24 SEP 2020

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Ms Yvonne Blake
Area Coroner for Norfolk
Carrow House
301 King Street
Norwich
NR1 2TN

21 September 2020

Dear Ms Blake

Re: Regulation 28 Report to Prevent Future Deaths following the inquest into the death of Mrs Pauline Russell.

Thank you for your letter received on 10 August 2020 following your inquest into the death of Pauline Russell. Firstly, I would like to offer my condolences on behalf of the Trust to Pauline's family for her sad passing.

Following the evidence heard at your inquest, the medical cause of death was given as:

1a) Aspiration Pneumonia
1b) Hypoglycaemic Coma
1c) -
2) Insulin Dependent Diabetes Mellitis, Previous Stroke

I understand that you have made this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The Trust has carefully considered the issues set out in your letter in order to respond to your concerns.

Following your inquest, the hospital's Director of Nursing instigated a review of the admission and discharge documentation used across the Trust to identify any required changes.

As a result of this review, the admission and discharge documentation has been amended to include additional checks relating to literacy support. The Multi-Disciplinary Care Record now requires staff to check whether the patient is able to read English and if any additional support is required. The 'Discharge Checklist' also highlights language and literacy skills to the completing staff and signposts them to the new admissions booklet. Please see enclosed copy of the amended documentation. The updated documentation has been

shared with ward managers to cascade accordingly and the documentation will be formally launched at the Clinical Leaders Event on 7 October 2020. To ensure compliance, the Trust will carry out a monthly audit of this documentation with the first results available at the end of October.

During the discharge process, nursing staff are expected to discuss medications with patients and their relatives (if appropriate) to ensure that they have a full understanding of their medication administration. This discussion should include specific information about the dosage to avoid any misinterpretation. If concerns are identified during the medicines reconciliation process, this would be assessed and the patient and their carers supported accordingly.

Staff are encouraged to use a 'Check and Challenge' approach to ensure patients have a full and safe understanding of their medications. This approach includes staff asking questions to patients and carers to evaluate their understanding and identify if further assistance is required, for example an interpreter.

In March 2020, the pharmacy department implemented a new system which communicates a patient's discharge letter to their usual community pharmacy: this allows a further opportunity to offer medication support. In addition, the discharge letter is sent to the patient's General Practitioner to arrange any required follow up and make them aware of any medication changes.

I understand in this case, nursing staff were unaware of the patient's and carer's literacy difficulties and I am satisfied that the changes to documentation and learning from this case will help prevent a similar incident occurring.

I would like to thank you for bringing your concerns to my attention. If you require anything further, then please do not hesitate to contact me.

I understand that this letter may be shared with Pauline's family and I would like to take this opportunity to personally extend my sincere condolences for their loss.

Yours sincerely

[redacted]

[redacted]
Chief Executive