Plymouth Hospitals NHS
NHS Trust

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PRIVATE & CONFIDENTIAL
Mr A J Cox
Assistant Coroner
Her Majesty's Coroner for the County of Devon
Plymouth, Torbay and South Devon
1 Derriford Park
Derriford Business Park
Plymouth PL6 5QZ

Dear Mr Cox

Re: Harry GLIBBERY

Thank you for your letter of 16th August 2016 outlining a Regulation 28 notice in relation to the aforementioned patient.

You have identified a number of points in your letter which I will respond to in order.

1. The doctor who originally prescribed the Clexane did not do so in accordance with Derriford protocol.

   We have reviewed the records and can identify that the original prescription of Clexane was in the form of prophylactic treatment at 40 milligrams once a day, and this dose was continued for some months from the patient's admission in January until he developed a pulmonary embolism in March 2016.

   At this point he was commenced on a therapeutic dose of Clexane at 80 milligrams twice daily (160 milligrams total in the day). This is at variance with the Trust's protocol of 120 milligrams once a day, which is I would point out dependant on weight. This dose was continued, but on review it would appear that on 21st March the patient's weight had reduced from 83 kilograms to 75 kilograms and at this time it would have been appropriate to have reduced the dose to 100 milligrams once a day. The dose was therefore higher than expected but still at the extreme of therapeutic dosage.

There are currently three protocols for the use of "therapeutic" Clexane (i.e. not prophylactic use) – DVT / PE protocol; "Bridging therapy" protocol for patients that are routinely prescribed warfarin prior to admission; protocol for the management of Acute Coronary Syndrome.
In response to this incident, these protocols will be reviewed by the Thrombosis Committee and clear guidance disseminated across the Trust.

Furthermore, the Trust will be investing in the implementation of an electronic prescribing and medicines administration (ePMA) system during 2017. This system will include the use of "order sets" linked to diagnosis, which will ensure that the correct protocol is chosen. For weight specific dosing the patient's weight will have to be entered in to the system and the dose will be automatically calculated. It will be possible for this functionality to be time limited, such that a new weight would have to be entered at a defined point in time (e.g. every 7 days) and a new dose calculated.

2. The doctor's prescription error was not identified during pharmacy reviews intended to pick up precisely this sort of shortcoming.

   Your assertion is correct. We have reviewed the pharmacist that checked this - there were at least two pharmacists and we believe that the secondary pharmacist had accepted that the primary review had confirmed that the dose of Clexane was correct. There is no record of whether the initial pharmacist had challenged / confirmed the dose of Clexane being at variance with the DVT / PE protocol.

   In response to this incident we have developed a learning package which is being delivered by the Deputy Senior Pharmacist to all pharmacists within the department emphasising the following points:

   I. Correct dose of 120 milligrams BD.
   II. The fact this this is weight dependant. Difficulties in weighing patients following operations which could result in a failure to appreciate a significant loss of weight which would modify medication dosage.

   In addition, steps are being taken to ensure that the pharmacists make appropriate records in the medical notes when challenging / confirming treatments. In the future, this will be required to be input into the ePMA system.

   All patients are screened on admission using the MUST assessment tool to identify patients who are malnourished, or at risk of becoming malnourished.

   All patients are then weighed weekly during their hospital admission, and this is recorded on the MUST Risk Assessment document. The weights are currently updated not on the Drug Chart but on the Observation Chart and at the time of the ward rounds when patients information, clinical circumstances are discussed between medical and nursing staff, any significant changes in weight are discussed and any modifications made as a secondary step to the pharmacist updating the Drug Chart.

   As highlighted above, with the implementation of ePMA (2017) it will be possible to set time limits for weight dependant drugs, so that a new weight has to be recorded at pre-defined points in time. This will ensure the doses of drugs are always matched to an accurate and up to date weight.

   In relation to weighing patients who have had operations, this can be difficult particularly with hip operations because of the risk of damaging the hip with a hoist system and secondly that the hoist with the weighing scales in place does not clear the beds. We have discussed this with the nursing staff and identified the importance of these weight

measurements being taken, even if there are considerable technical issues. We will monitor this with the Senior Nurses. This does represent significant challenges, both as a result of the patient's condition and the various mechanisms which are common to patients in this particular.

With regards.

Yours sincerely

[redacted]
Medical Director