Tameside Hospital NHS
NHS Foundation Trust

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Date: 14/03/2016

Your Ref: JSP/ER/02302-2015

Mr John Pollard
Senior Coroner for Manchester South
The Coroner's Court
1 Mount Tabor
Stockport SK1 3AG

Dear Mr Pollard,

Re: Regulation 28: Report to Prevent Future Deaths following Inquest into the death of Ranjan Raman Mistry (Deceased)

I write further to your letter dated 4th March 2016 enclosing a Regulation 28 Report issued at the conclusion of the inquest touching upon the death of Ranjan Raman Mistry, which took place on 2nd February 2016. I am, of course, very sorry that you had cause to issue this report.
I hope to be able to address your concerns, as set out in section 5 of your report, to your satisfaction, in this letter. I have addressed the areas of concern, adopting the same numbering in section 5 of your report as follows:

You stated:

1. *The evidence showed that there was no, or no sufficient, assessment of her Falls Risk.*

The records indicate that there was a falls assessment undertaken for Mrs Mistry. This was updated and reviewed several times during her admission. The Trust acknowledges the Coroner's observations that the assessment was not sufficiently completed and the Falls assessment tool should have been updated and reviewed after Mrs Mistry was found to have been on the floor following unwitnessed events on the 14/09/15 and the 17/09/15. The Trust has initiated one to one training and support for the members of staff involved and is currently undertaking a review of the documentation as a result of the Coroner's comments. This piece of work will also align to actions and improvement plans we have in

place as part of the Trust-wide Patient Safety Work stream and from recommendations following the Trust's participation in the National Falls Audit.
The Trust is also focusing on falls prevention and falls assessment in the wider context. Working with our community partners, service users and supporting agencies to look at improving the quality and lifestyle of Tameside residents and identifying and assessing those patients who may be of particular risk in relation to falls, and agreeing how we ensure pathway continuity. This involves ensuring that information held by the GP and community services and other healthcare and social services provide an integrated view of the patient's overall picture
We will also be looking at the wider picture in respect of earlier diagnosis of osteoporosis and identification of patients at higher risk of a bony injury from a fall, intervention and reablement and the benefit of exercise and mobility therapy meaning that people and their carers are less dependent on intensive services and less likely to need admission to hospital and to have to mobilise and be cared for in unfamiliar environments.

2. The Neurological observations charts were either never completed or had been lost from the notes

The Trust has a Falls Policy in place which clearly includes a flowchart which relates to the requirement to assess the patient following a fall or suspected fall. The Falls Policy and flowchart indicates that neurological observations would only be appropriate where a head injury was indicated or suspected. The Trust acknowledges that in the unwitnessed event involving Mrs Mistry on the 17/02/2016 a head injury could not be ruled out. In this event the flowchart indicates the taking of neurological observations (Unwitnessed fall and was verbalising that she had banged her head). However staff did not commence the charts. There is no evidence to suggest that these charts had been lost from the records. Any inference to this would be conjecture. This indicates that the requirement for staff to undertake neurological observations as cited on the flowchart needs to be reinforced and practices monitored to ensure robust implementation of the policy standards.
In view of this, the flowchart has been reissued to all areas and Matrons and Ward Managers have been asked to ensure that where there is an unwitnessed fall and the patient is not able to verify whether or not they have injured their head or there is any doubt as to this, neurological observations should be taken in line with the policy and these should be charted and recorded in the medical records.

3. There was clear evidence that the medical staff were not reading (or even looking at) the nursing notes, and the nurses were similarly not looking at the medical entries

The decision to use the records of a patient is a clinical decision for individual clinical staff on a continuous basis. The Trust is not unique in that nursing and medical staff record their observations and interactions separately in the patient's medical records. This is a matter of practicality from the user's viewpoint and allows the medical and nursing staff to access and update their records at the same time without hindering each other but also allows the staff to contemporaneous records and to access the most recent records which fall within their main area/discipline of practice without having to find entries amongst other disciplines entries. However the Trust acknowledges the Coroner's observations that this traditional approach to records keeping in practice can sometimes lead to a fragmented view of the patient's overall care and inconsistency in knowledge of recent interventions if

those medical and nursing staff do not have methods of keeping updated with the status and condition of the patient.
To ensure that staff maintain an overview of the patient from a medical and nursing perspective the Trust has introduced Board rounds when multidisciplinary teams including discharge case managers meet to discuss and agree the approach to the management of the patient, these are held on the Wards daily and augment information provided at shift handover. Nursing staff attend Ward Rounds with medical staff to ensure that they are aware of the patient plan and that they can ensure that patients and relatives are updated. Additionally the multidisciplinary team will hold formal and informal MDT meetings where patient have complex needs.
The Trust also has an electronic patient system and information such as test results and letters, appointments and other information can be accessed by appropriate staff and is used alongside the handwritten notes. As is happening Nationally the Trust is moving towards a paper light system of medical records which should support a more accessible and seamless approach to medical records.

4. The hand-over sheets for each shift were being shredded by the nurses as soon as the shift was completed. Whilst it is appreciated that these cannot be placed on the record of an individual patient for reasons of confidentiality, there is no reason why they could not be filed on the wards and retained for say 14 days which would allow further reference to be made to them, should this be deemed necessary or helpful.

The Coroner's observations are noted and the Trust acknowledges that the Trust does not keep an archived copy of handover sheets, this is for many reasons including confidentiality and to ensure that the sheet being referred to is an up to date one and not one from a previous date. However following the Coroner's observations the Trust recognises that there is no reason why handover sheets which are electronically produced could not be electronically archived to provide a record of what information was being communicated at handover at a point in time. This would as the Coroner observes provide a record should it be necessary to refer to them.
As a result the Trust will be considering introducing a system of archiving at Ward and Departmental level to support the availability of these at a future date.

5. Although an "Incident Report" was carried out in this case, the details available to the Coroners court were sketchy and inadequate.

The Trust has a standard in place which details the expectations regarding processes for reporting of and management of incidents within the Trust. The type, process for and level of incident investigation is proportionate to the impact and level of harm sustained by the patient. For an event where the patient is found on the floor following an unwitnessed event which was ascertained at the time to have resulted in no harm (as occurred in Mrs Mistry's case) the investigation is undertaken is concise and local and the important aspect of the interventions are to review the falls risk assessment and to try to reduce the risk of a fall occurring again to either that individual patient or to other patients within the hospital environment.
The Trust has initiated a guidance document which is available online for staff involved in a concise and local falls investigation and as previously mentioned is currently undertaking a review of the documentation as a result of the Coroner's comment and to align actions from recommendations following the Trust's participation in the National Falls Audit.

The Trust has been recognised as having outstanding levels of openness and transparency in learning from mistakes and has been ranked 8th out of 230 Trusts in relation to a report published in March 2016 by the Department of Health.
I do take your concerns seriously and I hope that I have addressed your concerns and reassured you of all that the Trust has already undertaken and is currently undertaking, in order to prevent the recurrence of a similar set of circumstances in the future.

Should you have any further questions arising from the contents of this letter, please do not hesitate to contact me.

Yours sincerely

Karen James
Chief Executive

cc. Monitor
CQC
Tameside and Glossop CCG