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BY EMAIL and POST

Ms. Henrietta Hill QC
London Inner South
Southwark Coroners Court
1 Tennis Street
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SE1 1YD

31 March 2017
Ref: [redacted]

Care Quality Commission
Health and Social Care Act 2008

Dear Ms. Hill,

Re: Section 28 request for information from CQC regarding the Coroner's report into the death of Robert Entenman

Thank you for your Regulation 28 Report dated 3 February 2017 which identified the CQC as a named responder in respect of the third area of concern identified during the Inquest into the death of Mr Entenman. The concern being there were delays in identifying that the endotracheal tube had become blocked between 5.32 and 6.00 am on 23 May 2015 which affected its earlier replacement, subsequent similar delays and possible delays in providing information the suction catheter difficulties to doctors who arrived after the cardiac arrest call was put out. This letter is the CQC's response to the issues raised by the Regulation 28 Report which is required by 31 March 2017.

Prior to the death of Mr Entenman, the CQC carried out a comprehensive inspection of the Hospital on 13 December 2013, with the report published in January 2014. At that inspection, the Hospital met all of the standards under the CQC's model inspection model of that time.

Inspectors found that:

Hospital staff were trained in the use of equipment. We reviewed the training records for equipment in the operating theatre suite and saw evidence of training provided by manufacturers. Staff also received training on induction to ensure that they had the relevant knowledge, skills and competencies for relevant equipment.

The chief nursing officer and the medical director told us incident reporting was encouraged. We were given examples during our visit of learning that had been implemented as a result of reports. If human error was found to have contributed to an incident there was an emphasis on retraining and subsequent reassessment of

competence.
The CQC was formally notified of the death of Robert Entenman on 1 June 2015. The notification initially stated that this was an expected death. However, on 20 August 2015, the Hospital sent a further notification clarifying that this had, in fact, been an unexpected death. On that notification, the Hospital stated that they were carrying out a full Route Cause Analysis of the incident.

CQC inspectors monitor all enquiries and notifications relating to individual providers, including statutory notifications, complaints or concerns from members of the public and whistleblowing concerns. The decision to undertake unannounced, focused inspections is informed by, but not dictated by such information. A single unexpected death, where the provider followed its duty in informing the CQC, was undertaking an RCA and there was a Coroner's investigation ongoing would not necessarily trigger an unannounced inspection, unless in association with other related concerns. Such incidents are, however, likely to be discussed at engagement meetings between CQC inspectors and the provider.

The CQC requested a final copy of the RCA document as part of the inspection process in 2016, and received this on 28 October 2016. The document had been completed on 30 October 2015. It set out the background to the incident, the possible causes and a proposed action plan to prevent the re-occurrence of similar incidents. The CQC was satisfied that the actions set out in the RCA would be sufficient to mitigate the risk of re-occurrence and, further, that those actions had been carried out.

Actions included re-training for all nursing staff on humidification purpose, function and monitoring, with one-to-one training for 'key staff'. The majority of the actions were identified for immediate action, or to have been enacted by December 2015. Other actions were audits and were therefore of an ongoing nature. The Hospital have confirmed that all nursing staff have been re-trained on the humidification purpose, function and monitoring. There is also a rolling programme for new starters on the unit. Further, a weekly spot check was introduced for medical documentation, following the Hospital's auditing criteria. The Hospital has confirmed that the InteliSpace Critical Care and Anaesthesia lead nurse carries out this check, the audits are followed up and any learning from the audit is discussed with the individual. The audits are also shared at the appropriate Critical Care forum.
Prior to the scheduled inspection of September 2016, enquiries relating to the Hospital were re-examined to inform inspectors of areas to examine during the inspection. During the inspection, inspectors were satisfied that critical care staff were practicing safely and that clinical governance structures and training programmes were sufficiently robust to ensure the delivery of safe care; mitigating against the issues identified that led to Mr Entenman's death. In particular, the Critical Care inspector identified:

Leadership at a local level was excellent and staff told us about being supported and empowered and enjoyed being part of a team. The service had reviewed its governance arrangement in order to ensure it continually met best practice and ensured its systems were robust and fit for purpose. There was an open, transparent no blame culture.

Further;

The CCU was part of the weekly records audit which ensured that quality checks were undertaken before scanning documents. This resulted in action plans being developed where non-compliance was found. CCU was found to be compliant with these standards.

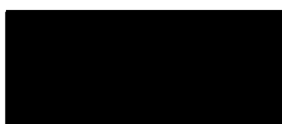
In November 2015 TLBH introduced a critical care daily safety briefing sheet. This included any staff sickness or training issues, any specific problems with individual patients, admissions, discharges and specific safety issues such as sepsis, breathing problems, risk of pressure injuries or any new equipment being used. This was attended by the RMOs, the duty hospital manager, senior nursing staff, outreach staff and some Clinical Nurse Specialists. Roles were the allocated for the day such as the lead for outreach, resuscitation lead and the runners' roles.

This was followed up by a ward round at 9.30 am led by the consultant in charge which was multi-disciplinary and included senior nursing staff, occupational health staff, physiotherapists, dieticians, the diabetes nurse specialist and RMOs. The purpose for this was to update staff on the condition of individual patients over the night time period.

For further detail of the findings, please follow the link below to our full report:
http://www.cqc.org.uk/location/1-126955902

Following its inspection of the Hospital, the CQC continues to monitor the care provided through regular engagement meetings, notifications from the Hospital, information from patients and whistleblowers. The next engagement meeting is due to take place in April 2017. At that meeting, inspectors will discuss the Hospital's response to the Coroner and any additional actions it has assured the Coroner that it will take.

Yours sincerely,



Head of Inspection – Hospitals, London South
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