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NHS
Norfolk and Norwich
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NHS Foundation Trust

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**Private & Confidential**
Mrs Jacqueline Lake
Senior Coroner for Norfolk
Norfolk Coroner's Office
County Hall
Martineau Lane
Norwich, NR1 2DH

[redacted]

21 April 2022

Dear Mrs Lake

**Response to Regulation 28 report – Death of Mrs Irene Fitches**

I write in response to the above report, which was received via email on 18 February 2022, following the conclusion of the Inquest into the death of the above named lady on 14 February 2022. The medical cause of death was: 1a) subdural haematoma; 1b) fall; 1c) Benign Positional Proximal Vertigo (BPPV). After considering all of the evidence the conclusion was 'accidental death'.

During the course of the Inquest the evidence revealed the following matters of concern:

1. The Trust's present Falls policy does not comply with NICE guidelines;
2. Evidence was heard that a Falls policy was drafted, and a Risk Assessment trialled at the beginning of 2020, the Covid-19 pandemic intervened and delayed its completion;
3. There is no person appointed as Falls Lead. The job application has not yet been advertised, although it is recognised that someone is required to lead the Falls process;
4. Staff will need training and the training package has not yet been developed; and,
5. Assisted Technology is being considered to alert staff to movements and the needs of patients. This has not been progressed since October 2021 and is still at an early stage.

I hope that this letter and the accompanying documentation provide you with sufficient assurance that the concerns raised have been carefully considered by the Trust and necessary actions taken and changes implemented.

As you are aware, in accordance with the Trust's Falls Policy, a Root Cause Analysis (RCA) investigation was completed following Mrs Fitches inpatient fall and a copy of the RCA report was shared with the deceased's family. RCA is a systematic process whereby the factors that contributed to an incident are identified. As an investigation technique for patient safety incidents, it looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which an incident happened. The recommendations following completion of the RCA SI investigation were: staff must complete a baseline lying and standing blood pressure for all patients aged over 65 years, as per Trust policy; ensure that a patient's past medical history (PMH) is reviewed and updated following arrival of old medical notes; patients to be provided with a leaflet detailing self-help strategies to reduce symptoms of BPPV; and, staff to be provided with information to aid their understanding of BPPV and what recommendations should be given to patients to help reduce symtpoms. [redacted] (Deputy Divisional Nurse Director for Medicine) attended the Inquest hearing on 14 February 2022 to give live evidence and address questions/issues relating to the RCA SI investigation process; contents of the report; and, discuss the actions taken. I should explain that the responsibility for actions arising from an RCA SI investigation are specified in the report and assurance that actions have been taken, and that they are effective, is undertaken by the Divisional Board, in this case the Medical Division.

**Actions taken prior to the Inquest and receipt of the Regulation 28 report**

The Trust's Falls Policy

Norfolk and Norwich Hospitals NHS Foundation Trust (NNUH) recognises and is committed to its duty of care to patients in reducing the risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained. A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level (NICE, 2017).

A copy of the Trust's 'Guideline for the Management of Falls in Adults and the Prevention of Falls in Adult in-Patients' (ID 1083) [Falls policy] in place at the time of Inquest on 14 February 2022 was submitted as evidence (the document had been re-approved by the Trust's Professional Protocols, Policies and Guidelines Committee on 20 April 2020). This policy states that the NNUH guidelines procedures and documentation has taken account of NICE CG 161 2013 'The Assessment and Prevention of Falls in Older People' (which should be read in conjunction with NICE CG 21 (2004) and NPSA (2007) in formulating its recommendations). However, multifactorial falls risk assessments were not being completed and hence the Trust's Falls policy was not NICE compliant. Both NICE (2013) and NPSA (2007) support the use of multi-faceted and multidisciplinary approaches to falls reduction strategies within the hospital setting. Multifactorial assessment identifies a patient's individual risk for falling in hospital due to the following factors: cognitive impairment, continence problems, falls history including fear of falling, footwear, pre-existing health problems that may increase their risk of falling, assessment of osteoporosis risk, medication both existing and new, postural instability, balance and mobility problems, and, visual impairment.

During the Covid-19 pandemic, the Trust's Falls policy was reviewed and an extension for a further review and update of its contents (where necessary) was granted by the Chair of Senior Practitioners Forum until 31 March 2022 [**enclosure 1**].

A copy of the NICE CG161 - The Assessment and Prevention of Falls in Older People (2019) is enclosed for information [**enclosure 2**].

I wish to assure you that the Trust takes falls in the hospital very seriously and is working hard to identify ways in which to reduce the number of patient falls that occur in hospital. Staff assess the potential risks of patients falling at the time of their hospital admission and complete assessments to identify any concerns and ways in which to mitigate these risks for the individual. NNUH aims to take all reasonable steps to ensure patient safety and independence. With NNUH's patient population increasing in age and complex multi-morbidity, the challenge of reducing the number of falls and injuries from falls is significant. To assist with this, patients admitted under the care of the Older People's Medicine (OPM) team are provided with advice leaflets setting out ways to help reduce the risk of falls whilst in hospital [**enclosure 3**].

Enhanced Observations

When a patient is identified as being at risk of harm to themselves, to others and/or the environment the level of observation is increased. The 4 levels are:

- Level 1 - Routine observations, 2 hourly care rounding. The patient has predictable safe behaviour;
- Level 2 - Increased care rounding and patient contact from staff. The patient has mainly predictable behaviour with occasional unsafe behaviour. Staff can use falls alarms and begin pathways such as delirium or alcohol detoxification;
- Level 3 - Patient has unpredictable unsafe behaviour towards self, others and/or the environment. Staff increase patient safety by cohort nursing, using delirium, dementia and alcohol detoxification pathways if appropriate; and,
- Level 4 - Patient has unpredictable unsafe behaviour towards self, others and /or the environment and requires one to one care from staff or security.

Recording of lying and standing blood pressure

The recording of a baseline lying and standing blood pressure (L/S BP) is an integral part of the Trust's Multifactorial Falls Risk Assessment for all patients 65 years and over; patients aged 50-64 years who are judged by a clinician to be at higher risk of falling; and, any other patient who has been admitted after a fall. All patients who are at risk of falling are to have a L/S BP recorded as a baseline as soon as possible after admission to hospital and this must be repeated if clinically indicated and after a fall or change in treatment which may affect the person's BP. The recording of LS BP is to identify whether there is a fall/drop in blood pressure due to postural/positional changings, i.e. when standing from a sitting position, which could cause dizziness and potentially increase the patient's risk of falls. A draft copy of a Trust's NICE compliant Falls Risk Assessment, which includes the recording of lying and standing blood pressure, and draft Falls Prevention Care Plan, were submitted as evidence and considered at the Inquest hearing [**enclosure 4**].

Falls Masterclasses

Three Falls Masterclasses were prepared and presented to clinical staff prior to the Inquest hearing (the Masterclass captures all grades of staff and includes newly appointed staff). The Falls Masterclass that took place after Mrs Fitches' inpatient fall incorporated information on the diagnosis and symptoms of Benign Positional Paroxysmal Vertigo (BPPV - causes short episodes of vertigo or dizziness when moving your head in certain directions) to identify to the attendees the multifactorial

reasons patients may fall whilst receiving care in hospital (e.g. patients diagnosed with BPPV may become dizzy and lose their balance). Further Falls Masterclasses are scheduled to take place in 2022.

Education Boards – falls prevention

It is recognised by senior clinical staff across the Trust that education is fundamental to falls prevention. A number of Older People's Medicine (OPM) wards, including Elsing Ward, display very helpful information about the cause of falls and prevention and management of falls.

Audits

Daily AIMs Falls audit data is completed on the wards as part of falls Quality Initiative (QI) project (the results of these audits are discussed at the weekly falls meetings). Understanding time and location of falls is key to identifying ways in which to mitigate the risks and implement ways to reduce the number.

To assist with the reduction of inpatient falls and identify ways to reduce the occurance, staff record the times and location of falls on laminated ward maps. This ensures that staff are able to map the location of falls and times they occurred and helps them identify any potential risk areas and ways to mitigate the risk. Thematic analysis can be completed and the most high risk times and patients identified. Nights and post-operative patients have been idenitifed at being the highest risk and cohort of patients in the Surgery Division.

Increasing staff/patients' awareness of the signs/symptoms of BPPV

Following Mrs Fitches unwitnessed fall, to increase staff awareness and understanding about BPPV information is now displayed on the Education Board in the Staff Room on Ingham Ward and the potential falls risk this condition presents. The Education Board is reviewed and updated (as necessary) by the Clinical Educator assigned to each ward.

BPPV information leaflets, which includes details of the condition and symptoms experienced by people diagnosed with this condition, and self-help strategies, are available on the OPM wards for patients/carers to access and also available to view on the Trust's intranet, which can be accessed/viewed by all NNUH staff.

Falls prevention and use of Assistive Technology

*Medical literature reviews and published papers re falls prevention*

There is very little scientific evidence that fall policies or comprehensive falls prevention programmes are able to prevent all falls. Published systematic reviews and meta-analyses have been conducted to evaluate the effect of gold-standard falls prevention measures. Notably, these studies reflect trial conditions and therefore represent the best possible chance of influencing outcomes. These studies and reviews have not found fall prevention measures statistically effective in preventing falls in hospitalised elderly patients. A meta-analysis found that the effect of multicomponent measures was so small that only one fall would be prevented for every 1250 patient-days in hospital (DiBardino et al 2012). A randomised control trial of over 45,000 inpatients found no difference in rates of falls or fall injuries when trial

conditions of multicomponent falls interventions were adhered to (Barker et al 2016). When all possible interventions are implemented, it is possible to reduce the risk of falls by at most 30% (Morris et al 2017). The scientific literature thus shows that even gold-standard nursing care is not able to prevent falls and injury in high-risk patients. Even with a perfect implementation of policies and procedures, it is only possible to reduce falls by around 20-30%.

*Trial of Assistive Technology*

The causes of falls can be multifactorial, with many risk factors having a contributory effect. These include: environmental hazards, muscle weakness, poor balance, visual and sensory impairment, medical conditions such as dementia or delirium, polypharmacy – and the use of certain medicines.

Prior to the beginning of the Covid pandemic, the Trust trialled two types of assistive technology in the Older People's Medicine (OPM) Division (Elsing Ward trialled the use of pressure mats in June 2021 and Ingham Ward trialled BEAMS). With a variety of sensors available, assistive technology has been designed to detect individuals falling, wandering, or even suffering panic attacks. Equipment usually has built in sensors that automatically detect a fall and raise an alert. BEAMS (Bedside Equipment Alarm Monitoring System - an intelligent listening device which monitors alarm sounds from healthcare equipment, such as syringe pumps or pulsed oximeters, and alerts hospital staff when a patient is in need of attention) involves collecting data relating to the ward call bell system. This was trialled on Ingham Ward and information/data was obtained during the trial period, with staff being in regular contact with the company (including identifying any potential problems/difficulties). The equipment is a form of assistive technology that alerts staff via the call bell system. The specific type of equipment to be implemented on a ward and the costs involved will depend on the data obtained/analysed.

Although different types of assistive technology have been trialled at the Trust, the use of pressure mats (a form of assistive technology) would not have been appropriate to use in Mrs Fitches case as she did not meet the criteria. She was a lady who had mental capacity to make her own decisions and was independent of her own care needs. Restricting her movement around the bed area would have deprived her of her liberty. Staff had provided her with verbal and written information about BPPV and she was advised not to stand from a seated or lying position too quickly because of the possible risk of dizziness or light headedness. Assistive technology is usually used for individuals who have been assessed as having cognitive impairment and being at high risk of falls. However, the use of falls alarms is sometimes considered to be controversial, especially with patients who have cognitive impairment. Falls alarms can cause further/additional distress to those who are confused or have a cognitive impairment due to the alarming noise that they emit.

**<u>Actions taken by the Trust following receipt of the Regulation 28 report</u>**

*Fall improvement team meetings*

Two falls meetings a week have taken place at the Trust from 7 March 2022 (10:00 hours – 11:00 hours Tues/Wednesday). Over the sessions there has been representation from the Medical Division, Surgical Division, Physiotherapy, Emergency Department (ED), Patient Representative, QI Representative; QI Matron for Medicine and Band 7 HCA Clinical Lead for Medicine. These were split into two

meetings as a repeat (to ensure greater engagement). A representative from Women and Children has attended the meetings from 5 April 2022.

*Falls Improvement group*

The first meeting to define the Terms of Reference (TOR) for the Falls Improvement Group took place on 23 March 2022.

*Staff training – Completion of lying and standing blood pressure (LS BP)*

Safety huddles take place twice daily and patients at high risk of falls are identified. Healthcare Assistants (HCAs) on Loddon Ward are allocated the responsibility of completing lying and standing blood pressures during the ward safety handover. A copy of the documentation to be completed is attached [**enclosure 5**]. All patients on the ward are checked in the morning and afternoon. Daily afternoon teaching sessions around how to undertake blood pressure (BP) readings are completed by senior nursing staff on their daily ward visits. Ward visits are logged and rotated round to capture as many staff as possible across different ward area. In addition, a credit card size education card has been created to be given to HCAs; explaining how to correctly record lying and standing blood pressure. A number of wards have introduced a laminated above bed prompt to ensure staff have recorded and documented a patient's lying and standing blood pressure [**enclosure 6**].

*Initative to introduce luminous tape*

An initiave to introduce luminous tape and attach to items such as drains and catheters so patients can see potential trip hazards at night time has been introduced on wards within the Surgical Division.

I will now address your specific matters of concern:

1. **The present Falls policy does not comply with NICE guidelines; and,**
2. **Evidence was heard that a Falls policy was drafted, and a Risk Assessment trialled at the beginning of 2020, the Covid-19 pandemic intervened and delayed its completion.**

   Extensive work has been undertaken at the NNUH around the subject of falls assessment and prevention prior to and following the Inquest on 14 February 2022. Weekly Falls Meetings, attended by members of the multidisciplinary team, commenced at the beginning of March 2022. The Trust's Falls Assessment and Prevention Policy has been reviewed, updated and re-written to incorporate and comply with NICE Guidelines around the reduction/prevention of falls. The Trust's new (NICE compliant) Falls Assessment, Prevention and Management policy aims to minimise and manage the risk of falling for all inpatients and includes a multifactorial falls assessment. It sets out the systems and processes the Trust has put in place to optimise patient safety, quality and best practice and minimise harm from inpatient falls whilst safeguarding patients' dignity, rights, freedom and ability to mobilise. The policy outlines the process, procedures, duties and responsibilities to identify and manage those who are at risk of falling and provides managers and staff with advice and guidance to minimise falls and consequential injuries and optimise falls management and safety [**enclosure 7**]. The policy includes ongoing multifactorial assessment, actions and

interventions, bedrails assessment, patient information and engagement and staff traning.

The Multifactorial Asessment (MFA) has been updated and implemented [**enclosure 8**] to ensure all patients have an individualsed patient action plan. This should be completed in addition to the standard assessment and falls prevention actions. It is comprised of 11 sections and is accompanied by a care plan. The NICE Clinical Guideline "Falls in Older People: assessing risk and prevention (2013) provided recommendations for falls prevention and includes standard guidance to be given to all adult in-patients. These are incorporarted into the MFA as mandatory actions. These mandatory actions must be carried our for all adult inpatients regardless of age as routine measures. The MFA is contained in the Patient Risk Assessment Booklet and is to be completed for all adult inpatients within 6 hours of admission and on transfer to another clinical area. This is reviewed following a fall, a change in the patient's clinical condition (deterioration or improvement) or every week as a minimum. The patient and their family are to be included in the assessment and action planning, taking into account the patient's ability to understand/retain information. The following factors are taken into consideration: the patient's history of falls; bone health/fracture history; underlying medical conditions; cognitive/mental state; mobility needs; sensory impairment; and essential care issues (e.g. continence). Multifactorial Actions and Interventions must be reviewed with each reassessment and the documentation completed.

A bedrail assessment [**enclosure 9**] and Patient moving and handling assessment and plan [**enclosure 10**] form an integral part of the Trust's Falls Policy.

3. **There is no person appointed as Falls Lead for the Trust. The job application has not yet been advertised, although it is recognised that someone is required to lead the Falls process.**

Trust's Falls Prevention and Management Lead

Following the Inquest on 14 February 2022, the Trust advertised for a Falls Prevention and Management Lead and we appointed a person to this post at the beginning of April 2022. As a senior member of the nursing team this individual is required to work a period of notice with their current employer and a number of necessary checks are to be completed by our Human Resources department before commencing the role. The newly appointed Falls Prevention and Management Lead will start working at the NNUH on 6 June 2022.

The key responsibilities of the Trust's Falls Prevdention and Management Lead are:

- Responsible for providing expertise in falls assessment, prevention and management.

- Providing advice and guidance to staff.

- Ensure arrangements are in place to keep up to date with national and local developments in the assessment, prevention and management of inpatient falls.
- Support and report to the Falls Steering Group and provide information on falls assessment, prevention and management to relevant Trust boards and committees.

- Lead and facilitate regular Falls Champion updates and meetings.

In addition to the newly appointed Falls Prevention and Management Lead the Trust already has in place Falls Champions and Clinical Educations. Falls Champions are identified on the ward each shift. The Falls Champions are not responsible for completing all Falls Risk Assessments and Falls Prevention Care Plans. All competent clinical staff are responsible for completing this assessment when indicated. The key responsibilities of the Falls Champion are:

- Acting as a role model and visible advocate for the prevention and management of falls.

- Enabling individuals and their teams to learn and develop their falls prevention and management practice.

- Communicating and networking around falls prevention and management.

- Supporting individuals and teams in local audit/surveillance related to falls prevention and management.

- Raising awareness of this policy in their clinical area and assisting with implementing the fall management and improvement activities.

- Attending Falls Champion workshops and cascading learning from these to staff within their team.

- Encouraging discussion of risk factors for falls prevention and management at the safety huddle, handover, and multidisciplinary team meetings.

- Educating all staff on appropriate actions following a fall relevant to their service.

- Ensuring that information about falls prevention is readily available on the ward or in the team for staff to offer to patients, their families and carers.

- Completing or supporting with the falls audit.

- As appropriate to their service and in conjunction with the ward/team manager, ensuring that they monitor the environment.

4. **Staff will need training and the training package has not yet been developed**

All staff members receive information, instruction and training on fall safety, assessment, prevention and management as part of their induction to the Trust and as part of their mandatory training. A copy of the PowerPoint Slides which was prepared and presented by the Clinical Educator and Practice Development Nurse for Medicine as part of the Falls Masterclass and Falls Summit 2022 are attached [**enclosure 11**]. The NICE quality standard QS86 was discussed. In addition, a copy of the Falls Improvement presentation to the CQC on 28 March 2022 is attached [**enclosure 12**].

An integral part of the Trust's multifactorial falls assessment and updated Falls Policy is the education and training of staff. The Trust's 'Preventing Falls in Hospitals training' is attached [**enclosure 13**] which lists the topics covered. The Training is available online and has already commenced. The aim of the course is to provide clinical staff with the knowledge they need to prevent falls and help patients stay safe and independent. The learning outcomes for the course are to:

- Explore why falls are not inevitable;
- Understand the impact of falls on patients;
- Recognise the importance of balancing patient safety, independence, rehabilitation and dignity including patient choice;
- Learn how to act on patient risk factors to reduce the likelihood of falls;
- Identify environment al risk factors and create a safer environment; and,
- Explore clinical skills related to falls prevention.

The training includes an assessment of knowledge and understanding. It is expected that all staff will have completed the training by the end of June 2022. The training is linked to ESR, which means that the number of Trust staff who have undertaken the training and completed the assessment of knowledge and understanding can be obtained/reviewed.

5. **Assisted Technology is being considered to alert staff to movements and the needs of patients. This has not been progressed since October 2021 and is still at an early stage.**

It is recognised and acknowledged that the use of Assistive Technology does not necessarily prevent falls, but may assist staff in the management of individual patient risk. It is imperative that any equipment is trialled and evaluated on an individual basis considering its suitability. It is important that assistive technology must not compromise the individual's dignity or independence and should not impact on other patients comfort, for example, repeated alarm noises. Data gathered during the trials of different ypes of assistive technology at the NNUH is being reviewed; other companies have been approached; and, the cost of implementation is being considered against the possible reduction in inpatient falls.

The Trust has included the use of assisted technology as part of the Multifactorial Assessment in the Additional Targeted Interventions sections. The use of this equipment while not necessarily preventing falls may assist staff

in the management of individual patient risk. Any equipment should be trialled and evaluated on an individual basis considering suitability and must not compromise the individual's dignity or independence and should not impact on other patients comfort e.g., repeated alarm noises.

*'Think Yellow' initiative – identifying high risk patients*

As part of the falls improvement project, one of the Nursing Sisters in the Emergency Department (ED) is currently undertaking work looking at the introduction of yellow blankets and yellow socks to identify patients in the department who are at high risk of falling (the 'Think Yellow' initiative – **see enclosure 12)**. The intention is that the yellow blanket/yellow socks will migrate with the patient within the hospital environment (i.e. on transfer to a ward) and can go home with the patient on discharge

**Summary of improvement initiatives taken at NNUH – Falls Prevention**

In summary, following the Inquest on 14 February 2022 the following initiatives have been implemented at the NNUH with the aim of reducing/preventing falls within the hospital environment:

1. Commencement of weekly Falls Improvement team meetings (Medicine, Surgery and Emergency `department) from beginning March 2022 (attended by members of the Multidisciplinary Team (MDT)).
2. Revised and updated Falls assessment prevention and management policy.
3. Multi-factorial assessment – MFA (in compliance with NICE guidelines).
4. Falls Steering Group – responsible for developing and reporting on Key Performance Indicators (KPIs) to deliver Trust wide improvements in the assessment, prevention and management of adult in-patients falls.
5. Appointment of a Falls Prevention and Management Lead – one of the key responsibilities is to lead and facilitate regular Falls Champion updates and meetings.
6. Cross divisional QI programme.
7. Preventing Falls in Hospitals training.

I trust that this letter and enclosures provides you with the assurances you require that the Trust has taken a number of actions and made some significant changes to reduce the number of inpatient falls and prevent a recurrence of the concerns you have raised in your report.

Please pass on my sincere condolences to Mrs Fitches' family for their loss.

[redacted]

[redacted] H[redacted]
**Chief Executive**

Enc.

1. Guideline for the Management of Falls in Adults and the Prevention of Falls in Adult in-Patient' (ID 1083);
2. NICE CG161 - The Assessment and Prevention of Falls in Older People (2019);

3. Reducing patient falls – advice leaflet for patients, relative and carers (ID 9477 & ID 10398);
4. NICE Compliant Falls Risk Assessment & Care Plan (Draft);
5. Recording of lying and standing blood pressure;
6. Laminated above bed prompt – recording of lying and standing blood pressure;
7. Falls Assessment, Prevention and Management of Inpatient Falls;
8. Multifactorial Assessment (MFA) and Care Plan;
9. Bedrail risk assessment;
10. Patient moving and handling assessment plan;
11. Powerpoint presentation – Falls Masterclass June 2021 and Falls Summit 2022;
12. Falls Improvement – PowerPoint presentation to CQC – 28.03.2022;
13. Preventing Falls in Hospitals online training.