North Middlesex University Hospital NHS
NHS Trust

Legal Services Department
Sterling Way
London
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SENT VIA EMAIL TO
[redacted]

HM Area Coroner Mr Tony Murphy
North London Coroner's Court
29 Wood Street
Barnet
EN5 4BE

Email [redacted]
Tel: [redacted]

Date: **25** September 2024

Dear Sir,

Re: Inquest touching the death of the late Maria De Ceita

We write following the inquest touching the death of the late Maria de Ceita which was heard at North London Coroner's Court on 16 February 2024. At the conclusion of the hearing, you indicated that you intended to issue a Prevention of Future Deaths (PFD) report to the Trust in relation to the concern you raised regarding documentation of falls risk assessments. The PFD report was subsequently issued on 31 July 2024, stating the matter of concern to be "the lack of an effective system to document and address the risk of elderly patients falling while in the hospital".

We set out the steps taken by the Trust below in response to this concern.

Improving Consistency in Documentation of Falls Risk Assessments and Communication

On 21 February 2024, the Trust held a meeting between the following senior members of staff:

- [redacted], Chief Nurse
- [redacted] - Divisional Director of Nursing, AHP & Quality for Medicine and Urgent Care
- [redacted] - Divisional Director of Nursing, AHP and Quality for Community
- [redacted] - Divisional Clinical Director and Divisional Director of Nursing, AHP and Quality for Surgery, Anaesthetics, Critical Care and Associated Services

The Chief Nurse is part of the Trust's Executive Team and is the senior executive responsible for nursing and allied health care professionals and the senior responsible officer for quality governance. The Divisional Nursing Directors are responsible for the quality, workforce, and fundamentals of care at a divisional level.

At this meeting, and because of the concern raised at the inquest, a plan was discussed regarding documentation of falls risk assessments and the communication of the same amongst clinicians; particularly when patient needs change, or when the care/risk dynamics of a ward change during the shift. For example, if there is more than one patient on the ward who is at risk

of falling, or when a new patient with complex needs is admitted during a shift and requires nursing resources to be reallocated/reassessed to incorporate the needs of an additional patient with complex needs. The plan, as discussed at the meeting, is set out below.

1. Documentation of Falls Risk Assessments and monitoring

    a. A baseline audit in June and again in August, documented that the majority of patients received an inpatient falls risk assessment on admission. To ensure full compliance with completing and updating the falls risk assessments, and for better oversight of any gaps, the initiatives described below have been developed and rolled out across the Trust.

    b. The digital team and our Chief Nursing Information Officer (CNIO) have developed a ward dashboard of digital assessments within Careflow (part of our electronic clinical patient system) where ward leaders can view any outstanding risk assessments, providing an opportunity to ensure they are completed/updated in a timely manner. This innovative measure offers us a great opportunity to ensure risk assessments can be overseen and monitored across the entire trust.

    c. The risk assessments are digitally monitored by ward managers and matrons in real time each shift and the information is refreshed every 24 hours.

    d. For individual patients that have experienced a fall, their risk assessment will be updated accordingly.

    e. Monthly falls summaries record the overall audit of falls risk assessments completed (pre and post fall), providing assurance that risk assessments have been completed.

    f. The monitoring and assurance of the Trust's falls profile is monitored through divisional governance meetings, the Trust wide fundamentals of care meeting and the Trust quality committees. In addition, the overarching assurance around the management of falls prevention access is reported to trust board via the integrated performance report.

2. Communicating changes on wards which impact risk

    a. A 'dynamic risk' assessment has also been developed and has now been fully implemented across all ward areas. This document includes a combination of detail from ward-based safety huddles, daily staffing allocations and acuity assessments. It is used to assess the shift-by-shift ward risk profile and includes a number of key risk factors including the number of patients receiving enhanced care e.g. those at high risk of falls and the number of staff on duty.

    b. The risk assessment documents the team member allocated to support any patient/s receiving enhanced care and also documents an allocation of an appropriate alternative team member should additional cover be required, or to take over to cover the breaks etc.

    c. Ward managers review the risk assessment a minimum of three times during their shift and record any changes. It is also an opportunity for staff to highlight any safety matters that need to be escalated/actioned.

d. The effectiveness of the dynamic risk assessment is being monitored through local audit and the need for consistent compliance with its use has been included as part of the essential criteria for achieving the appropriate level of assurance via our ward accreditation programme. The ward accreditation programme is a process through which each ward's compliance with key quality and safety indicators are reviewed by a multi-professional team. The risk assessment process is now a core component of assessment during this accreditation process and compliance with its completion is an essential component of accreditation for each ward.

Clinical judgement training

A programme of tabletop training has also been rolled out via the education team and the Trust falls lead. This training focusses on scenario-based opportunities to exercise clinical judgement and reasoning regarding acuity, dependency, and effective staff allocation during a shift. Scenarios represent varying acuity levels and changes to the dynamics of the ward during a shift, to reflect real-life challenges and to develop a consistent approach in responding to such risks as they arise. This training has proved to be popular and successful in supporting staff to make decisions based on real-life scenarios in the classroom, which are directly transferrable to the ward environment. Past and future training attendance is monitored via the Trust Phoenix training platform and we intend to maintain this training for all new staff.

Enhanced care register and review of guidelines

The Trust has revised its enhanced care guidelines and their application to patients with enhanced care needs e.g. risk of falls and sets the North Middlesex University Hospital NHS Trust's standards for providing appropriate staffing for patients requiring enhanced care following a detailed clinical assessment.

The enhanced care guidelines reinforce the critical need for assessment to identify the clinical need for enhanced care, the level of enhanced care required. For example, a Registered Nurse (RN) may be required for enhanced physical care and a Registered Mental Health Nurse (RMN) may be required for patients with enhanced mental health needs. The guidelines require a comprehensive prescription and plan of care which is recorded into the patient's care records with daily reassessment of those needs.

The Nurse in Charge of the ward ensures all patients have an up-to-date risk assessment, plan of care and decision using the enhanced care assessment and in line with safer staffing levels and this is reported to the Matron daily.

The Matron is responsible for reviewing safe staffing levels and decisions made by the nurse in charge in line with the enhanced care assessments, making any changes and recording why these changes were made and notifies the Associate Director of Nursing daily.

The Senior Nurse of the Day (Matron) is responsible for ensuring safe staffing levels across all adult and children inpatient areas taking into consideration the enhanced care requirements and decisions made by the Nurse in Charge and Matron responsible for the individual wards. This role is supported by the Associate Director of Nursing identified on a daily basis who leads the twice daily safe staffing reviews for the Trust. Out of hours, the Senior Nurse of the Day responsibility is taken over the by Clinical Site Manager and Matron.

The guidelines also describe the specific roles and responsibilities within the nursing structure, with daily senior oversight being provided by the Associate Directors of Nursing on a daily basis and weekly oversight and scrutiny by the Divisional Directors of Nursing.

The Trust has also implemented an enhanced care register to ensure visibility of all patients across the organisation receiving enhanced care and allows senior oversight, scrutiny and challenge and ensures the timely review of patients.

These changes have been cascaded across the organisation through the Divisional Directors of Nursing to all Ward Managers, Matrons and Associate Directors of Nursing and forms part of the daily management of patients in the effective clinical assessment of complex needs, the planning and implementation of those needs and the recording and communication of the clinical plan across all staff to ensure there is an effective system to address the risk to patients at risk of falls and other complex care needs.

If you require any further information in respect of the Trust's actions and ongoing work following this inquest, please do not hesitate to contact us.

Yours faithfully,

[redacted]

[redacted]

Chief Nurse

[redacted]

Medical Director

[redacted]