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Enclosed

Sheffield City Council

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28 September 2018

Mr David Urpeth
Assistant Coroner for South Yorkshire (West)
Office of HM Coroner
The Medico-legal Centre
Watery Street
Sheffield
S3 7ET

Dear Mr Urpeth

Following your recent Regulation 28 Report to Prevent Future Death issued on 8 August 2018, please find the details of the Trust's response.

The MATTERS OF CONCERN and the Trusts responses are as follows:

1. **Mr Dransfield was on an inappropriate observation regime with no written record of why he was moved from 10 minute observations to routine observations**

The Trust's internal Serious Incident Investigation report (supplied to the Coroner by the Trust) supports the assertion that the rationale for the change in levels of observation were not recorded in Mr Dransfield's records. It is expected by the Trust that such decisions are made after full consideration of the presenting level of risk and discussion between members of the Ward Multi-disciplinary Team.

These decisions should then be recorded onto 'Insight' (the Trust's electronic care record) with a clear explanation of the rationale for the change. Although staff members assert that conversations about the proposed change in levels of observation did take place, this was not entered onto the care record system and therefore cannot be clearly evidenced.

The Trust has taken action to address this since the incident as follows:

- Each member of staff directly involved in the care of Mr Dransfield during his stay on the ward has received one-to-one supervision where they have been informed of the

outcomes of the investigation and the actions identified and required of them to ensure learning from Mr Dransfield's tragic death.

- Staff have been clearly instructed about their personal and professional responsibilities in relation to the timely recording of clinical information, particularly where significant changes are noted in the level of presenting risk, or changes have been made to the care plan of service users. A failure to comply with this essential requirement of care may result in disciplinary action.

- Feedback has been given to the whole ward team to ensure that lessons are learnt by each ward team member.

- The Trust has devised a Standard Operating Procedure (SOP) for handovers between each shift, across all the Trust inpatient wards, to ensure accurate and timely communication of patient information.

  The Standard Operating Procedure (SOP) standardises the way handovers in the Trust are conducted, ensuring key clinical information, such as changes in levels of observation, are effectively communicated and handed over to all staff members of the oncoming shift. The SOP will be fully implemented by 31 October 2018.

- To determine whether the lack of recording of information was a problem in other wards the Nurse Consultant undertook a care records check in each acute ward. These checks included reviewing evidence that risk assessments, care plans and significant changes to care had been regularly updated. These checks identified that records on the acute wards are being updated regularly and key clinical information recorded.

- The Trust's Standard Operating Procedure for Record Keeping has been reviewed and revised to ensure that expected standards are clear, consistent and all staff are aware & fully understand requirements.

  Formal audits of care records on all inpatient wards are now conducted on a quarterly basis. These incorporate an audit of care records, risk assessments and care plans for timeliness and quality. The quarterly audits commenced in April 2018.

  Audit results will be used to help the Trust to understand whether there are systemic issues around record keeping standards, or whether there are individual practitioner issues. The findings of the audits will be used to inform relevant action plans and/or training and development plans as required.

  The Trust's Clinical Effectiveness Group and the Clinical Operations, Performance & Governance Meeting structures will receive the audit reports and will monitor progress against action plans to ensure that changes and improvements are made.

- Maple Ward is piloting various clinical improvements, including the use of hand held tablets to improve timeliness and ease of recording clinical information and to move away from paper systems. The system will enable the Trust to extract information about changes to observation levels and more clearly identify who made or authorised the change. 'Insight', the Trust's electronic care record system is not able to provide this information which would have assisted the Coroner's enquiries had this been available at the inquest.

- The Trust has reviewed and revised its Policy: Observation of Inpatients – Routine and Enhanced Observations of Patients. In light of national evidence, and in line with accepted best practice, observations at 10 minute intervals have been removed. The Trust has taken steps to ensure that all staff are aware of the new policy and the changes to practice that will be required to implement the policy safely.

- The Regulation 28 ruling states that Mr Dransfield was on an inappropriate level of observation at the time of his death. The Trust takes a thorough and proactive approach to the management of risk and, to support our staff in making clinical decisions about levels of risk, the Trust has initiated a programme of bespoke suicide prevention training. This programme of training has commenced, and the Trust has and will continue to review the course content in light of feedback received to improve, refocus and to ensure it is effective and fit for purpose.

2. There was not a clear risk assessment of Mr Dransfield

The Trust notes that there was no clear evidence that the Detailed Risk Assessment and Management (DRAM) form had been updated in a timely manner. There were entries in the daily progress notes on the electronic care record noting staff's interactions with Mr Dransfield and summaries of his daily presentation, but these were not pulled together into an updated DRAM and care plan.

The quarterly record keeping audit described above will enable the Trust to assess the timeliness and quality of the completion of the DRAM, ensuring that risk assessments are up-to-date and contain clear, good quality information.

The Trust policy requires that a review takes place of each service user on the ward 72 hours after admission. We will ensure that refresher training around the policy and the requirement of the 72 hour review is provided to staff so that an opportunity is not missed for the ward team to consider the needs and presentation of service users in their care to support a clinical formulation around their risks and plan accordingly.

The Trust actively promotes the use of clinical supervision to support our staff to practice safely. Supervision focusses on the key aspects of good nursing care such as reviewing observations and documenting daily risks and provides protected time for staff to reflect on aspects of their practice and receive advice and support from experienced practitioners to improve their own practice.

In addition staff have opportunities for clinical discussion through a range of forums such as ward handovers, incident debriefings, multi-disciplinary team meetings and Care Programme Approach (CPA) Meetings. These enable staff to discuss individual service user risks and their approach to the management of these. In collaboration with Sheffield University the Trust has developed and delivered a programme of supervision training. This year's programme of 2 day training commenced in September 2018 offering 20 places.

3. Staff did not routinely consult patients records

The Trust notes that the named nurse and associate nurse responsibilities on the shift in question were not fulfilled. The Trust expects that named and associate nurses make sure they know what is happening with their service users and are aware of the plans of care

that are in place for them. The Trust found no evidence that notes were looked at nor did the two staff know they were the named nurses for Mr Dransfield on this shift. Staff have been informed of their responsibilities when undertaking the named and associate nurse role and the Ward Manager is responsible for ensuring all Ward staff fulfil their responsibilities effectively.

The Standard Operating Procedure for Handover as referenced above will ensure that key information is passed clearly and concisely to the incoming shift.

4. **Lack of appropriate training**

The Trust strives to provide the appropriate training for staff at all levels and carries out regular audits in relation to training compliance. The monitoring of training compliance is taken very seriously within the Trust and is achieved through Clinical Operations Performance & Governance Meeting structures; the Mandatory Training Steering Group which reports to the Executive Directors' Group and also through the Quality Assurance Committee.

The Trust's Mandatory Training Framework focuses on 21 key areas of training with a compliance target of 80%. As at 31 March 2018 the wards had attained 91.34% compliance.

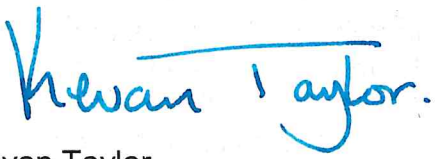
In addition, new non-qualified starters are required to complete training in The Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should be covered if a member of staff is 'new to care' and forms part of a robust induction programme. 69% of new starters have completed The Care Certificate.

Suicide prevention training (as referenced above) has been reviewed and updated to ensure there is a clear and specific focus on community and inpatient services and continues to be rolled out across our services.

The content of our Clinical Risk Training has also been reviewed and updated with an enhanced focus on Suicide Risk Assessment.

We trust that this response is to your satisfaction.

Yours sincerely



Kevan Taylor
Chief Executive