1442 63/2014 reg 7.4.14

Stockport NHS
NHS Foundation Trust

Our ref. AB/RF/CM/PR-letter to HM Coroner-I=L-Hill
Your ref. JK//KA/02190-2013

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31st March 2014

Dear Ms Kearsley

Re: Laura HILL 13.09.1936 (Deceased)

Thank you for your letter of 17th February 2014, concerning the inquest of the above named. As always, I am grateful to you for highlighting your concerns on the Regulation 28 'Report to prevent future deaths' and for providing me with an opportunity to respond.

Ms Hill was admitted to Ward C3 on 28th September 2013 and on admission a falls risk assessment was completed. Ms Hill was identified to be at risk of falls and as a result of that assessment bed rails were recommended. The nurse who carried out the falls risk assessment has stated that, prior to attaching the falls risk wrist-band and completing the care plan, she went to find bed rails for the patient but could not find any immediately; she then became very busy and unfortunately forgot to go back to attach the falls risk wrist-band, fit bed rails and complete the care plan.

On 1st October 2013, shortly after 01:00 hours, Ms Hill was transferred to Ward B6; however the falls risk assessment was not updated by the nursing staff, as per the trust policy, and on 2nd October 2013 at 03:30 hours Ms Hill had an unwitnessed fall.

Actions

We have instigated an escalation process whereby, if any equipment cannot be located within the immediate ward environment, staff must contact the senior nurses on 'professional cover' for the Business Groups by bleep in the first instance to assist in locating the equipment. Should the bleep-holder be unable to resolve the problem, this is to be escalated to the hospital site manager who will either locate the equipment or assist in the re-assessment of those currently in use across the hospital. This will be monitored via the Datix incident reporting system to ascertain the need for further equipment to be purchased.

As a result of our investigations, in the case of the falls risk assessment undertaken on ward C3, the nurse failed to follow Trust Policy in applying the falls risk wrist-band and in completing the falls risk care plan; had she done so this would have alerted other staff to the fact that the patient was at a higher risk of falls. The nurse concerned has been formally counselled on her failure to follow Trust Policy.

In the case of the nurse on ward B6, who failed to update the falls risk assessment on transfer of Ms Hill, the investigation found that she had also failed to follow Trust policy and she too has been formally counselled regarding this.

This case has been presented by the managers of both wards involved to a wider audience of ward managers at a Surgical Sisters' meeting on 17th March 2014, so that they may disseminate the lessons learned to their respective teams.

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

Ann Barnes
Chief Executive