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07 August 2014

Mr John S Pollard
Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

RECEIVED
15 AUG 2014

Dear Mr Pollard

Re: Audrey Garland (Deceased) Ref: JSP/KA/02556-2013

Thank you for your letter dated 17th June 2014. Please find our response below.

Matters of Concern

2. There was a failure by District Nursing service to fully appreciate and treat appropriately the necrotic ulcers from which Mrs Garland was suffering.

5. The District Nurses did not perform their duties correctly in a number of ways as conceded at the inquest by their Head of Service.

Introduction

As a result of an internal investigation into the care Mrs Garland received some areas of concern had been identified. Two focus group meetings took place with the team on 11th March 2014 and 17th April 2014 to discuss these areas of concern.

Following the inquest on 25th April 2014, the details of the findings and concerns raised by the Coroner were discussed with the District Nursing Team on the 30th April 2014. This meeting was attended by all of the team members who were involved in Mrs Garland's care. The outcome of the meetings and actions are detailed in an action plan monitored by the Head of Service. The action plan covers a number of specific themes:

- Leadership
- Record Keeping
- Communication with the GP practice
- Mental Capacity Act and Deprivation of Liberties
- Documentation specifically in relation to a record of risk assessments – MUST, Waterlow, Skin Integrity and Pain

- Communication with patient and carers.
- Non-compliance policy and escalation.

Taking action to address these themes will improve patient care, reduce harm and prevent future deaths.

Matters of concern

2. There was a failure by District Nursing service to fully appreciate and treat appropriately the necrotic ulcers from which Mrs Garland was suffering.

Clinical supervision has been strengthened, specifically in relation to the management of leg ulcers. Supervision – in the form of joint visits with a senior nurse is happening daily on a rotational basis with individual members of the team. This is to support the changes in practice required and to ensure good practice is embedded. Individual nurses are also having more focused support by a senior nurse in the management of wound care and how to manage wound infection.

Any ulcer that fails to improve or deteriorates and there is an issue of noncompliance is highlighted using the organisation's untoward incident system. Joint visits with other health care professionals such as the Specialist Tissue Viability Advisor and General Practitioners to review patients with deteriorating wounds are now embedded into practice within the team.

A training needs analysis for the team has taken place and clear individual plans to meet their learning needs are under development in line with the organisation's appraisal system. All members of the team will have a personal development plan to support their learning and development by the end of August 2014. A separate training needs analysis with a focus on diabetes care is currently underway as part of the development of diabetes skills across the whole of the community nursing workforce. Training will then be developed and plans put in place for the team to attend.

The team has an improved understanding of the referral processes to secure Tissue Viability Advisor support in relation to complex wound management. In line with best practice standards, the measurement of wounds and documenting progress or deterioration are now being monitored robustly by the team.

5. The District Nurses did not perform their duties correctly in a number of ways as conceded at the inquest by their Head of Service.

The following themes were identified as areas that needed addressing within the team to improve performance in the delivery of safe care for patients.

Improvements in leadership capabilities within team specifically with regard to problem solving

A new clinical lead was appointed to the team in June 2014. This role will focus on improvements in clinical standards and compliance with clinical supervision. The clinical lead has a clear action plan with priorities for delivery. The action plan was developed in early June in conjunction with the Clinical Improvement Team within the Division.

A daily face to face clinical handover of care is in place with high risk complex patients being identified and clinical discussions held in order that all members of the team are aware of the risks and the actions required to support good clinical care and improvement.

Record keeping – Documentation, and Risk Assessment

Record keeping audits are now undertaken quarterly within the team as part of a wider organisational requirement. There is an agreed single set of new clinical records which will be introduced into community settings in August 2014.

Performance management systems are now in place with individuals being called to account when their clinical practice fails to meet the required standard. This includes joint visits, reflective practice

and development plans. If performance does not improve there is an option to manage individuals under the management of performance policy within the organisation.

Improvements needed with regard to communication with the General Practitioner

A series of meetings are being held with the GP practice to improve communication. A meeting was held with Mrs Garland's GP on 8th May 2014, followed by regular review meetings with other key professionals within the practice during June and July to further develop relationships with the practice based team. A review meeting has been agreed with Mrs Garland's GP for 1st August 2014.

Implementation of the EMIS web electronic record system later in 2014 will further enhance effective communication as joint records will then be available to all staff working in primary and community care settings.

Team trained in Mental Capacity Act and Deprivation of Liberty

A training event was held on 18th June 2014 which focused on Mental Capacity Assessment and Deprivation of Liberty standards. All of the team attended to ensure they understand how to assess mental capacity in patients. The team has also been trained during clinical supervision in the use of the Trust non-compliance and escalation policy in order that every effort is made to ensure patients understand the choices available to them and the implications of non-compliance.

Improvements needed with regard to communication with families and carers

The team are aware following the series of reflective meetings of the need for effective communication with families and carers to ensure they are made aware of any risks associated with patient care and any actions being planned to support the patient. The team recognise following the lessons learnt as part of Mrs Garland's care that all communications with families and carers should be clearly documented in the nursing record.

Yours sincerely

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DIRECTOR OF NURSING AND QUALITY