NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

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26 September 2022

Letter sent by e-mail t[redacted]
Mr Robert Sowersby
HM Assistant Coroner
Coroner's Court
Old Weston Road
Flax Bourton
Bristol
BS48 1UL

Your ref: 21890

Dear Mr Sowersby,

RE: Regulation 28 report to prevent future deaths relating to the inquest of Mr Gerwyn John Rees

Thank you for your report relating to the inquest of Mr Rees raising your concern that there remains a risk that future deaths will occur unless action is taken. We value insights from outside of the Trust to enable further improvements to be made to the quality and safety of our services.

Following the receipt of your Regulation 28 report, we have reflected on our Root Cause Analysis report relating to Mr Rees and we have reviewed our Enhanced Care Observation and Meaningful Activities Policy. We have summarised the work we are already doing to improve our patient safety incident investigations.

The Trust takes patient falls very seriously and is committed to reducing the number by mitigating the risks of falling as much as possible. Where falls do occur, we are committed to learning from these events to identify any areas for improvement in our patient care. The dementia, delirium and falls team has clinicians from nursing and allied health professionals background who provide support, specialist assessments and advice to ward based teams

across the Trust. The ward based teams also identify and have falls champions within each team to facilitate and cascade evidence based practice in falls prevention and care. The Team also has updated the falls prevention information leaflet as well as providing simulation based bespoke training to ward teams in the management of falls.

We have reflected on the Root Cause Analysis carried out in this case with particular regard to the concerns you have raised. When assessing the falls risk for new patients admitted to hospital, we consider many aspects including their past medical history, reason for admission, and the presentation of the patient at that time. In Mr Rees' case he was assessed on admission and assigned ECO level 2. At the time of presentation Mr Rees was found to be alert, orientated, not agitated, and calm. Mr Rees was able to hold a coherent conversation and was able to understand instructions to sit and wait for help to assist him to mobilise. Mr Rees was not putting himself at risk e.g., he was not attempting to mobilise on his own. We recognised that Mr Rees was an elderly gentleman with a history of previous falls and underlying mental health and medical health issues. Whilst this history helps to inform a risk assessment, it is used in conjunction with a patient's presentation at the time. Mr Rees was not confused or agitated in his presentation to trigger a higher level of observation under the Enhanced Care Observation Policy at that time. As Mr Rees was able to engage in a conversation and understand instructions, his behaviour was considered to be predictable as he was able to follow instructions to wait for assistance. When Mr Rees sadly suffered a fall on A413, this should have prompted a re-assessment and assignment to ECO level 3. We accept that the communication around the ECO level 3 when Mr Rees was transferred to ward A515 was suboptimal and this has been considered in the Root Cause Analysis.

As a direct result of this case, we have reconsidered our Enhanced Care Observation (ECO) and Meaningful Activities Policy and are in the process of implementing a revised policy to take on board our learning from this case. It is expected that this updated policy will be in place by November 2022. The updated policy removes the levels of 1, 2, 3, and 4 for ECO, which sometimes causes confusion amongst practitioners and replaces the levels for all inpatients requiring observations with:

- General observation,
- Intermittent supportive observation,
- Continuous supportive observation – within eyesight and
- Close supportive observation – within arm's length.

The ECO guidance now provides a holistic view of patients, instead of a risk assessment based on falls or confusion alone, i.e. accounting for any behavioural changes, confusion, previous/current history of falls, requiring supervision or assistance for transfers and mobility, lack of insight etc. There is additional guidance on appropriate care and referral for persons with learning disabilities, dementia/delirium, alcohol or drug withdrawal and patients with acute mental illness in an acute care setting. The updated policy also provides guidance on using the multi-disciplinary team's expertise and input, for e.g., occupational therapists for advice on meaningful activities for patients with ECO and referrals to appropriate specialist care teams (liaison psychiatry, dementia, delirium and falls team). In addition, to provide equitable and consistent care for all our patients, we will look at strengthening the ECO policy along with our partners in North Bristol NHS Trust.

It is expected that reducing the reliance on a 'numbered' level of care for ECO and reinforcing the actual level of care a patient requires, staff would provide adequate and appropriate enhanced care observation for patients who require it. In addition, considering the holistic needs of a patient would allow staff to provide the most appropriate level of care for a patient rather than a reliance on risk assessments for falls or confusion alone.

Once the updated policy has been approved, key staff groups affected by the ECO policy will be provided support, education, and training in applying the policy in practice. This will include display signs in ward areas, a meaningful activities list and task kits, and additional training to the ECO team from the dementia, delirium and falls team.

In relation to the Trust's investigatory processes, it may be helpful to explain that since 2020 University Hospitals Bristol and Weston NHS Foundation Trust has been learning about and preparing for the transfer to the new national Patient Safety Incident Response Framework. The Patient Safety Incident Response Framework supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement.

Unfortunately, pace was impeded by the Covid-19 pandemic and the need to prioritise clinical service provision however in the past 12 months practical preparations have taken off to enable transfer to the new framework by June 2023. A number of changes have already been made which are relevant to this response with more currently underway and planned which are summarised below.

- A new model for patient safety investigation has been agreed and funded. This will provide for a small central team of expert investigators, including a human factors specialist, who will carry out the majority of patient safety incident investigations which meet the criteria for a full patient safety incident investigation. It is anticipated these roles will be in place by the end of 2022/23.
- The criteria for a full investigation will include those events for which a full investigation is nationally mandated and events related to key patient safety risks identified as priorities for learning and improvement within UHBW's Patient Safety Incident Response Plan. This plan will be published on our website by the end of 2022/23.
- The expert investigators will be required to have completed the relevant specialist investigation training and to meet the standards and competencies which have now been set nationally.
- Seven members of staff working in patient safety roles in UHBW have undertaken the new level 3 investigation training made available by the Healthcare Safety Investigation Branch (HSIB) in early 2022 (or possess a recognised Masters level

- equivalent). Further level 2 patient safety training modules have been made available by the HSIB in the past couple of weeks and UHBW staff in relevant roles are accessing these over the next few months.
- There will be alternative methods for reviewing and learning from patient safety events that do not meet the criteria for a full patient safety incident investigation.
- Governance arrangements for learning and improvement from patient safety incidents will continue and be enhanced.

We trust that our response provides you with the assurance you require with regards to consistent rigour of patient safety incident investigations and supports our staff to better identify the level of observation appropriate to patient needs.

Kind regards,

Chief Executive

Head of Quality and Patient Safety