The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

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25 January 2021

Mrs J Lake HM Coroner for Norfolk
Carrow House
301 King Street
Norwich
NR1 2TN

Dear Mrs Lake

Re Mrs Margaret Lilian Sales

I write to set out the Trusts' response to the Regulation 28 Report dated 11th November. With respect to your three concerns listed, I will respond to each using the same numbering

1. *Evidence was heard that Records were not always completed as required. It is understood clinical teams have been notified of this and the records are being audited. There was no evidence as to the outcome of those audits and any further action taken.*

I attach the latest audit on medical records carried out across the Trust's wards. The wards involved were Oxborough and Marham for the admission in question. With medical record completion, action taken is taken on a regular basis and I set out the detail of this process below.

The findings from the documentation audit are taken through appropriate governance channels such as the Harm Free Care Group, Learning from Deaths Forum, Hospital Thrombosis Committee, Divisional Governance Boards to feed into Clinical Governance Executive Group (Executive level) to Quality Committee (sub-committee) and finally to the Trust Board. Assurances provided this way help with enabling visibility and also focus on areas of improvement. Whilst this is a framework and continuing process, we are aware of the areas requiring improvements and have created dedicated quality improvement projects which also report to the Trust Board to track the progress on the work undertaken. For example, there was a decline in the Venous Thrombo-embolism (VTE) screening uptake since January 2020 until April 2020.

The quality improvement project (QIP) led by the Medical Director reviewed and revised the existing pathways, improved awareness through training and inclusion in the induction programs, increasing capture of the harms caused through the patient safety teams (Audit and Effectiveness Group) and over 3 months of this effort the VTE screening rates improved back to above the nationally recommended target levels. A similar project is now in place with regard to improving Dementia screening rates, reduction in prescribing and administration errors

with insulin and anticoagulants with clear milestones. There is clarity in approach and framework of reporting acknowledging that there is always more work to do.

The Multidisciplinary Documentation Forum oversees all the documentation aspects of Health Records that not only capture medical documentation but all multidisciplinary input into patient records. Equally this forum is planning to facilitate a seamless transfer to Electronic Patient Records that will improve quality of care for patients. Through this forum, improvements in documentation of clinical care that includes, medicines, fluids, feeds, monitoring of vital signs are planned and where deteriorations occur, improved focus to address deterioration is identified and facilitated through examples described above. The Trust is fully committed to identifying issues which may occur regarding all aspects of our documentation and responding accordingly when identified.

2. *Nurses had difficulty in contacting front line on call medical staff on two occasions. Several members were contacted before anyone attended. Bleeps are now to be provided to all on call medical staff. However, some of the team had bleeps and still did not respond to the requests to attend the patient.*

Firstly we have redesigned the clinical escalation pathway with providing a compliant 7-day standard service. This has increased the medical workforce required to improve cover for the patients. Access to medical personnel has improved through this. This is set to improve further with the Urgent and Emergency Pathway Reset program led by the Chief Operating Officer that encompasses system-wide changes to improve early access for patients and facilitate timely treatment. A dedicated Project Management team is set up to expedite this process looking at our medical workforce.

The bleep tracking system and the use of smart phones with video calling facilities is in place to enable tracking and access to our medical work force. Inability to access doctors to escalate problems is captured through our incident reporting system (Datix) and actions are enabled through this. Feedback to defaulters for not accessing properly is part of this and if there are avoidable lapses identified then they are put through an internal process. In this way the system is strengthened significantly.

The escalation process is also captured through the New Early Warning Score (NEWS) audit process that not only captures accuracy of scoring system but also escalations or lack thereof. Where escalations have failed to happen this is addressed through feedback to the individuals involved. Improving awareness within nursing teams that they are empowered to access consultants where local escalation plans have failed is in place. This is done at induction and monitored through incident reports, documentation audits, NEWS audits etc. Previously, junior staff have not felt confident to contact people higher up in the command chain which has cultural origins and will take time to address. However there is general improvement in the process and the Board is committed to facilitate this via the team approach.

3. *On a previous discharge from hospital, it was noted Mrs Sales had been referred to the Home Enteral Nutrition service for monitoring and follow up and that in situations such as this, requests will be place with the GP. However, no such request was placed with the GP. The Discharge Letter in fact stated: "Actions for the GP: No recommendations". As a result, the GP did not monitor Mrs Sales' capillary blood glucose following discharge.*

For this matter, some clarification is needed. Mrs Sales had Type 2 Diabetes Mellitus (T2DM), for which she was being diet-controlled when she was admitted at the end of September 2019. On imaging a left cerebellar infarct was found and she was treated for a stroke. This caused her to lose her ability to swallow so PEG tube feeding was initiated. However, during the admission the diabetes remained fully controlled without the need for insulin or any oral hypoglycaemic medicine, and so was regarded as stable. She was discharged on 6th November 2019 and she had developed no additional needs with respect to her diabetes.

Regarding the PEG feeding itself, she was seen prior to discharge by our dietetics team and they handed care of the tube feeding over to the community based Fresenius Kabi nurses for training of the relatives on the feeding pump and general care of a PEG tube. The handover to Lincolnshire dietitians includes the fact this patient has T2DM – but that would be for their awareness only. I attach the referral forms from the Dietetics team to show this.

If the patient needed regular blood glucose testing as an inpatient (and had not required this prior to that admission) because of treatment for T2DM, then the GP would have been advised that blood glucose testing was necessary. The records show that at the point of discharge Mrs Sales did not have any additional medical requirements with respect to the diabetes and so this instruction would not have been given to the GP.

We know that when Mrs Sales returned on 13th December 2019 she had become acutely unwell and had a very high blood glucose with condition known as Hyperosmolar Hyperglycaemic State (HHS) so treatment with insulin was necessary to save life. She remained on this medication from that point. Antibiotics were also given for her probable acute lung infection, and it is well known that infection can precipitate an acute diabetic crisis. However, patients with T2DM who are effectively diet-controlled do not require blood glucose monitoring at home. In fact The National Institute for Health and Care Excellence has specific guidance on "Do not do" which concern treatments and investigations that should not be carried out and monitoring of blood glucose levels is not required[1] except where:

- the person is on insulin or
- there is evidence of hypoglycaemic episodes
- or the person is on oral medication that may increase their risk of hypoglycaemia while driving or operating machinery
- or the person is pregnant, or is planning to become pregnant. For more information, see the NICE guideline on diabetes in pregnancy.

At this Trust our Diabetic Specialist Nurses would ensure that the GP was made aware that they had to ensure blood glucose monitoring was done at home if a patient had been put on either Gliclazide or Insulin during an admission. It is true to say that if Mrs Sales had had her blood glucose monitored at home between 6th November and 13 December 2019 her subsequent illness would have become apparent sooner, but in terms of current practice and guidelines there was no indication for us to make such a recommendation to the GP.

I have heard from our consultant [redacted] and also Legal Services Manager that we had not expected this issue to be raised at the inquest, if so we would have taken the opportunity to supply evidence on this point for you at the time from one of our Dietetics or Diabetes team members who deal regularly with referrals to Fresnuis and the General Practitioners in Norfolk, Cambridgeshire and Lincolnshire. With hindsight, perhaps our RCA could have gone into more detail on that point; but presently we think that the system remains robust and with no discourtesy intended do not propose to take any further action on this point at the present time.

I would be happy to provide you with any further information you require on any of these concerns.

Yours sincerely

[1] **Type 2 diabetes in adults: management**
NICE guideline [NG28]Published date: 02 December 2015 Last updated: 16 December 2020 - Para 1.6.13

Deputy Medical Director