1. Title:
Trust Response to the Prevention of Future Deaths notification issued on the 1st September 2021

2. Vision:
Strive to ensure that patients are kept free from harm, and develop a culture where there is accountability to deliver a zero tolerance for the development of pressure ulcers within Croydon Heath Services

3. Purpose:
This paper outlines the Organisations actions in response to meeting the ask as set out by the Assistant Coroner on the 1st September 2021 in relation to the prevention pressure ulcers and their deterioration whilst within our care from non-concordant patients.

4.Prevention of Future Deaths Notification:
There was an inquest into the death if Mr Humphries which concluded on the 5th August 2021, the conclusion of the inquest was:

Mr Humphries died from fluid on the lungs and a lung infection caused by a range of conditions including an infection caused by catheterisation in the context of diminishing reserves to which pressure sores contributed

Following this verdict, the following matters of concern were raised by the assistant coroner and a regulation 28 PFD report was issues for action by the Trust

- I heard evidence that Mr Humphries' pressure sore probably started in A&E where he stayed for a long period before being moved to a ward. I was not informed of any skin integrity assessments or measures whilst he was in A&E.
- When Mr Humphries resisted being turned, no advice was sought from external professionals or the nursing home as to how to manage the situation. The nursing home in particular had effectively employed a range of strategies to deal with the situation and would have been able to provide guidance had the staff been contacted.

5. Response of Pressure Ulcer Reduction group:
Following the receipt of the PFD the Organisations Pressure Ulcer Prevention group met on the 22nd September 2021 to discuss and review the immediate actions but in place by the Associate Director of Nursing as an immediate response to the notification.

These actions and the agreed monitoring and evaluation would be a standing agenda on the monthly pressure ulcer prevention meeting for a period of at least 3 months until assurances are in place that the required improvement is imbedded within the clinical environments.

There was discussion within the group that that of the required actions were in place in some of the trust clinical setting and therefore there needed to be improved communication across the adult inpatient and emergency department setting to ensure these benefits are realised by all patients and staff.

6.Agreed Actions:
Although there was a particular focus in the Emergency Department and Fairfield 1 in response to this PFD the actions have been rolled out across the organisation.

There were 4 high level Care and Service delivery problems identified, which have agreed actions and action owners allocated as well as a clear monitoring and reporting process. These have been agreed by the Directorate and Ward teams.

These high level issues are:

- Risk of impaired skin integrity related to extended time spent in the Emergency Department lying on trollies
- The knowledge and skills of all staff to be improved to manage patients diagnosed with Dementia on the ward
- There is a need for the ward to demonstrate clear evidence that there is involvement of patients' next of kin and any other support services in patients' ongoing care.
- Communication of all the initiatives and new actions from the Pressure Ulcer prevention group to be effectively cascades to all departments

The full action plan is attached as appendix 1

7. Next Steps:

One of the challenges highlighted is the cascade of information across all the organisations departments, to increase awareness of the pressure ulcer initives being carried in discrete departments, such as the emergency department with quality / comfort rounding.

One of the areas of focus going forwards is to ensure that there is robust and effective cascade of information from all focused groups such as Pressure Ulcer and Falls to all the clinical departments.

The full action plan and paper will go to the Nursing, Midwifery, AHP and Carers Board on the 21st September 2021 and will then be discussed at the Integrated Quality Assurance Group on the 16th November 2021.

8. Appendices

- **Appendix 1 Action Plan**
- **Appendix 2 Regulation 28: Prevention of Future Deaths Report**