Wye Valley NHS Trust

Trust Head Quarters
County Hospital
Union Walk
Hereford
HR1 2ER

Tel: [redacted]

Date: 27th August 2024

Dear Mr Bricknell

Re: Regulation 28 - Your Ref: [redacted]

Please consider this letter a formal response to the prevention of future deaths report received by Wye Valley NHS Trust on the 19th July 2024 concerning the inquest into the death of Mrs Rita Howells.

The Trust would like to offer the family of Mrs Howells our sincerest condolences. As an organisation, we have considered the concerns detailed in the Regulation 28 report with the utmost seriousness. This is an opportunity for us to learn and improve our practice in this area. The issues you have raised were known areas of risk and were subject to quality improvement, which is ongoing. This response sets out to provide a comprehensive overview of how we are addressing these issues.

Background

Mrs Howells was admitted to the Frailty unit on the 1st March 2023 following a fall at home, and transferred to Bromyard Community Hospital on the 5th March 2023. On the 15th March 2023, Mrs Howells had an unwitnessed fall from the bed whilst attempting to get to the toilet. She told staff that she was unable to call for help to mobilise, as the call bell was broken. Staff confirmed this.

Mrs Howells was transferred to the Emergency Department due to concerns that she may have sustained a head and shoulder injury and following assessment was transferred back to Bromyard Community Hospital the following day. A CT scan was performed on the 23rd March 2023 following concerns about behavioural changes, this showed acute cerebral haemorrhagic contusions. Neurology opinion was that there was no neurosurgical intervention required. Mrs Howells died on the 28th April 2023.

Following investigation, the following issues were identified:

- Incomplete falls risk assessments on admission and at weekly reassessment intervals
- The level of supervision Mrs Howells was receiving was lower than the advisory assessment
- The bedrails assessment was not updated on transfer to Bromyard Community Hospital
- The bedrails were in the raised position at the time of the fall despite the advisory on the last assessment stating bedrails should not be used
- The call bell was known to be broken by non-clinical staff, but this had not been reported or communicated to clinical staff
- There was no process to routinely check call bells are in working order

Further to your letter dated 19th July you asked for a response to the following findings;

1. Contrary to policy as advised, bed rails are routinely erected before falls assessment
2. The procedure to establish whether a call bell is working are unsatisfactory

Trust bed rails policy

The Trust bedrails policy supports staff to ensure the safety of patients using bed rails whilst promoting their independence and respecting their right to make their own decisions about their care. It clearly details how to reduce potential harm to patients caused by falling from beds or becoming trapped in bed rails. It gives guidance to support patients, carers and staff to make individual decisions around the risk of using and not using bed rails and suggests alternatives to the use of bed rails where their use may prove more hazardous to the patient than not using them. The policy gives instruction relating to standardised practice concerning the assessment, supply and fitting of bed rails and clarifies the responsibilities of individuals regarding safe and appropriate use of bed rails in all settings across the Trust.

The policy is valid until 2026, but is currently undergoing review as part of the National Patient Safety Agency Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls (NatPSA/2023/010/MHRA). Once this policy has been ratified, a copy can be sent to you upon request.

Training

The Trust provides the following training to registered nurses and health care support workers on Falls Prevention; this includes how to assess the use of bed rails and bed rails positioning.

- **e-Learning**

There are two on line training modules available for staff, Falls Prevention (for registered nurses) and Safe use of bed rails (for all clinical staff). The training is classified as 'essential to role' for all clinical staff working in bedded areas and compliance is monitored by the Trust falls lead.

- **Clinical Practice Weeks**

Clinical Practice Week(s) is a rolling programme of education delivered in practice (rather than in the classroom) by subject matter experts. They support staff to focus on specific issues, and relate teaching to real incidents to drive locally owned improvement initiatives. Falls prevention is included in this programme and includes training in ward/ inpatient areas. The training covers;

  - Deconditioning and safe mobilisation
  - Falls risk assessments
  - Lying and standing blood pressures
  - Walking aids
  - Post falls actions
  - Bed rails
  - Delirium
  - Enhanced Observation/supervision (for patients at higher risk of falls)

- **Bespoke training**

This is offered upon request and the training will be tailored to the needs of the individual and/or team.

Audits

The Trust undertakes routine audits in relation to falls prevention as follows;

1. **Weekly incident sample audit**

Falls panel is a weekly meeting where **every** inpatient fall is reviewed by the inpatient falls lead, patient safety and clinical representatives.

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As part of the panel review, a random sample of 5 patients are subject to a more in-depth review including; compliance with the falls risk assessments, bedrails assessment and assessment for enhanced observation/supervision. In addition, all falls where the bed rails are up at the time of the fall are subject to the same in-depth review, the findings of this help to inform the full investigation which is undertaken by the investigating officer for the case.

These audit results are showing that compliance with completing assessments accurately and on time is improving. The results of the audits are presented at Patient Safety Committee as part of the falls report and our ongoing quality improvement work.

2. Weekly matrons quality audit

Similar to the falls panel the matrons also select at random five patients from each of their wards and undertake an audit in relation to the quality of nursing care and treatment based on their documentation and care planning. This includes the assessment and management of patients at risk of falls.

For 2024 (to date) the audit shows that falls assessments have been completed in line with policy requirements 92% of the time and bed rail assessments completed 97% of the time.

3. Quarterly bed space audit

The bed space audit is a rolling programme to review all inpatient areas, and is undertaken by the Falls Expert Lead and supported by students as part of their training.

This includes assessing compliance with all aspects of falls prevention;

- completion of falls assessments
- correct measures being in place as an outcome of assessment (including bed rail placement)
- patient subject to correct level of observation/supervision based on risk assessment
- physical hazards (wires, furniture placement, cluttered environment etc.)
- call bell in reach and working

This year the audit has been undertaken in February and July. Compliance is in the tables below.

Community hospitals- Bed space audit results		
	February 2024	**July 2024**
Completion of risk assessments	76%	93%
Compliant bed rail position	88%	97%
Call bell within reach	83%	86%

Acute wards- Bed space audit results		
	February 2024	**July 2024**
Completion of risk assessments	66%	93%
Compliant bed rail position	90%	95%
Call bell within reach	73%	83%

The audit tells us that completion of risk assessments has improved and the correct positioning of bed rails is improving. Call bells being within reach is also improving (albeit not at the same rate) and is part of our ongoing improvement work; covered in the section below.

4. Bespoke audit as part of Quality Improvement

Inappropriate use of bed rails was identified as an area of concern during our routine reviews and audits; this prompted a more in depth audit to understand the problem and in summary identified the following;

- Falls over bed rails resulting in harm to patients
- Compliance with bed rails assessment
- Compliance with bed rails position and automatic lifting of bed rails by staff
- Level of observation compliance, with a high level of unwitnessed falls

[redacted] [redacted]

The audit reviewed all falls between November 2023 and July 2024. The findings of the audit were presented to the Patient Safety Committee in August.

- 160 falls incidents relating to use of bed rails were reported (129 acute, 31 community hospitals); with half suffering no harm from the fall and half experiencing some level of harm (minor to severe including 1 death)
- 130 (81%) were unwitnessed falls
- 151 (94%) had a falls risk assessment completed prior to the fall
- 135 (84%) bed rails were in the correct assessed position at the time of the fall
- Where bed rails were not in the correct assessed position (25); 13 cases the bed rails were raised, 8 cases the bed rails were down and in 4 cases, the bed rail position is not documented.

Audit Summary

In summary, our routine and deep dive audits show an improved picture in relation to completion of risk assessments and bed rails being in the correct position. However it is an issue that recurrently emerges from incidents and in particular, the more severe harm incidents. The recurrence of the issue suggests a 'habitual' positioning of bed rails. With modern beds, bed rails are an integral part of the bed, historically with older equipment they were attachments stored separately to the bed; it is felt that the ease of access may have led to a tendency for some staff to raise the bed rails without first accessing the risk assessment to confirm the assessed position. We have identified we need to improve our communication of the assessed position for bedrails in our handover processes.

Call bells

The Trust operates inpatient services across four sites. The County Hospital (Hereford) provides acute inpatient services. Our PFI partner Sodexo manages the call bell system.

Community inpatient services are provided at Bromyard, Ross-on-Wye and Leominster hospitals. The Trust estates team manages the call bell system at these sites. The management of the systems differ and are outlined below;

The County Hospital (Acute)

The Call Bell system is maintained under the PFI contract and is subject to routine maintenance every six months by Sodexo our facilities management provider. This includes testing of the system to ensure all is working as expected. The system has recently been replaced with a new system as it was at the end of its lifecycle. This work was completed in August 2024.

Ward areas perform checks of the call bell system and report issues directly to Sodexo, who undertake any remedial works. Upon review, the checks vary in frequency across our different wards and are not subject to a standardised checking process. A standard approach will be implemented in response to this regulation 28.

Community hospitals

The Call Bell system is managed and maintained by the Trust Estates team. This is a different system to the acute site. The power supply for the system is checked annually.

Local areas perform checks of the call bell system and report issues to the Estates team who undertake any remedial works. The frequency of check varies between locations, and like the acute site, we seek to standardise the frequency of checks to provide more robust assurance that call bells are in working condition.

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Improvement

In response to our local intelligence and in responding to the regulation 28 the Trust has further developed its quality improvement approach and a summary of the mitigations and plans are detailed below;

As part of the improvements to our digital nurse noting, a review of all assessments (questions, layout, and functionality) has been ongoing for a number of months. A number of changes are being implemented to improve the risk assessments associated with falls, bedrails and level of observation. This will simplify and combine these assessments to ensure completion at the same time. Given the inconsistency with call bell checks a prompt for a check of the call bell has been added to the digital system and additionally as a safety net, the housekeeper will perform a weekly check.

Falls risk and bed rail position has been added to the nursing handover sheet and communicated at handover of every shift and new posters displayed in every bed space to remind staff to check the correct bed rail position.

The community hospital settings have implemented 'Falls Friday' where the senior nurse reviews all patient falls assessments and ensures they are up to date, accurate and that all measures are in place as per the assessment outcome.

The Frailty Unit have implemented yellow socks and wristbands as a visible and clear identifier that a patient is at risk of falls. This has raised awareness of the risk and has demonstrably seen the number of falls reduce. This initiative is now being rolled out in community hospitals and wider acute inpatient wards.

The most recent initiative is a trial of securing bed rails in the down position (with a yellow cable tie) until the bed rails assessment has been completed. The cable ties will be applied once the bed space has been cleaned and can only be removed by a registered nurse who has undertaken the risk assessment that identifies the need for the rails to be raised. The initiative will be monitored through the routine audits outlined above to ascertain whether this results in a reduction in falls and improvement with correct bed rail positioning.

To conclude, the Trust has identified concerns that correlate with your findings and we are committed to making the necessary improvements to address these concerns. The improvement work in relation to falls is closely monitored and remains a priority for the Trust as identified in our Patient Safety Incident Response Plan for 24/25.

I trust this answers the questions you have raised. Lucy Flanagan our Chief Nurse and her colleague Natasha would be more than happy to meet you in person if you require further information or clarity in relation to points in this letter.

Yours sincerely,

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Managing Director

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