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Dr D Skipp
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Monday 28 April 2014

Dear Dr Skipp

I write in response to your Regulation 28 letter dated 6th March 2014 following the inquest touching the death of Natasha Raghoo which concluded on 21st February 2014. I am grateful to you for bringing these matters to my attention as Partnerships in Care ("PiC") take all patient safety issues very seriously and act to ensure that lessons are learned throughout the company.

The death of Miss Raghoo was an extremely sad event and very upsetting for her family and friends and my sympathy goes out to each and every one of them. However, from the perspective of PiC I want to ensure that the company and its hospitals learn lessons from the events leading up to and following the death and from the ways in which the communication was managed to ensure that the quality of services we provide are continually strengthened and improved.

Issue 1

During the course of the evidence, concern was expressed concerning the training that staff had received in the techniques of cardio pulmonary resuscitation and the use of the defibrillator. The latter was reported not to have been used by hospital staff although available on the ward.

Cardio Pulmonary Resuscitation (CPR) and Defibrillator Training

The nursing staff had all been trained in CPR and use of the defibrillator, and indeed I understand that the training records were supplied to you confirming this.

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CPR Techniques

Evidence was heard that two paramedics arrived on the scene following the emergency call. They had instructed the company staff member to continue with chest compressions and it is of note that they did not raise any issues about the competency of the staff or the compressions. The paramedics took over the CPR themselves and did not raise any concerns over the techniques being used.

A senior paramedic arrived shortly afterwards. He indicated that he felt that the chest compressions were not of sufficient depth or pace; he then instructed the member of staff to continue with compressions but to make them deeper and faster. The Senior Paramedic gave evidence that, the efficacy of CPR is a common issue for those administering CPR and that, even paramedics in his service use a metronome to assist them maintaining the pace. Whilst I appreciate that an issue was raised, it seems to derive from a difference in clinical judgement and it is of note that the two original paramedics did not consider there to be any issue.

Defibrillator Use

I understand that the evidence showed that our staff had brought the defibrillator to the scene and unpacked it, but had not utilised it at the time the first paramedics arrived. This was acknowledged to be a timing issue and, of course, once the paramedics arrived our staff naturally left them to take the lead with issues such as the use of the defibrillator.

Lessons Learned and changes made

Iunderstand that is important to ensure that, when CPR is given, it is as effective as possible and accordingly, since the incident, a programme of monthly emergency incident drills has been implemented. This gives staff the opportunity to practice their skills.

At the time of the death, PiC CPR training complied with the NHS requirement for Basic Life Support. This staff training was provided by an employee of The Dene who had undertaken an accredited Train the Trainer course. All staff undertaking the training were signed off as competent by the Trainer and anyone not achieving the standard required would have been required to repeat the training course until they could evidence their competence.

In 2013, and subsequent to the death, PiC implemented a company-wide training programme to move from the provision of Basic Life Support to Immediate Life Support. This training has been delivered to all qualified nurses and doctors across PiC. This training specifically includes the use of the defibrillator.

Issue 2

Physical observations of blood pressure, pulse and temperature were sporadic and few in number. This was cause for concern as Miss Raghoo had a raised blood pressure and had been commenced on treatment. Observations stopped two days prior to death and no member of staff was able to explain who was responsible for this action.

Evidence was provided that the patient had 17 blood pressure readings taken over 5 consecutive days in the week prior to her death; we do not agree that this was sporadic or few in number, and as far as I'm aware, there has been no medical evidence criticising this.

It is acknowledged that PiC was unable to provide written documentary evidence showing blood pressure readings for the final 2 days of observations. However, clear verbal evidence was given, by two senior members of staff, that blood pressure readings were continued during this time but that the new sheet covering these days had been misplaced. Although it is not known when the sheet was misplaced, it should be noted that the company did not have control of the original documents following the death as these were removed by the police. Therefore, I do not believe that these were stopped as your report suggests.

Lessons Learned and changes made

PiC is always seeking to improve its practices and I hope that it will assure you to learn that, since the time of the sad death of the patient, we have made a number of changes in our procedures.

In particular, the company has introduced enhanced physical health monitoring procedures. These include, as a minimum, daily physical observations for each patient which are conducted every morning by the trained nurse, at the time of the first medication administration round.

We have also introduced an electronic 'dashboard' across PiC. This tool provides staff with up to date information to ensure that regular physical health screening requirements are undertaken.

In addition, patients with particular physical health requirements have individual specialised care plans developed and reviewed by our employed, permanent Advanced Nurse Practitioner in conjunction with the patient's primary nurse.

Issue 3

Whilst under the care of The Dene, and on antipsychotic drugs with a raised blood pressure an electrocardiogram was not carried out because all routine ECGs are performed by a visiting nurse from a General Practitioners surgery on a set day of the week. An ECG machine is available within the hospital but is not routinely used.

As you note, there is an ECG machine available at the site. This is regularly used by the visiting GP and the employed, permanent Advanced Nurse Practitioner.

However, as you will appreciate, the Dene is a psychiatric unit and PiC complies with The Maudsley Guidelines for such matters as ECG usage. The Maudsley Guidelines in place at the time of the death (the 10th edition) do not recommend that routine ECGs be carried out for every patient. We would expect that if there were any enhanced needs for physical observations or tests of this sort, these would be ordered by either the visiting GP or the Consultant Psychiatrist responsible for the patient's care.

Further, as a result of the patient's acute manic state, which had led to her admission, it would not have been possible to obtain a meaningful ECG reading.

Lessons Learned and changes made

The changes relating to the physical health screening are outlined in Issue 2 above

Issue 4

Staff handovers occur twice daily in the morning and evening. Those finishing a shift hand on information about the patients to the incoming shift. It was apparent that communication was inconsistent, particularly when bank or agency staff were involved.

All staff, regardless of their employment status, attend the nursing handover. On the shift in question, there were no agency staff.

Staff coming late to shift, will be given a separate handover (appropriate to their level and grade) by the nurse in charge. This is what happened in this case; the Nurse in Charge gave an appropriate handover to the Healthcare worker.

Lessons Learned and changes made

We understand the importance of ensuring that the handover between shifts is comprehensive and effective and, since the time of the death, PiC has reviewed and standardised its handover procedures across the company. The new procedure includes the completion of a formal handover document which is signed by the Nurse in Charge of the shift confirming that a complete handover has been given. There is a specific section in the new handover document relating to physical healthcare.

Issue 5

Communications between staff and family were haphazard and the policy of involving family in care planning was not clear.

The service is an acute service that provides overspill for South London & Maudsley ("SLaM") patients and patients from other Trusts. Many of these patients only stay in the service for a matter of days. The very short periods of time spent by the majority of patients does not allow for significant liaison and input from families and carers. However, the service does attempt to involve families and carers wherever possible and within the constraints of patient confidentiality.

In the case of this patient, I know that the staff at The Dene were aware that the patient had a close relationship with her family and was in contact with them. However, I regret that the way communication was dealt with in this particular case caused concern to the patient's family.

Lessons Learned and changes made

Since the death of Miss Raghoo we have reviewed the way we communicate with families and carers and communication issues are now discussed at the regular Multi-Disciplinary Team meetings to ensure that families and carers are consulted with, when the patient gives their consent for this to happen.

Issue 6

The policy of access to GP services was not clear leading to misunderstanding by the Princess Royal as to where to send a report.

I regret that I do not understand the premise for the report in relation to this issue.

PiC's and, in particular, The Dene's policy for access to GP services is, and was at the time of the incident, clear. The Dene has a visiting GP attending its services and all long-term patients are under the care of this GP. Short-term patients, such as Miss Raghoo, remain registered with their own GP. This arrangement is to my knowledge not dissimilar to that in place in many psychiatric hospitals.

If the Princess Royal had any misunderstanding about where to send the report then they could have clarified the position with The Dene. They did not do this. Indeed, when the patient attended the Princess Royal Hospital, they provided her with a discharge summary to take with her when she returned to The Dene. This discharge summary was reviewed by the medical team at The Dene.

Lessons Learned and changes made

Notwithstanding my belief that this does not relate to The Dene, the medical team at the Dene ensure they contact the general hospital in all cases for a handover and discussion regarding any patients that attend and receive treatment, thus ensuring appropriate handover and ongoing care.

Issue 7

Unclear as to whether checking to ensure that when using agency staff they have not already worked a shift elsewhere that day

Again, I apologise but I am unclear as to the premise underlying this concern. There were no agency workers on shift at the time of Miss Raghoo's death and no concerns were raised about staff on shift having worked anywhere else prior to reporting for work at the Dene that day.

Lessons Learned and changes made

However, despite it not being clear why this is relevant to this case, PiC has, in its desire to strengthen its services and practices, reviewed and revised the standard terms and conditions that the Company now uses when contracting with nursing agencies. All contracts now entered into include a condition that states that they cannot send us staff who have just worked a 12 hour shift elsewhere.

Issue 8

Obtaining records, particularly from community services involved with the care of the patient, was difficult and slow.

As you will know from the evidence that you heard, this was indeed an issue in this case and I know that the Chief Executive from SLaM has written to you separately setting out the changes that the Trust has made internally.

Lessons Learned and changes made

Since this incident both PiC and SLaM have worked closely together to improve information flow. As a result communication between PiC and SLaM has improved greatly thus ensuring access to patient records is satisfactory.

In particular, a Liaison Nurse attends The Dene from SLaM several days of the week thus ensuring access to SLaM records directly utilising a VPN link. Strong working relationships between ourselves and SLaM have also developed since this incident.

Issue 9

The policy on length of time staff are expected to conduct observations, and the quality of handover from one member of staff to another.

The quality of handovers and the changes made have already been dealt with in Issue 4 above.

All staff are trained on how to undertake observations and records are maintained of the length of time between observations and the individual undertaking the prescribed observations.

Lessons Learned and changes made

Since the sad death of Miss Raghoo, PiC has reviewed, revised and reissued its observation policy and, as explained previously, its handover protocols.

This was followed up by face-to-face meetings with all staff who may undertake observations or who are involved in handovers explaining both the content of the policies and their responsibilities in respect of handover and observations. Staff were required to formally acknowledge that they understand these responsibilities.

The implementation of the observation policy and handover is being regularly audited and spot checks are carried out.

In conclusion, I am grateful to you for bringing these matters to my attention and I hope that this letter provides useful information in response to how PiC as a company and, most importantly, how The Dene hospital have changed practices and learned their lessons.

Yours sincerely

Joy Chamberlain
Group Chief Executive
Partnerships in Care Group Limited