Pride in Pennine | Quality-Driven Responsible Compassionate

The Pennine Acute Hospitals NHS
NHS Trust

If calling please ask for: Gill Harris, Chief Nurse

Trust Headquarters
Delaunays Road
Crumpsall
Manchester
M85RB
Telephone:

26 May 2016

Private and Confidential
Mr S Meadows
H M Senior Coroner
H M Coroner's Court
Manchester Town Hall
Albert Square
Manchester
M8 5RB

Dear Mr Meadows,

Re: Inquest following the death of Mrs Milly Zemmel held on 29th March 2016

Please find the Trust's response to the recent Regulation 28: Report to Prevent Future Deaths, served on the Trust on 7 April 2016 following the Inquest into the death of Mrs Milly Zemmel.

The Trust response and action taken to address the concerns that you raised are detailed below.

Background

Mrs Zemmel was transferred to Ward E5 on 9th February 2015. Ward E5 was a temporary ward opened in response to increased demand due to seasonal pressures at the beginning of 2015.

1. **The Trust should consider reviewing their own internal investigation systems and ensure that they are transparent, thorough, appropriately candid and up to date. Those involved in the deceased's care and management or who have line management responsibility should not form part of any investigative team.**

It was recognised early in 2015 that the Trust need to make improvements in how investigations were conducted within the organisation. An external review of serious incident investigations was commissioned by the former Chief Executive and following this review the Trust instigated a number of actions:

- The Trust revised and launched a new policy and procedures for investigation called the Incident Reporting and Investigation Policy, including the Serious Incident Framework (EDQ008 V6.4) in June 2015. This has provided clearer guidance for managers undertaking investigation. The policy provides clear guidance on the grading, level and type of investigation required for all incidents including those for serious incidents. These are now investigated by a team independent of the clinical area where the incident occurred and involve senior clinical staff who have the expertise and knowledge to undertake the investigations.

- A two day programme of root cause analysis training was commissioned by an external company specialising in root cause analysis (RCA) training and 103 staff, including senior clinicians and managers, were trained during 2015/16. In addition the Trust delivered training on Duty of Candour (being open) to ensure that patients and families receive support and feedback when a serious incident investigation is commenced. An internal programme of investigation training will continue throughout 2016/17 to ensure that the quality and breadth of Trust investigations continues to improve.
- To accompany the RCA training programme the Clinical Governance team have also developed an investigation toolkit that covers all aspects of investigations and advice on preparing and writing investigation reports.

Please see Appendix 1 for the full Policy - Incident Reporting and Investigation Policy, including the Serious Incident Framework

2. **Whilst the introduction of a new falls policy is commendable and to be applauded, there was failure in nursing and clinical hand-over, escalation and management which should not have been allowed to occur. This was part of basic nursing and clinical management. The Trust should consider reviewing the hand-over and escalation policies and protocols so as to ensure a fail-safe system.**

The Trust has piloted and now introduced a 'Safety Huddle' at the commencement of each ward and departmental shift which includes the discussion and handover of any recent incidents, as well as safety issues relating to patients. This includes a prompt for discussion of any patients who will require additional observation or enhanced supervision as part of their care. This allows nursing staff to report on any unexpected and significant events involving patients and helps them to proactively plan and agree how to resolve them. The policy is within Appendix 2 - Safety Huddle document.

The Trust launched a policy for Clinical Communication and Handover in September 2015 which includes handover documentation templates with more robust information for recording safety concerns such as a patient who may be at risk of falls information and a standard framework for escalating concerns about a patient. The policy also includes the standard required for doctor to doctor handovers including for patients who have been referred and who need to be assessed. The policy has been disseminated across the clinical teams in the Trust and the senior nursing team undertake quarterly audits to assess the quality and level of compliance. This policy is within Appendix 3 - Clinical Communication and Handover Policy.

The introduction of the New Falls Policy and Enhanced Patient Observation Policy

The new Fallsafe Policy for the prevention and management of in-patient falls was introduced in April 2016; this includes newly launched tools for assessment, care planning and a care bundle. As part of the launch, training was included using the Fallsafe resources produced by the Royal College of Physicians and is available to all staff.

The Trust has now employed two Specialist Practitioners for falls to further enhance and develop the systems and processes for the education and training of staff. Part of their work will be to develop the processes for patient risk assessment and for auditing the implementation and effectiveness of the policy in clinical areas. The FallSafe Policy is in Appendix 4 and the Fallsafe staff information booklet is within at Appendix 5.

The Enhanced Patient Observation Policy was also introduced in February 2016 to ensure patient safety and to help provide the appropriate level of supervision and observation for adult in-patients. This policy provides advice and support to staff on the different requirements and needs of patients who require observation. This can be found in Appendix 6 - Enhanced Patient Observation Policy.

Dissemination of Lessons Learned

Failure to act and escalate the lack of medical review will be included in the Lessons Learned Bulletin within the Medical Division and disseminated to all wards and departments across the division. The learning for nursing staff is to escalate to the medical team and in the first instance to the registrar and then consultant or on call Consultant, with assistance if required, from within the senior nursing site team or on call/ bleep holder out of hours to ensure that any request for urgent review occurs. Staff will be required to use the communication handover SBAR tool (situation, background, assessment and recommendation) to support any communication. This is contained within the Clinical Communication and Handover Policy.

I sincerely hope that the above response addresses your concerns and provides you and Mrs Zemmel's family with the assurance that we have addressed the learning following the inquest and our own investigation. Should you require any further information then please do not hesitate to contact me.

May I take this opportunity to again convey the Trust's sincere apologies and condolences to the family of Mrs Zemmel.

Yours sincerely

Chief Nurse