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Chief Executive
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NHS
Surrey and Sussex Healthcare
NHS Trust

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East Surrey Hospital
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Ms Anna Crawford
H M Assistant Coroner for Surrey
HM Coroner's Court
Station Approach
Woking
Surrey
GU22 7AP

29 June 2022

By recorded delivery post

Dear Ms Crawford

Regulation 28 Report – response by Surrey & Sussex Healthcare NHS Trust
Inquest touching upon the death of Seb Nottage

This response comprises the formal response of Surrey & Sussex Healthcare NHS Trust (the Trust), pursuant to section 7(2) to schedule 5 of the Coroners and Justice Act 2009 and Regulation 29 Coroners (Investigations) Regulations 2013, to the issues raised in the Regulation 28 Report to Prevent Future Deaths, dated 18 May 2022, made subsequent to the inquest into the death of Mr Nottage which was concluded on 18 March 2022.

The Trust was given until 12 July 2022 to respond to the coroner, pursuant to Regulation 29(5) Coroners (Investigations) Regulations 2013.

Background:
Mr Nottage attended the Emergency Department at East Surrey Hospital on 29 June 2020 and was assessed by a junior doctor at around 11.00am. He reported a ten day history of epigastric abdominal pain, fever, headache, vomiting, diarrhoea and a cough. He was referred to the surgical team and admitted to the Surgical Assessment Unit (SAU) with suspected pancreatitis. He had a past medical history of osteoporosis, osteomalacia and hiatus hernia. He also had a diagnosis of Asperger's syndrome, anxiety and attention deficit hyperactivity disorder (ADHD). On admission he was deemed to have capacity and he was noted by staff to be able to communicate his needs and appropriately request pain relief. He stayed overnight on SAU. At around 7.15am on 30 June 2020 he left the ward having earlier told staff that he wanted to go for a walk. Just after 9.00am the police telephoned SAU and informed staff that Mr Nottage had been hit by a train and had died.

HM Coroner Regulation 28 Report:
The concerns raised by HMC are in relation to this completion of the Trust's "7 day Short Stay Booklet" and specifically:

1. There is no clear guidance in place in relation to the timeframe for the full completion of the 'Seven-day short stay booklet for admission/discharge' and the steps to take if the booklet has not been fully completed on the day of admission to the unit. The Coroner considers that further guidance and/or training on this matter may be required.

2. There is no clear guidance in place in relation to the manner in which the 'Seven-day short stay booklet for admission/discharge' ought to be completed, and particularly whether it is permissible to rely on information recorded in the Emergency Department without checking it directly with the patient. The Coroner considers that further guidance and/or training on this matter may be required.

Trust response:

The current 7- day Short Stay Booklet Admission/ Discharge and Daily Evaluation outlines the expectation that the nursing staff will complete the information within the booklet during the early stages of the patient's admission. It is not possible to provide a definitive time frame within which this is completed, as this will be dependent upon the patient's admission pathway (whether they are emergency or elective) the time of day they are admitted and their capacity and presentation at the time.

The booklet is being reviewed and will be reprinted to incorporate enhanced instructions regarding completion of the booklet. Specifically, the wording at the top of each page will be:
"Page 1-14 complete within 24 hours and check daily to ensure completion."

In addition, at page 15 onwards it will state:
"Please check pages 1-14 have been completed or ensure explanation for any gaps is written on continuation sheet."

The Trust has revised the teaching session for "Ward documentation" which is part of the Ward Ready Course. I attach a copy of the revised lesson plan detailing the content provided to all new nursing staff. This training is delivered via the Trust's Practice Development Team to all new members of the nursing workforce during their induction programme. The current nursing workforce will be reminded of the expectations and importance of completing documentation via the daily Ward Handovers, daily Safety Huddles, and monthly Ward Manager and Matron Meetings. In addition, the Matron's Monthly Documentation Audit will continue to address compliance with completion of documentation, and any training requirements for wards and individuals.

In respect of the manner in which the booklet ought to be completed, page 8 currently outlines the expectation that the nursing staff should not solely rely on information that is already with the patient's medical records. Specifically, it states:
"Take the patient history, do not rely on information from the medical notes."

A patient's medical records "travel with" the patient during their admission and they are reviewed by the nursing staff at the time of their admission to wards. However, where a patient has capacity and/ or family and / or carers are present the nursing staff will be reminded to engage with the patient and / or family and / or carers during the admission process so that there is a further opportunity to obtain information.

Nursing staff will be reminded not to reply solely on the medical records during the above teaching sessions. These reminders will be via the daily Ward Handovers, daily Safety Huddles, and monthly Ward Manager and Matron Meetings.

As part of the Trust's teaching programme for all nursing staff, it is planned (completion in August) that there will be a simulation video to demonstrate the "Perfect Admission" which will incorporate engagement with patients, how to extract information to ensure there is completion of documentation and will include the 7-day Short Stay Booklet Admission/ Discharge and Daily Evaluation.

In September 2022, the Trust will roll out Digital Documentation (an electronic patient record system). The information from the 7-day booklet will be "built in" to the digital programme, and there will be one record in which all information is accessible to all clinicians. The digital documentation will largely replicate the content of the current paper booklet to ensure that the same information is captured, and it has been reviewed as part of the digital programme to ensure it reflects current best practice. It is envisaged that the electronic patient record will enable all the clinicians to access the patient's entire record; and it will help clinicians to ensure there is a safer, leaner and "real time" documentation of the care they provide to patients.

Nurses when accessing the electronic system will have a 'landing page' for their allocated ward where all automated patient tasks are viewed and are allocated a time frame for completion. From "Care Compass", nurses are able to access the clinical documentation on safety assessments and medications due to be given. An important feature in "Care Compass" is the ability to set tasks in accordance with the relevant NICE standards or local standards. These tasks are colour coded indicating the status that the Nurse in Charge will be able to view and manage in their teams.

The updated paper booklet will be retained for use as a downtime resource in the event of any temporary outage of the electronic system, once it is live.

Yours sincerely

[redacted]

Chief Executive Officer
Surrey & Sussex Healthcare NHS Trust

Ward documentation - Lesson plan for ward ready

Session duration	I hour	**Venue**	Nightingale/Seacole
Lesson date	various	**Tutor**	The Practice Development Team (various)

Aims of session:	To provide staff with an understanding of how to complete ward documentation correctly, this to include the 7-day short stay bedside safety booklet risk assessments and care plans and 7-day short stay booklet.
Learning outcomes:	By the end of the session delegates will be able to: • Understand how to complete workbooks for patient documentation • Understand the importance of timely completion of both work books • Understand the need to check all documentation on each shift and handover to next shift any missing assessments • Understand the importance of involving patients, relatives and carers in completing assessment paperwork.
Handouts	Copies of both ward documentation booklets for their referral. Link to video of The perfect assessment.

Time	Content	Trainer Activity	Resources
5 mins	Introduction - housekeeping, phones off Session rules agreement – confidentiality respect, listening and sharing	Set out expectations	
5 mins	Overview of documentation – Introduction to both workbooks and what they are used for.	presentation	Samples of reflective cycles
15 mins	Workbook short stay assessment booklet - assessment pages 1-14 To be completed within 24 hours with patient and their relatives not using medical notes. For daily care plan to be documented daily and pages 1-14 checked for completion daily Outstanding assessments handed over to next shift. Watch video for how to complete a patient assessment.	Presentation/ video	Documentation booklets Presentation slide deck of each page of documentation Video
15 mins	In pairs complete assessment on one another	Group work	Blank documentation forms Pens
15 mins	7-day short stay bedside safety booklet risk assessments and care plans – Go through each assessment tool and how to use.	presentation	Presentation slide deck of each page of documentation
15 mins	Group scenarios	Group work	Printed scenarios to give to each group Pens Blank 7-day short stay bedside safety booklet risk assessments and care plans

Time	Tutor Activity/Content	Student Activity	Resources
5 mins	Fluid balance monitoring demonstration	Presentation	Slide deck of fluid monitoring
10 mins	Fluid balance practice individual practice in groups	Supervised individual work	Blank fluid monitoring Pens
5 mins	Wrap up and close	Discussion	