NHS
Worcestershire
Acute Hospitals
NHS Trust

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Chief Executive
Worcester Royal Hospital
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08 November 2024

Mr David Reid
HM Senior Coroner
Worcestershire Coroners Court
The Civic
Martin's Way
Stourport on Severn
Worcestershire

Sent via email: [redacted]

Dear Mr Reid

Re Regulation 28 Report to Prevent Future Deaths

Please accept this letter in response to your Regulation 28 Report to Prevent Future Deaths received on the 26th September 2024, following the Inquest touching on the death of Mrs Margaret Maycroft

In your Regulation 28 report, you identified the following matters of concern relating to the Worcestershire Acute Hospitals NHS Trust (WAHT).

1) ***While at Worcestershire Royal Hospital, Ms. Maycroft sustained a number of falls:***

   (a) on 5.12.23 in the Emergency Department;

   (b) on 19.12.23 in the Emergency Department;

   (c) on 23.12.23 in the Acute Frailty Unit.

2) ***In respect of each of these falls, Matron Claire James gave evidence that whilst staff in the Emergency Department (ED) and the Acute Frailty Unit had completed falls risk assessments, no measures to mitigate that risk, such as might be found in a falls prevention, assessment and intervention plan, were documented in Ms. Maycroft's notes. This meant that no documented falls prevention measures were put in place for her.***

3) ***Furthermore, I heard no evidence at the inquest which satisfied me that steps have now been taken to ensure falls prevention measures are now being properly considered and documented in both the Emergency Department and the Acute Frailty Unit at the hospital.***

RESPONSE:

- The Trust is compliant with NICE Guidance for falls risk assessment.
- The Trust set its own metric to complete the Risk assessment (RA) within 4 hours, this is for patients admitted, not those in ED. The Trust has recognised patients are staying longer than anticipated in ED and ED have developed a risk assessment and processes to cover that period which sits within the ED nursing paperwork, however the ED are going live with EPR in November which will allow ED to complete the same assessments as the rest of the trust and make it visible to the receiving ward.
- There has been a 6-month deep dive review of all falls in A&E and AMU - preliminary findings show – of 112 falls, 3 resulted in moderate harm. The findings of the deep dive were presented to the Quality Governance Committee on 31st October.
- The number of all falls occurring in ED equates to 0.3% of the total ED attendances in that time period

Percentage of Falls in ED against attendance

Site	Ward	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Total
ALEX	Accident & Emergency	0.3%	0.2%	0.2%	0.2%	0.4%	0.6%	**0.3%**
WRH	Accident & Emergency	0.3%	0.2%	0.3%	0.3%	0.3%	0.3%	**0.3%**
Trust		**0.3%**	**0.2%**	**0.3%**	**0.3%**	**0.4%**	**0.4%**	**0.3%**

- There are trust wide falls prevention measures in place and work is being undertaken to review the post fall record and intervention document on the electronic patient record and for the expectations around completion to be clarified.
- The barriers faced by staff in documenting falls interventions in place on EPR will be explored and actions taken and monitored through Improving Safety Action Group (ISAG)
- The EPR team will distribute an update on how to document interventions on Sunrise.
- There is a trust-wide audit in place (Quality Checks) which is completed weekly and requires a check of “are falls measures/interventions in place?” and is further scrutinised in the Fundamentals of Care Committee (FoCC) which is chaired by one of the Deputy Chief Nursing Officers.

Actions taken in the ED:

- Introduction of yellow falls bundle in ED (yellow blanket / socks to highlight patients at risk visually)
- Falls risk assessments now added in to ED Nursing packs (as they had previously not been due to it not being an admitting area

- 1:1 enhanced care tabards are now used in ED (to highlight the staff supervising falls risk patients to reduce the risk of them being distracted by other staff)

- Introduced safety huddles throughout the day lead by the band 7 – Patients at risk of falls discussed – verbally remind each other.

Actions taken in AFU:

- Discussed in safety huddles if the patient is identified as a high falls risk
- AFU staff have been reminded that they have the use of 6 Ramble Guard devices which are allocated to high-risk patients and those that are at risk but maybe not able to be located in the high visibility bays (due to infection prevention / gender mix of bay or capacity)
- The high visibility bays operate a 'stay in the bay' function - allocation to these bays would be dependent on the assessment of all patients at risk of falls on the unit.
- Those patients unable to be allocated a high visibility bed or a ramble guard unit may be suitable for 1:1 supervision which would get arranged accordingly.
- Staff risk assess patients on arrival to AFU
- Gripper socks are also available for at risk patients who are mobile.

Actions taken trust-wide:

- Falls that have occurred are discussed at the ward MDT Board Round to identify any additional local interventions required
- Staff training has been enhanced through falls simulation sessions to better manage high-risk patients.
- There are initiatives being implemented to enhance the quality of multifactorial falls risk assessment, particularly focusing on lying and standing blood pressure measurements which are detailed specifically in the FoCC monthly update.
- There has been a review of lifting equipment resulting in the procurement of devices for the Worcestershire Royal Site, with training provided by the Moving & Handling Team.

Trust-wide measures to monitor and review controls and actions:

- There is a mechanism for all ward managers to monitor falls interventions on EPR and audit their falls documentation – these are reviewed in the weekly check and challenge forum.
- Check and challenge – are meetings with the DCNO, falls lead and the ward manager/matron of the ward the fall occurred on. They talk through what happened, and any omissions in care and learning and identify on areas for learning or improvement.
- Falls are also discussed weekly via the CNO production board to identify any immediate action / support needed and identify any area require additional resource or focus – this production board also happens at divisional level with Matrons required to give assurance to Divisional Directors of Nursing following any inpatient falls.
- The IPR is the integrated performance review that is shared at QGC and Trust Board, includes a section on quality and safety. This now includes any falls with moderate or above harm.

I hope that the above addresses the concerns which you raised. I have no representations in respect of publication of the Regulation 28 or this response by the Chief Coroner.

I shall be grateful if you could kindly send a copy of my response to anyone to whom you copied your Regulation 28 report.

Yours sincerely

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Chief Executive