MANCHESTER CITY COUNCIL

Manchester Mental Health and Social Care Trust NHS

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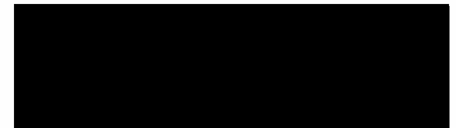

Ref: *HH/Regulation 28 response SD/03022014*

Date: 3 February 2014

PRIVATE AND CONFIDENTIAL

Mr Nigel Meadows
HM Coroner
Coroner's Office
Manchester City Area
PO Box 532
Manchester Town Hall
Albert Square
Manchester, M60 2LA

Dear Mr Meadows

Re: Stephanie Daniels (deceased) Inquest hearing concluded 29 November 2013. Regulation 28: Report to Prevent Future Deaths

Thank you for your Regulation 28 Report following the Inquest Hearing at Manchester Crown Court into the death of Stephanie Daniels.

I have provided a response to your concerns, as detailed in your report of 13 December 2013, as follows:

1. **Serious Untoward Incident / Serious Incident Requiring Investigation (SIRI)**

Following the concerns raised in your report about the Serious Untoward Incident the Trust will be reviewing the Serious Incident Requiring Investigation (SIRI) policy to consider the engagement of an independent investigator in complex cases. The Trust will also develop further guidance for investigators regarding the learning from this case. As part of the review, the Trust will look at identifying a resource to carry out such independent investigations.

2. **Handover process**

As you are aware, the Trust has a handover of care policy, which sets out the arrangements for the handover of care, and the documentation of information handed over. The Matrons will carry out weekly checks on compliance with the quality of the documentation on the handover forms. To address your concern that issues may be overlooked, the Head of Nursing is writing to all Ward Managers to instruct all registered nursing staff that they must read the recent admission records and risk information relating to all patients who are not known to them or have not been known during the current period of admission. Ward Managers will be required to ensure their registered nursing staff have received and understood the instruction, which will be monitored through management supervision.

3. **Bed availability**

I understand that you have raised this concern in your Regulation 28 Report as a national issue. However, as you are aware, following [redacted] evidence at the inquest, this Trust implemented a change to how inpatient beds are accessed in January 2013 and we do not have a waiting list of service users requiring admission.

4. **Clerking In**

The Trust acknowledges the importance of clerking in service users upon admission. In order to strengthen our processes the admission checklist requires the nurse to sign that they have contacted the doctor to clerk in a new service user, and an additional sign-off once the doctor has clerked the service user in. It also incorporates the action to inform the consultant by email of hospital admissions. This will be monitored through audits.

5. **Supervision of junior doctors**

I appreciate you have also sent your Regulation 28 Report to the Deanery at Manchester University. From a Trust perspective, all trainees graded CT1-3 and StR 4-6 have weekly supervision. Trainees and Consultants have been reminded of the importance of this and a discussion has taken place with the Deanery. This will be additionally monitored through the annual handover and supervision survey data completed by junior medical staff.

6. **Prescribing of medication by junior doctors**

[redacted] Interim Medical Director, will ensure that all trainees will be informed about the Rapid Tranquillisation protocol through the induction process. In addition, consultants will be made aware of their responsibilities in respect of supervision of junior doctors prescribing. The Trust has amended the prescription card to ensure that Rapid Tranquillisation is clearly identifiable and not confused with PRN (as necessary) medication. The Trust incident reporting system is being adapted to record whether Rapid Tranquillisation was administered intramuscularly or orally and whether physical / safe observations were maintained in line with Trust policy. This is be monitored through induction attendance records, pharmacy daily monitoring of prescriptions and Datix incident reporting.

7. **Mechanism by which the Consultant in charge of the patient would learn of the patient's admission**

As referred to under point four, the admission checklist system incorporates contacting of consultants by the nursing staff. The compliance with this system will be monitored through audit.

8. **Performing and recording of observations on other patients**

I share your concern about incomplete observation forms and the Head of Nursing has instructed staff that observation record forms must be completed contemporaneously and without any gaps. In addition, the nurse in charge must review the observations records during and at the end of the shift and ensure any gaps are addressed and reported through the Datix incident reporting system. The Matrons will monitor the recording of observations and the Trust will audit the compliance with the Safe and Supportive Observation policy.

I have attached the action plan detailing the timetable for actions to be undertaken in line with the requirements of the Regulation 28 Report.

I hope this response provides you with assurance that the Trust has taken action in response to your Regulation 28 Report.

Yours sincerely

Michele Moran
Chief Executive

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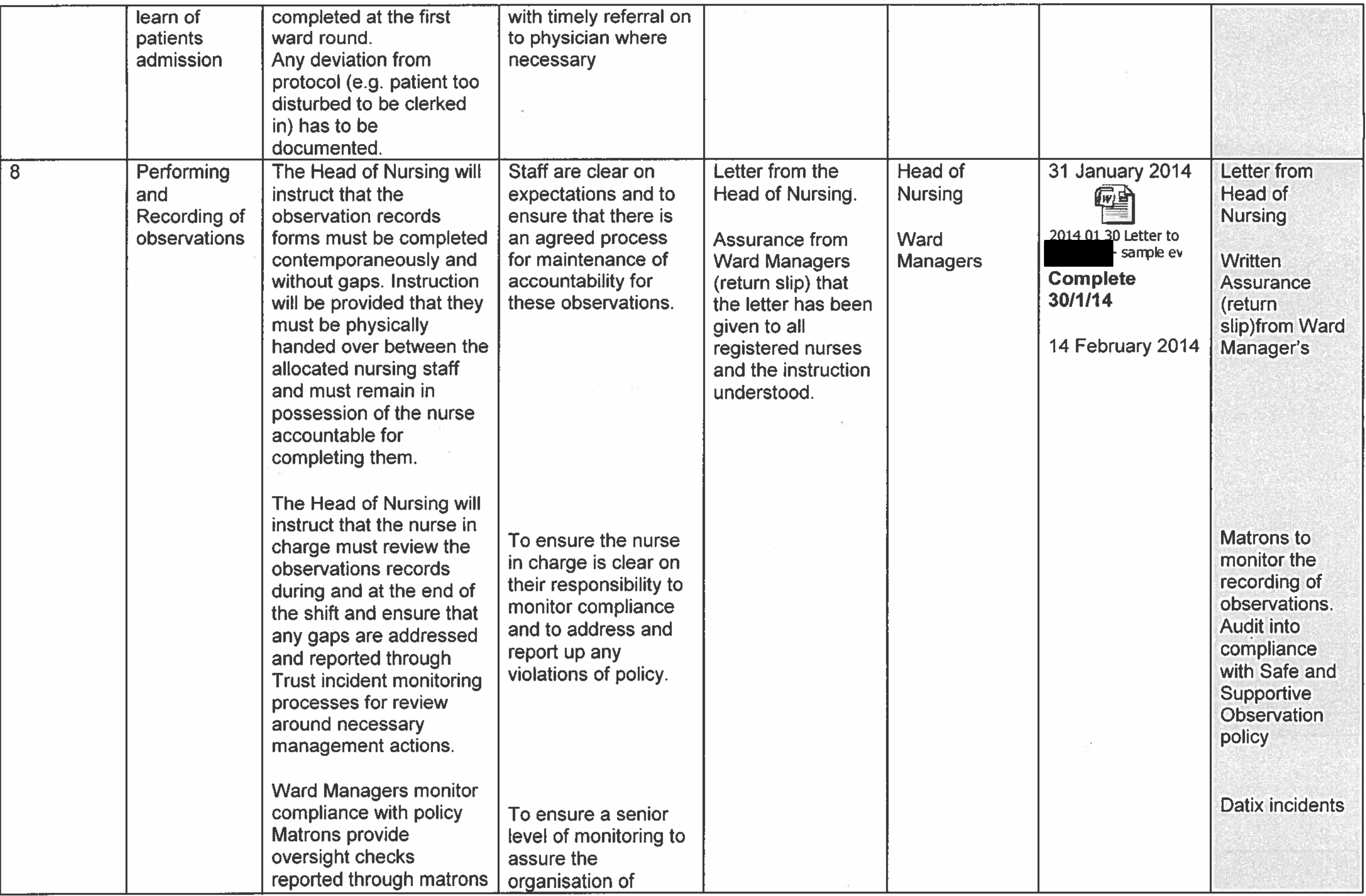
Regulation 28 Report: SD – Action Plan 13/14

Date Action Plan Developed:	Ref Number:	Care Group/Area:	Purpose:	Name of Manager (Band 7>):	Consultation with:
17 January 2014	D32871	Inpatient services	Regulation 28 report	[redacted] Head of PALS, Complaints and Legal Services	Chief Nurse & Director of Quality Assurance Interim Medical Director Head of Patient Safety Interim Head of Nursing

Issue	Theme	Action	Outcome and Benefits	Method of Measurement	Lead / *Involved*	Target Date	Evidence
1.	Serious Incidents Requiring Investigation (SIRI)	The Trust will consider where there is a complex SIRI engaging an independent panel chair to lead the SIRI. The Trust will also develop further guidance for panel chairs regarding the learning from this case to include Rationale for scope of the SIRI Interviewing of witnesses The Trust to identify a resource to carry out independent	Improved investigations.	The SIRI procedures will be reviewed to include a consideration of engaging an independent SIRI lead. The decision to review independently will be with the Chief Nurse. Work will be undertaken to identify an agreed list of independent reviewers.	Head of Patient Safety	30 April 2014	Reviewed Serious Incidents Requiring Investigation (SIRI) policy Resource identified

		neighbouring NHS Trusts, extended NHS, then private beds. The Trust does not have a waiting list of service users waiting for admission to a mental health bed					Commissioner review of capacity in line with demand.
4	Clerking in Informing the Consultant of admission to ward.	The admission checklist incorporates a sign-off for the nurse contacting the doctor to visit the ward to clerk a new patient in and a sign-off for the doctor once the patient has been clerked in. It also incorporates the action to inform the consultant by email of hospital admission.	There are prompts to ensure that patients have been clerked in and received a physical examination and that the Consultant Psychiatrist has been informed of admission.	The completion of checklist is monitored through the Acute and Urgent Care Service Improvement Board. A specific audit will be carried out to monitor the actions and documentation related to clerking in and informing the Consultant Psychiatrist.	Deputy Acute Services Manager Head of Nursing	31 July 2014	Audit results Checklist
5	Supervision of Junior doctors	All trainees in the grades CT1-3 and StR 4-6 have weekly supervision. Trainees and consultants have been reminded of the importance of this, and discussion has taken place with the deanery on this. Supervision will be reinforced at every induction and the juniors' and seniors' timetables.	Supervision arrangements clearly set out in timetables. Junior doctors will receive regular clinical and educational supervision from their consultants	Consultant job plans Regular surveys with trainees	Interim Medical Director/ Consultant Psychiatrist and Director of Medical Education	31 December 2014	Survey data Deanery information on junior doctors involved in Serious Incidents requiring Investigation



	learn of patients admission	completed at the first ward round. Any deviation from protocol (e.g. patient too disturbed to be clerked in) has to be documented.	with timely referral on to physician where necessary				
8	Performing and Recording of observations	The Head of Nursing will instruct that the observation records forms must be completed contemporaneously and without gaps. Instruction will be provided that they must be physically handed over between the allocated nursing staff and must remain in possession of the nurse accountable for completing them. The Head of Nursing will instruct that the nurse in charge must review the observations records during and at the end of the shift and ensure that any gaps are addressed and reported through Trust incident monitoring processes for review around necessary management actions. Ward Managers monitor compliance with policy Matrons provide oversight checks reported through matrons	Staff are clear on expectations and to ensure that there is an agreed process for maintenance of accountability for these observations. To ensure the nurse in charge is clear on their responsibility to monitor compliance and to address and report up any violations of policy. To ensure a senior level of monitoring to assure the organisation of	Letter from the Head of Nursing. Assurance from Ward Managers (return slip) that the letter has been given to all registered nurses and the instruction understood.	Head of Nursing Ward Managers	31 January 2014 2014 01 30 Letter to [redacted] - sample ev **Complete 30/1/14** 14 February 2014	Letter from Head of Nursing Written Assurance (return slip)from Ward Manager's Matrons to monitor the recording of observations. Audit into compliance with Safe and Supportive Observation policy Datix incidents