NHS
Stockport
NHS Foundation Trust

Oak House
Stepping Hill Hospital
Poplar Grove
Stockport
SK2 7JE

[redacted]

Private and confidential
By email.

[redacted]

Ms Lauren Costello
Assistant Coroner
Coroner's Court
Mount Tabor
Mottram Street
Stockport
SK1 3PA

5 December 2022

Dear Ms Costello

Re: Kenneth GOODWIN (Deceased)

I am writing to you further to the inquest of the late Kenneth Goodwin, which concluded on 9 October 2022 and the concerns you have raised relating to the care provided to Mr Goodwin by this Trust in June 2022.

I am grateful to you for highlighting these concerns and for providing me with an opportunity to respond. I asked [redacted], Deputy Director of Quality Governance, [redacted] Matron for Surgery, [redacted], Matron for Patient Experience and Quality Improvement and [redacted], Governance and Quality Manager for the Division of Surgery to investigate on my behalf. They have reviewed the matters of concern which arose during the inquest and these are:

The Inquest heard that the transfer process between wards for patients at risk of falls does not require a specific written confirmation that a handover in relation to that risk has taken place.

We can confirm that the Trust does have in place a formal hand over document that, amongst other important information, highlights whether or not a patient is at risk of falls. This information is completed and handed over for all patients who are transferred from one area to another. In Mr Goodwin's case, it has come to light that staff on ward D6 used a hand over document that was not formally authorised for use and this did not contain the patients falls risk status. This therefore meant that although standard process would ensure that the handover of risk of falls would be communicated upon patient transfer, that this did not happen in the case of Mr Goodwin, and for that we apologise.

Action – The Trust's formal patient handover document was re-launched across the Trust on 15 November 2022, via the Trust's 'Risky Business' weekly bulletin and also via targeted e-mails from the divisions governance teams. Alongside this all unauthorised handover documents have been removed from use. The use of the handover document will be audited by the senior nursing team during their ward audit programme to ensure that the correct handover document is reliably utilised. The patient handover document will also be a focus of a senior nurse walkround led by the Chief Nurse to highlight the importance of communication upon transfer of all appropriate risks.

The falls risk assessment on the new ward was not completed for just over 4.5 hours. The Inquest heard that the target time for this assessment is within 6 hours, a length of time which is of concern for patients transferred at night, displaying signs of confusion, and already identified as a fall risk.

The Trust can confirm that there is a six hour standard for risk assessments to be completed following transfer of a patient to a ward. This window allows the receiving team to admit the patient into their care, undertake all

appropriate care for the patient, and document any necessary risk assessments. This timeframe is in line with other NHS acute providers and recognises the time required to complete accurate medical documentation whilst caring for the patient.

We do however recognise that alongside this process that there must be a reliable process to identify risks to patients on handover, such as the risk of falls. Alongside the admission process documents referenced above, the transfer process includes transfer of the patient's medical records and formal patient handover document to provide the receiving ward with all necessary details relating to patient risk factors. The formal handover document is imperative for patients regardless of time of transfer and where the patient is transferred to within hospital to ensure that there is a standardised and reliable method of immediate communication regarding key patient information. We again apologise that in the case of Mr Goodwin that the correct formal handover document was not used.

The Inquest heard that the use of signs on beds to visually identify falls risk to the staff is not consistently used.

The Trust uses a maple leaf sign to identify patients at risk of falls. In the case of Mr Goodwin we have identified that an agency nurse was not aware of the need for the use of the maple leaf sign. The Trust recognises that all temporary staff must be made familiar with Trust policy and practice for each area in which they work.

Action – The requirement for the use of the maple leaf sign, identifying patients at risk of falls, was re-launched across the Trust on 15 November 2022, via the Trust's 'Risky Business' weekly bulletin and also via targeted e-mails from the divisions governance teams. The requirement for the use of the maple leaf sign will also be added on all agency staff induction check lists to ensure that their use is explained to staff who are new to the organisation. Completion of the checklists is already included within the audit programme.

Once again I would like to thank you for giving me the opportunity to respond to your concerns and trust that my response has been helpful to you. If there are any areas where I could provide further clarification, please do not hesitate to get in touch.

Yours sincerely,

[redacted]

Chief Executive