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Stockport
NHS Foundation Trust

Our ref. LR/18-05-2020 letter to HM Asst. Coroner- DCK
Your ref. Case 312830

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Mr Jason Wells
HM Assistant Coroner
Coroner's Court
Mount Tabor
Mottram Street
Stockport
SK1 3PA

4 June 2020

Dear Mr Wells,

Re: David Craig KERR (Deceased)

I am writing further to the inquest of the late Mr David Craig Kerr held on 16 October 2019 and the concerns you raised relating to the care provided to Mr Kerr by this Trust, between 15 and 27 April 2019.

I am grateful to you for highlighting these concerns and for providing me with an opportunity to respond. Please also accept my apologies for any undue stress and anxiety that has been caused to the family by the delay in the information being provided.

I asked the Surgical, Gastroenterology & Critical Care Business Group to investigate on my behalf. Mr [redacted], Associate Medical Director and Mrs [redacted], Associate Nurse Director have reviewed the matters of concern which arose during the inquest. I have chosen to respond to each concern in order, which I trust is satisfactory to you.

Mr Kerr's medical care on ward D2 was poor and probably contributed to his death.

Mr Kerr was quite an unwell gentleman, who had a fall in the toilet before being discharged from hospital. The cause of his syncope was felt to be due to his respiratory condition. Mr Kerr sustained an extra-capsular fracture neck of femur from the fall and underwent surgery without delay in less than 24 hours. He was on Ward D2, a designated fractured neck of femur ward over the Easter weekend and had a stable post-operative period.

Mr Kerr did not receive an orthogeriatric review on the 22 April as this was a bank holiday weekend. Our usual practice, during weekend and bank holidays, is for the on-call team of doctors to provide care should the need for their intervention arise. In Mr Kerr's case, this happened on 2 occasions. Further reviews were well detailed and patient-centric. He was reviewed from the 23 April 2019, by both the orthopaedic and orthogeriatric teams. The majority of the interventions were provided by the orthogeriatric team, as being physicians they are best placed to manage Mr Kerr's medical conditions during his post-operative recovery and rehabilitation. He was also reviewed daily by the Orthopaedic team.

The medical team had noted the positive fluid balance within the post ward round notes. These were appropriately recorded. The food and fluid intake charts were completed, but were not dated for 24 and 25 April; the charts were fully completed pre and post these dates. From review of the documentation within the medical notes, oral intake was noted to be reducing. Mr Kerr was encouraged to increase his intake of diet and fluids. Discussion of oral and intravenous intake was documented.

On 26 April 2019, Mr Kerr had a tonic-clonic seizure and this was managed by the medical and nursing teams. Physiological observations were recorded and scored using the National Early Warning Score (NEWS 2). Escalation for medical review when required was detailed in the medical records. The seizure occurred at

13:42 and observations are noted in the documentation during this emergency situation, although I accept these were not transcribed electronically on Patientrack as should have been done. Vital signs were not recorded when Mr Kerr went for a CT scan of his head. They should have been undertaken on his return to the ward although these were not completed. The scan report was noted in the medical records at 16:42. The next set of observations was recorded as being taken at 21:06 when a NEWS score of 0 was noted.

On Mr Kerr's initial presentation in AMU, the cardiologist had advised that his bisoprolol should be reviewed and stopped if his blood pressure was low. We acknowledge that this advice provided by a specialist was not acted upon expediently. Mr Kerr continued to be monitored during this time and was being managed with fluids to improve his BP, as he was within his peri-operative phase. It is the clinical teams view that the low BP was more likely to be related to a decrease in intra-vascular volume; hence improving this with fluids was the first line of treatment.

The clinical team acknowledge that the food and fluid intake charts should have been dated and the physiological observations should have been recorded on his return from CT.

We have discussed his case with consultants across all clinical business groups and agreed the following Trust wide actions:

- When speciality advice has been given, this should be acted on, or a conversation consultant to consultant should be undertaken, to ensure patients get the right treatment at the right time
- Improved communication for weekend/ bank holiday handovers
- Reiterated the critical importance of reviewing and accurately documenting fluid balance and alternative reasons for hypotension being explored

Between 24th and 26th April 2019, Mr Kerr was allowed to become increasingly dehydrated; on 24th April he received a total of 300mls of fluid and the input/output chart was not filled in on 25th/26th April, despite the fact that he was seriously unwell.

As noted previously in this response, on review of this case, Mr Kerr was in positive fluid balance from 24 to 26 April 2019, although this was reducing over those 3 days. On 24 April it was 1.6 litres, on 25 April it was 398 ml and on 26 April it was 180 ml. The team recognize that fluid balance charts are not consistently completed to the standard expected.

In order to ensure compliance with best practice standards in Ward D2, the following actions are being taken:

- All staff involved in this incident are being spoken to by the Matron or Associate Nurse Director and reminded of the importance of accurate fluid balance
- Training sessions are being delivered on the ward to ensure that all staff involved in this incident are able to complete the fluid balance correctly and in a timely manner
- The Ward are undertaking daily audits on the ward to monitor the compliance of fluid balance recording, providing feedback to clinical teams to promote best practice
- To ensure objectivity of audits, matrons outside the Business Group have been requested to undertake peer reviews.
- Consistent individual failings will be addressed with the individual concerned, recorded in their personal file and appropriate actions taken.

In addition, to ensure that learning is applied across the organisation, we have embarked on a Quality Improvement Project focussed on all aspects of hydration and nutrition. This will be supported by the transformation team unison recognised quality improvement methodology to achieve rapid and sustainable change.

There were few clinical observations undertaken for Mr Kerr. On 26th April, clinical observations were performed at 11:12 (NEWS 1) and 21.06 (NEWS 0). There were no clinical observations thereafter. No protocol was produced regarding the frequency of observations in sick patients on Ward D2.

On 26 April 2019, Mr Kerr had observations undertaken at 11:12, 13:42 when the seizure occurred (and were repeated during that episode but not recorded on 'Patientrack') and at 21:06. He was off the ward at 15:03,

undergoing a CT scan when his observations were due. These should have been undertaken on his return to the ward and this was an omission.

In order to ensure compliance with best practice standards in Ward D2, the following actions are being taken:

- All staff involved in this incident are being spoken to by the Matron or Associate Nurse Director and reminded of the importance of appropriate and timely recording of observations
- Training sessions are being delivered on the ward to ensure that all staff involved in this incident are competent and capable in observation recording and escalation in accordance with Trust policies and procedures
- EWS daily reports are produced and sent via email to Matrons and Ward Managers with details for each area of patients who have scored on the NEWS2 which is reviewed to ensure appropriate action has been taken.
- Consistent individual failings will be addressed with the individual concerned, recorded in their personal file and appropriate actions taken.

In addition, to ensure that learning is applied across the organisation, we have started the roll-out of a fundamental care framework across the Trust which includes common best practice standards for the management of nutrition and hydration.

Summary

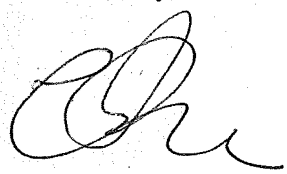
Following the review of Mr Kerr's care on Ward D2, it is acknowledged that documentation requires improvement, as there were missing dates for 2 days with regards to nutrition and hydration chart recordings. The observations are noted in the documentation during the emergency situation on 26 April 2019, but these were not transcribed on Patientrack. Mr Kerr should have had his observations undertaken on his return to the ward after his CT scan on 26 April 2019.

As part of the governance processes for the Trust, quality and care standards are monitored through the completion of audits which are reviewed at service level on a monthly basis and reported for further assurance through to the Trust's Patient Safety and Quality Group (PSQG). These are quality metrics which are completed by the senior nursing team and are discussed at ward, business group and Trust quality meetings.

The audits have shown that compliance for ward D2, over a six month period is variable between 82-100%. The identified areas for improvement on ward D2 are being addressed with the senior nursing team on the ward, the Matron and Associate Nurse Director. An action plan has been implemented a copy of which is attached for reference.

Once again, I would like to thank you for giving me the opportunity to respond to your concerns and trust that my response has been helpful to you. If there are any areas where I could provide further clarification, please do not hesitate to contact me.

Yours sincerely,



[redacted]
Chief Executive