237/2014

Central Manchester University Hospitals NHS

NHS Foundation Trust

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Room 217
Medical Directors Office
Trust Headquarters
Manchester Royal Infirmary
Oxford Road
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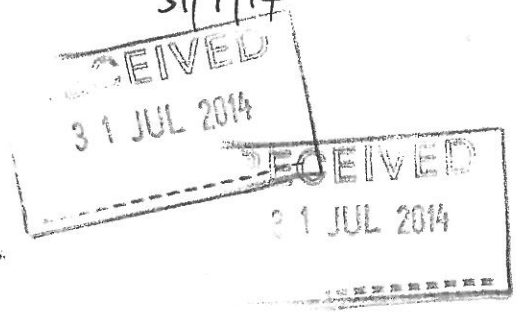
[redacted]



24 July 2014

Mr J S Pollard
Senior Coroner
HM Coroner Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

Dear Mr Pollard

Re: **Thomas Patrick MAHER (deceased)**

Thank you for your letters of 05 and 11 June 2014. I instructed the clinical team to review the case and have set out the answers to the points noted in the Regulation 28 notification below.

> *All the nursing notes, observation charts and pressure ulcer charts for the period 20 December 2013 to 29 January 2014 are missing and despite a widespread search by the hospital, it has proved impossible to locate them. This has had the effect of hampering the High Level Investigation and potentially the Inquest itself*

Trafford Hospital acknowledges that the loss of these nursing records is unacceptable. In order to minimise the risk of this issue arising again, a new process has been implemented by the Trafford Medical Records Manager that all records, including nursing charts, for any patient who has died and for any patient involved in a high level incident will be scanned into the electronic patient records (EPR) system as a priority.

In the future, the recording of observations will be electronic with the implementation of the Patientrack early warning score monitoring system. The implementation of this new system is planned to commence across Trafford Hospital from the end of October 2014. Once fully installed, observation charts will always be available electronically.

There is a longer term aim that all patient records, including nursing notes and charts, will be electronic across the whole of the Trust using a system called Chameleon. This will minimise the risks that documentation will be lost. The timeframe for this to be complete across the entire Trust is 2018. However, this is being developed and implemented in stages so it is likely that Trafford will be fully electronic before then.

On a number of occasions during his stay in the hospital, the falls risk assessment and bed rails risk assessment were not updated per policy

The Head of Nursing for Trafford has taken steps to address this issue and has established robust monitoring processes. Matrons undertake daily rounds of the ward areas and review the completion of all nursing documentation; this review focuses specifically on the completion of appropriate risk assessments and helps raise awareness with staff. Ward Managers also have responsibility for ongoing monitoring of compliance in their areas. In addition, the Out of Hours team review compliance with the completion and updating of risk assessments at night and at weekends with any non-compliance being addressed at the time with the individuals concerned and highlighted to the Ward Manager or Matron.

As a result of his perceived propensity to fall and to get out of bed, Mr Maher had a TAB alarm attached. It subsequently transpired that when he fell and broke his pelvis, this alarm had been removed and placed on his bed. If this were removed by a member of staff then this would indicate a potentially negligent act: if removed by the patient then surely the alarm should activate to show that this is no longer offering protection

Mr Maher was in a bay with a number of patients considered to be at risk of falling. To minimise the risk, a member of staff was present in the bay at all times. This member of staff was present in the bay when Mr Maher fell but unfortunately did not see him fall as she was with another patient at the time who was displaying challenging behaviour.

TAB alarms are useful only as part of the wider falls prevention strategy as they reduce rather than eliminate the risk of falling. TAB alarms are battery operated alarms which are clipped to the clothing and alert staff that a patient has started to mobilise independently when they are unsafe or unsteady to do so. It is not a feature of TAB alarms to activity if they are unclipped, only if they are pulled. They do not alarm to indicate that they are no longer offering protection. Mr Maher's TAB alarm had been removed and placed on his bed. There is no indication that the TAB alarm was removed by a member of staff. Mr Maher told staff on the ward that he had removed it himself as he did not want to bother the staff.

The hospital has recently increased the use of seat alarms for those patients who are not compliant with the use of TAB alarms. These have a sensor which alarms when the patient stands up and are considered to be more reliable than the TAB alarm system for this patient group.

On or around 03 February, a discussion took place between the treating doctor at Trafford and an Orthopaedic specialist at MRI, during which it was agreed that a bed was available at MRI and that Mr Maher would be transferred. The ambulance was ordered to transport him and Mr Maher was taken and placed in the vehicle. In fact it then transpired that there was no bed available so he had to be taken from the vehicle and returned to the ward at Trafford General. In the course of his evidence to me, the Consultant Physician stated "We have major problems getting patients transferred to MRI and other hospitals, we frequently have to wait 3 or 4 days for transfer of a patient who should have gone immediately". He then went on to state that in his opinion, the ability to transfer patients between Divisions of the same Trust should be "second to none" and in fact is less than adequate

[redacted] Orthopaedic Consultant, has explained that unfortunately there are no records kept at Manchester Royal Infirmary of the telephone discussion between [redacted] and the Orthopaedic team when the decision was taken to transfer Mr Maher, though these discussions are documented at Trafford by [redacted] in Mr Maher's records. [redacted] did not record the names of those he spoke to, but documented that at 15:55 hours on 03 February 2014, he discussed Mr Maher with the Orthopaedic Senior House Officer (SHO) on call at Manchester Royal Infirmary as the Orthopaedic Registrar was involved in a trauma call. The SHO advised [redacted] that he would discuss Mr Maher with his Registrar then get back to [redacted] with a management plan.

At 16:20 hours, [redacted] documents that he discussed Mr Maher again with the Orthopaedic SHO who had now discussed Mr Maher's images with the Registrar. The images demonstrated a fractured pelvis. The SHO on call agreed that Mr Maher should be discussed at the trauma meeting and should be transferred to MRI Orthopaedics. It was agreed that Mr Maher be transferred to the Emergency Surgery Treatment Unit (ESTU) at MRI. The Consultant on call was not involved in this decision and the Clinical Site Coordinators, who are responsible for the allocation of all emergency and elective beds across the Trust, were not contacted to confirm the availability of a bed on ESTU prior to the ambulance being arranged. It is later documented, at 19:15 hours by the Foundation Year 1 doctor that Mr Maher was not to be transferred to MRI due to there being no bed available.

It has been agreed that in future all transfers between sites will not be arranged without liaison with the Clinical Site Coordinators to ensure that this unacceptable situation does not arise again.

[redacted] has advised that the SHO who was on duty at Central Manchester that afternoon was a locum who has now left the Trust. [redacted] assumes that he discussed Mr Maher with [redacted] Deanery Trainee, who rotated to Stepping Hill Hospital 2 days later. [redacted] has therefore not spoken to either of the doctors concerned regarding this. Mr Maher was not discussed with [redacted] until the trauma handover meeting on Tuesday 04 February 2014. At this meeting, [redacted] made the decision that Mr Maher did not require transfer to Manchester Royal Infirmary. [redacted] was confident that Mr Maher did not need to be on an Orthopaedic ward because of the type of fracture. Mr Maher did not require surgery or any level of enhanced care for his fracture and therefore could be cared for appropriately at Trafford Hospital.

Trafford Division acknowledges that since implementation of the New Clinical Model in November 2013, there has been a period of significant change and time needed for the new transfer process to be embedded. A transfer policy has been in place since the New Clinical Model was established but adherence to this policy was variable in the early stages. Continuous efforts have been made to ensure that this is fully embedded in practice and we can offer assurance that since the start of this new system there have been 485 patient transfers between the two sites with no instances of patient harm reported as a result. Trafford Division is confident that staff are aware of the transfer policy and that this has been communicated to them. The Division is continually reviewing and making small adjustments to the transfer process in order to make improvements.

[redacted] has provided examples of a small number of other patients where problems had occurred with transfer. [redacted] Clinical Effectiveness Lead, has contacted the Consultants concerned to identify the patients and will investigate to see what lessons can be learned. The Consultants concerned have been reminded of the importance of escalating these concerns to the management team and reporting any incidents through the Trust's incident reporting system so that they can be investigated in a timely way.

On returning to the ward, the doctors prescribed intravenous Morphine but the nursing staff were not trained/confident in giving this so the prescription had to be altered to oral Morphine

The intravenous morphine was prescribed by a Foundation Year 1 doctor. IV Morphine would be drug of choice to relieve severe pain, even in elderly and frail patients like Mr Maher. However, very few ward-based nurses are trained to administer a bolus dose of Morphine intravenously. Nurses trained to administer Morphine are usually based in areas such as Recovery, Acute Medical units and Accident and Emergency departments. This has been discussed with the Foundation Year 1 doctor who now recognises that he should have administered this intravenously himself rather than amending the prescription to an oral dose.

Mr Maher received a combination of analgesia to manage his pain. Prior to his fall on 03 February 2014, Mr Maher was receiving regular doses of Paracetamol orally. Following the fall, the route of delivering Paracetamol was changed to intravenously as intravenous Paracetamol is known to be effective in controlling acute pain. Mr Maher also received 10mgs of Oxycontin orally that day. On 04 February 2014, Mr Maher was prescribed Oromorph, of which he could receive between 2.5mgs and 5mgs every 4-6 hours depending on his level of pain.

On 05 February 2014, [redacted] Elderly Care Consultant, read Mr Maher's notes and said that a complex discharge ward was not the appropriate place for Mr Maher to be and that he should be transferred to a Medical or Orthopaedic ward. Why was he on the inappropriate ward in the first place?

On 03 February 2014, [redacted] agreed with [redacted] view that Mr Maher should move to an Orthopaedic ward at Manchester Royal Infirmary as Mr Maher had a fractured pelvis. Mr Maher was not transferred on 03 February 2014, as previously explained, due to the unavailability of a bed. Mr Maher was discussed by the Trauma team at MRI on 04 February 2014. [redacted] made the decision that Mr Maher did not require transfer to Manchester Royal Infirmary as he was confident that Mr Maher did not need to be on an Orthopaedic ward as he did not require any level of specialised orthopaedic care for his fracture. Mr Maher needed bed rest, pain relief and pressure area care, all of which can be provided through good nursing care on any ward.

On 05 February 2014, a chest x-ray and blood test confirmed that Mr Maher had acquired pneumonia. He was commenced on intravenous antibiotics to treat this. [redacted] wrote in the case notes and communicated to senior nursing staff that Mr Maher needed to move to either an Orthopaedic ward or Medical ward with both his fracture and the fact that he had developed pneumonia. There was no bed available on Ward 4 on 05 February 2014 but at this time, Ward 16 was able to give Mr Maher the care and interventions needed.

Mr Maher was moved to Ward 4, which is an Acute Medical ward, on the evening of 06 February 2014, as his condition continued to deteriorate and a bed became available.

Ward 16 is a ward which specialises in complex discharge planning. The Trust would like to reassure the family that the level of medical and nursing input on Ward 16 is as good as on a Medical ward and Ward 16 is able to manage patients with complex problems.

After he sustained a fall in hospital, there was a delay of almost four hours before his next of kin was informed

Mr Maher fell at 12:50 hours. The Ward Manager, [redacted] returned to the ward and spoke to him at approximately 13:05 hours. Mr Maher had been returned to bed following the fall and had eaten lunch. At this stage, he appeared to be pain free and settled. The ward doctor had already been to assess Mr Maher but he had been eating at that point. The doctor returned to Mr Maher at approximately 13:30 hours to review him and identified at this point that he was experiencing pain in his hip. Prior to this the team did not feel Mr Maher had sustained an injury. At 15:30 hours, the fracture was confirmed. It is not documented what time the call was made to the family by a Staff Nurse (not the Ward Manager). The Staff Nurse unfortunately rang Mr Maher's home number rather than the next of kin. One of his family fortunately happened to be at the house and took the call.

It is usual practice to notify the family immediately of a fall occurring on the ward. It is not acceptable that the family were not informed for 4 hours. The Trust would like to apologise for this and to reassure the family that this has been addressed with the Ward Manager. The Ward Manager now recognises that a call should have been made directly after the fall to inform his family, rather than awaiting the outcome of the x-ray.

There is an apparent major problem with regard to patient notes where those at MRI are paper-based whereas those at Trafford are electronic. I was told that it will be at least 2 years before this situation is reconciled. This is inherently dangerous in that treating doctors may not have the up to date notes available to them. Both senior doctors who gave evidence to me described the system of transfer of notes between hospitals as "impossible"

Medical records at Trafford Hospital are electronic and are easily accessible to all medical staff at MRI on any computer. However, until February this year Ward 16, which is a ward based at Trafford but managed by Manchester Royal Infirmary, were still using paper documentation. This is why [redacted] was unable to access Mr Maher's records. Ward 16 is now using the EPR system in line with the rest of Trafford Hospital therefore, up to date case notes are now available to Clinicians at both sites with no further need for transfer of paper notes between sites.

The Trust acknowledges that the management of patient records is a significant risk. The risk is included on the Trust Risk Register and a Health Records Improvement Programme is underway to address the issues. As explained earlier, there is a longer term aim that all patient records, including nursing notes and charts, will be electronic across the whole of the Trust.

This will minimise the risks that documentation will be lost and will ensure more timely and efficient communication between the Trafford and Central sites in future. The Chameleon EPR system is currently being trialled in some areas of Manchester Royal Infirmary and will be rolled out across the Trust.

I do hope the above information answers your queries and gives you some reassurance that we are addressing the problems identified. Please do not hesitate to contact me should you require anything further.

Yours sincerely

[redacted]

Medical Director

cc: [redacted] Clinical Head of Division, Trafford Division
[redacted] Clinical Director of Orthopaedics
[redacted] Divisional Director, Trafford Division