REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive,** **Blackpool Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 22nd April 2013 an investigation commenced into the death of **Ethel Cross**, aged **91 years**. The investigation concluded at the end of the inquest on 22nd October 2013. The record of the inquest confirmed as follows: The Medical cause of death was Ia Fat Embolism Ib Fractured Neck of Femur II Chronic Heart Failure and Coronary Heart Disease The conclusion of the Coroner as to the death was Accidental Death
4	**CIRCUMSTANCES OF THE DEATH** Ethel Cross had a history of falls. On 12th April 2013 at 0630 hours who had a history of falls, fell whilst returning from the bathroom on ward 4 at the Clifton Hospital. She sat on a chair for a rest. The chair slipped. She suffered a fracture of her neck of femur. Initially, she was not noted to be in pain. She later did complain of pain and was therefore taken to Blackpool Victoria Hospital. She died on the 13th April 2013.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. –

	At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009. During the Inquiry, I received evidence that chairs utilised by staff which have wheels attached to them had been present on ward 4 and that Ethel Cross had sat on one of these chairs which slipped and she suffered a fracture. I heard evidence that these chairs have been removed from two wards – including ward 4 - on which elderly patients at significant risk of falls may be cared for. I am concerned that such chairs may continue to be present on other wards within the Trust where such patients may have access to them and similar incidents may occur. During the course of the evidence I heard that although at high risk of falls, and someone who would need one to one assistance from staff when mobilising, Ethel Cross was not provided with an alarm that in the event of her moving when staff are not nearby could alert members of the medical staff to such movement allowing the staff to attend to her. All such alarms on the ward were in use and such alarms are rarely not deployed. Having concluded this inquest, I now write to the Trust to confirm that in my view the Trust should take action because: • the presence of such chairs - with wheels attached – in an area frequented by elderly patients may lead to further such fatalities should elderly patients access them • patients who are at high risk of falls may try to mobilise themselves unsupported when staff are busy elsewhere on the ward with other patients and all of the available alarms are in use. I would therefore be obliged if the Trust would write to me in due course to confirm what steps if any the Trust proposes to take to address these two areas of concern.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd January 2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons The family of Ethel Cross The Coroners Society I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your

	response, about the release or the publication of your response by the Chief Coroner.
9	**Alan Wilson** **Senior Coroner for the area of Blackpool & Fylde** **Dated: 5th November 2013**

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Trust Headquarters
Blackpool Victoria Hospital
Whinney Heys Road
Blackpool
Lancashire
FY3 8NR

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Your Ref: AVH/KAH

Our Ref: DG/Cross

Date: 31st December 2013

Mr A Wilson
HM Coroner
Blackpool & Fylde District
Municipal Buildings
PO Box 1066
Corporation Street
Blackpool
FY1 1GB

Dear Mr Wilson

Re Ethel Cross
Formerly of 29 East Cliffe Lytham St Annes FY8 5DX
Date of Birth -8th December 1921
Date of Death13th April 2013

I am writing to respond to your Regulation 28 report to prevent future deaths made pursuant to the powers given to you under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

At the end of the Inquest into the death of Ethel Cross, which concluded on the 22nd October 2013, you raised the following concerns:-

1. The presence of chairs with wheels attached in an area frequented by elderly patients may lead to further such fatalities should elderly patients access them.

2. Patients who are at high risk of falls may try to mobilse themselves unsupported when staff are busy elsewhere on the Ward with other patients and all of the available alarms are in use.

Subsequent to receipt of the Regulation 28 report a meeting took place at the Trust with the following members of staff:-

1. Marie Thompson - Director of Nursing & Quality
2. Simone Anderton – Associate Director of Nursing Unscheduled Care Division
3. Tracy Burrell –Assistant Director of Nursing Patient Safety
4. Debra Mathlouthi – Health & Safety Manager

As you are aware following the initial incident on Ward 4 at Clifton Rehabilitation Hospital all the wheeled chairs were removed from that Ward and Ward 1 at Clifton Rehabilitation Hospital.

Debra Mathlouthi carried out a risk assessment in respect of the chairs and the falls prevention monitors, a copy of her findings are attached. You will see the recommendations noted therein.

The potential implementation and viability of those recommendations were then discussed with Simone Anderton and Tracy Burrell and the following action plan has been implemented:-

1. Identify the nurse stations within the Trust which pose a high risk to patients who may access wheeled chairs.

2. The following areas have been identified as high risk areas, i.e due to the positioning of the nurse station, patients have easier access to wheeled chairs within the nurse station area:

    - Wards 1, 2, 3 & 4 at Clifton Rehabilitation Hospital site.

    - Ward C at the Blackpool Victoria Hospital site.

All wheeled chairs have been moved from nurse stations in these areas.

3. In respect of patient falls the Trust has developed a Falls Steering Group which monitor, assess and develop, through educating staff and identifying trends and individual patient risk, systems and working practices to reduce the risk and incidents of falls within the Trust.

    The Trust, as part of the staffing review completed in July 2012, has invested £1.3 million pounds into staffing levels which has supported the concept of Bay based nursing within areas of high risk.

    The concept of Bay based nursing utilises the allocation of staff per shift to work in the Ward Bays with attached side rooms, rather than across two teams split over the Ward.

    The aim of Bay based nursing is to increase visibility and the presence of the nursing staff within patient areas, which has proved to show a reduction in the incidents of patient falls and harm.

The Trust has also incorporated a "Tag" system within the Bay nursing concept which means the Bay is never left unattended, as when one nurse leaves she is tagged by the incoming nurse.

However, that said, I would note that, sadly, it is a fact of hospital life that patients, particularly elderly patients and patients with multiple co-morbidities, do fall. The falls monitors which are attached to patients can, and are, on a regular basis, removed by patients, which negates the purpose.

It is an ongoing task for the Trust to reduce the level of falls.

The information below is a summary of the Trust Falls Steering Group.

- There has been targeted support and training given to wards within both the Scheduled and Unscheduled Divisions to improve the staffs understanding in relation to bone health and falls risks this included education around the falls risk assessment and the formulation of a care plan for patients at risk of falling.

- Introduction of movement sensors in all the clinical divisions, both on the acute wards and in the community hospitals, for patients who are identified to be at high risk of falling. The sensors are discreet and can be placed either under the mattress of the bed, or on the chair if the patient is sitting out of their bed. The sensors alert the ward nurses via a pager system if a patient attempts to get out of bed or move from the chair unaided. The sensors have already helped prevent potential injury to patients as the nursing staff have been alerted swiftly and assistance given.

- Low beds have been trialed and the trust has introduced these (7 in total) to prevent falls for those patients at higher risk.

- A footwear trial has been completed and we have changed and standardised the products used across the Trust.

- We have developed a slipper exchange scheme in the care of the older adult wards.

- Greater cross boundary working with colleagues working in the community.

- The Trust Falls Steering Group has been re-invigorated and is now multi-disciplinary and includes voluntary agencies.

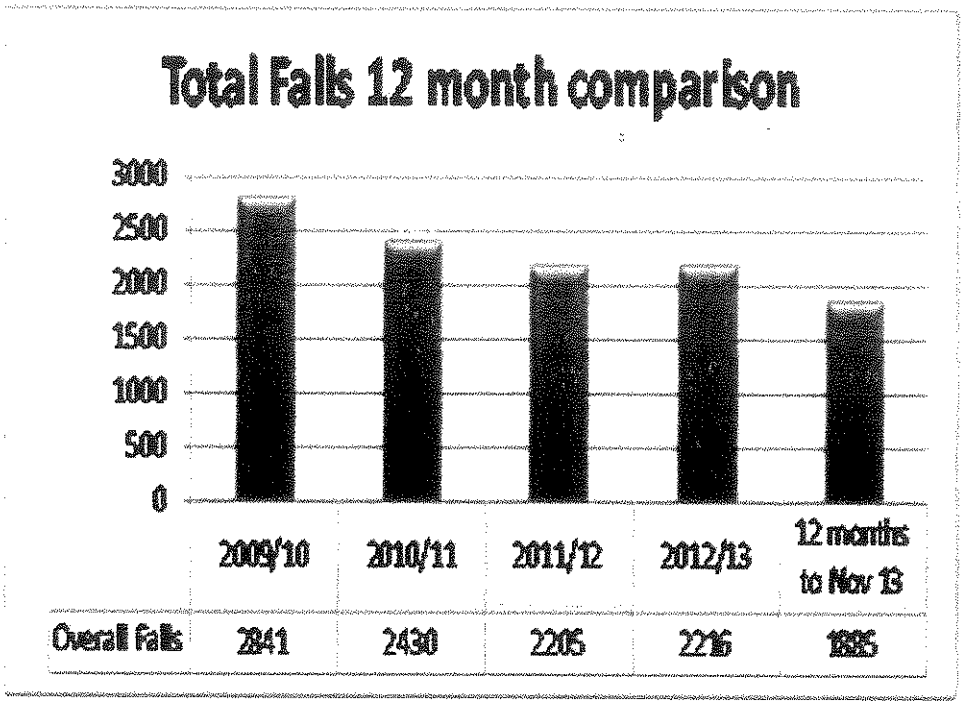
- A falls prevention workbook has been developed and rolled out across the organisation to improve staff education, this is currently being reviewed following feedback to simplify it for staff.

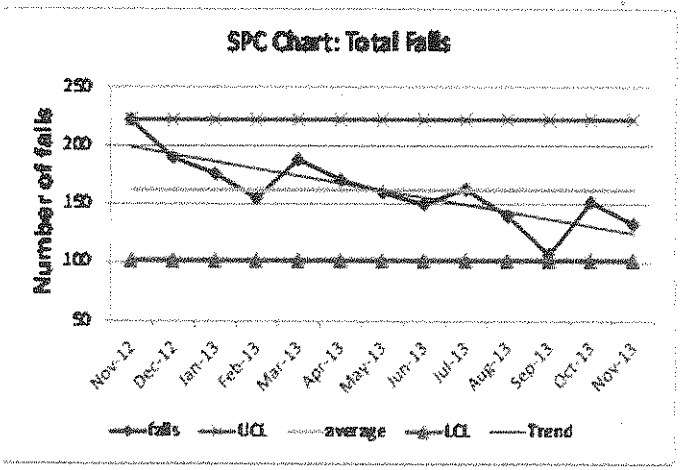
- Falls prevention leaflets have been developed to improve patient education.

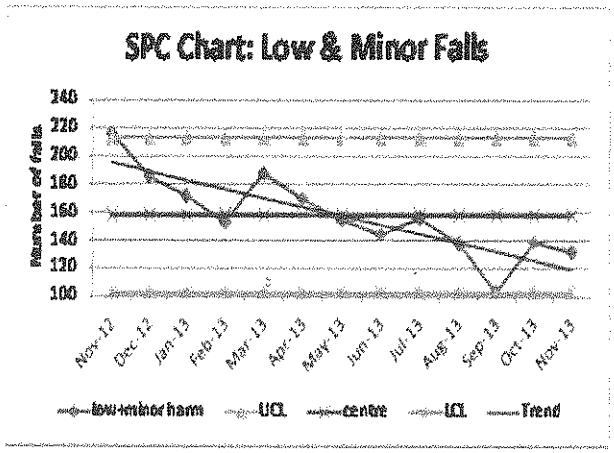
- Ward level standards have been introduced in Scheduled Care.

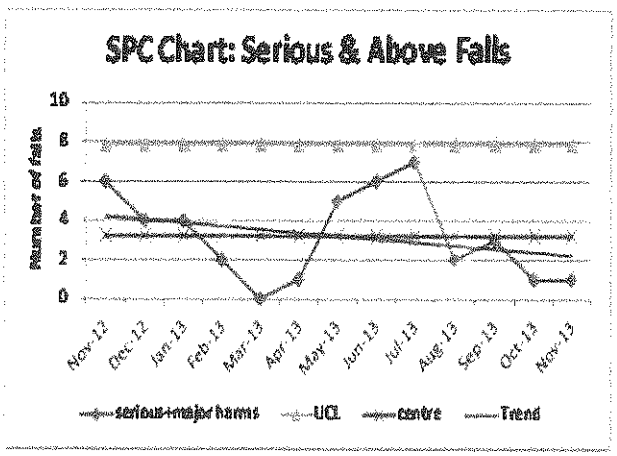
In 2011/12 there were 2205 falls with harm compared with 2216 in 2012/13. There were 35 patients who experienced a fall that resulted in a moderate/serious harm. This is a 15% reduction on the number of patients who experienced the same harm in 2011/12. In the rolling twelve months to November 2013 there have been 1885 falls with harm. In year, in the 8 months to November 2013 there have been 1129 falls with harm and at this

rate we would expect to see no more than 1694 falls with harm for 2013/14, a reduction on last year's total of 30%. Measures have been put into place as outlined above and it is anticipated that the Trust will continue to see a downward trend in serious falls.







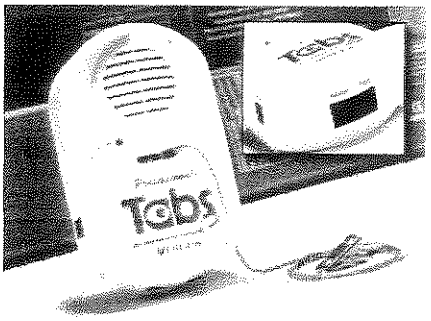


We hope the above is a satisfactory response to the Coroners Regulation 28 report. Please don't hesitate to contact the Trust for further information if required.

Yours sincerely

Marie Thompson
Director of Nursing and Quality

All such alarms on the ward were in use and such alarms are rarely not deployed..(please see image below)



A Fall Prevention Monitor easily moves from bed to chair, eliminating the need to have multiple monitors. The pull string functions work independently making a versatile fall alarm monitor.

The Pull String feature of the Fall Prevention Monitor works by simply clipping the garment clip onto the patients clothing and attaching the monitor to bed or chair.. If the cord is pulled away from the monitor the alarm is triggered, alerting staff.

Recommendations

1. All chairs with castor wheels to be removed from patient areas where there is a foreseeable risk of patient falls.

2. Static chairs to be put in place preferably with arms which would help stabilise a patient in the event that they pulled out the chair to sit down.

   Or

3. Chairs with castor wheels on can be replaced with locking/breaking castor wheels however, this will be financial implications to the Trust.

4. Chairs with castor wheels are used in clinical / nursing areas across the Trust. A full audit of all clinical areas to be carried out to identify the high risk areas to make the recommended changes.

5. More fall monitors to be purchased to reduce the risk of patient falls.

Debra Mathlouthi
Health and Safety Manager

Incident number 89193 – Ethel Cross

Investigation / findings following Letter 28

Chairs utilised by staff which have castor wheels attached to them had been present on ward 4 and patient E C had sat on one of these chairs which slipped and she suffered a fracture. (please see image below)

The chair has been removed from ward 4 - on which elderly patients at significant risk of falls are cared for and replaced with a static chair tucked under the nursing station when not being used. (please see image below)

The Coroner is concerned that such chairs may continue to be present on other wards within the Trust where such patients may have access to them and similar incidents may occur.

It has been identified that the chairs with castor wheels are used in clinical / nursing areas across the Trust

Although at high risk of falls, and someone who would need one to one assistance from staff when mobilising, E C was not provided with an alarm that in the event of her moving when staff are not nearby could alert members of the medical staff to such movement allowing the staff to attend to her.