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NHS Foundation Trust

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Walthamstow Coroner's Court
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E17 8QP

[redacted]
Acting Chief Executive
Trust Head Office
West Wing
CEME Centre
Rainham
Essex
RM13 8GQ
[redacted]

13 January 2023

[redacted]

[redacted]

Dear Madam

Re: Inquest touching upon the death of Mary NWANONYIRI

I refer to your letter dated 01 December 2022 and the enclosed Regulation 28 report, issued in respect of your concerns regarding the risk of future deaths.

Concerns

At the conclusion of the hearing into the death of Mary Nwanonyiri, you expressed concern regarding the matters below:

1. Senior nursing staff who gave evidence at the Inquest did not appear to appreciate the importance of an agreed comprehensive care plan in which the multi-disciplinary ward team, patient and relatives are involved. The nursing staff did not acknowledge the value of a holistic care plan which incorporates the consideration of the many ways in which patients can be supported to engage in their recovery. Such a care plan could also incorporate assessments of capacity to refuse physical observations. There was no clear evidence of assessment of Mary's capacity to refuse physical observations.

2. A number of nurses failed to recognise the acute clinical severity of Mary's condition on the morning of the 19th April 2021. They did not respond to her very concerning clinical state with the necessary urgency.

I have provided a summary of the actions we have taken in relation to your concerns. A detailed action plan addressing specific aspects of the improvement work is attached.

Senior nursing staff who gave evidence at the Inquest did not appear to appreciate the importance of an agreed comprehensive care plan in which the multi-disciplinary ward team, patient and relatives are involved. The nursing staff did not acknowledge the value of a holistic care plan which incorporates the consideration of the many ways in which patients can be supported to engage in their recovery. Such a care plan could also incorporate assessments of capacity to refuse physical observations. There was no clear evidence of assessment of Mary's capacity to refuse physical observations.

The Executive Team currently have oversight of care planning compliance Trust wide. Compliance with care planning is monitored regularly through the 3 C's app on our Power BI performance platform and reviewed by the monthly Acute and Rehabilitation Directorate (ARD) Quality Leadership Team. Exceptions are escalated to the Executive Director and presented at the Quality and Safety Committee for assurance to the Board. ARD compliance is currently 100% and the expectation is that it will remain at this level.

All patients will have a named nurse and an associate nurse to deputise in their absence. The Named Nurse/Health Professional Standard Operating Procedure (SOP) will be amended to make this explicit as it currently states: '*In most cases* the named nurse/professional will have an associate who will deputise in his/her absence'.

With regard to the quality of care planning, nursing leadership have further reviewed our processes. The admitting nurse will write an initial care plan and the expectation is that the named nurse, or associate nurse in their absence, will review the care plan within 72 hours and weekly thereafter. This will ensure timely completion of a multidisciplinary (MDT) care plan for each patient, which will be co-produced with patients and carers, with patients' consent.

Clinical leads will ensure capacity assessments are completed for all patients regarding their care and treatment, including patients who have declined to participate in their care planning or are non-compliant with their care plan. Multidisciplinary decisions will be made in the best interest of patients who lack capacity in consultation with their carer and the respective stakeholders.

The quality of care planning is monitored through the bi-weekly peer care planning audit. Audit questions include multi-disciplinary team input, physical health, patients' views, carers' views and capacity in relation to treatment decisions. Results and actions taken to address findings will be monitored through the monthly Respect Approach meeting, and any concerns identified will be escalated to the Quality Leadership Team. The January 2023 Respect Approach Meeting will have a specific focus on care planning and the care planning audit tool. This has recently been reviewed by a task and finish group, including our Clinical Effectiveness Team and Audit Team to ensure it remains fit for purpose.

As indicated in the attached action plan, the Trust has piloted a non-contact vital signs monitoring medical device (Oxevision) on one of our in-patient wards. The device is currently being installed in single bedrooms across our wards to complement routine vital signs checks by nurses, particularly where the service user is uncooperative with their physical health care plan, or it is unsafe to approach them for physical health checks due to aggression or violence towards staff.

Focus groups will be held with Matrons and Ward Managers to look at existing care plans and emphasise the importance of person-centred care planning to the patient, carer and staff involved in delivering care. The focus groups will also involve patients and carers.

The Regulation 28 findings will be shared at the ARD quarterly Serious Incident Learning Event, with a specific focus on the importance of care planning.

A number of nurses failed to recognise the acute clinical severity of Mary's condition on the morning of the 19th April 2021. They did not respond to her very concerning clinical state with the necessary urgency.

As previously stated, the Oxevision device is currently being installed in single bedrooms across our wards to complement routine vital signs checks by nurses, particularly where the service user is uncooperative with their physical health care plan.

Resuscitation drills have been increased from every 2 months to monthly for every ward. A program of resuscitation drill training/refresher training is being progressed which now includes all ward managers as well as matrons. 16 managers and matrons have been recently trained, with 8 outstanding to be trained in January 2023. Resuscitation drill action plan monitoring is now a standing agenda item on the Quality Leadership Team Meeting as is Intermediate Life Support training compliance.

A business case will be submitted to the Executive Management Team for increased capacity for Resuscitation Officers, including a dedicated Resuscitation Officer for ARD. Funding is approved for a band 6 general nurse to support the physical health needs of patients on Picasso Ward and to provide training to staff, and recruitment is being progressed.

The process for auditing the content of our emergency equipment resuscitation trolleys on our wards has been reviewed and is now inputted via the 'my kit check' app. Non-compliance with daily and monthly equipment checks is automatically emailed to matrons, managers and the resuscitation officer. The system also automatically re-orders items that are nearing their expiry date. The app includes a visual display of each item of equipment being checked.

An emergency response SOP is in place. A new SAS Alarm system with a display panel indicating the location of an incident has been installed in all clinical areas to expedite the attendance of the Emergency Response Team (ERT) in the event of a medical emergency. Furthermore, to enhance current emergency response process, each cardiac arrest/CPR emergency call is followed by a direct radio message by the lead Incident Coordinator (IC) to alert the ERT to medical emergencies as distinct from calls for support with the management of incidents of violence and aggression. A guidance process is being developed, clearly outlining expectations for all staff involved in incident response and detailing actions that will be taken for staff who do not respond appropriately to medical and other emergencies.

I would like to take this opportunity to thank you for raising your concerns as part of this inquest. We find learning from inquests extremely valuable and are very grateful for your

comprehensive investigation, which benefits not only the families of the deceased, but also the Trust and its service users.

I trust that the above and the attached action plan will reassure you that the Trust has taken this tragic death very seriously indeed, and that it reflects our commitment to improve care quality and patient safety.

If I can further assist, please do contact my office[redacted]

Yours sincerely

[redacted]

[redacted]
Acting Chief Executive

Enc: Action Plan