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NHS Foundation Trust

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Mr Alan Walsh
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Howell Croft North
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26th October 2017

Dear Mr Walsh

Regulation 28 Response: Patricia Forshaw (Deceased)

Thank you for your Regulation 28 report dated 8th September 2017.

I understand that an inquest relating to the death of Patricia Forshaw took place on 21st August 2017. I have been fully advised of the circumstances relating to Mrs Forshaw's death and have read your report. I am grateful to you for bringing these concerns to my attention.

I would like to take this opportunity to respond to the issues raised in your report and to advise you of the actions already undertaken by Wrightington, Wigan and Leigh NHS Foundation Trust ("the Trust") and the ongoing action in respect of this matter.

I am aware that you have the following concerns regarding the care provided to Mrs Forshaw:

1. The telephone number on the card given to the Deceased when she was discharged from hospital related to appointments only but the purpose of the number is ambiguous and when the Deceased's husband telephoned the number on the card in the early hours of 20th October 2016 he believed he was speaking to the Emergency Department, particularly in view of the fact that he was given advice to give paracetamol to the Deceased.

2. The telephone call from the Deceased's husband to the hospital in the early hours of 20th October 2016 and the advice to give paracetamol was not recorded in any hospital records.

   Furthermore, the consultation with the Nurse who removed the dressing and who was aware of the Deceased requiring a blanket because she was cold and also aware of the offensive smelling discharge from the wound, did not record that information in the notes and did not

bring the information to the attention of the doctor at the time of his consultation with the Deceased.

3. [redacted] accepted that, having heard the evidence of the family at the Inquest, routine observations (pulse, blood pressure, respiratory rate, temperature) and blood investigations should have been conducted when the Deceased presented to the Out Patient appointment on 21st October 2016. [redacted] gave evidence that there has been some discussion between Consultants in the emergency department and there was mention that there should be a policy for checking routine observations in patients attending Clinic for wound review, particularly where there was an indication of infection. However [redacted] confirmed that there was no formal policy in place.

4. The evidence heard at Inquest confirmed that there had been a discussion between Consultants in the Emergency Department in relation to the treatment and care of Mrs Forshaw but the treatment and care of Mrs Forshaw had not been escalated as a formal report for consideration of a Serious Incident Review. Accordingly a Serious Incident Review had not taken place in relation to Mrs Forshaw's death, although it was accepted that, in retrospect, a Review should have taken place to enable any recommendations to be formalised within the Governance framework.

I appreciate that, in light of these concerns you have requested that the Trust conduct a review of policies, procedures and protocols in relation to:-

I. The information on appointment cards
II. The notes to be recorded by nurses, either in relation to telephone calls made to the hospital by or on behalf of a discharged patient or in relation to nurses conducting a preliminary examination prior to consultation with a doctor.
III. Routine observations and blood investigations in relation to patients attending hospital, particularly the Emergency Department or Out Patient Clinic, where there is evidence and diagnosis of wound infection.
IV. The reporting and escalation of incidents in the Emergency Department leading to consideration of a Serious Incident Review and appropriate action within the Governance framework.

I propose to respond to each of your concerns and recommendations in turn.

Appointment cards

For your information and assistance I enclose a blank example of the appointment card which would have been completed and given to Mrs Forshaw following her review in the Accident and Emergency Department on 19th October 2016. This card would have been populated with Mrs Forshaw's name and the date of her appointment in the Out Patient Clinic, which I believe was on 22nd October 2016. As you will see under the name of the Hospital at the top of the card there is a telephone number. At the bottom of the card it is stated;

> *"If the condition for which this appointment has been made has cleared up, there is no need to attend (please inform reception on above number)"*

The number at the top of the card is therefore intended to be used if the appointment is no longer required or if the date needs to be changed. I apologise if Mrs Forshaw or her husband found this

information to be ambiguous. I am aware that the Trust's outpatient appointment card is to be updated to include advice for patients to contact NHS 111 or their GP if their condition deteriorates.

I also understand from the Clinical Director for Emergency Care that a Memo has been sent to all Emergency Care staff to notify them that if a patient or relative calls the department for advice, the caller is to be told that if they have any questions about their/the patient's condition or treatment they are to consult their GP, call 111 or to re-attend Accident & Emergency. The Emergency Care Staff have been informed that under no circumstances should they be providing any medical or treatment advice.

The Emergency Care Staff will also be notified that calls should not be put through to the minors or majors area in the Accident & Emergency Department as even though these calls are answered by a medical professional, the advice given is not always recorded in a patient's notes and as such there is no audit trail. The Accident & Emergency Department is not to be treated as an advice line and this information will be re-iterated to all Emergency Care Staff.

Records/notes

I appreciate that Mrs Forshaw's medical notes did not include a record of any discussion she had with the nursing staff either whilst waiting for her out patient appointment or during her initial nursing review before her examination by the Doctor. However, I understand that when [redacted] reviewed Mrs Forshaw in the outpatient clinic a description of her wound was recorded in the notes and it was noted that there was swelling around the wound, together with slight pretibial erythema (redness to the skin overlying the tibia). As a result of these signs of infection [redacted] prescribed Clarithromycin as an antibiotic and arranged a further review appointment four days later. A letter was sent to Mrs Forshaw's GP outlining this management plan.

All of our nurses are aware of their duty to ensure patient records are accurate and to document relevant information as appropriate. However I understand that a notification has been circulated to all nursing staff by the Matron for Unscheduled Care to reiterate the requirement for nurses to document in the patient's notes any relevant care or treatment provided. The Clinical Director for Emergency Care will inform all the Consultants of this issue and this matter will also be discussed at the Clinical Governance Meeting. I have also been informed that this notification will be incorporated into the ongoing local induction for nursing staff.

I can therefore assure you that if there is any information or history which is brought to the attention of the nurse by a patient, all nursing staff have been notified of the need to inform the reviewing clinician so that this can be considered when determining the appropriate course of treatment.

Routine Observations

I appreciate that during the course of the evidence at Inquest, [redacted] candidly acknowledged that routine observations should have been conducted on Mrs Forshaw and had they been done, and if her results had triggered the sepsis pathway, she would have been admitted and commenced on IV fluid and IV antibiotics.

Both [redacted] have reassured me that all clinicians working in the outpatient clinic are very aware of the sepsis pathway and conduct routine observations and blood investigations where appropriate when a patient is displaying clear signs of infection. Following careful consideration and discussions between senior Emergency Care clinicians, they do not consider that it would be possible

to implement a formal policy or standard operating procedure for conducting routine observations on patients in the Outpatients Clinic. Unfortunately patients and their symptoms do not fit into clearly defined categories as to when observations are required and when they are not. Patients attend with a vast range of symptoms and as such, the standard practice at WWL is for the clinician to examine the patient, consider their presentation and determine the treatment and advice to be given on the basis of their clinical judgment. I do not believe this is out of line with the procedure followed at all other NHS Trusts.

[redacted] has confirmed that he did not, in his clinical judgment based on Mrs Forshaw's presentation on 22 October, consider her to be showing clear signs of infection which warranted routine observations and blood to be taken. [redacted] impression of Mrs Forshaw's presentation was one of localised wound infection. I have been assured that the clinical staff in the Outpatient Clinic are very aware of the Trust's sepsis guidelines and trigger the sepsis pathway whenever required.

[redacted] has discussed Mrs Forshaw's care at a meeting of the Emergency Care Consultants to heighten awareness of wound infection and sepsis and to gather feedback from the senior Consultants in relation to routine observations; this senior opinion has been incorporated into this response.

Mortality review / Governance process

As you may be aware one of our Consutlant Paediatricians conducts a weekly mortality review to consider the care and treatment provided to all in patients who have died during the course of the week. In Accident & Emergency a similar mortality review is undertaken by [redacted] I have been informed that at the clinical governance meeting on 27 September 2017 it was confirmed that the criteria of this review is now to be widened to consider whether the patient has attended the hospital at any time in the previous four weeks. This will enable the Consutlant conducting the Mortality Review to identify whether there is anything of significance from these previous presentations to be considered when reviewing the care provided.

In Mrs Forshaw's case, such a review would have identified her attendance to A & E and her subsequent attendance at the Outpatient clinic in the 48 hours prior to her death. Consideration would therefore have been given to whether there was anything which could/should have been done at these presentations to have altered the outcome for Mrs Forshaw and the decision could then have been taken as to whether this matter required further investigation and escalation through the governance procedures at the time of Mrs Forshaw's death. I apologise that this did not happen and I hope that the improvements made to the mortality review process provide reassurance that any future deaths in the Accident & Emergency will now undergo a greater level of scrutiny to ensure that lessons can be learnt wherever possible and improvements made to the care provided to patients.

Continued action

As noted above several changes have already been put in place following Mrs Forshaw's sad death and the following actions will be taken:-

- Emergency Care Staff are to be notified that calls should not be put through to the minors or majors area in the Accident & Emergency Department. Guidance has already been issued to staff to confirm that patient's or relatives calling about a patient's condition or treatment should be directed to their own GP, advised to call 111 or re-attend Accident & Emergency. Under no circumstances should treatment advice be given.

- Nursing staff will continue to be notified at local induction sessions of the requirement to document in clinical notes any relevant care and treatment provided
- The Accident & Emergency weekly mortality review will now include a review of any hospital in or outpatient attendances in the last four weeks prior to the final attendance, to consider any significant issues relevant to the patient's care and treatment.

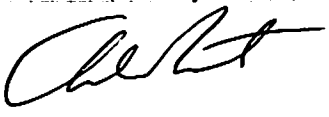
The above actions will be monitored via the Trust's Quality and Safety Committee which is chaired by a Non-Executive Director and attended by several members of the Executive team, including the Medical Director and Director of Nursing.

I hope the above response is a testament to how seriously the Trust considers the concerns raised by Mrs Forshaw's death. I can reassure you that WWL has and will continue to learn lessons from Mrs Forshaw's care and the Trust is constantly seeking to improve the service we offer to our patients.

Please can I pass my sincere condolences to Mrs Forshaw's family for their loss.

If you have any comments or suggestions in relation to the proposed actions above, I would be only too pleased to hear from you.

Yours sincerely



Andrew Foster CBE
Chief Executive