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Our ref. MF1852
Your ref. 4424

5 October 2016

H. M. Coroner
Greater Manchester South District
Coroner's Court
Mount Tabor
Mottram Street
Stockport
SK1 3PA

Dear Mr Bridgman

Re: Maureen Patricia FLYNN (Deceased)

Thank you for your letter of 26 August 2016 concerning the inquest of the above named patient. As always, I am grateful to you for highlighting your concerns and for providing me with an opportunity to respond.

Please see attached our updated Patient Safety Investigation report, which includes evidence of the completed actions. I will refer to this throughout my response.

As per your regulation 28 report to prevent future deaths, I will respond to each point as you have raised them:

1) **The evidence at the Inquest suggested that if, from the falls risk assessment, there were concerns as to Mrs Flynn's mobilising in and out of bed and / or in and out of her chair and her stability then these would have been highlighted in the nursing notes / care plan and discussed at any handover. However, as the assessment had not been completed out no-one knew, least of all the HCA.**

   For your information and to clarify, falls risk assessments for this patient were completed on 30 March 2016 at 21:37 hours whilst the patient was in the Emergency Department at which time the patient was deemed not to be at risk of falls. This is referred to in the Patient Safety Investigation report, Care Delivery Problem 1 (CDP1), page 5.

   The patient was transferred to Ward AMU2 on 31 March 2016 at 04:23 hours and a falls risk assessment was completed at 05:20 hours. The patient was deemed to be at risk of falls.

   The patient was then transferred to Ward E2 on 31 March 2016 at 23:13 hours. A falls risk assessment was undertaken on 1 April 2016 at 05:00 hours. Again, the patient was documented as being at risk of falls with bed rails being required. All appropriate interventions were put in place, which continued on 2 April 2016 and the morning of 3 April 2016. During this time, the

patient was being cared for in bed. On the morning of 3rd April 2016 the Healthcare Assistant has confirmed in her statement to you, which I have attached for your ease of reference, that she received a verbal and written handover; she was informed that the patient was in bed 13, of her mobility and her mental state along with any other relevant information. The Healthcare Assistant took note of the dementia symbol above the patient's bed.

The Healthcare Assistant offered for the patient to sit out in her chair whilst taking breakfast, however, the patient declined and remained in bed at that time. Once the trays were cleared away, the Healthcare Assistant has confirmed that the patient requested to sit out in her chair at approximately 09:00 hours. The Healthcare Assistant confirmed that the patient had her call bell at hand.

The Healthcare Assistant is not responsible for the completion of falls risk assessments; however, as the falls risk sign was displayed above the patient's bed, the Healthcare Assistant would have been aware of the patient's risk of falls.

The ward missed an opportunity to re-evaluate the patient's falls risk assessments due to her improved condition, as she was now able to sit out in a chair which she had not done previously during this admission. I refer you to Care Delivery Problem 2 on page 6 of the Patient Safety Investigation report which confirms that a visual assessment of the patient was undertaken by the Healthcare Assistant and the patient was felt safe to be sat out of bed.

It is routine practice on Ward E2 to sit patients out of bed as often as possible, as long as this remains safe to do so for the patient. This is to encourage mobility and recovery ahead of discharge.

2) **It is of concern to me that those caring for a patient were ignorant of the fact that Mrs Flynn's falls risk assessment had not been completed. It is clear that the HCA was unaware. It is reasonable for staff, in my view, to assume that all assessments have been appropriately carried out and completed. Why would the HCA have thought otherwise given the high falls risk sign above Mrs Flynn's bed? It would seem eminently sensible to adopt a system whereby staff are alerted to the fact that a falls risk assessment has not been completed. My concern extends to any other assessment required for a patient's safety and well-being.**

I would like to confirm that the falls risk assessment had been undertaken in line with Trust policy. The patient transferred to Ward E2 on 31 March 2016 at 23:13 hours; a falls risk assessment was undertaken on 1 April 2016 at 05:00 hours. The Healthcare Assistant has confirmed that she received a verbal and written handover providing information regarding the patient.

Falls risk assessments are formally undertaken within six hours of arrival to the ward and thereafter every seven days unless the patient sustains a fall, a near-miss fall or their condition changes such that it would affect their falls risk. However, all staff undertake an informal visual assessment on each occasion that a patient is mobilised as a patient's condition, ability and compliance can vary especially in elderly patients. Patients at higher risk of falls are discussed twice daily at safety huddles (07:15 hours and 19:45 hours).

In addition, on Ward E2, a core huddle agenda is in place to ensure information is then transcribed into the electronic handover. This action ensures that beds and fall station beds are allocated appropriately. There is a fall station in each bay with dedicated falls sensors ensuring that patients with the highest risk of falls are allocated appropriately as needs or conditions change.

3) **I am further concerned that the Patient Safety Investigation did not identify the fact that the falls risk assessment had not been completed.**

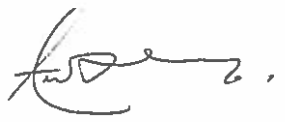
As confirmed above, the falls risk assessment had been completed within 6 hours of the patient's arrival to Ward E2 and this was in line with Trust policy. This assessment deemed the patient to be at risk of falls and bed rails were in situ. As the falls risk assessment was completed appropriately, this was not deemed to be a care or service delivery problem and therefore was not included within the Patient Safety Investigation report.

As part of our investigation, we did identify that the falls risk assessment could have been reviewed when the patient's condition improved and she started to sit out in the chair. The Senior Sister on Ward E2 did confirm, however, that had this been the case there would have been no change to the precautions put into place to reduce the risk of falls. The details of this can be found in Care Delivery Problem 2, page 6 of the Patient Safety Investigation report.

Following the investigation, Ward E2 shared the findings of the investigation via their Newsletter in June 2016. Please see attached the June ward newsletter for your information (page 2). In August 2016, I can confirm that the findings of the Coroner's Inquest was shared on Ward E2 and attention drawn to the need for fall risk assessments to be reviewed when a bed-bound patient starts to sit out in a chair. Please see attached the August ward newsletter for your information (page 2).

I hope that this response answers your concerns and provides you with the assurance that the Trust is committed to improving the quality of care we give to all our patients. Please do not hesitate to contact me if you have any further questions regarding this matter.

Yours sincerely



ADL Barnes
Chief Executive

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