At the end of the inquest into the death of Mr Jones, the coroner indicated that she was considering issuing a PFDR to reflect her remaining concerns on a number of issues arising from the evidence given. At that the time the Trust was offered 5 days to respond with any additional information which might assist with this decision.

As a result the Trust has reviewed the Coroner's areas of concern and responds as below.

I would be grateful if you would place this email in front of the Coroner.

1&2 Whether sufficient consideration is given to falls prevention measures on surgical wards and sufficient understanding of the post falls protocol .

All Trust nursing staff are trained locally in their ward areas on the use of Trust policy and documentation connected with falls assessment, preventative measures and the protocol for managing a patient following a fall. These are regularly refreshed by mandatory training and other educational opportunities.

Evidence was heard from [redacted] at the inquest about specific measures being taken to improve staff awareness and appreciation of falls prevention and management on Ward 5b. One main measures is the Silver QI project being undertaken by [redacted] part of which is directed at reducing the risk of falls by more reliably acquiring knowledge of individual patient risks, and also ensuring more consistent use of preventative measures eg magnet signage above patients beds (see attached Driver diagram and GSAIA Quality Improvement summary which details the issues to be addressed). The aim of the project is to increase completion of the First Hour Priority Form (renamed Safety Hour Checklist) by 70% by May 2019. This form will record (amongst other factors) the handover of any falls risks for the patient being transferred. The intention of this form is that it will transfer with the patient if they are moved to another clinical area, thus providing a falls history in one document.

The most recent audit of Ward falls documentation shows that for the 10 patient falls care plans audited there was a 90-100% compliance with the documentation, which is an improvement (see attached audit)

Patient falls are routinely investigated and learning from those falls is disseminated to staff in all clinical areas through the use of Safety Briefings (see attached Safety briefings – patient falls for March and October 2018)

3. Whether there is sufficient understanding of post falls management including consideration of anticoagulants (this refers to the fact that anticoagulants were not stopped at the time of medical review of 5th fall)

After the inquest the Trust has reviewed the medical contribution to post falls management and , in particular, the inpatient post falls assessment sticker. Although this sticker is an effective tool for standardising medical post falls care and assessment, the Trust's conclusion is that this could be improved. Analysis of Mr Jones' drug chart shows that he was prescribed a daily dose of anticoagulant in the form of a prophylactic dose of Dalteparin. Despite this, on the post falls assessment stickers the reviewing doctor has answered 'No' to the question 'is the patient on anticoagulation'. The Trust proposes to undertake some work to address the fact that low dose prophylactic anticoagulants in the form that Mr Jones received must be included in this medical assessment, and instructions given to nursing staff as to whether this medication should be continued or stopped. This likely to include redrafting part of the post falls sticker to this effect, and providing accompanying training to doctors about this change, and the reason for it.

4. Whether when the patient is transferred between wards there is handover of all safety information for the patient

Following the inquest, this concern was put to Matro[redacted], Divisional Chief Nurse for Surgery who reviewed the evidence/supporting information provided to the inquest with S[redacted] and [redacted], Matron for Surgery. In the context of the prevention of harm to future patients, she confirms the following

- The safety' huddles' are now embedded across surgery to ensure effective communication and that on the 5th floor wards these now take place regularly at 10am and 3pm (see Daily Safety Briefing form attached).
- The Trust nurse handover documentation is currently subject to a Quality Academy Silver project to be presented in June. [redacted] (Ward 5a) and [redacted] (Ward 5b) have trialled a modification to the usual handover process. The modification now enables all previous handover information from all clinical areas where the patient has been placed to be contained on one form, rather than on several forms from each of the previous clinical settings . the intention is that this will ensure that a receiving ward can see a complete history of concerns during that admission of concerns from all the previous clinical settings from which the patient has been transferred, thus giving a more complete picture. This was not available for Mr Jones.

If this improvement work is successful the suggestion will be to modify the Trust handover allowing an audit trail of all risks identified throughout a patient's stay. So far they have achieved 90% completion, and a reduction in falls on 5b by 60% since the start of the trial.

5. When a patient is sent to be scanned for CT there are sufficient checks made before scanning takes place,

The identification of patients undergoing an investigation using Ionising radiation is covered by the Trust Procedure

'EMPLOYER'S PROCEDURES FOR EXAMINING PATIENTS WITH IONISING RADIATION' and I have copied the relevant sections below:

4. PROCEDURE FOR PATIENT IDENTIFICATION

The operator initiating the radiation exposure is responsible for ensuring that the patient has been correctly identified, in accordance with this procedure.

If the exposure is carried out by more than one operator, then at least one operator in the team must identify the patient in accordance with this procedure. The operator designated to identify the patient must identify the patient to the other operators making the exposures.

4.1 Outpatients

• Patients who present themselves at reception should be asked to provide their full name, address and date of birth by the receptionist.

• Porters must notify reception when they bring a patient to a department. The person responsible for booking the patient in must ask the patient for their full name, address and date of birth.

• The operator carrying out the exposure must ask the patient for their full name, address and date of birth.

• Babies and small children must be identified by asking parent or carer to give the patients name, address and date of birth.

• For patients with learning difficulties, the operator must ask the carer to give the patients name, address and date of birth.

• For patients with communication difficulties (including non-English speakers) the operator may need to use the services of the Trust's interpreters/sign language interpreters if the patient cannot give his/or her own name, address and date-of birth. Relatives or carers may be able to assist with communication or provide identity on behalf of the patient.

4.2 Inpatients

• Where verbal identification is possible, this should be carried out as described above, but the wristband must also be checked. This includes checking name, date of birth and medical record number from the standard identity wristband.

• For interventional radiology procedures it may be the responsibility of the nursing staff to identify the patient by asking the patient their full name, address and date of birth. The operator receiving the patient

must then confirm the patient's identity verbally if possible, otherwise from the identity name band issued by the nursing staff.

Unconscious or confused patients whose name is not known should be issued with an Emergency Department number and identity band prior to arrival in the department. If an identity band has not been issued the accompanying nurse must confirm the patient's identity including Emergency Department identity number to the operator and this information must be used to identify all information appertaining to the patient.

• For patients in theatre, the operator must confirm the correct identity of the patient with the theatre nursing staff or the anaesthetist caring for the patient, the standard identity band and WHO surgical safety checklist should be used for this purpose.

4.3 All Patients

If the referral information does not tally with the patient identity information, then the operator identifying the patient must seek further confirmation before he or she proceeds. It may be helpful to enquire if the patient has recently changed address. It may be necessary to contact the referrer for further confirmation. If identity wrist band information appears to be incorrect or unclear the nursing staff caring for the patient must confirm the identity for the operator before the exposure can be carried out. In either of these cases a brief note of the action taken must be made in the comments Section on the CRIS system

Evidence suggest that these checks, in addition to the additional questions relating to Clinical history, are proving effective in identifying patient referral errors. We know that for the period Oct 2018 to Mar 2019 there was one wrong patient scanned, however there were an additional 5 incident reports where the Radiographer had identified a referral error and did not perform the investigation.

I hope this information is of assistance.

Yours sincererely

[redacted]
Head of Legal Services
Lead for Data Protection and Freedom of Information
Gloucestershire Hospitals NHS Foundation Trust
[redacted]