


Dr Peter Harrowing, LLM
Assistant Coroner for Avon
The Coroner's Court
The Courthouse
Old Weston Road
Flax Bourton
Bristol
BS48 1UL

Trust Headquarters
Jenner House
Langley Business Park
Chippenham
SN15 1GG
Tel: 01249 468023
Email: 

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Dear Dr Harrowing

Response to Regulation 28 Report MG 11/9/15

In response to your concerns we would like to provide you with a summary of both actions already taken and those planned.

- 1. There was inconsistency record(s) of engagement with service users. The Engagement and Observation policy of the Trust should be reviewed to consider how the policy operates and how engagements with service users are to be recorded in a consistent manner with appropriate staff training in application of the policy.**

The Trust Engagement and Observation Policy is based on guidance in the recently revised Mental Health Act Code of Practice, (Chapter 26, Safe and Therapeutic Responses to Disturbed Behaviour). The Policy is also informed by the recently published NICE Guidance - Violence and aggression: short-term management in mental health, health and community settings, (NICE 2015).

The Engagement and Observation policy is clear on what engagement is, what observation consists of and where and when these observations should be recorded. Please see extracts from policy below:

1. Introduction

1.1 *Engagement and observation with a service user includes the reporting and recording of a service user's location, mental state, well-being and behaviour, which is central to the role of inpatient staff. Observation provides an opportunity for positive engagement with service users to assess and respond to their individual needs to aid their recovery.*

1.2 *Every inpatient who is receiving care and treatment is observed at some level as a necessary part of their care. Where there are specific concerns, the service user may need to be placed on higher levels of observation for periods of time.*

2. Policy Statement

- 2.1. *Engagement and observations are an integral part of a therapeutic plan. The service users care plan must specify the level of engagement and observation for them.*

Chair
Anthony Gallagher

Trust Headquarters
Jenner House, Langley Park, Chippenham SN15 1GG

Chief Executive
Iain Tulley

2.5. *Service users and their carers will be involved in the decision making and offered a clear rationale for the level of engagement and observation, unless their clinical presentation prevents this. This assessment, discussion and outcome will be clearly recorded.*

2.8. *Reductions in levels of observation may also be appropriate where it can be demonstrated that certain levels of observation are counter-therapeutic. In any such case the risks and rationale must be clearly documented.*

5. Content

5.1. Assessment and Planning of Engagement and Observations

5.2. *All service users admitted to an inpatient unit will have their risk assessment updated by the community team responsible, with a stated reason for admission and purpose of admission. A handover of care will be provided, which will inform the assessment of level of engagement and observation. The electronic record will be updated in all occurrences.*

5.8. *The care plan will reflect any leave status / restrictions of a service user, the plan of care for undertaking observations when attending other therapeutic activities, i.e. whether to be escorted or not and who should undertake any escort, and when receiving visitors, with these decisions supported by a documented risk assessment.*

The monitoring of engagement and observation recording is through monthly management supervision. This is when the line manager sits with individual clinicians and goes through their caseload on the ward and highlights any issue or remedial actions to take. However, this has not been consistently monitored by the Clinical Executive; our plan is to undertake monthly spot audits of the caseload supervision records to ensure consistent application of the Engagement and Observation Policy. This audit will be taken to the Integrated Governance Group (IGG) meeting for action (attendees include Quality Directors from all localities). These audits will commence from October 2015.

There are several Statutory and Mandatory Training Courses which cover the Engagement and Observation Policy; these are 'Prevention and Management of Violence and Aggression (PMVA)', 'Violence and Aggression' (Older Peoples Units); 'Care Programme Approach' (CPA). A new training package for Suicide Prevention is currently being designed.

Local training in the implementation of the Trust Engagement and Observation Policy has been rolled out across all wards in Bristol following learning from root cause analysis process.

During January to April 2015 the Trust carried out targeted training in inpatient suicide prevention. This included training in engagement and observation. The Trust plans to continue this targeted training between July and November 2015 and to include this as part of mandatory Care Programme Approach and Risk Training for inpatient staff from December 2015 onwards.

2. There was no one member of staff with overarching responsibility for reviewing any risk assessments. Therefore any trends in changing risk, e.g. increasing risk of self-harm or suicide could not be identified. The Trust should consider designating a member of staff with this responsibility in the same manner as it has one member of staff with responsibility for ensuring the care plans(s) are reviewed and maintained up-to-date.

The Trust has in place processes and procedures for the co-ordinating of risk assessment information for inpatients.

On day to day basis risk is constantly assessed and reviewed and changes to the care plan implemented accordingly, including reviews of engagement and observation levels, response to treatment, leave and time away from the ward and activity involvement including occupational therapy. The Nurse in Charge is responsible for ensuring that any day to day changes in risk are responded to appropriately, including involvement of the wider multi-disciplinary team where appropriate.

Ward Teams are made up of a variety of members of the multi professional team including Nurses, Doctors and Allied Health Professionals. A review of care provided by the Multi Professional Team is undertaken on a weekly basis. The Trust operates a functional model for acute inpatient areas and therefore each ward has a designated Consultant. The Consultant is responsible for co-ordinating the weekly multi-disciplinary ward review and ensuring that the review considers information from all

professionals, and carers. The chair of this meeting should ensure that all changes in risk are considered and plans are reviewed and amended appropriately. This process encourages the identification of trends in changing risk.

Staff performance against the expected standards of practice are reviewed through the Trust appraisal and supervision processes.


The Clinical Executive appreciates the Coroners comments re responsibility for reviewing and as a result have commissioned an audit of reviewing risks across inpatient units. The Clinical Executive will take the information from this audit and design a framework of staff responsibilities for all staff to follow.

- 3. The Trust has a comprehensive single care record for each service users. However, the ward rounds rely only on a brief summary prepared by a nurse the night before when that nurse may not have made any entries in the care record nor would be present at the ward round. The Trust should review its planning and preparation for ward rounds so that reliance is not placed solely on a brief summary with the inherent risk of errors and omissions.**

When undertaking ward rounds, the care team have access to the patients full and comprehensive care record. However, it is accepted that there are occasions when the nursing summary is not as comprehensive as it should be. A full review of nursing models of care is to be undertaken by the Nursing Directorate with recommendations generated for a standardised model of care delivery (ie. named professional / team nursing structure). This will facilitate a more comprehensive recording of a patients presenting needs state at any given time. Also a review of the existing multi professional weekly review meetings has been undertaken. The findings and recommendations will be taken to the Integrated Governance Group, chaired by the Executive Director of Nursing and Quality in October 2015. The review was completed by the Heads of Quality for each of the six local delivery units.

Yours sincerely

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Iain Tulley
Chief Executive