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Se[redacted]
Ms Lorraine Harris
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West Yorkshire (Eastern District)
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Dear Ms Harris

Re Inquest of Mary Ann LINCOLN (dcd) – 27.04.1936 to 21.05.2020

I am responding on behalf of the Trust to the Regulation 28 Report to Prevent Future Deaths that you issued to The Mid Yorkshire Hospitals NHS Trust (MYHT) on 2 August 2021 (notification received by MYHT on 17 August 2021).

The Matters of Concerns raised in your report were:

(1) During evidence it became apparent that there is no guidance or policy with regard to checks on patients overnight (who are not subject to NEWS, turning etc). Mrs Lincoln was put in to bed at around 2130 and only checked once in the night despite being in hospital, having a history of falls and knowledge of the fact she needed the toilet overnight. Although she had previously used the call buzzer she was also known to mobilise herself. She was not discovered until 0630, and then only because someone noticed as they passed her door. She had lain on the floor for some time, with an open fracture. The hospital conducted a serious incident review in which it recommended the checks policy should be reviewed. It appears it was reviewed but no changes were made. Evidence had been heard that previous rounding checks were deemed inappropriate and therefore no further action was required. Therefore there is no policy or guidance with regard to people who are vulnerable, a falls risk and known to get up in the night (for any reason) to be further assessed for checks overnight.

(2) *There is a bedrails policy in place, the author of the SI report found that it appeared to be comprehensive. During evidence however the staff responsible for [redacted] either unaware of it (it appears it is not circulated to [redacted]. There is obviously a void between producing a policy [redacted] and understood by all concerned.*

[redacted] bringing these matters to MYHT's attention. We have reviewed our processes and are presently undertaking a number of actions.

Frequency of Checks

This matter of concern was received and discussed with the senior nursing team within the corporate division. It was acknowledged that regular checking of patients, vulnerable or not, is a Trust-wide issue applicable to all divisions who have in-patients.

[redacted] As part of the Trust's serious incident investigation it was identified as an action that there was a need to review or develop guidance for nursing staff surrounding the frequency of patient checks during a night shift. One option considered at the time was whether this guidance should be included as part of the Standard Observations Policy already in operation at the Trust. However, following discussions with the Matron for Quality and Patient Safety, it was felt that the existing policy was not a suitable vehicle to include this type of guidance, as the policy's focus is on vital observations and escalation.

Reintroduction of an "intentional rounding observation tool" was also considered but as this tool had previously been discontinued because it had become a "tick-box" exercise, it was considered inappropriate to reintroduce it when meaningful (albeit quick) checks should occur.

It was also noted that a patient who is nursed in a bay, is more likely to have an increased level of observation due to the likelihood that a member of staff will enter the bay to provide some level of care to another patient e.g. toileting, vital sign recording etc. Equally, a patient nursed in a side room may receive a lower level of *ad hoc* checking, just by virtue of being in a (single) side room as opposed to a (multi-occupancy) bay.

In addition, it was recognised that a patient who has a level of vulnerability (falls risk, pressure ulcers, lacking capacity, DOLS) will have had an enhanced care assessment and may already be receiving an increased number of checks through bay tagging, cohort nursing or 1:1 care.

There is also a level of nursing activity for all patients after the night shift team comes on duty including medication rounds, drinks, observations (formal), settling down for the night, and dimming of the lights. This activity usually takes place between 19:30 and 22:00hrs.

Regardless of this activity, it is accepted that staff at the Trust would benefit from written guidance around the frequency of checks expected to take place overnight.

[redacted]rector of Nursing, Division of Medicine will communicate [redacted]rd Operating Procedure (SOP), the following minimum [redacted]nd documentation expected between the hours of 22:00

The SOP will include the following:

- Patients who are cared for in **side rooms** (including patients assessed as high risk of falls, or with increased toileting needs etc.), should be visually checked **hourly**, as a minimum
- [redacted]**ays** (including patients assessed as high risk of falls, [redacted]or with increased toileting needs etc.), should be visually checked **two hourly**, as a minimum
- Where there are no concerns regarding the patient, this must be documented on the electronic record on PPM+ as follows:
  - "Patient checked hourly overnight, no concerns", or
  - "Patient checked two hourly overnight, no concerns".
- Any concerns regarding patients during the checks must be actioned and escalated appropriately as per normal practice, and documented within the records.
- The one hourly or two hourly checks are <u>in addition to</u> the regular vital sign observations, medication rounds and any further care required overnight.

Compliance

The Trust recognises that it will take a period of time to implement and embed this practice in all wards across all divisions. It is proposed that this SOP will be implemented by the end of this calendar year; however, in the meantime, communication has been sent to Assistant Directors of Nursing across the Trust with the above guidance to disseminate to their teams. Once introduced into a ward, Divisional Assistant Directors of Nursing and their teams will be able monitor compliance through the monthly Ward Health checks as these 'overnight patient checks' will form part of the auditing of night-time documentation, to demonstrate continued learning. Furthermore, compliance will be reported through the Patient Safety and Clinical Effectiveness Group (PSCE) three months following implementation and any further concerns will be actioned accordingly. PSCE is a sub-committee of the Trust Board Quality Committee and is chaired by the Trust Medical Director. PSCE meets monthly and has clinical representatives from each of the operational divisions and corporate functions.

Falls/Bed Rails Policy

The Trust has taken the following individual steps to share the learning from the serious [redacted] investigation and the Coroner's Inquest findings and recommendations [redacted] ties for the Falls Policy to be accessed and understood [redacted] mportantly, this has included highlighting individual staff [redacted] cy when assessing the use of bed rails.

[redacted] luding issues raised by the Coroner and/or family and lessons learned, was emailed widely throughout the Trust to senior management [redacted] for dissemination to all appropriate staff.

2) Email communication was sent to Assistant Directors of Nursing [redacted] and forwarded to their respective inpatient areas for Ward Managers to discuss within their services the Trust's bed rails assessment processes.

3) This was followed up by discussions at Matrons meetings and Ward Manager [redacted]

4) Learning from other Trusts in relation to bed rails management (identified through CQC inspections) was circulated by MYHT's Falls and Quality Practitioner to a number of high level groups including the Patient Safety Improvement Group, Nursing Review Group, Patient Safety Panel and PSCE. The learning was subsequently incorporated into an addendum to the falls policy published in July 2021.

5) In August 2021, the Gate 43 Newsletter featured a 'learning from incidents' section which included an anonymised summary of the events surrounding this particular incident and learning. This also included the responsibilities of staff members when assessing a patient for bed rails.

6) This particular 'learning from incidents' will be highlighted again through an upcoming Patient Safety Bulletin which will be circulated trust-wide by end of October 2021.

7) In addition to this learning being shared globally, where required, individualised counselling / training with staff members will be undertaken in relation to the assessment and use of bed rails.

I trust this advice is helpful and provides you with assurance that MYHT has taken appropriate steps to address these important matters of concern and we thank you for bring them to our attention.

In closing, on behalf of The Mid Yorkshire Hospitals NHS Trust, I would also like to take this opportunity to once again offer our sincere condolences to Mrs Lincoln's family in relation to her sad death.

Yours sincerely

[redacted]

[redacted]

Dr [redacted]

Medical Director

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