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NELFT NHS
NHS Foundation Trust

NELFT Action Plan		
Action Plan Title: Regulation 28 Report to Prevent Future Deaths, 1091		**Start Date: May 2023**
Action Plan Owner: [redacted]	**Priority:** High ☑	**Service/Team:** [redacted]
Target Date: July 2023	**Business Unit: Acute and Rehab Directorate**	**Directorate: ARD**

Source: Complaints ☐ Clinical Audit ☐ External Inspection ☐ Internal Inspection ☐ Internal Audit ☐ Safeguarding ☐
Serious Incident ☑ Medicines Management ☐ Infection Control ☐ QPS ☐ H&S ☐ Serious Case Review ☐ Safety Thermometer ☐
External Inspection ☐ Dashboard ☐ Other ☑ **Regulation 28**

Summary of the concerns of the Coroner:

1. **Risk assessment (lack of appropriate consideration of risks)** – the Coroner found that poor record keeping and a failure to read electronic records meant that important information was not considered at a Multi-Disciplinary Team (MDT) ward round on 06 April 2021. The MDT arrived at a conclusion that Mr Charles' risk of self-harm was "no risk". A psychologist's assessment on the clinical record that assessed Mr Charles risk of the self-hard as high on 31 March 2021 was neither read nor incorporated into the MDT discussion.
2. **Risk management (inappropriate care plan)** – the Coroner found that a decision to reduce observation frequency made by the MDT on 6 April 2021 was not supported by the Trust Policy guidance which indicated that enhanced observations were appropriate.
3. **Risk management (lack of adherence to care plan)** – the Coroner found that observations between 16.00 and 17.00 on the day of Mr Charles' death were suspended by the ward shift co-ordinator. The decision meant all patients subject to general observation on the ward were ignored.
4. **Risk management (shortcomings in responding to the emergency)** – the Coroner found that the Trust did not respond to the cardiac arrest adequately, and that the Trust itself described the emergency response as chaotic, that Trust staff agreed that they "panicked" and did not follow policy; specific issues include;

    a. A ward emergency bell was not sounded.
    b. An anti-barricade key was not used to open Mr Charles' door, instead the door was forced open causing risk of harm to Mr Charles.
    c. A ligature cutter could not be used promptly as it was secured in a box with a combination lock – staff did not know the combination.
    d. Duty doctors were not called promptly.
    e. Oxygen administration was delayed.
    f. An on-site defibrillator was not used by staff.
    g. Staff could or would not provide clear and relevant history to paramedics.

5. **Poor record keeping** – the Coroner found that:

   a. Two Trust witnesses declined to answer questions put to them regarding whether their observation records were truthful.
   b. Observation records appeared to have been created utilising a "cut and paste" function.
   c. Records often inaccurately recorded the prescribed frequency of observation.
   d. Factually inaccurate entries were made in the record following Mr Charles' death. On 11 April 2021 an entry stated that Mr Charles was "Awake in his bedroom sitting on his bede (sic)" at 07.21. On 12 April 2021 two entries made at 9.48 and 11.40 recorded that Mr Charles was alive and well. Senior Trust witnesses characterised these entries as dishonest.

6. **Lack of learning from the incident** – the Coroner found that:

   a. A Datix incident report created on the evening of 10 April 2021 by a senior nurse and Modern Matron contained misleading information that suggested that emergency response policies were followed when in fact they were not.
   b. The Datix failed to mention the observations had been suspended by the shift coordinator, a fact that was understood at that time. This obvious and significant piece of information that should have been escalated through the Trust governance team for action.
   c. The Trust 72-hour report was written by the Modern Matron and was signed-off by an integrated care director on 15 April 2021. This document also failed to identify or escalate the significant issue of suspension of observation at 16.00 on 10 April 2021.
   d. The Trust SI report presented to the inquest failed to address the poor risk assessment or inadequate Datix & 72-hour reports.

Concern raised by the Coroner	Action no.	Action (short form)	Action (long form)	By Whom	By When
1. Risk assessment (lack of appropriate consideration of risks) – the Coroner found that poor	1.	Handovers and daily run through to take place using live RiO	1. Matrons, Ward Managers and Consultant Psychiatrists to be made aware that this needs to be in place 2. To be audited to ensure compliance	DON/AMD	June 2023

record keeping and a failure to read electronic records meant that important information was not considered at a Multi-Disciplinary Team (MDT) ward round on 06 April 2021. The MDT arrived at a conclusion that Mr Charles' risk of self-harm was "no risk". A psychologist's assessment on the clinical record that assessed Mr Charles risk of the self-hard as high on 31 March 2021 was neither read nor incorporated into the MDT discussion.	2.	MDT/Ward Round to use live RiO Care plans and risk assessments to be reviewed and updated as a result of this meeting Trust to move from current Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management	1. Matrons, Ward Managers and Consultant Psychiatrists to be made aware that this needs to be in place 2. To be audited to ensure compliance 3. To be audited through above audit process Task and Finish Group including Users of Service, Carers and Experts by Experience has been set up	DON/AMD Matrons Executive Chief Nursing Officer	June 2023 June 2023 December 2023
2. Risk management (inappropriate care plan) – the Coroner found that a decision to reduce observation frequency made by the MDT on 6 April 2021 was not supported by the Trust Policy guidance which indicated that	3.	Observation training to be refreshed to ensure this is explicit The Safe and Supportive Observations Policy includes this already but needs to be more explicit in training	1. Observation training available delivered by DON and ADON 2. At a glance appendix from Safe and Supportive Observations to be shared again 3. Ward Managers to discuss in safety huddles and meetings 4. Medical staff to attend training	DON/ADON Matrons AMD	June 2023 June 2023 June 2023

enhanced observations were appropriate.		Following the Inquest an independent review commissioned to review the clinical decision made by the MDT.	Independent Review commissioned by the Chief Nursing Officer	Chief Nursing Officer	October 2023
3. Risk management (lack of adherence to care plan) – the Coroner found that observations between 16.00 and 17.00 on the day of Mr Charles' death were suspended by the ward shift co-ordinator. The decision meant all patients subject to general observation on the ward were ignored.3. Risk management and record keeping.	4.	The Safe and Supportive Observations Policy does not allow for this to happen. However, if this becomes an issue due to teams being short staffed then escalation needs to be clearer	1. Review of Policy to encompass escalation process 2. Professional accountability, referrals made to professional board based on the new information which came out during inquest. 3. Refresh of training to make this process explicit.	DON DON DON	May 2023 May 2023 June 2023
4. Risk management (shortcomings in responding to the emergency) – the Coroner found that the Trust did not respond to the	5.	Resus drills which include all of these elements are taking place monthly.	1. Resus drills to take place monthly 2. Review of the quality of Resus Drills 3. Review of action plans following Resus drills 4. Refresh staff on Cardiac checklist as part of the above	Matrons Resus Officer/DON DON	May 2023 July 2023 June 2023

cardiac arrest adequately, and that the Trust itself described the emergency response as chaotic, that Trust staff agreed that they "panicked" and did not follow policy; specific issues include;			5. Refresh staff as part of the above on whereabouts of Ligature cutters (2 on each ward) 6. Coordinator would provide all clinical details to paramedic on their arrival.	Matrons Matrons Matrons	June 2023 June 2023 June 2023
a. A ward emergency bell was not sounded.	6.	The ERT alarm should be sounded in all ward emergency situations and the ERT team will respond	1. Roll call which happens daily will pick this up and remind staff that this includes medical emergencies 2. To ensure ERT response is robust and timely	Matrons /Duty Coordinators	June 2023
b. An anti-barricade key was not used to open Mr Charles' door, instead the door was forced open causing risk of harm to Mr Charles.	7.	All bunches of keys have an anti barricade key on them. Key audits have taken place in 2023	1. Anti barricade keys to be picked up in Resus drills 2. Audits of staff awareness of anti barricade key function to take place	Matrons	June 2023 July 2023
c. A ligature cutter could not be used promptly as it was secured in a box with a combination lock – staff did not know the combination.	8.	There are 2 ligature cutters on every ward, one in a combination box and one in the grab trolley	1. Ligature cutter training to be refreshed 2. To be identified as part of the monthly Resus Drill	DON/Clinical Effectiveness Team Matrons	July 2023 June 2023
d. Duty doctors were not called promptly.	9.	Duty Dr should be alerted as a result of the ERT alarm	1. Medical staff to be reminded of response in relation to the ERT alarm	AMD	June 2023

e. Oxygen administration was delayed.	10.	This is already in ILS training which is mandatory for all ward staff	1. Resus drills to be carried out monthly	Matrons	June 2023
f. An on-site defibrillator was not used by staff.	11.	This is already in ILS training which is mandatory for all ward staff	1. To be addressed in Resus drills monthly	Matrons	June 2023
g. Staff could or would not provide clear and relevant history to paramedics.	12.	The use of the SBARD tool is included in ILS training and is a recognised method of handing over patients. The Adult Cardiac Checklist is in all the grab bags and included in ILS training and provides another framework for handing over cardiac incidents.	1. To be addressed in Resus drills monthly	Matrons	June 2023
5. Poor record keeping – the Coroner found that:					
a. Two Trust witnesses declined to answer questions put to them regarding whether their observation records were truthful.	13.	Staff involved were exercising their legal right not to self-incriminate when answering questions at an inquest. In relation to the NMC Code of Conduct this does not meet the criteria of Professional and Honest in relation to the Registered Nurses.	1. Revisit original evidence provided to the SI report. 2. Review if disciplinary criteria met. 3. Referral to NMC	DON/HR	June 2023

b. Observation records appeared to have been created utilising a “cut and paste” function.	14.	Cut and paste should not be used in any part of the EPR	1. Observation records to be revisited in this case and any actions to be reviewed in relation to staff 2. Observation training to be explicit 3. Review of Electronic Observation functionality	DON/Matron	June 2023
c. Records often inaccurately recorded the prescribed frequency of observation.	15.	Record keeping training is available and audits take place	1. Observation training 2. Audits of records by Matrons 3. To be addressed in supervision 4. Review of Electronic Observation functionality	DON/Matron	June 2023
d. Factually inaccurate entries were made in the record following Mr Charles’ death. On 11 April 2021 an entry stated that Mr Charles was “Awake in his bedroom sitting on his bede (sic)” at 07.21. On 12 April 2021 two entries made at 9.48 and 11.40 recorded that Mr Charles was alive and well. Senior Trust witnesses characterised these entries as dishonest.	16.	HR action to be reviewed.	1. To be reviewed and action to be taken on staff who completed these 2. Disciplinary process 3. Referral to NMC if required	DON/HR	June 2023

6. Lack of learning from the incident – the Coroner found that:					
a. A Datix incident report created on the evening of 10 April 2021 by a senior nurse and Modern Matron contained misleading information that suggested that emergency response policies were followed when in fact they were not.	17.	Review of SI report and HR processes.	1.Revisit original evidence provided to the SI report. 2.Review if disciplinary criteria met. 3.Referral to NMC if required	SI team DON	July 2023 May 2023
b. The Datix failed to mention the observations had been suspended by the shift coordinator, a fact that was understood at that time. This obvious and significant piece of information that should have been escalated through the Trust governance team for action.	18.	The suspension of safe and supportive observations is not an agreed response in any situation. Where providing observations is challenged by short staff or other issues this should be escalated through line management structure.	1. Safe and Supportive Observations policy has been reviewed to make escalation of this clear, to be shared through Leadership Team meetings, team meetings and individual supervision	DON	June 2023
c. The Trust 72-hour report was written by the Modern Matron and was signed-off by an integrated care director on 15 April	19.	The 72 hour report is what is known about an incident at that point in time, the investigation	1. Review of SI processes	SI Team SI Team	July 2023 June 2023

2021. This document also failed to identify or escalate the significant issue of suspension of observation at 16.00 on 10 April 2021.		report SI or local is the method of identifying further learning.	2. Implementation of new PSIRF framework, all 72hr reports will be reviewed and signed off by the panel.		
d. The Trust SI report presented to the inquest failed to address the poor risk assessment or inadequate Datix & 72-hour reports.	20.	To be addressed by the SI team	1.Review of SI processes 2.Implementation of new PSIRF framework	SI Team	July 2023.