Lancashire Care NHS
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Mr Alan Wilson
Senior Coroner
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08 January 2016

Dear Mr Wilson,

Piotr Kucharz (deceased) – Regulation 28 Report to Prevent Future Deaths

The Trust acknowledges receipt of your letter dated 24 November 2015.

In the Regulation 28 report you raise the following concerns:

1. Staff are unclear what constitutes effective observation
2. Staff inconsistently applied the Observation Policy
3. The circumstances which may allow staff to refrain from engaging with a patient or from entering a patient's room to check the environment are unclear.

Shortly before Mr Kucharz died the Trust was in the process of revising its clinical risk assessment tool and policy. New standard and enhanced risk assessment tools, which sit in the Electronic Care Record (ECR), were developed by a multi-disciplinary group of clinicians. From March 2015 these tools replaced the previous Standard Safety Profile which was in use at the time of Mr Kucharz's death. The aim of the new risk assessment tools are to improve the quality of the clinical risk assessment conducted by staff, to promote better collaboration with patients, more structured clinical risk assessment and more robust clinical risk formulations and risk management plans. This helps staff understand better the risks that patients pose to themselves and others, vulnerability and any safeguarding risks and therefore the level and type of support they need to stay safe including observations.

Since March 2015 the Trust has been training in-patient staff to use the new risk assessment tools and formulation model. This training supports staff in using the 5P's model (presenting needs, predisposing factors, precipitating factors, perpetuating factors and protective factors).

We are planning an external review into the effectiveness of this new clinical risk assessment tool and policy, to be completed in April 2016 once we are twelve months into the usage of the new tool. This will provide us with robust assurance into the implementation and effectiveness of this new approach.

The Trust is also in the process of reviewing the observation policy and procedure. We are taking into account the learning from previous serious incidents and national best practice. This review is currently underway and we will be developing and implementing a revised observation policy and procedure. The new observation policy and procedure will be implemented by 31 March 2016.

In the interim, until this new policy and procedure is developed and implemented, an internal patient safety alert has been issued to remind staff of the current policy and procedure. This alert was sent to all inpatient services across the Trust.

I hope this addresses your concerns and wish to assure you that we are keen to learn and improve the care we provide, to prevent similar incidents in the future.

Should you require any further information the Trust will be more than willing to assist.

Yours sincerely

Dee Roach

Dee Roach
Executive Director of Nursing and Quality