Mr R Bishop
Chief Executive

Management Centre
St Mary's Hospital
Milton Road
Portsmouth PO3 6AD
Code A

PRIVATE AND CONFIDENTIAL

3 November, 1999

Code A

Dear **Code A**

Further to our previous correspondence I have now, as promised, taken the actions agreed at our meeting, with the following outcome:-

1. The Nurse Practice Group has considered the issue of the positioning of commodes on the wards, and they have responded to me that, as with all nursing procedures, it is the responsibility of the nurse undertaking the task, (i.e. placing the patient on a commode, in your late **Code A** case) to assess each situation. For example, it is more appropriate to assist a patient onto a commode and to leave them behind a curtain until they have finished. However, it would be the responsibility of that nurse to ensure the patient was well enough to be left unsupervised in the first instance and, if Code A was, then the nurse should ensure that the patient was suitably covered to maintain dignity, that the patient could reach the nurse call bell, that the patient was safe, i.e. brakes were on, and that the patient was happy to be left alone. If a patient expressed the wish to be left alone but was too frail or unstable, it would be acceptable for the nurse to ensure that the patient was safe and then wait outside the curtains ensuring that Code A was keeping a close eye on the patient from a safe distance, while still meeting the patient's wishes.

   When transferring any patient from bed to commode, it is current and accepted practice to raise the bed to a suitable level that will enable the patient's knees to drop lower than their hips to enable the transfer to be completed. The commode would be placed at right angles to the bed so that the patient could be manoeuvred across to the commode. Once the patient is on the commode, the bed should be suitably lowered ready for the transfer back to bed, but also to provide easy access to tissues, wipes and the nurse call bell. **Code A**, the Chair of the Nurse Practice Group, cannot comment on whether the nurses should have left **Code A** unattended as she did not witness **Code A** condition at the time, however, she can only reiterate that the nurse must make that assessment.

It may have been the case that the nurse was called away and in that time your Code A ventured off the commode, unassisted, but we do not know. As you know, your family were not happy that your Code A was left facing away from the bed, and Mrs Bartlett explained that it is extremely impractical to transfer a patient who is obviously unwell to a commode that is facing directly opposite the bed.

I stated earlier that it is accepted practice for ease of lifting safely, for the commode to be placed at right angles to the bed and this is the safest and most recognised way of transferring a patient in this situation.

If nurses intend to leave the patient unattended, and sometimes for safety reposition the commode so that it is facing the bed, this does have a side effect of reducing patient movement. However, all that is achieved is that the patient is encouraged to move as they use the bed as a lever and, rather than falling onto the bed due to restricted space as the commode remains fixed, it results in the inevitable fall.

I also raised the question of elevating the bed or having it at such a level that the patient's knees are underneath to restrict movement. This suggestion actually horrified Mrs Bartlett as it does of course suggest physical restraint of the patient, which we must avoid at all costs.

Code A the Trust's Health & Safety Advisor, has also supported Mrs Bartlett's statement regarding the correct practice for transferring the patient from a bed to a commode, and neither have ever come across a nurse who knowingly wedges a patient under the bed when sitting on a commode.

In conclusion, therefore, Code A has reinforced that it is vital that nurses assess their patient and treat every situation individually according to the degree of complexity, while adhering to the correct procedures at all times. However, it cannot be overlooked that the situation with your Code A may have arisen because the nurse was called away for a more serious matter, the nurse involved may have been an agency nurse who was not aware of the severity of your Code A condition or perhaps the ward was short staffed for some reason and, if any of these are the case, or indeed the nurse incorrectly assessed Code A condition, I can only apologise once again.

2. The use of cot sides is a very similar issue in that the use or non-use of cot sides has to be made by the nurse looking after that particular patient, after undertaking an assessment of their individual needs.

Hospital beds are not routinely provided or fitted with cot sides. If cot sides are required for whatever reason, they have to be acquired from within that clinical area. The appropriate use of cot sides has to be evaluated against the patient's condition as, used inappropriately, they can be hazardous to patient safety. For example, to use cot sides on a confused or irritable patient would only encourage the patient to climb over the top, resulting in more severe damage. The Health & Safety Advisor confirms that individual assessment and re-evaluation is paramount.

Mrs Barlett comments that the nursing documentation records that your Code A was very frail and weak, requiring regular oxygen therapy. A patient in that condition would not routinely require cot sides. It would be more appropriate that the patient be nursed in an observation area, fully visible to the nursing staff.

In conclusion, therefore, Code A can only reiterate that individual assessment is foremost and that cot sides are not used routinely on all patients.

I have checked with Sister Jackson about the incident reports and she confirms that they were completed on 21st January but that she did not sign them off as Ward Manager until her return to duty on 23rd January, as she was not on duty on 21st or 22nd January. She also confirms that the left side of your Code A bed was against the wall and she, therefore, fell from the right hand side. The staff found your Code A on the floor on Code A left side and Code A therefore either rolled over after Code A fell or it is possible that Code A was sitting on the side of the bed when Code A fell. I am afraid we cannot be sure as no-one witnessed Code A fall.

3. I contacted NHS Supplies about the over bed tables and whether they knew of any other incidents that have been reported in connection with accidents. I received a response that they have no records of any other notified incidents in respect of over bed tables and that the design used by the Trust has been purchased for many years and is marketed industry wide without brakes to the castors.

4. I asked the Trust's Risk Advisor for information on all patient slips, trips and falls during the last three years and, as you can see on the enclosed statistic report, Blendworth 4 in fact has the second highest number of this type of incident. I must say, however, this is indicative of the type of patients nursed on Blendworth 4 who are usually very ill and frail. However, the information collected in this way is used to try to reduce the number of incidents and you will see that the highest incidence is on Exton 4 ward at St Mary's Hospital and this ward has been targeted for a pilot study of a spontaneous call monitor, a device which, when placed under the mattress, detects pressure changes and so alerts staff to patients who are felt to require assistance. Although the trial has yet to start, the results of trials from other areas look promising and we are hopeful that it will prove successful and can be used across the Trust on all appropriate wards.

5. Unfortunately I was unable to identify whether we have had any other accidents identical to the two suffered by your late mother, as the accidents are only recorded at this stage as a slip, trip or fall.

6. In addition, I have raised the issue of the high number of slips, trips and falls on Blendworth 4 with the Operational Director for the Medical Directorate and asked her to do all she can to reduce this figure.

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Finally, I would like to reassure you that the comments in your letter of 31st August in respect of my summary of our meeting are on file.

I hope this outstanding action will reassure you that I have done everything possible to raise awareness of the issues that your complaint about your late mother's care has raised.

Yours sincerely,

Mr R Bishop
Chief Executive

Enc

s.c. Code A General Manager, Surgery & Chair Nurse Practice Group, QAH
Code A, Ward Manager, Blendworth 4, SMH
Code A Consultant Physician, Respiratory Centre, SMH
Mrs L Kennett, Operational Director, Medical Services, QAH
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