NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

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Friday, 24 May 2024

Dear Ms Slater

Robert Fuller Regulation 28 Report to Prevent Future Deaths

Thank you for your letter addressed to [redacted], Chief Executive at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) enclosing the Regulation 28 Report which was issued to the Trust following the conclusion of the Inquest into the death of Mr Robert Fuller on 22 July 2022.

Firstly, I would like to offer our sincere condolences to Mr Fuller's family. Following receipt of your letter I have met with relevant teams at the Trust to discuss the issues you identified in relation to the care provided to Mr Fuller. I have set out below, information in response to the Regulation 28 report, which I trust will provide you with the assurances as to the learning which has already taken place at the Trust and indeed the ongoing improvements.

Accordingly, I can respond to the matters of concerns you have raised as follows:

1. There was evidence of poor record keeping on the ward. This included behaviour charts, enhanced patient supervision records and daily evaluation charts not being consistently recorded. There was either no or poor documentation of other professionals entering the ward and evaluating patients, and the outcome of such assessments not being recorded. Some of the documentation was also described as not fit for purpose within the frailty unit due to the needs of the patients. This insufficient record keeping prevented any patterns of challenging behaviour to be assessed and managed accordingly putting other patients, staff and visitors at risk of harm.

We have taken the opportunity to review and refine our Enhanced Care Policy and this is proceeding through our governance process for sign off over the coming weeks. One of the changes has been to separate our Falls Risk Assessment and Confusion Risk Assessment to

support easier recognition of patients who are either a falls risk or those patients who need a designated level of supervision due to behaviours of concern.

In April 2024, we reviewed and implemented two new behaviour charts in our frailty areas.

The 'ABC chart' is used as an observational tool, allowing recording of information about a particular behaviour. The aim of using the 'ABC chart' is to interpret patterns of behaviour including the triggers.

- 'A' refers to the *antecedent* or the event that occurred before the behaviour was exhibited. This can include what the person was doing, who was there, where they were, what sights/sounds/smells/temperatures/number of people that were in the environment.
- 'B' refers to an objective and clear description of the *behaviour* that occurred eg. X threw item on the floor.
- 'C' refers to what occurred after the behaviour or the *consequence* of the behaviour eg. other patients moved away from X, noise levels in the room decreased.

Our second chart is a behaviour of concerns chart, which allows recording time specific information around the patient's behaviour. It further supports documentation of any triggers for behaviour, any de-escalation used and what worked well/settled the patient.

The easy identification of the behaviour charts for review by the Multi-Disciplinary Team is now by a bookmark in the notes, easily visible to the clinicians. Compliance with the completion of the new behaviour charts is scheduled for audit in May 2024. All audits are discussed at the Trust Audit and Effectiveness forum. This forum monitors compliance and improvement, and escalates via the Trust Effectiveness Committee to allow Trust Executive oversight.

The Trust's Person Centred Care Practitioner and Named Practitioner Safety in Care have carried out training on the use of and completion of the charts for our frailty teams. There is a plan to roll this out Trust-wide over the course of the upcoming year.

A Safety Seminar on Behaviours of Concern was held on 8 March 2024 attended by our ward teams to further enhance understanding in this regard. All safety seminars are recorded and uploaded to the Trust Intranet. This supports the education of a wider audience and is a resource to sign post all ward teams to access for their continued professional development.

Within our Trust, we use Nerve Centre for documentation. There have been challenges to our external colleagues being able to access Nerve Centre and therefore unable to record entries in the patient's electronic notes. I am able to assure you this has now been rectified and the older persons' mental health team (OPMH) and mental health liaison (MHL) teams are able to record entries alongside Trust staff. This improves the Multi-Disciplinary Team's ability to see other entries on a patient care record and aids communication. An audit of

the use of this mechanism is planned. A further enhancement is planned for deployment on 27 May 2024, which is a dedicated field in the Nerve Centre handover section specifically for our OPMH and MHL teams.

Further measures include staff recording referrals and subsequent visits by the MDT members in our clinical notes. Record keeping is a Trust priority under the Patient Safety Incident Response framework. Additionally care planning and documentation is a strategic priority within the Trust Nursing Midwifery and AHP Quality Strategy. A quarterly audit is scheduled in relation to the referral documentation, review visits by external professionals and documentation of the process and outcome by our Ward Team on a quarterly basis.

2. This poor record keeping also lead to poor/inaccurate communication following the incident with the family.

As an organisation, we transitioned to the Patient Safety Incident Response Framework (PSIRF) on 1 December 2023. PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. We have a locally defined Patient Safety Incident Response Plan (PSIRP).

As part of our PSIRF transition and in line with the framework, we are appointing to specific and dedicated roles to be known as Family Liaison Officers (FLO). Family Liaison Officers support patients and families through the process of an investigation into a patient safety incident, or a serious complaint against a service provided by the Trust. The Trust is actively recruiting two professionals and hope to have individuals in post by the autumn. I would like to assure you our teams have also received training in line with the PSIRF training framework on engaging and involving patients, families and staff following a patient safety incident. We have also reminded staff of the importance of effective communication and recording of conversations with patients and or their families following a learning from patient safety event. Our learning from patient safety events panel maintain oversight of this process. The new PSIRF process also includes a Trust Executive Patient Safety Oversight Group. This group is responsible for agreeing the terms of reference for any Patient Safety Incident Investigation commissioned. The terms of reference include family involvement and ensure any concerns raised by the family are addressed within the investigation report.

3. There is no system in place for agency staff, who frequently work on the Frailty Unit to access communications, reminders or new policies and procedures.

There was a system in place for agency staff working across our wards; this included frequent and infrequent staff members. As part of our review, it was clear the process was not widely understood. The system includes a dedicated information pack for staff, which includes key information such as falls, pressure ulcer management, enhanced care and signposts staff to our electronic local knowledge toolkit. All new agency/bank staff have a locally delivered induction. Our ward management teams have been reminded in one to one meetings of the importance of local induction. This is now a fundamental role of the Nurse in Charge.

Additionally, the introduction of Safety Huddles is currently being piloted on a number of inpatient wards. The plan is to launch this safety intiaive Trust wide in June 2024. Safety Huddle reseach undetaken indicates this initiative will improve internal communication and escalation of safety concerns regarding specific patients. The huddle includes all team members on duty including our agency workers, and considers all at risk patients with behaviours of concern and supports the delivery of safe care.

Conclusion

Immediate actions were implemented following the completion of the patient safety incident investigation. However, the Trust acknowledges and regrets we were unable to provide you with the level of assurance required at the Inquest. We acknowledge that this may have created unnecessary additional distress for the family of Mr Fuller and for that, we sincerely apologise.

I trust that this letter has addressed the concerns raised, but please do contact me if I can be of further assistance.

Yours Sincerely

[redacted]

[redacted]
Chief Nurse