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Your Ref: JSP/KN/00585-2015
Our Ref: SA/TJB-Ellams-7229761

17th September 2015

Mr J S Pollard
H M Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Pollard

Re: Amanda Jane Ellams (Deceased)

I am writing in response to your Regulation 28 Report of 7th August 2015 2015, following the Inquest of Amanda Jane Ellams.

You have asked The Alexandra Hospital for a response to the matters of concern raised within the report and to detail the actions and proposed actions to be taken by the Hospital, along with the timetable for these actions. Please see our responses below.

Concern 1

During the course of the inquest it was apparent that the standard of note keeping at the Alexandra Hospital (both medical and nursing) was well below that which would be generally regarded as satisfactory. There was even one attendance on the patient by the consultant surgeon in February (according to the surgeon's evidence to me) for which there was no written record whatsoever. The surgeon conceded that he did not have a full medical history available to him pre-operatively and he was not aware of all the prescribed drugs which she was taking, (BMI Healthcare)

The patient record has been reviewed and this issue has been discussed directly with the consultant surgeon and the nurse involved in the care of the patient. Whilst the majority of the notes entered within the patient record are satisfactory, it is clear there were a number of entries or omissions that were not of the standard expected.

The hospital expects and works to uphold, the highest standards of record keeping. At the time of this response, hospital-wide completion of training on documentation and legal aspects for patient records was 95%. Further documentation training has been scheduled to be delivered by the Royal College of Nursing and we continue to work with all staff and consultants to maintain and improve the standard of record keeping.

The consultant surgeon agrees that his hand written notes on occasion were very brief. As he explained at the hearing, these were personal notes, which act as reminders when writing dictated letters, which contained more detailed information. The consultant surgeon will, in the future, ensure that he writes such information and clinical findings in more detail in order to better comply with the guidelines of the Royal College of Surgeons.

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The consultant surgeon accepts that one post-operative visit to the patient was not documented. He recalls that the patient was not on the ward when he visited but he met her outside the building and walked her back to her room and consequently he omitted to write this interaction in the notes. The consultant has reflected on events and has confirmed that he will work to ensure that each visit to a patient is recorded in the patient record.

The consultant surgeon fully appreciates the importance of understanding details of past medical history and medications. However, the consultant surgeon has advised that no such information was provided by the patient's GP, (who would have provided details of the patient's past medical history on referral) and neither Mrs Ellams nor her husband provided such information when asked in the clinic. The consultant does however accept that more could be done to elicit past medical history when discussing treatment with patients and he will work to ensure that additional enquiry of the patient history is made.

We have taken the following actions:

1. From June 2015 a new documentation standards audit has been established. The audit is completed by nursing staff and any variances, omissions or errors are recorded and the results shared through a peer review to ensure learning is shared and improvements made, where identified.

2. The company lead for care pathway development has been asked to attend the hospital to deliver education sessions on the completion of patient care pathways to all clinical staff. The delivery of this training is expected to be complete by the end of October 2015.

3. The Royal College of Nursing have been invited to attend the hospital to deliver presentations to nursing staff on the importance of documentation standards. This training is expected to be complete by December 2015.

Concern 2

The Alexandra Hospital Staff Nurse conceded that Mrs Ellams was discharged from hospital even though it is now clear that her oxygen saturations were still too low for such discharge to take place. There was what appeared to be a very lax attitude to recording and monitoring the Blood/Oxygen levels and the patient was allowed to disconnect her oxygen supply and walk out of the ward to go for a cigarette. (BMI Healthcare)

The consultant confirmed during the hearing that the patient's oxygen saturation readings of 90-92% would generally be adequate in view of her cigarette smoking and the recorded oxygen saturation level was 89% on the morning of discharge when the nurse decided to commence oxygen. It is unsatisfactory that information regarding the patient's oxygen saturation level prior to discharge was not recorded. The consultant and the nurse accept that all actions and decisions taken must be clearly documented in the patient record.

The nurse has reflected on her note keeping on that day, and admits that she should have documented Mrs Ellams' observations while off oxygen, before discharge. It should be appreciated that there are difficulties in attempting to stop patients who wish to smoke outside of the hospital premises, especially on the day they are due to be discharged. As discussed at the hearing, the nurse made a clinical assessment of the patient's condition due to the patient frequently removing the oxygen to leave the ward to smoke a cigarette, and walking up and down the hospital corridor and stairs with no signs of shortness of breath at the time. Having reflected on events, the nurse now always ensures that all observations are recorded in the patient notes.

We have taken the following actions:

1. During September 2015 all relevant nursing staff will be notified that nursing notes should always include a record of observations taken after patients have been taken off oxygen.

2. Following the hearing, the nurse involved was reminded of her responsibility for accurate record keeping and has reflected upon events and clearly recognises that judgements in relation to the clinical presentation of a patient must be documented in the patient record.

We have taken the matters of concern identified in your report extremely seriously and I would like to assure you that the actions identified above are ongoing and will be continually monitored.

I trust the responses given above have addressed your concerns and may I take this opportunity to again express the Hospital's sincere condolences to Mrs Ellams' family.

Yours sincerely

S. AGNEW

Sarah Agnew
Acting Executive Director