Medway NHS
NHS Foundation Trust

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18 April 2016

Strictly Private & Confidential
Ms Patricia Harding
Senior HM Coroner Mid Kent & Medway
Kent Register Office
The Archbishop's Palace
Mill Street
MAIDSTONE
Kent ME15 6YE

Dear Ms Harding

Regulation 28: Report to Prevent Future Deaths: Alwyn Ann Head ("the Report")

I refer to your Report issued following the inquest pertaining to Alwyn Head and reporting the circumstances of the death to me, pursuant to Regulation 28 of the Coroners (Investigations) Regulations 2013.

The Trust has sent a letter of apology to Mrs Head's family and has offered to meet with them to discuss the circumstances of her death, and the actions taken by the Trust as part of our coronial investigation process.

A full investigation was carried out following Mrs Head's death and a copy of the actions from that investigation are provided to you within this response (Appendix 1).

I can confirm that lessons have been learnt and the Trust has changed its practice to minimise the chance of any other family having the same experience.

I will address the specific issues that you identified in your Report of 23 March 2016, as follows:

1 That Mrs Head had a history of MRSA that was not established prior to surgery despite opportunities in 3 different hospital departments to obtain this information from Mrs Head or her family.

We acknowledge that although Mrs Head had a history of MRSA this was not established prior to the surgical procedure. We have therefore introduced a series of measures to reduce the risk of this situation re-occurring, which are:

- New admission/transfer assessment documentation of patient infection status was introduced in April 2016.
- Staff are made aware of the new documentation on the twice monthly level 3 infection control update sessions.
- As part of their daily routine patient reviews the infection control team are checking the new documentation has been completed and provide the nursing staff with feedback at the time.

- The outcome of the patient reviews are reported monthly and areas of poor compliance will receive additional support from the infection control team.
- The new documentation will be incorporated into a new nursing patient assessment / care planning document which is due to be implemented in July 2016.

2 Prophylactic Teicoplanin was not provided pre or post operatively even though the results of the MRSA Screen would not have been available at the time of the surgery (MRSA –ve written on pre-op form erroneously)

We have recognised the importance of ensuring that MRSA status is checked and appropriate antibiotic regime applied. The orthopaedic antimicrobial guidelines have been updated to provide more clarity over the prophylaxis for patients with unknown MRSA status.

The surgical safety checklist is being amended to ensure MRSA status and MRSA History is verified by two staff and with the patient pre operatively in the Anaesthetic Room before induction and again with the whole theatre team at 'sign in'.

3. A post-operative wound care plan was not instituted contrary to NICE guidelines and
4. There was no evidence of the surgical wound having been inspected by nursing staff or doctors between 13th August and 25th August 2015 and
5. Entries in the nursing notes relating to dressing and wound were meaningless and would not assist a determination of whether there was deterioration in the wound.

We are updating our tissue viability policy and associated standard operating procedures (SOPs) to include NICE guidance and standards for post-operative surgical wound management.

Wound care documentation, care plans and wound assessment standards have all been reviewed. The wound care documentation will be incorporated into the new nursing assessment / care planning document in July 2016.

The documentation and standards will be presented to the Trust Patient Safety Group and the Nursing & Midwifery Quality Forum. Directorate representatives will be responsible for cascading the information through their Directorate.

Compliance with the policies and SOPs will be monitored as part of our established assurance audits. Results of audits are presented at Patient Safety Group which has responsibility for monitoring compliance in this area and the Nursing & Midwifery Quality Forum. .

In addition, the recognition and management of Sepsis and the Deteriorating Patient are key priorities for the Trust. A programme of work has commenced which aims to improve patient safety, outcomes and reduce the incidence of deterioration and sepsis, through early recognition and timely response.

Summary of actions:

- Ward to Board rounds to assess and monitor patients' conditions more regularly
- Deteriorating Patient Programme commenced in January 2016 which includes three key work streams - 1. Recognise 2. Respond, 3. Data Quality
- A multi-disciplinary Sepsis Action group is in place which monitors performance against the Sepsis six bundle, the National CQUIN performance and sepsis mortality.
- The Trust has provided feedback to the NICE consultation on the proposed new Sepsis Guidance (due to be published in July 2016).

- Trust representation at the Sepsis Nurse Forum.
- Monthly auditing against the Sepsis bundle
- A robust Education and Training programme in place
- Learning events have commenced across the Trust

The Standardised Mortality Ratio for patients with a primary diagnosis of Septicaemia is currently the lowest it has been in the last two year period. This reflects the work undertaken currently.

The learning from our investigation into Mrs Head's death has been shared with the specific ward and also Trust wide.

I hope you will agree that the learning points have been acted upon, and the actions developed following Mrs Head's death continue to be actively and robustly implemented and reviewed. Although we know that we will never eliminate risk completely, the action plan will continue to be addressed and monitored via the Trust's Governance processes to ensure that we reduce our risks to the lowest level possible.

We apologise unreservedly to Mrs Head's family for any distress and anxiety caused by us.

Yours sincerely

Lesley Dwyer
Chief Executive

Encl: Appendix 1: Action Plan