Brighton and Sussex University Hospitals NHS Trust

The Royal Sussex County Hospital
Eastern Road
Brighton
BN2 5BE
Tel: [redacted]

Your ref:
Our Ref: [redacted]

Miss V Hamilton-Deeley, HM Senior Coroner
Coroner's Office, Woodvale
Lewes Road
BRIGHTON
BN2 3QB

Dear Miss Hamilton-Deeley

**The Late Christine Street, date of birth 31.03.1944**
**NHS No: 418 862 7476**

Thank you for your letter of 6 May 2016, and for drawing your concerns to the attention of the Chief Executive. As [redacted] is currently away from the Trust, she has asked that I respond to you on her behalf. I am aware that the Chief Executive acknowledged that the care provided to Mrs Street was unacceptable, and indeed wrote to the family shortly after her arrival at the Trust early in April 2016, to apologise about this before the inquest took place. She and I both believe it is vital that the Trust staff really learn from experience when something has gone wrong.

I am aware that the quality of documentation for Mrs Street was poor in several respects and this has been followed up with both nursing and medical staff. The staff had recognised that Mrs Street was at high risk of falls, and had intended her to have constant attention knowing that she lacked capacity to comprehend her risk of falling as a result of the tumour. It appears that the ward nurses had mistakenly thought that the 'care record for patient requiring specialling', which was available as an appendix to the Trust's 'policy for the observation of adult patients with mental health problems', was not intended for use when caring for a patient who was suffering not from a mental illness but from a specific neurological condition - in this instance, a brain tumour. Rapid action was taken when this came to light, to correct their understanding.

A series of study days has been held for the nurses on L8AW, to help them understand fully their responsibilities and obligations. Topics addressed have included Deprivation of Liberty; falls prevention and management; one to one care; end of life care; and documentation. A practice educator took up post on the ward earlier this year, who provides training both on specific neuro-competencies for nurses and also on more general nursing skills.

It is particularly disappointing that Mrs Street was injured in a fall as this Trust has worked very hard indeed over several years to implement an active falls prevention programme. As a result the Trust has one of the lowest rates of inpatient falls of any acute Trust in the country. Nevertheless, in her weekly message to all staff, the Chief Executive has

reminded all staff of the scope for further improvement, as well as taking the opportunity to remind us all of the actions to be taken should someone fall. Following receipt of your letter, she has also used her weekly message to remind staff to make sure they are familiar with the Trust policy on observation of patients mentioned above, as well as to use the adult care pathway for people requiring one to one care, acting on the prompts contained within it and documenting these actions comprehensively and contemporaneously.

Since Mrs Street's fall, more work has been done to ensure the bank staff are well-informed about the policy for the observation of adult patients with mental health problems, and the associated documentation to be used if they are asked to provide one to one care for a patient. Teaching sessions have also been run for the Trust's health care assistants, to refresh their knowledge about what is required when they are asked to provide one to one care to any patient.

Furthermore an audit has been carried out very recently of every patient being specialled. The findings are now being collated and action will be taken, including if necessary revision of the current policy, in the light of any learning points that emerge from this audit.

In order to improve the quality of documentation, the neurosurgeons have organised a monthly records audit. Senior nurses have also been performing spot checks of records and taking action to remedy any shortcomings identified, as well as educating those individuals concerned about how to improve the quality of their records.

Learning from these sad events is not limited to the Directorate of Neurosciences and Stroke Services. The Directorate Lead Nurse gave a formal presentation to her fellow senior nurses from across the whole Trust, after the inquest, to disseminate the lessons to be learned as widely as possible.

Thank you once again for raising your concerns with the Trust.

Yours sincerely

[redacted]

[redacted]
Interim Chief Nurse