Stockport NHS
NHS Foundation Trust

Our ref. AB/CM/PR-letter to HM Coroner-FWeston
Your ref. JSP/ER/01161-2015

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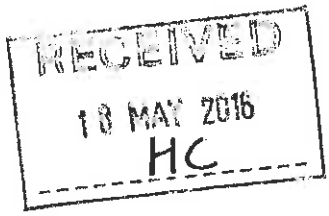

17th May 2016

Dear Mr Pollard,

Re: Freda WESTON (Deceased)

Thank you for your letter, of 2nd March 2016, concerning the inquest of the above named patient. As always, I am grateful to you for highlighting your concerns on the Regulation 28 'Report to prevent future deaths' and for providing me with an opportunity to respond.

Your concerns are as follows:

1. Mrs Weston was discharged from hospital after being started on Septrin, without allowing sufficient time to ensure that the new drug 'suited' her.

Septrin treatment was advised by our Microbiology Department (Dr M. Taylor) on 15 April 2015; this was because the patient failed to tolerate oral Doxycycline. There is clear documentation in the notes from [redacted] the Foundation Year 2 doctor, of this discussion. This stated that Microbiology had advised there was a known risk of pancytopaenia with Septrin treatment and that ideally the patient should have her bloods checked monthly by the General Practitioner, providing the patient agreed to this. Mrs Weston was informed of the risk and agreed to go ahead with the Septrin treatment.

We have used Septrin routinely in this Trust for step-down oral treatment for many intra-abdominal infections for about 5 years and this is the first time we have had a serious incident associated with its usage. The Antibiotic Management Team (microbiologists and antibiotic pharmacists) have discussed the future of Septrin usage and they do not feel it appropriate to change our current practice, as the alternatives would be more risky in terms of C.difficile and antibiotic resistance. We have not had a C.difficile infection associated with Septrin use, but we have had several associated with Co-amoxiclav and Ciprofloxacin, which would be the alternatives.

The Surgical and Critical Care Team do not feel that a period of observation in hospital after starting Septrin would be beneficial, as the most serious adverse events that can occur while taking Septrin are more likely to occur after being on Septrin for a more prolonged period. The advice recommended by the various manufacturers of Septrin is to monitor the patient's blood results monthly, therefore the Trust will continue to abide by this recommendation. Notwithstanding this, Mrs Weston remained on the ward for a further week, prior to her discharge on 22 April 2015 and was well at the time of discharge.

2. Mrs Weston was advised for Teicoplanin on 8 April 2015 at 17:10 hours, yet she had not been given the first dose until 15:56 hours on 9 April 2015.

On 8th April our Microbiology department contacted the Trauma and Orthopaedic registrar to advise that the aspirate taken from the knee was growing an organism, although they were unclear as to what the organism was. They therefore recommended to the registrar that the patient be given intravenous Teicoplanin (as they normally would for an infected joint).

The antibiotic management of infected joint replacements is very different from the management of acute bone and joint infections. Antibiotic treatment will not 'cure' an infected prosthesis; the usual definitive treatment is revision surgery and antibiotic treatment is not commenced until an organism is clearly identified and first stage revision surgery has been carried out. Antibiotics will usually only suppress infection to help patients' symptoms if revision surgery is not being considered and these are usually given orally. Our records show that Mrs Weston therefore did not, in fact, receive any Teicoplanin during this admission. Mrs Weston had her knee washed out on 11 April 2015 and was commenced on oral Doxycycline, on microbiology advice, following this.

3. There was a 48 hour delay in Mrs Weston being given any antibiotics.

In Mrs Weston's case she was clinically well, showing no signs of generalised sepsis and therefore giving intravenous antibiotics would have had no clear benefit for her at that time. [redacted] had already ruled out the option of revision surgery and therefore the Trauma and Orthopaedic registrar made the decision to withhold intravenous antibiotic treatment until a definitive long term plan had been discussed with [redacted] the outcome of which was likely to involve a joint washout to reduce the microbial load followed by long term oral antibiotics [redacted] Consultant Orthopaedic Surgeon, confirmed this plan with [redacted] the following day and clearly documented that IV antibiotics were not indicated, as the plan was for washout followed by long term infection suppression with oral antibiotics and that IV antibiotics would only be indicated if Mrs Weston became clinically unwell.

4) **The junior doctor gave evidence that she was unable to "get around to seeing" this patient as there was insufficient doctor-time to do so on that shift. The doctor went on to say "this is not an uncommon situation". The hospital as a whole was being covered by one FY1 doctor and two SHOs, one of whom was 'clerking in' the new patients. This meant that the FY1 was covering 13 wards of the hospital. Clearly an impossible task**

There is no on-call national guidance with regards to staffing numbers and broadly the total number of on-call doctors in Stepping Hill Hospital is the same for most district general hospitals of a similar size. Out of hours on-call work is primarily for urgent reviews and emergencies.

When the junior medical staff are working in the hospital out of hours they are supported by the iBleep co-ordinators to prioritise patients to be seen in order of need. Should a FY1 or FY2 working out of hours in the hospital be concerned about their ability to see the patients as needed, there is a Medical Registrar also present in the hospital. The Medical Registrar is usually based in the acute wards but can be called upon to see patients in other wards as needed. There is also a Medical Consultant on call who can be called upon to attend the hospital. In this instance, as the patient safety investigation identified, the deterioration of the

patient was not recognised by the nursing staff so the need for a doctor to see this patient was not escalated.

5) In general terms the matron reporting the Root Cause Analysis agreed that on a scale of one to ten, where one is appalling and ten is excellent, "this case was very low down the scale indeed".

We have investigated this case in detail and would agree that care was not as it should have been for this patient. I am confident that the investigation identified lessons learned and that the actions will be completed to reduce the likelihood of an incident such as this occurring again. I can confirm that all appropriate human resources processes have been followed for the staff involved.

6) The "Escalation guidelines for the iBleep system" were either unknown to the staff or were not adhered to.

Please see enclosed the current standard operating procedure for the Escalation of iBleep jobs which is to be used by the iBleep Co-ordinator. This guides the staff monitoring the iBleep system to escalate to senior staff as and when required.

This is going to be updated, and taken through the Trust's approval process to include information regarding what escalation should be done for staff who put 'calls' onto iBleep. It will include that the professional judgement of the registered nurse should be used at all times and staff should escalate more frequently as and when required.

7) There was an acknowledged shortage of nurses at the time.

The nursing staffing levels regarding this incident show no evidence of 'red flag' staff events, which would be triggered if staffing was 25% or lower than establishment.

I can confirm that in April 2015 ward E2 had 2.8 whole time equivalent (WTE) registered nursing (RN) vacancies and 1.8 WTE Band 2 Health Care Assistant vacancies.

Nursing staff levels has been a concern, particular within the Medicine Business Group over the last 18 months. I can confirm that we are actively recruiting to nursing posts within the Trust. We are also proactively recruiting European and International nurses as part of our 5 year plan.

We currently have 50 whole time equivalent (WTE) vacancies within the Medicine Business Group compared to over 70 WTE 12 months ago.

We have cohorts of European registered nurses starting every quarter with the next cohort of 35 due into post next month. More than 20 of these are planned to start in Medicine on 23 May 2016.

8) The pharmacy staff did not give precise details of the drug which they were dispensing and the potential side effects thereof.

Patients who are discharged with their medicines supplied in a monitored dosage system will have a Patient Information Leaflet supplied with the dosage system for each medicine

supplied and in addition will include a generic medicine patient information leaflet that details a website for accessing information and advice about drugs.

9) **The handover sheets on the ward are "shredded by the nurses" immediately after handover. Why cannot these be kept in a folder on the ward for at least 14 days should they be needed for reference purposes? I was told of the transition from paper to electronic notes. This seems to have been happening for a very long time and one wonders when it will be complete.**

I can confirm that all wards in the Medicine Business Group have access to an electronic handover. Staff print these for each shift so they can be viewed as they move around the wards. The handover sheets are shredded at the end of each shift to make sure information is not taken home by staff, which would compromise patient confidentiality and make sure that incorrect information is not used on the ward. The information, per patient, can be accessed electronically retrospectively.

I hope that this response answers your concerns and provides you with the assurance that the Trust is committed to improving the quality of care we give to all our patients. Please do not hesitate to contact me if you have any further questions regarding this matter.

Yours sincerely,

Ann Barnes
Chief Executive