Tameside Hospital NHS
NHS Foundation Trust

Chief Executive Office
Silver Springs
Tameside General Hospital
Ashton-Under-Lyne
OL6 9RW

Our Ref: [redacted]

Date: 19 December 2014

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

Dear Mr Pollard

Agnes Hannan (Deceased)

Thank you for your letter dated 27th October 2014 enclosing a Regulation 28 report following your investigation into the death of Agnes Mary Hannan.

I am sorry to note that the evidence raised a number of concerns. I hope that the responses below will provide you with reassurance of the steps that have been taken by the Trust to improve patient safety and minimise the risk of future deaths. Addressing your concerns individually (adopting your numbering):

1 **That there was an actual, or perceived, lack of availability of the hospital notes and records of previous diagnoses and treatments by hospital doctors, for the staff working in the Emergency Department.**

Response

The computer system for medical records which was in place at the time of Mrs Hannan's attendances at the Accident & Emergency Department has since been replaced by a new system. Staff working in Accident & Emergency are able to access extensive details of patients' medical records including correspondence, previous in and out-patient attendances including attendances in Accident & Emergency.

The physical records of all patients seen in the Accident & Emergency Department are held within the department for ease of access for a period of five weeks following a patient's attendance so that they are easily accessible for staff attending on patients who might return to the department within that period. After five weeks the notes are scanned on to the computer system. In order to minimise delay in those notes being accessible on the system the Trust is purchasing a scanner specifically for the Accident & Emergency Department and

once in place staff training will be arranged to ensure that the scanning and uploading process is carried out efficiently.

2 **On one occasion whilst she was an in-patient, Mrs Hannan who was desperately ill and needing intravenous hydration, was found to be lying in a soaking wet bed because the tube leading to her cannula had become dislodged and disconnected. The nursing staff had failed to notice this problem. The doctors in evidence, acknowledged that her lack of hydration would inevitably have worsened her already thrombosed veins.**

Response

The Trust's nursing staff are trained to carefully insert and tape cannulas to the skin to minimise the risk of them becoming loose, disconnected or falling out. Unfortunately, despite taping them down cannulas do, on occasions, become loose, for example, if patients inadvertently dislodge them. If a cannula becomes dislodged patients may alert nursing staff so that it can be re-secured to prevent the loss of fluid. We appreciate that on occasions patients are not aware or are not well enough to alert nursing staff themselves. If that occurs our staff should become aware that there is a detached cannula and/or loss of fluid on next attending at the patient's bedside.

Whilst the risk of cannulas detaching cannot unfortunately be completely avoided we have taken steps to minimise that risk by training our nursing staff to carefully insert and tape cannulas and to be observant and check for problems when attending on patients.

3 **There was extremely poor communication between hospital staff and the patient (and her family), and between and amongst themselves. There was evidence of a lack of handover between staff, and this was exacerbated by the fact that the medical and nursing notes were frequently inadequate.**

Response

The Trust promotes safe handover of patient care by providing protected time, to enable handover of all relevant patient information, both at the beginning and end of shifts. The Trust is currently undertaking a review of its current training on record keeping standards which will include an emphasis on the importance of good communication between staff and the importance of careful handover.

4 **Whilst it was, or should have been apparent that she was under the long-term care of [redacted], no-one made any attempt to speak with him or his department for advice.**

Response

The Trust's medical staff treating Mrs Hannan had access to details of her previous medical history including her care under [redacted] and therefore should have been aware of [redacted] previous involvement in her treatment. The records available to the clinical staff did provide the means by which they could obtain information about it and contact [redacted] or other members of his department whenever they needed to. Professional staff have been reminded of the importance of both reviewing the patient's notes (either the physical notes or electronically on the Lorenzo system) and communicating with the previous relevant

consultant and / or their department if advice is required in order to ensure the patient receives appropriate treatment.

5 **Throughout the hospital notes for this patient, there is widespread use of initials and abbreviations. On at least one occasion in court, none of the medical / nursing staff present could explain to me what the abbreviation in the notes meant.**

Response
As mentioned above the Trust is undertaking a review of its current training on record keeping standards. The training will reinforce the need for clarity and the importance of avoiding the use of unclear abbreviations.

6 **This patient needed very careful monitoring at all times and yet there was a period of 24 hours when no nursing observations were carried out or recorded.**

Response
At the time of Mrs Hannan's treatment the Trust used a PARS scoring system for recording nursing observations. That system is designed to track observations, determine the regularity of them and trigger escalation of care whenever required. Instructions for use of the PARS score system was provided to nurses through training and also by clear explanatory notes within each individual nursing observation chart. The insufficient observations in this case arise from failure to adhere to the Trust's PARS system.

Since Mrs Hannan's treatment the PARS scoring system has been replaced by a different system called the NEWS system and all of the Trust's staff have been trained in the use of it. A quick reference NEWS escalation and response guide has also been made available to all staff. The NEWS system is more sensitive than most other existing systems and it provides an enhanced level of surveillance and clinical review of patients with greater specificity in identifying those at risk of clinical deterioration.

7 **The communication of medical / nursing diagnoses and decisions to the family, was extremely poor and frequently did not happen. An example of this was the failure by the staff to explain the critical nature of Mrs Hannan's condition, so that the grandson of the deceased failed to be able to come and see his grandmother in hospital before she died.**

Response
The Trust is striving to improve communication between staff and family members. The Trust has created a bedside booklet available for patients and relatives – "Patient Safety – Keeping you safe during your stay in hospital". This includes a section on recognising acute illness and how this is monitored and empowers patients and their families to ask questions. Professional staff have been reminded of their duties to communicate proactively and effectively.

8 **I was told that there is no CT scanner facility available for the use of the ED out of normal hours. This meant that a scan was delayed / missed and led to a delay in diagnosis of her underlying condition.**

Response

This is incorrect; there was in September 2013, as there still is, a CT scanner available for the use of the Emergency Department, both in and out of normal hours, so that could not cause a scan to be delayed or missed or lead to a delay in diagnosis. Please be reassured that the arrangement for this service pre-dates 2002. There was also the facility to report the images acquired using our outsourced reporting company Radiology Reporting Online. I can only apologise that this was not clearly conveyed during the Trust witnesses' evidence.

9 **I was told in evidence that it takes up to three months for the paper records of the ED to be scanned electronically. This means that recent notes may not be available on the computer screens for the staff in the ED.**

Response

A new scanner has been purchased specifically for the Accident and Emergency department to minimise any delay in records being accessible on the computer system. That will avoid any delay in records being uploaded on to the system. Staff training has already been scheduled to ensure that the scanning and uploading process is carried out efficiently.

10 **When a patient is admitted there is little or no logic as to determining which Consultant shall be in charge. In this case she was allocated under the care of [redacted] who was not even in the hospital for the first two days of her admission and in fact who never actually saw the patient.**

Response

I apologise for any confusion at inquest and if the patient's family were not informed of the arrangements in place for the medical care of Mrs Hannan. I understand that [redacted] was in the hospital when Mrs Hannan was transferred from MAU to Ward 31, Adult Medicine. At the time, [redacted] was on-call for emergencies and was with other patients in another department. [redacted] who is [redacted] Registrar was asked to undertake a clinical examination of Mrs Hannan and as supervising consultant, [redacted] provided advice over the telephone. Please be assured that whilst on the ward, Mrs Hannan was seen on a daily basis by other well qualified doctors. The concerns regarding the direct contact of consultants will be fed back to all division.

11 **The End-of-Life Care Pathway must be initiated only after full and meaningful discussion with the patient and / or her family. In the present case there was no evidence to show that any such discussion had taken place.**

Response

The Trust's DNACPR policy has been reviewed since Mrs Hannan was treated at the Trust and in accordance with *R (on the application of [redacted]) v Cambridge University Hospitals NHS Foundation Trust*. The new policy emphasizes the importance of discussion with patients / their family. Also, a DVD has been created and is available on the Trust's intranet. This was also promoted through screensavers to inform staff of the new policy and emphasize its importance.

The current Trust policy dealing with decisions relating to DNACPR, which was updated in November 2014, stresses the importance of clear, accurate and honest communication with the patient and those close to the patient (unless the patient has requested confidentiality) including provision of information and checking their understanding of what has been explained.

I do hope that I have addressed your concerns and that I have reassured you that the steps taken by the Trust will prevent the recurrence of a similar set of circumstances as those in the case of Mrs Hannan.

Should you have any further questions arising from the contents of this letter please do not hesitate to contact me. I am again sorry that your investigation into this death caused you such significant concern to issue a Regulation 28 Report but I hope that you are now reassured.

Yours sincerely

[redacted]

Karen James
Chief Executive