NHS
The Shrewsbury and Telford Hospital
NHS Trust

Chief Executive's Office
Royal Shrewsbury Hospital
Mytton Oak Road
Shrewsbury
SY3 8XQ

Date 24 June 2021

Mr J P Ellery
HM Senior Coroner
Shropshire, Telford & Wrekin Area
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Dear Mr Ellery,

Thank you for your letter dated 4 May 2021 issued under Regulation 28: Report to prevent future deaths, in relation to the risks you identified through the Inquest touching the death of the late William Arthur John Simons.

I write to provide assurance that we have taken steps to resolve the issues highlighted in your letter.

1. Teletracking

a. *It was not clear what the purpose was of a doctor expressing a preferred option of transport (i.e.by trolley/bed/chair) if that doctor did not have sufficient information to make it.*
b) Whilst it became clear that, that option was subject to review by the nursing staff on the ward it was not clear why a doctor would not either liaise with the nursing staff or expressly make it clear that the nursing staff should make that assessment and inform the Porters accordingly.
c)The system on the day led to confusion and a breakdown in communication with the patient being taken instead by wheelchair with his zimmer frame.

Actions Taken:

The mode of transport to the department for the investigation for an inpatient is specified on the form by the doctor making the request. This should be done in discussion with the nursing staff. However, the patient's condition may change from the time of the request to the investigation being undertaken and so a further assessment should be made by the registered nurse (RN) caring for the patient at the time of transfer of the patient.

When Mr Simons was going for his investigation, it was appropriate for him to go in a wheelchair as he had been mobilising with the assistance of one member of staff and was comfortable sitting in a chair. However, there was no process in place for this assessment

or documentation of it. Following the Serious Incident investigation a process was put in place whereby a form was generated by Radiology for the Porters to take to the ward for sign off by the Registered Nurse prior to transfer and on return to the ward. This included:

- Patient Details
- Any Infection Prevention Control concerns
- Mode of transfer
- Whether patient required escort and if so if this is a Registered Nurse, Student or Healthcare Assistant.
- To be signed by the RN prior to transfer and on return

Further actions taken since 4 May:

- A review of the form has taken place with all key staff, to ensure this is a dynamic risk assessment, and there is clear documentation for the RN caring for the patient prior to the patient being transferred to and from an investigation/procedure.
- A Standard Operating Procedure (SOP) for Transporting Patients to and from Radiology has been put in place and this new process has been included in that (enclosed).
- Snapshot audits of forms have been carried out by the Trust's Quality Matrons. Audit results will be discussed at ward managers meetings to highlight any areas of concern.
- The process, including roles and responsibilities, will be included in a new wider Hospital Transfer Policy. This has been drafted and is currently going through the Trust's ratification process.

2. <u>Assistance</u>

It was established that assisting a patient to move meant by a member of the nursing staff and not a Porter. It should be clear what a Porter is to do if no nursing staff are available.

This was communicated as part of the SI and Porters DO NOT transfer patients from chair to wheelchair or bed without the assistance of a nurse when being transferred off or onto the ward.

Action taken:

As part of the response to the Regulation 28 this has been recommunicated across the Trust via:

- Trust wide safety alert (attached)
- A discussion at a Ward Manager's meeting with the Director of Nursing on 12 May 2021 to ensure that a Nurse (either a Registered Nurse or a Healthcare Assistant) always assists the Porter with the transfer of the patient on their return to the ward from another department

- A discussion with all Porters with the Head of Portering
- In addition a letter has been sent to each individual Porter outlining that the responsibility for the safe transfer of the patient from chair to wheelchair or from wheelchair to chair or bed, is the responsibility of the nursing staff caring for the patient. If a Nurse is not available the Porter should take the patient in the wheelchair to the ward desk and request Nurse assistance.

3. Risk Awareness.

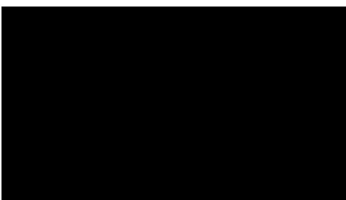
The Porter did not know the patient's level of risk of falls.

Action taken:

Falls awareness training is currently being delivered by the Falls Practitioner to all Portering staff. This training includes making Porters aware of visual alerts that patients at risk of falls have in place, for example yellow wrist bands and icons both at their bed space and on the patient safety screens near the nurses' station. The expectations around undertaking falls awareness training for Porters will be included in the Procedure for Managing Inpatient Falls. This training will now be delivered to Portering staff on induction and 3 yearly as part of statutory mandatory training for Porters. The training, in combination with a clear briefing from the Registered Nurse to the Porter transferring the patient, should ensure the Porter is aware of the individual risk for the patient being transferred.

Thank you for bringing your concerns to my attention. I hope you are assured that I have taken them seriously and investigated them appropriately. If I can provide any further information, please do not hesitate to contact me at the above address.

Yours sincerely



Chief Executive