NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

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11 December 2020

Mr Tim Holloway
Assistant Coroner Blackpool & Fylde
PO Box 1066
Corporation Street
Blackpool
FY1 1GB

Your reference: [redacted] - Prevention of future deaths Reg 28-1

Dear Mr Holloway

Re: Douglas Owen (deceased) – Inquest concluded Tuesday 7 October 2020

Further to my letter dated 4 November, in which I confirmed receipt of your Regulation 28 Report to Prevent Future Deaths, dated 19 October 2020, in relation to the death of Douglas Owen, who sadly passed away on the intensive care unit of Blackpool Victoria Hospital on 7 July 2018.

In my letter, I explained that we would take actions to prevent a similar event from occurring.

I have below outlined my responses to the matters of concern you have raised with us and what action we have taken:

1. **That Blackpool Victoria Hospital has not yet finalised an agreement with Spire Fylde Coast Hospital for the urgent transfer of patients to the Ophthalmic Unit at Blackpool Victoria Hospital when appropriate. Unless arrangements are formalised, the lives of patients may be put at risk.**

The matter of an agreement with Spire Fylde Coast Hospital for the urgent transfer of patients to the Ophthalmic Unit at Blackpool Victoria Hospital has been considered and discussed at length with relevant consultant colleagues. After much deliberation, it was felt that an agreement with Spire Fylde Coast Hospital may not be sufficient to prevent similar incidents from occurring and thus the focus was directed to the development of more responsive and effective protocols in our existing services, to ensure that handover from Spire Fylde Coast Hospital to the Emergency Department (ED) and then ophthalmology would be performed quickly and comprehensively.

To that effect, the Clinical Director of Ophthalmology, who is a Consultant Ophthalmic Surgeon, has developed a protocol that details a number of elements (please see attached) that ensures the safe care and treatment of ophthalmology patients:

- **Handover Document (Ophthalmic Emergency Patients)**
- **In-house pathway (Ophthalmic Emergency Patients)**
- **Securing of a room in ED for ophthalmic Casualties** in the new Emergency Village. This will primarily be the new ED room for ED Ophthalmological patients to be seen and part of our new ED Minors area. It will also be used specifically as a room for Ophthalmology to see Ophthalmology patients who have been transferred from. Spire Fylde Coast Hospital with post-operative complications. For clarity, Ophthalmology patients within the ED have always been able to be seen by Ophthalmology in the department, but this dedicated room will enhance the services we provide.

To further develop the safety of services we provide, the Clinical Director of Ophthalmology has also drafted a number of recommendations for Spire Fylde Coast Hospital to bring out essential in-house changes to their Ophthalmic Services. Spire Fylde Coast Hospital will then be able to evidence to yourself the changes they have brought to ensure the safe care and treatment of ophthalmology patients at their hospital.

2. **That the Deceased was not seen by a speciality doctor in the Emergency Department notwithstanding the need for him to be seen. Unless action is taken there may be a continuing risk that patients in the Emergency Department will not be seen by on call doctors in speciality disciplines, in particular, ophthalmology, even when the need arises in that Department.**

Following on from the previous concern, the protocol developed by the Clinical Director of Ophthalmology details the mechanism in which the ophthalmology specialty doctor attends the Emergency Department (ED) to assess and treat patients when the need arises.

In addition, the Medical Leadership Forum has agreed a policy for Internal Professional Standards for Blackpool Teaching Hospitals NHS Foundation Trust. The purpose of agreeing a set of professional standards, is to provide a clear reference point against which the organisation can function and to which medical colleagues can be accountable. They are commonly used by Emergency Departments to clarify patient flow though the front end of a hospital, but can be used across an entire organisation.

To support the implementation of the Internal Professional Standards, the Trust is currently recruiting to a Director of Professional Standards / Deputy Medical Director post. One of the main responsibilities of the postholder will be to work with colleagues to support the Trust's plans for quality improvement in clinical safety, mortality, clinical efficiency and effectiveness, by providing day to day responsibility for delivery of safe, personal and effective care.

3. **That the evidence disclosed omissions in the taking of vital signs observations and in the recording of observations in the vital signs observation chart (incorporating the National Early Warning Score). Unless action is taken, there is a risk that any deterioration in the condition of patients which might put their lives at risk will not be identified at the earliest opportunity.**

See below

4. **That the evidence disclosed that the review process was not followed upon the Deceased's blood pressure dropping by more than 40mmHg, notwithstanding the fact that that observation had been recorded. Unless action is taken, there is a risk that any deterioration in the condition of patients which might put their lives at risk will not be reviewed at the earliest opportunity.**

See below

5. **That the evidence disclosed the fact that, whilst fluids had been prescribed, no prescription chart or fluid balance chart had been completed. Unless action is taken to ensure the completion of applicable documentation, the lives of patients may be put at risk.**

I have taken the liberty to answer your concerns 3, 4 and 5 in a combined response, that addresses all three concerns.

We sincerely apologise for omissions in the taking of Mr Owen's vital signs observations and in the recording of observations in the vital signs observation chart, that Mr Owen's drop in blood pressure was not followed up and that Mr Owen's prescription chart or fluid balance chart had not been completed.

Over recent months, the Trust and the Emergency Department (ED) have committed to major improvement projects and programmes to improve the 'recognise and act' element in the care and treatment of a deterioriating patient. The ED currently are 92.91% compliant with the Trust's Recognise and Act Mandatory Training (120 staff are compliant, nine staff are waiting to attend, three of which are new staff and two are paediatric nurses). We have a plan for all outstanding staff to attend the training, although limited places are available due to social distancing. Our two Advanced Clinical Practitioner's (ACPs) are running simulation training sessions for all staff to attend, following the Trust Pathways of the recognition of the the deteriorating patient. Both ACPs are Advanced Life Support (ALS) trainers and follow the ALS algorythms and the NEWS 2 Escalator.

Furthermore, the Trust monitors completion of the NEWS2 charts through spot audits undertaken by the Matrons and Ward Managers, with any gaps identified managed immediately at ward level and key themes are discussed at Nursing Quality Governance Meetings, with actions created for shared learning.

At an organisational level, the Quality Improvement Strategy describes a new Deteriorating Patient Collaborative, to test ways of working that will help teams to recognise and respond to the clinical deterioration of patients and reduce preventable deaths. A Project Initiation Document has been prepared and a Senior Responsible Officer and Improvement Programme Manager have been identified to support the work. The Board of Directors support commencement of the Deteriorating Patient Collaborative and agreed to receive regular updates on progress as part of the Quality Improvement Strategy reporting mechanism.

In the interim, the Head of the Emergency Department and the Matron will ensure senior clinical staff will undertake regular spot audits / huddles, to ensure all patients in the ED have their NEWS2 score recorded correctly, that any changes in score are acted upon promptly and that fluid charts are completed correctly and acted upon promptly. The ED complete a Consistency in Care Audit daily, where 40 patients' notes (approximately 20% of all patients daily) are reviewed in real time and this includes a review of the NEWS 2 and fluid balance. This is used to monitor the compliance and manage any inconsistencies in care at the time. Additionally the ED undertakes an intentional round, where all patients who have been in the department for longer than 4 hours, are reviewed by the EPIC (Emergency Physician in Charge) to ensure that appropriate plans of care are in place. The nursing team undertake two-hourly care huddles, where the nurse management of the patients' care is reviewed, to ensure that the coordinating nurse has a robust overview.

6. **That the evidence disclosed the fact that the Once-only and Pre-medication Chart does not make provision for the dose of medication actually given to be recorded in the event that the dose prescribed has been specified as falling within a range (for example, as here, morphine 1-10mg) and that, in any event, the actual dose given was not recorded in that chart. Unless the giving of medication is recorded fully the lives of patients may be put at risk.**

We sincerely apologise that the actual dose given was not recorded in once only and pre-medication chart.

The once only and pre-medication sections of the chart are to be used for STAT doses only where the exact dose to be given is clearly indicated. Variable doses are written on the PRN section of the chart with the person administering the medication completing the dose given. This is standard practice throughout the hospital and the ED have been reminded of this. The ED pharmacist will monitor to ensure this happens.

From November 2018 morphine elixir has been treated as a restricted drug within the Trust and all doses given are recorded in the restricted drugs register and are therefore traceable.

I hope that the above responses provide you with the assurance that we have taken your concerns extremely seriously and that we have taken appropriate actions as a Trust, to prevent a similar event from occurring.

Yours sincerely

Dr [redacted]
Executive Medical Director