Sheffield Health and Social Care
NHS Foundation Trust

27 June 2024

[redacted]
Director of Nursing, Professions & Quality
Sheffield Health & Social Care NHS Foundation Trust

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PRIVATE & CONFIDENTIAL
Ms Alexandra Poutney
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Dear Madam

I am writing in response to the Regulation 28 Report to Prevent Future Deaths received following the inquest touching the death of Mr Gareth Etchells-Height, heard between 10 and 12 October 2023. Following my last letter to you dated 11 January 2024, you requested an update be provided outlining the progress of our actions by 30 June 2024. This letter seeks to provide that update.

1. Discharge and safety netting

You were concerned that the discharge report for Gareth did not contain details of his diagnosis or sufficient information about high-risk behaviours/triggers; that the information within it was not fit for purpose and did not provide for an accurate or full handover to new healthcare professionals.

The Clinical Director for Acute and Community Services has provided instruction via email to all inpatient Responsible Clinicians that diagnoses must be captured in Insight (our electronic patient record system) to enable them to be pulled through onto the discharge summary. Discussions have taken place regarding the purpose of discharge summaries and the misunderstanding of their use. We commissioned 360 Assurance, our internal auditors, to undertake an audit of our clinical record keeping, including risk assessments and discharge summaries. This audit was completed in May 2024. From the findings of the audit and the new national guidance that was issued in January 2024, we have agreed to review the format and function of our discharge summaries to include early warning signs of deterioration. The revised format will be incorporated as we rollout our new electronic patient record system (Rio) in late 2024/early 2025.

2. Review of the medical notes

You told us that there was wholesale inconsistency in healthcare professionals reviewing medical notes before appointments, assessments, or handovers for Gareth and that there was no written guidance on this issue, which lead to Gareth being seen by healthcare professionals who did not have an up-to-date understanding of his condition and mental state.

We developed a clinical record keeping standards policy earlier this year to provide clarity on the expected requirements to ensure high quality, person centred clinical documentation across the Trust. Incorporated within this is a section to guide clinicians around preparing for service user appointments, ensuring they are briefed on the current issues, risks and concerns. It is accepted that this will depend upon the relationship between the service user and their worker. This will enable staff to have an up-to-date understanding of the service user's condition and mental state.

3. Failure to update risk assessment

You reported that there was a failure to update Gareth's risk assessment, which at the date of his death was last updated on 7 April 2022. Gareth's presentation had materially changed since 7 April 2022, and so the risk assessment effectively became redundant by virtue of the failure to update it. This impacted upon the ability of those caring for Gareth to identify and recognise changes in his behaviour that were triggers for acute mental health crisis or suicidal behaviours. In evidence it became apparent to you that the Trust did not have a system in place for routinely checking and updating the risk assessments.

Live dashboards have been developed for use by our community teams. These dashboards show staff at any given point in time when key documents were updated and what requires their attention to review, revise or update. We are currently considering the feasibility of developing these dashboards for other services. The internal audit of record keeping highlighted the need to ensure that the 'clinical risk and management of harm policy' has a clear governance route for reviewing audits of compliance for risk assessments, which will take place biannually across the Trust. A formal report will be presented biannually on progress with clinical record keeping and clinical risk assessment improvements to the Quality Assurance Committee, a sub-committee of the Board of Directors. In addition, as part of the new electronic patient record development, key clinical leaders will be scoping the development of a new clinical risk assessment tool.

4. Record Keeping

You recorded a failure generally to keep proper records. It became clear to you as the evidence progressed that many of the record entries did not accurately or fully reflect the interactions with Gareth and you were concerned there was no audit system in place to check the records.

All staff have been reminded about the importance of good quality record keeping through an alert cascade that was produced, disseminated and published on the staff intranet.

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Following the publication of the new clinical record keeping standards policy, a new training package has been developed to support the implementation of the policy and a pilot training session has already taken place with preceptee nurses. The feedback from this pilot session has been extremely positive. The training is now being rolled out across the Trust by the Clinical Risk and Patient Safety Advisor.

I trust that this provides the necessary assurance on our progress with the Regulation 28 Report. Please do not hesitate to contact me if you require any additional information.

May I again extend my sincere condolences to Mr Etchells-Height's family.

Yours sincerely

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Executive Director of Nursing, Professions & Quality