Surrey and Borders Partnership NHS
NHS Foundation Trust

Our Ref: FE/wc

11 April 2016

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Alison Hewitt
Assistant Coroner for Surrey

**Sent via email**

Dear Ms Hewitt

**Inquest into the death of Adam Withers – REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

Further to the recent conclusion of the inquest into Adam Wither's death on 9 May 2014, you wrote to Surrey and Borders Partnership NHS Foundation Trust in accordance with the Regulation 28 report to prevent future deaths, stating that during the course of the inquest the evidence revealed matters giving rise to concern. We would like start our response, by offering our sincere condolences to the Withers' family for their loss.

The areas of concern you raised that relate to our Trust and our responses are detailed below:

1. **It was clear from the evidence that nursing staff involved in Adam Wither's care failed to record sufficiently his presentation and their interactions with him.**

   We acknowledge that our record keeping practice did not meet our desired and expected quality levels in this instance and we have learnt from these identified deficiencies. We have already instigated work to further improve the quality of our engagement with people using our adult inpatient services, by ensuring that all interactions are meaningful, using a process of purposeful engagement (a modified form of intentional rounding). The purposeful engagement process assists our staff in ensuring continuous assessment of individuals so timely interventions can be undertaken when necessary. As part of this process we expect all staff in these services to record interactions in the person's clinical records in a timely way.

   We have also revised our Observation Policy to include much clearer guidance on how, when and where people should record all clinical interventions. This includes a review of the assessment section of this policy, which clearly states that all people that use our inpatient services will have a comprehensive Risk Assessment. This will include

looking at risk of suicide, absconding, self-harm, violence, vulnerability to exploitation and self-neglect.

It is further outlined that this assessment will be recorded in the person's multidisciplinary clinical records, along with the joint decision regarding the level of observations assessed, as being most appropriate. This record will include details about specific elements of risk, including any relevant trigger factors to be considered when carrying out the observations. There is also a clear expectation that where specific risks have been identified by the referrer, those people awaiting assessment should be kept within eyesight observation.

To ensure wider understanding of the observation expectations, we have issued a Trust-wide Clinical Risk Alert clearly outlining our expectations in this regard.

2. **It was clear from the evidence that any note made in a patient's record should be made contemporaneously or, if made later, should be timed, dated and labelled as retrospective. This is necessary to ensure all notes are accurate and reliable.**

We have since reviewed our Records Management Policy which has a section outlining the 'Standards for Record Keeping'. Under these standards there is clear expectation that:

a) All records will be factual, consistent, accurate and evidence-based. Where records are professional opinions, this must be clearly stated.
b) Records will be written as soon as possible after a contact has occurred, providing current information on the care and condition of the person who uses our services (within 24 hours).

It is also our expectation that all our registered staff work within their relevant professional codes of practice. The NMC state that, in line with local policy, staff should put the date and time on all records. This should be in real time and chronological order, and be as close to the actual time as possible (the contemporaneous record).

In an emergency where staff are unable to record the times we would expect them to highlight that the record/entry is retrospective, but should still follow a chronological format of proceedings. Our use of the electronic patient record system in our Acute Services now removes any doubt about record entry time as every entry now leaves a clear audit trail which can be reviewed as required. Quality is further maintained when we share learning from our record keeping audits which we undertake as part of our clinical audit program.

We have added the issues identified in the Regulation 28 report and our resulting actions to our corporate action plan, which we share with commissioners to ensure we continue to embed learning from issues raised. We would like to offer our sincere condolences again to the Withers family for their loss. We hope that the steps we have taken as outlined above assure you and Adam's family that we have learnt and

continue to learn from his death. Please do not hesitate to contact me or Jo Young, Director of Quality and Deputy Chief Executive (Nurse Director), if you require any further information.

Yours sincerely

Fiona Edwards
Chief Executive

cc
[redacted] - Director of Quality and Deputy Chief Executive (Nurse Director)
[redacted] - Co-Medical Director
[redacted] - Co-Medical Director
[redacted] - Director of Mental Health
[redacted] - Director Risk & Safety (DDoN)