University Hospitals of Leicester NHS
NHS Trust

Direct Line: [redacted]
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Your Ref: [redacted]
Our Ref: [redacted]

10 April 2015

Mrs C Mason
HM Coroner
The Coroner's Court,
Town Hall,
Town Hall Square,
Leicester
LE1 9BG

Dear Mrs Mason

Re: **Henry Dennis Whitwell Powell**

I write further to your Regulation 28 sent to us on 18 February 2015, and I am now in a position to respond. I note that the matters of concern are as follows:-

1. The discharge care planning is felt to be inappropriate with misunderstanding regarding the appropriate use of bed rails.
2. There was felt to be a conflict between the policies governing transfer arrangements between my Trust and the Community Services, and the provision and ordering of equipment.
3. Co-ordination between services provided by UHL and LPT was felt to be inadequate.
4. Implementation of an alert system to ensure communication between all stakeholders has not been implemented.

   Since the conclusion of this inquest I can report that we have taken steps to strengthen our processes

   In light of what occurred in this case, our Lead Discharge Nurse has met with all staff working in the Trust, who are authorised to order bed rails for discharge, to ensure they are up to date with the procedure for ordering bed rails and to ensure they fully understand how to use the bed rail risk assessment matrix for patients who are at risk of slipping, sliding or rolling out of bed. She has used this case to emphasise the importance of strictly

adhering to the approved process for discharge including when bed rails are to be provided. Supported by our Acting Chief Nurse, she will ensure that training is provided to relevant staff on the Trust's processes for discharge and this will include training on bed rails risk assessment.

All staff authorised to order bed rails are all now aware of their responsibility to forward a copy the risk assessment and care plan undertaken by UHL staff to the person responsible for the patient's care in the community setting following discharge from UHL and the information will also be recorded on the electronic transfer letter on ICE and audited. In addition, our Acting Chief Nurse will ensure that the Manual Handling Team will review the manual handling training undertaken by Ward staff, to ensure they are able to understand and interpret the risk assessment matrix, to aid their decision making, for the use of bed rails for patients who are at risk of slipping, sliding or rolling out of bed in the hospital setting.

This case has been discussed at the recent CMG Health and Safety Board and it was agreed that details of bed rail risk assessments will be recorded in the metrics that we collect and which provide an indication of current concerns within the clinical setting. In particular, we will be strengthening our guidance on the meaning of patient mobility to improve the quality of our bed rail risk assessments.

Our Acting Chief Nurse will ensure that all of the above action will be completed by June 2015.

On your second and third concerns I am pleased to be able to confirm that my Trust and Leicestershire Partnership Trust are working together to remove any conflict between our respective bed rail policies. Our Lead Discharge Nurse is working collaboratively with representatives from community hospitals, community nursing and NRS to agree a joint working policy for the safe use of bedrails. The working group have met twice to agree the process of assessment; development of a care plan and handover arrangements following transfer from hospital. A further meeting is scheduled for 10th April 2015, to make final adjustments to the policy, before this is sent for ratification. Our Acting Chief Nurse will ensure that this work will have occurred by May 2015. In addition, our Discharge Policy will be reviewed and will advise staff to consult the joint policy for the safe use of bedrails. This work will be completed by the end of June 2015.

In addition, to ensure Trust-wide learning, this case will be discussed at UHL's Falls' Group which is chaired by a senior clinician and also at the next meeting of the Trust's Nursing Executive Team which is chaired by our Acting Chief Nurse.

On your fourth point our Lead Discharge has confirmed that an alert system is now in place on the electronic ordering system to prompt staff to consider a bed rails risk assessment. If this information is not completed, then the system will prevent bed rails being ordered.

I trust that this response provides you with the assurance that we take these matters seriously.

If you would like any further information please do not hesitate to contact me.

Yours sincerely

[redacted]

John Adler
Chief Executive

cc: John Adler, Chief Executive
[redacted] Assistant Director (Head of Legal Services)
[redacted], Acting Chief Nurse