Barts Health NHS
NHS Trust

Barts Health NHS Trust
Trust Executive Offices
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Ms M E Hassell
Senior Coroner for Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

02 April 2015

By special delivery

Dear Ms Hassell

Inquest touching the death of Mrs Rufjan Bibi

I write in response to your Regulation 28: Report to Prevent Future Deaths, dated 11 February 2015.

Your first concern was related to the standard of nursing care afforded to Mrs Bibi. The family alleged that Mrs Bibi was often found by them in a state requiring urgent cleaning as she was incontinent. They were unhappy with the speed by which nursing staff gave assistance.

This matter was discussed with the family at the Local Resolution Meeting that was held between them and Trust staff. During this meeting the Trust apologised to the family. The Trust found that Mrs Bibi was not able to properly articulate her needs and was suffering from dementia. The communication issues arising from this were a significant contributing factor in the reduced speed of nursing care. Also, the family members did not raise this as an issue to Trust staff at the time on the ward and as such immediate action could not be taken.

Certain actions have already been taken. Intentional rounding has been implemented as have documentation audits as part of the Clinical Friday initiative which involves senior nurses carrying out a ward round every 1st and 3rd Fridays looking at safety and quality issues. Observations of care are also being carried out. This is an independent observation of the activity of a set team or ward area for a period of time which is then followed by a meeting between the observer and individual staff. The observation surveys a variety of things such as interactions between staff, patients and the public, telephone calls, 1:1 care and even practices such as infection prevention. The intention of the meeting afterwards is to allow the individual member of staff to reflect on their practice and on how they were perceived, allowing them to

think about how they would act if they were to encounter the same scenario a second time. Training to staff is being provided as part of the Older Peoples Education

Programme. There is also a Band 7 Ward Manager Supervisory role whereby a Band 7 if possible has a reduced patient workload allowing them to offer support and guidance to more junior staff on a range of clinical issues.

Your second concern involved a member of Barts Health staff telling the Bibi family that if they wanted closer care for Mrs Bibi that they should engage a nurse privately to come into the hospital and care for her on a 1:1 basis.

This was also discussed at the Local Resolution Meeting held between Trust staff and Mrs Bibi's family. Apologies were made; however, as there were communication issues between Trust staff and the family, the Trust did feel that this was very unlikely to have been said. It is not usual practice to have private 1:1 carers and it is not an option that the Trust would offer. All patients are assessed on admission and regularly reassessed throughout their stay. Mrs Bibi did not meet the Trusts criteria for 1:1 nursing and the staff caring for her at the time used professional judgement to determine if special care was needed for her outside of the written criteria.

Your final concern related to the five hour gap between Mrs Bibi's fall at 2pm and her first consultant review at 7pm.

This also was discussed at the Local Resolution Meeting and an apology made to the family. The consultant in charge, doctor [redacted] has spoken to the junior doctor who was assigned to the ward at that time. They remembered assessing the patient but did not remember documenting the assessment. The medical review was undertaken very soon after the fall as the Medical Team were on the ward when the fall occurred. Nursing documentation supports that a review and appropriate checks were instigated as per Barts Health Post-Falls procedures.

The delay in obtaining a consultant review is not usual practice and should not have happened. The member of staff involved has been given training about obtaining a consultant review when a patient is acutely unwell or suffers a potentially dangerous injury. The doctor will also reflect on this incident in their portfolio.

[redacted] has also discussed Mrs Bibi's case at one of the departmental morbidity and mortality meetings prior to the Inquest hearing, the Coroner's findings will be reported back to the department at the next meeting.

[redacted] has also met with the new trainees who joined the department on the 01 April 2015. She explained the department's escalation policy regarding patients on the rehabilitation site or on any of the wards, who become acutely unwell. Timely assessment and intervention with good documentation are essential in ensuring that acute serious problems are treated appropriately. Senior review should always be sought expeditiously so that on-going management can be planned. Any adverse incidents on the ward, whether resulting in harm or not, should always be discussed and documented with patients and/or relatives as appropriate. Plans for on-going care should be specified. The aim of this training to juniors is to prevent delay in care that is likely to result in harm to our patients.

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Thank you for bringing your concerns to my attention. I trust that you are assured I have taken them seriously and investigated them appropriately.

Yours faithfully

[redacted]

Group Director for Emergency Care and Acute Medicine (ECAM)
Barts Health NHS Trust