Essex Partnership University
NHS Foundation Trust

26th April 2023

Private and Confidential
Ms Sonia Hayes
Area Coroner
Coroner's Office
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Victoria Road South
Chelmsford
CM1 1QH

Chief Executive Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

[redacted]

[redacted]

Dear Ms Hayes,

I am writing to set out the Trust's formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 27th February 2023, which was issued following the inquest into the death of Doris Smith. The Trust has provided a response in acknowledgement of your concerns.

I would like to begin by extending my deepest condolences to Doris's family. This has been an extremely difficult time for them and I hope that my response provides Doris's family, and you, with assurance that the Trust takes their loss seriously and has taken action to address the issue of concern raised in your report.

1. **Essex Partnership NHS Foundation Trust staff:**
    a. **delayed the completion of a falls risk assessment**
    b. **completed the falls risk assessment with inaccurate information to assess Doris Smith's risk and updates were also inaccurate**
    c. **did not follow the advice of the physiotherapist that would have required Doris Smith to mobilise only with assistance of staff and whether her level of observations should have been changed.**

Since Doris was a patient with EPUT, the Trust have made a number of practice changes to improve the care provided to patients in relation to falls. These are detailed below:

- Within 24 hours of admission, the Guide To Action falls assessment is completed and staff are expected to update the falls risk assessment whenever there has been a change in the patient's clinical condition. This guide to action is an admission guide, which details the expected steps that the staff member takes when admitting a patient who is at risk of falls. The falls risk assessment provides staff with questions that are designed to prompt them to implement safety measures appropriate to that patient. For example, the risk assessment prompts the staff member to assess the patient's ability to transfer and mobilise and, if there are concerns, to review the height of the bed or chair and gives advice of how to prompt the patient to mobilise safely.

- The falls risk assessment is included in the local induction of all clinical ward staff band 2 to band 7 and for the induction of temporary workers. Knowledge and understanding is also reviewed in the probation period of substantive staff members through discussions, which usually concludes after the first six months of employment. This can be extended if there are further learning requirements or concerns for practice. Furthermore, the admissions checklist (which involves consideration of falls risk) is audited weekly by Ward Managers with action taken to ensure these assessments are completed if they are incomplete.

  Clinical dashboards are available for all wards on the Trust intranet and provide details of any outstanding assessments for patients in all wards which appear as red. The falls risk assessment is part of the data included on these dashboards and the target for completion is within 24hrs. The dashboards provide live information on the completeness of all relevant patient information and key performance indicators and is updated every 15 minutes. If it is recognised that the documents have not been completed, this will be noted by the Performance Team and raised with the clinical team to action. In addition, the Ward Clerk prints out the daily clinical dashboard which is included in the handover and this is monitored as part of the Matron's assurance audit. Performance is also discussed in the Ward Manager's meetings and monthly team meetings. If there is a capability issue, this would be identified and managed.

  In addition to the falls risk assessment and the admission checklist which aid the staff member to introduce falls reduction interventions and strategies for that patient, the Trust is currently engaged with Carradale futures in a project to produce two Standard Operating Procedures (SOP) that relate to the management of inpatient falls. These are management of falls the inpatient setting and the management of a patient following a fall.

  The SOP for falls management in the inpatient setting will guide staff through the process required when there is a concern about the risk of a fall, how to prevent a fall within the inpatient setting including specific information on expert advice from occupational therapy and physiotherapy teams, and the steps required to safeguard a patient's safety when a patient does have a fall. This will include advice on how often the patient is visualised by the staff member throughout the course of the shift. For example, for a patient at high risk of falls and all safety measures are unable to fully mitigate the risk of a patient fall, it would be recommended that they will be within eyesight of a staff member at all times. The staff member will be promoted to check the physical observations of the patient specifically where there are postural blood pressure differences and to ensure that the patient is clinically safe to mobilise. The purpose of these documents is to ensure that in a high pressured environment such as the ward, staff may not have capacity to review an entire guideline or policy, which maybe several pages in length in its entirety. The SOP take the key information for the policy, and will provide practical step by step actions to be taken to immediately improve the safety of the patient. As part of the implementation plan, there will be a supporting training session delivered to staff on usage of the SOP.

Following an event where a patient experiences a fall, the details of this are shared in written communication methods such as emails, along with handover and safety huddles. Safety huddles are attended by the multidisciplinary team and allow for prompt discussion to review the incident and identify risk, and review risk mitigations and the patient's level of observations. Agreed actions and recommendations are communicated with the wider team in handover and changes to care updated within the clinical records. This helps to support the culture for staff to feel confident to discuss safety concerns and be part of forming actions to make individual and ward-based improvements.

- Falls are reported on Datix. Local investigation of the incident occurs by the Datix handler, which is usually a senior clinician assigned to review actions required and learning from the incident. Datix allows incidents to be clustered to ascertain any themes or trends within the incidents which had been reported, so this can be analysed and understood by the care team. Ward Managers and Matrons have access to view the ward Datix dashboard to review any themes for learning. Analysis can be completed for an incident of a particular nature, a team/ward, or for an individual patient which can inform their care plan. Incident trends are established and discussed in safety huddles, team meetings, Ward Manager's assurance meetings and the senior huddle and sit rep calls.

- Posters are displayed in patient bedrooms to clearly inform the patient and supporting staff of the mobility assistance they require, and includes details of aids they may require for the hearing and visual needs. The posters are initiated by physiotherapy staff and updated by them or the occupational therapy staff. When an update is completed, this is emailed to the team, updated within the clinical records, discussed at the safety huddle and handover. This ensures prompt and thorough communication sharing. This was in place at the time Doris was an inpatient and remains current practice.

- The Falls Champions Networks were re-launched in January 2023 as part of the Trust's Physical Health Care meeting. Each ward have an identified registered member of staff who attend the meeting and feedback learning, changes in policy and practice developments in their local team. The Champions will also support the implementation of the revised falls policy once approved and will audit clinical records to ensure patient's falls risk assessments are updated.

2. Neurological observations following a sustained head injury were not completed as required.

- Training for staff related to the understanding of neurological observations is covered in several mandatory training courses, including; Grab Bag, Preventing Falls in Hospital and Immediate Life Support. This covers theoretical components and the use of case studies and scenario based training to ensure embedding of knowledge in a practical sense. This training is completed by substantive and bank staff and currently includes non-registered staff members.

- There may be instances which occur whereby the patient declines neuro-observations being taken. In this scenario, the staff would be expected to record all of the observations they are able to complete and record these within the clinical records. Clinicians may also consider the risk of the patient, and whether additional engagement and supportive observations would be required to support and monitor the patient. Staff would be expected to escalate this non concordance to the clinical/ medical doctor if they are unable to complete neurological observations. I would expect that a medic would clinically assess if this was safe based on an examination of the patient. If neurological observations are clinically required, all efforts must be made to do these observations using skills available to them. At the least, a patients Glasgow Coma Scale or AVPU score can be recorded.

3. Doris Smith had falls on the ward and her level of observations was not reconsidered in light of advice from the physiotherapist after each fall.

and

6. Lack of effective communication as to the care and treatment required for Doris Smith between Trust staff and the levels of observations required to keep her safe on the ward

- The unit physiotherapist attends the daily safety huddle to ensure effective communication with and between the clinical team. Where this is not possible, the physiotherapy assistant attends to provide a handover of assessments and plans and to receive updates on any patients requiring physiotherapy input. During these meetings, the physiotherapist or their assistant will contribute to discussion around requirement for observation and other risk mitigating interventions. Any changes to the patient's care are communicated with the team and are updated within the clinical records, and the mobility poster displayed in their bed area where relevant.

4. The Trust Observation Policy is used in different therapeutic settings and is confusing as to the Levels of Observation required and the focus is on risk for mental health rather than physical healthcare issues that may arise.

- The Trust has an Engagement and Supportive Observation Policy (CLP8) which provides staff with the standards of expectation for how to engage with and supportively observe mental health patients. If defines this supportive observation as: 'Supportive observation calls for empathy and engagement combined with readiness to act. It provides an opportunity for staff to interact with the patient in a therapeutic way. Supportive observation can increase understanding of the feelings and motivations of the patient to act in a particular way. It can also offer the patient support and guidance in how to deal with those feelings and thoughts.

- These supportive observations are a different nursing skill to physical health care, physiological observations and the Trust has a separate clinical guideline for these

observations. The 'Clinical Guideline on the Use of National Early Warning Score System (NEWS2) (CG87) provides staff with a framework for the identification and management of patients who are at risk of physiological deterioration. It has information on when physiological observations must be taken, when to complete a monitoring plan for physiological observations, how to record these observations and what to do if the metrics are abnormal.

- For neurological observations, the guideline prompts staff to monitor the level of consciousness and assessment of new or pre-existing confusion as a minimum. Section 7.0 of the CG87 policy gives staff guidance on Neurological observations and the trigger system and clinical response required to NEWS2. It prompts staff on steps to be taken following a fall which includes a full assessment and recording of the patient's neurological condition using the Glasgow Coma Scale (GCS).

- Appendix 2 of the CG87 Slips, Trips and Falls Policy, which is available to all staff on the intranet, is a Neurological Observation Chart. This prompts staff to complete a GCS on admission and then gives minimum frequency of neurological observations and NEWS post fall. Every 30 minutes for 2 hours, then 1 hourly for 4 hours, then 2 hourly for 24 hours. This is stored in the patient record. The SOP for post fall will also ensure that staff are prompted to complete this.

5. Quality of record keeping:

a. The Trust medical records recording system is electronic and evidence was heard that the window on the screen used for staff to type their records is very small and difficult to use.

b. There were significant examples of cut and paste including out-of-date information recorded in the medical records.

- Within the clinical records, Paris, there is a function to expand text boxes for clinicians to type information within, and text can be made larger on the screen for this to be readable for the clinician. This technique will be re-circulated to staff in May's edition of the Lessons Identified Newsletter or 5 Key Messages.

- A recent Trust-wide audit on record keeping was completed to review patient records for all clinical teams and the report finalised in April 2023. It was a retrospective audit looking at information recorded for the most recent contact with the patient to obtain assurance the records meet procedure regarding health and social care records. Clinical teams carried out the audit on their own records and submitted the information for analysis by the Clinical Audit Team. One of the findings from the report raised an issue of copying and pasting in records for teams in the Mental Health Inpatient and Urgent Care group. Discussions with the teams are being held to agree next steps to reduce copying and pasting with one suggestion is to use a current assurance process to review some records using the clinical dashboard as part of monitoring. Namely the Matron's Assurance, this is where matrons will complete an inspection of their wards/units to review key areas are meeting standards. Where standards are not met

the i.e. assurance has not been obtained matrons will address with the ward/unit team, discuss the issues and develop an improvement plan as necessary.

- In addition, EPUT's Lessons Team produced a short animated video with record keeping tips included, and this was cascaded across the organisation on 25th January 2023. The tips included the accuracy and purpose of maintaining adequate records. On 1st February, the Lessons Team hosted a live learning event entitled "Learning Matters: Your Monthly Insight". The topic of discussion focussed on record keeping, themes of good practice and also the legalities around medical records.

- On 10th March 2023, EPUT's Lessons Team released a Safety Learning Alert, which focussed on copying and pasting within clinical records. The Alert noted that copying and pasting had been evident in records within recent inquests, and provided examples of where this had been completed. Learning themes were included within the alert, and actions were set for managers to ensure the key learning had been disseminated and actions had been taken to address the concerns raised. The final action is due for completion in May 2023. I have attached a copy of the Safety Learning Alert.

I hope that I have provided you with robust assurance that the Trust has taken steps to address the issues of concern in your report, that we are continuing to take action to strengthen the care provided to our patients, and that patient safety is the Trust's top priority.

Yours sincerely,

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Chief Executive
Essex Partnership University NHS Foundation Trust