**OFFICE OF THE CHIEF MEDICAL OFFICER**

Medway
NHS Foundation Trust

Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY
[redacted]

7th June 2021

Mr Scott Matthewson
Assistant Coroner
Mid Kent and Medway Coroners
Cantium House
County Hall
Sandling Road
Maidstone
Kent
ME14 1XD

Dear Mr Matthewson,

**Prevention of Future Deaths Regulation 28 Report – Derek Russell**

We refer to your report issued following the inquest touching upon the death of Mr Derek Russell dated 23 April 2021 pursuant to Regulation 28 of the Coroner's (Investigations) Regulations 2013.

Background:
On 11 January 2021 Mr Russell was found at home having had an unwitnessed fall. He was taken to the Medway Maritime Hospital. He had a GCS score of 13/15 and was confused. A CT brain scan showed no acute pathology. Mr Russell was treated for a suspected infection with fluids and antibiotics, assessed as being at "high risk" of falling and the need for a falls alarm equipment was identified but no falls alarm equipment was provided to Mr Russell due to lack of availability.

By 16 January 2021 Mr Russell had still not been provided with a falls alarm and at 01.45h on that date Mr Russell suffered an unwitnessed fall. A CT brain scan revealed chronic bilateral subdural haematomas. Advice was sought from a specialist brain injury team at King's College Hospital in London and conservative treatment was recommended. Nursing staff had to take a falls alarm from another patient and give it to Mr Russell. Mr Russell's condition appeared to stabilise but he then developed lung crepitations and was tested for Covid-19. The test result the following day was positive. Mr Russell's condition deteriorated and he died on 27 January 2021.

**The following is our response in relation to the matters of concerns raised:**

(1) The reason Mr Russell was not provided with falls alarm equipment was because there was a chronic shortage of this equipment within the Medway Maritime Hospital.

Since 2015 Medway NHS Foundation Trust has purchased 236 falls alarms, the last purchase being 100 alarms available for use February 2020 with each ward being allocated two dedicated falls alarms. Our Frailty Assessment Unit has also purchased nine additional alarms, and in response to the concerns raised by HM Coroner the Trust is in the process of increasing stock by purchasing a further 75 falls alarms, 75 bed sensor pads, and 10 chair sensor pads.

Our comprehensive investigation following this Regulation 28 report identified that the tracking of stock throughout the hospital was not as robust as it could be, and as such changes are being implemented to stocktake current provisions and equip wards with the ability to monitor and maintain their own stock in addition to the centrally held reserve; falls equipment levels and availability will be added to the daily checks each ward completes. Budget will be identified and Clinical Engineering, who maintains the equipment stores, will be establishing a robust process for the RFID tagging, logging and tracking of falls equipment as they do with other critical equipment. We have also contacted other local Trusts to learn from any helpful processes they have in place.

All staff have been reminded of the importance of maintaining good stock management processes as well as prompt identification and escalation of any supply issues. The attached standard operating procedure for procuring falls equipment for patients will be disseminated and must be followed, and the outlined escalation process actioned in the event of non-availability. In addition, Clinical Engineering will now contact the dedicated falls team if there is any shortage of falls equipment in their stores, with a twice yearly report of stock levels and stock integrity/expiry, and a full yearly stocktake occurring. There will be 10 dedicated and tracked falls alarms held within the Emergency Cupboard at all times.

(2) The shortage of falls alarm equipment was a long-standing problem and pre-dated the Covid-19 pandemic.

Since January 2019 there have been 9 reports of inability to obtain a falls alarm, with all incidents occurring overnight. Escalation of these incidents to the dedicated falls team did not always happen, but where they were alerted additional alarms were purchased in response. The occurrence of the majority of these incidents being overnight has led to the Trust ensuring training is up

to date for those staff who work predominantly nights, to ensure correct process is well known and followed by all staff regardless of working pattern. Where incidents of shortage are appropriately escalated our records show the average time for provision of an alarm was one hour, including overnight. It follows that increased training on the need for, and importance of, prompt reporting of any shortages is key and all appropriate staff will be reminded of this as outlined above and in the attached standard operating procedure documents.

(3) The 'second wave' of Covid-19 hospitalisations had made the problem even worse than normal.

The Covid-19 Pandemic did impact on availability of alarms as infection control guidance directed Covid patients to be nursed in side rooms or with curtains drawn on bays, these patients were less visible to staff therefore a more risk averse approach was taken and patients were more frequently issued with falls alarms in recognition of this decrease in visibility. Equipment also needed to be fully decontaminated and quarantined after use which slowed supply.

(4) Whilst the risk of falling cannot be eliminated altogether, if falls alarm equipment had been available the chances of Mr Russell falling and sustaining a traumatic brain injury would have been significantly reduced.

A falls alarm does not always prevent a fall, but it does alert a staff member that a patient may be attempting to move and can mean quicker staff response times. It must be recognised that staff response time to a falls alarm is dependent on staff locality within the ward and the type of care delivery they are undertaking when the alarm sounds.

(5) Falls alarm equipment is an essential tool for nursing staff in reducing the risk of falls and related injuries because they enable staff to identify a patient who is about to fall and prevent it (or attend to the patient more swiftly if unable to prevent the fall in the first place).

Falls alarms are not just an essential warning device for nursing staff but the whole multidisciplinary team. A falls risk assessment identifies the need for prevention equipment and this should be available and supplied to patients as indicated. Please see above responses to points (1) and (2).

We thank the Assistant Coroner for raising this with us and highlighting the opportunity for an improvement in our process.

Yours sincerely,

[redacted]
**Chief Medical Officer**
**Appendix 1 – SOP Falls Equipment and Escalation Process for Non-Availability**
**Appendix 2 – Action Plan**