	CONCERN	ACTIONS TAKEN	TIMESCALES
1.	Quality of staff training, particularly in regard to record keeping and communication.	All inpatient staff issued with training packs and e-learning named “personalised care planning”. Training records available to evidence above. A system of care plan audits are in place to monitor compliance with standards for record keeping. Handover practice has altered so that patients care plans are taken into handover and records of risk, progress and presentation can be communicated to all staff.	Completed November 2013. Weekly monitoring by modern matrons. Commenced December 2013.
2.	The emphasis on taking a holistic approach to care and whether there is an imbalance between such an approach and patient safety.	The Trust has designed some bespoke risk management training that incorporates the learning from this incident and the Coroner’s comments and inpatient staff are all attending the programme. The training also includes the findings and recommendations from “Quality of Risk Assessment Prior to Suicide and Homicide”: A pilot study, June 2013. This was led by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) and commissioned by The Healthcare Quality Improvement Partnership (HQIP).	Commenced 10 January 2014 - Weekly programme running until all staff have completed.
3.	The absence of clear guidance for checking patients and their rooms for potential self-harm items both in the rooms themselves and for items brought into the hospital.	A Standard Operating Procedure for room searches has been developed to sit below the Trust Policy of the searching of a person or their property. The aim of the Standard Operating Procedure is to provide ward staff with more detail guidance when consideration should be given to the need for a search to be conducted and the recoding of such a search. Statements regarding room searches and searches on admission have been included in the patient admission information leaflets.	To be distributed for comment and ratified end February 2014.
4.	The absence of a single reference sheet in the notes summarising key issues, risk factors, significant incidents, and concerns readily accessible to all involved in patient care.	This issue has been built into the electronic patient record development programme to include a front page outlining current risk and management plan, significant incidents and any other concerns.	Awaiting notification from the current electronic records service provider as to time scale for completion.