

Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP


Trust Headquarters
Executive Offices
Ground Floor
Pathology and Pharmacy Building
The Royal London Hospital
80 Newark Street
London
E1 2ES

17 October 2014

By special delivery

Dear Coroner Hassell

Inquest Touching the Death of Irshad Ali

I write in response to your Regulation 28: Report to Prevent Future Deaths, dated 29 August 2014.

The investigation into your concerns regarding the lack of documentation recording intentional rounding on the night of 24/25 March 2014, the missing chart recording neurological observations carried out after his fall, the lack of documentation of the neurological examination carried out by the consultant's junior colleagues, the lack of a physiotherapy assessment prior to discharge, that this was not communicated by the nurse-in-charge to her colleague and to the family, the provision of the discharge pack to the family when he was not yet ready to be discharged, and the evidence that a nurse accompanying the doctors on their ward rounds would be helpful, has now been concluded.

I am satisfied that this investigation has been sufficiently robust, in that we have scrutinised all relevant records and interviewed staff to inform our investigation. I write to apprise you of the conclusions of the investigation.

During the investigation, senior qualified nursing staff contacted the nurse allocated to care for Mr Ali on the night of 24/15 March 2014, who confirmed that the intentional rounding did take place. The intentional rounding chart for this night remains missing. Evidence has been adduced that this is because the medical notes had been filed incorrectly. This will be dealt with by a monthly senior nursing audit of the integrity of the filing of patients' notes and spot checks for intentional rounding compliance and correct filing of medical notes.

The missing neurological observation chart has been located and it confirms that appropriate neurological observations were carried out after Mr Ali's fall. This chart had been inadvertently misfiled.

Senior medical staff have confirmed that the induction for new medical trainees now includes a section on documentation and management of falls, emphasising the requirement to document actions in the medical records.

To ensure that all future referrals (including physiotherapy referrals) made for patients are signed and dated in the medical notes when actioned, staff have been reminded of the importance of thorough clinical handover. This will be further highlighted during a twice daily staff safety briefing, and followed up by spot checks of patient notes to check that verbal referrals are being documented as actioned.

To ensure that the Trust falls protocol is being complied with, twice daily safety briefings will be held to highlight the falls protocol. Nursing staff have been reminded that the nurse in charge of shift has responsibility for ensuring the correct procedure is followed and documented in the medical notes. Training for nurses in neurological observations, is being provided by the Critical Care Outreach Team. Effectiveness will be measured by audit of nurses' understanding of the falls policy and documentation in the care plan, their understanding of neurological observations, and competence in the performance of neurological observations.

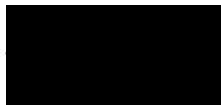
It is Trust policy that the copy of the patients' discharge letter should be given once all facets of the discharge process are complete. Nurses have been reminded of the policy and the requirement to update the patient information sheet with the information that the discharge summary should be given to the patient alongside their discharge medications. To facilitate this, the Trust continues to cultivate a continued effective relationship with the Trust discharge lounge.

Ward 14F currently has five specialties, all of which carry our doctors ward rounds. To enable a nursing presence on each of the ward rounds, the senior sister will be given a copy of the consultants' rota and proposed time of ward rounds, and agreement has been reached that the doctors will not leave the ward until they have verbally communicated the proposed plan of care for their patients to the Nurse in charge of the ward, or responsible for that group of patients. This will be reviewed daily with the feedback provided by the consultants, with a weekly combined nursing and medical review.

We have taken this as an opportunity to review our processes to enhance future care. The outcome of the investigation will be shared with all Trust medical and nursing staff, to ensure that staff involved implement the above changes and audit the adequacy and effectiveness of the changes.

Thank you for bringing your concerns to my attention. I trust that you are assured I have taken them seriously and investigated them appropriately.

Yours faithfully



Medical Director
Barts Health NHS Trust