acute sites and have been well received by both staff and the wider MDT. The matrons are now working 20% clinical on our wards weekly supporting with training and education and supporting with the identification of our high-risk patients and are leading on ward rounds and safety huddles with the ward senior leadership team. We are due to launch a test of change on Coleridge ward with a 5 day a week supernumerary role, titled the Quality and Safety Nurse, with clear aims and objectives and job planning, this will follow QI methodology. The ADPC supports a daily review of all incidents reported and the matrons will also review and ensure that all measures and steps have been taken to mitigate any further risk of harm for our patients. All ward-based staff are encouraged to complete the pressure ulcer training on LEAP.

The organisation has a personalised care improvement group that is focussing on 'no decision about me without me'. This work is being led by [redacted], Director of Allied Health Professions, and will be based on good communication with patients and those that matter to them. The basis for this is understanding what matters to patients and family, carers and ensuring they are involved in decision making. We are currently identifying projects on wards to help deliver care in this way.

5. Lack of learning identified following the death of Mrs Gilbert

Within the Trust there has been a change in learning responses to patient safety incidents, since December 2023 due to the change from the Serious Incident Framework to Patient Safety Incident Response Framework (PSIRF). Previous methodology has

been changed, and we are continuing to develop robust learning responses, supported by new guidance and training. This change is being led by Head of Tissue Viability with support from Head of PSIRF implementation; current areas of test and change are happening across the Trust and learning from reviews will be shared within clinical areas and within service group governance and safety meetings, allowing for shared learning.

Two Matrons within the medical service group (there is also one allocated for surgery in their portfolio) are now topic leads for pressure ulcer management within the medical service group. Their purpose, aim and involvement are to influence, support, guide and cascade wider learning across the service group via monthly matron portfolio meetings, patient safety review committee meetings which are held monthly, and additionally shared learning is also discussed at our 4 weekly Service Group Governance committee meetings.

I hope that the above information has been helpful. Can I also take this opportunity to once again, express my condolences to the family for their loss of Mrs Gilbert.

Please do not hesitate to contact me if you require further information.

Your sincerely

[redacted]

[redacted]

Chief Executive Officer
Somerset NHS Foundation Trust