Hinchingbrooke Health Care NHS
NHS Trust

Dr Samuel Bass
Assistant Coroner, South and West Cambridgeshire
The Coroner's Office
Lawrence Court
Princes Street
Huntingdon
PE29 3PA

By email to: [redacted]

29 October 2014

Dear Sir

Regulation 28 regarding Anne Elizabeth Sandever

I write in response to your letter of 03 September 2014, enclosing your Regulation 28 report to Prevent Future Deaths, following the Inquest into the death of Mrs Anne Sandever.

Coroner's Concerns

In relation to the four matters of concern listed in the Regulation 28 letter, I provide a response to each, below [adopting your numbering]:

1. **There was a lack of nursing care afforded to Mrs Sandever. She was not seen by any nurse or medical staff from 10.30 until 16.10 whilst on the ward.**

   Please see the full response to concern 4, below, which advises that we have conducted an investigation of these events, incorporating information gained via medical records and factual accounts and evidence given in your Inquest, including the family's account of events. Our investigation has confirmed that observation and engagement with Mrs Sandever between 10.30 and 15.00hrs on 4 February 2104 was limited, and this resulted in a failure to identify that IV fluids had run out and needed a timely response. Our review also recognised that a failure to respond to Mrs Sandever's daughter's request for a discussion with staff was a missed opportunity to become alerted to concerns.

   We have taken action as a result of this issue, developing and implementing a Trust-wide action plan to address the deficits highlighted in this case. In relation to this specific issue, actions have included the introduction of spot checks undertaken on wards, which include a review of the number of patient interactions, call bell response times and completion of required risk assessments, as well as the delivery of a specific training programme for all staff, in the recognition of a deteriorating patient, the importance of Modified Early Warning Scores (MEWS) and the importance of monitoring urine output as part of the MEWS system. This includes clear triggers and routes for escalation, including input from the Critical Care Outreach team.

   This training programme has commenced and is due to be completed by 31 March 2015. We will also conduct a Trust wide audit to ensure completion of the course, alongside a review of

incident data to identify any failure to treat incidents, as part of monitoring effectiveness of the training.

2. **Communication and handover was poor. No-one on the ward knew Mrs Sandever was diabetic or took appropriate care of her diabetic control**

Our internal investigation also identified that the handover from AAU to Walnut Ward did not ensure that all relevant staff who would assume responsibility for Mrs Sandever were made aware of her presence on the ward. In addition, the handover did not adequately cover the relevant medical history, including that Mrs Sandever had diabetes, nor did it explain the treatment plan to manage hydration.

The recommendations coming from our internal investigation on this issue were that the ward transfer policy and the SBAR chart [which documents the key information at transfer] should be reviewed and updated and that this update would specifically include a requirement to ensure and document that a face to face handover has occurred at the point of transfer from one clinical area to another. All patient transfers would also be risk assessed and any patients who have a MEWS score of ≥3 will be transferred by a nurse who knows the patient.

This work is already under way, with the revised policy implemented, and we have a target date of the end of December 2014 for all related actions to have been put in place. This will then be monitored for effectiveness via internal audit.

3. **She was left without intravenous fluids for many hours despite having renal failure**

Please see the response to concern 1 above, as the actions incorporate this issue. In addition, the investigating team recommended specific work around raising awareness of Acute Kidney Injury (AKI) in chronic renal patients. We have, therefore, re-circulated NICE guidance and a subsequent ALERT around AKI to all nursing and medical staff, through which we are raising awareness of the significance of a lack of urine output and fluid replacement in patients with Chronic Renal Failure in an acute episode. Minutes of Critical Care meetings have confirmed circulation and we will include AKIs in our review of incidents.

4. **There has been no SUI inquiry and the hospital has not investigated this sufficiently to ensure that this does not recur and has not taken the necessary steps to assure me of this.**

As mentioned above, following the Inquest the Trust instigated an investigation into the care provided to Mrs Sandever, to identify both positive practices and learning points for the Trust, to form part of our programme of continuous improvement.

In addition to the above issues, we identified a need for all agency nursing staff to be provided with a more robust induction pack, incorporating information about MEWS, escalation and the SBAR process.

We also identified a need to enforce and reiterate the Trust's, and the wider NHS', expectations in relation to documentation. Specifically, to emphasise the requirement of timed and dated entries, clear recording of the name and role of the person making the entries, and the use by medical staff of personalised stamps with their GMC numbers on. We also recommended that this should be followed up via a Trust wide documentation audit to identify hotspots and areas for targeted learning and enforcement.

Additional actions also include the need to highlight the importance of seeking and listening to relatives' views and concerns during episodes of care, and the need to apply good

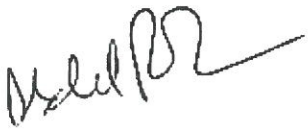
communication techniques in those interactions. Service excellence training has been developed and is available for staff but the Trust is also identifying a means of wider cascade. We will monitor communications issues via complaints received, and feedback specifically sought on communication.

The Trust's Serious Incident process is also being revised as part of a wider quality improvement programme.

Finally, we have presented this case, in an anonymised form, as part of the lessons learned section of a Clinical Governance Day, to make more staff aware of the issues identified and, especially, the core learning around safe handover and the recognition of, and response to, deteriorating patients.

I hope that the above information provides you with suitable assurance of the seriousness in which the findings of the Inquest are held. It is my great regret that Mrs Sandever and her family did not receive the high quality of care and communication to which we aspire and I fully recognise the additional distress this will have caused her family. I sincerely hope that the steps taken by the Trust in response, the work carried out to put actions in place to avoid a recurrence and the ongoing monitoring to assess the effectiveness of these actions goes some way to assuring you, and Mrs Sandever's family, of our recognition of the impact of the deficits in our care and communication and our commitment to improvement.

Yours faithfully



Hisham Abdel-Rahman
Chief Executive Officer/ Clinical Chairman
Hinchingbrooke Healthcare NHS Trust