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Coroner's Office
H M Coroner's Office
The Phoenix Centre
L Cpl Stephen Shaw MC Way
Heywood
OL10 1LR
1st June 2018

Dear Ms L Hashmi

Here is the response to the concerns raised within the Coroner's Report:

1) No Serious Untoward Incident protocol in place at EAM
2) Registered Nurses and Carers at EAM:
    i. Lack the ability to identify, recognise and act upon the deteriorating patient
    ii. Did not escalate for medical review
    iii. Demonstrated a poor standard of basic (physiological) observation and monitoring
    iv. Failed to read and use the care records appropriately (in particular the RN did not read important/critical entries on the 9th at all)
3) CQC inspection- insufficient action has been taken with regard to the recommendations made within the last CQC inspection

How we have addressed these concerns:

Background

1 We met with Commissioners from Trafford Council, to complete a Root Cause Analysis. This was beneficial as the commissioning team were impartial and brought valuable experience, as they have undertaken similar exercises with other provider organisations. This helped with some of our actions.

2 It was identified that the information provided to support LH's post-operative care was insufficient and it compromised care. Therefore in

future we would obtain a post-operative care plan or information from the Consultant, following a multi-disciplinary meeting, ahead of any proposed stay in order that we may assess the support needs. If the risks associated exceeded our capabilities then we would not proceed with an admission, until the risks associated had sufficiently reduced. Any post-surgical admissions would include a post-operative care plan, prior to admission, to ensure that all staff involved in the young person's care were adequately up to date in their support needs. We are currently developing deteriorating patient protocols specific to each young person's care needs. These are to be in place in the next three months.

3 We will ensure that we put the young people first. To support staff in delivering this we have introduced restricted visiting times to ensure we are supporting young people with their health and well-being needs at key times. We have also introduced protected meal times.

4 We have introduced a Duty of Candour policy, which sets out our reporting of incidents to interested parties together with time frames.

5 We will ensure that we are included in any reviews. If reviews do not take place, at the instigation of the placing authority we will now hold our own review, annually, to ensure that we have a record of multi-disciplinary reviews that steer us in supporting the revised needs of the young people in our care.

We will respond to each of your concerns raised, which are as follows:

1) **Serious Untoward Incident protocol**

- A Serious Untoward Incident Reporting Policy is now in place, together with a Duty of Candour policy.
- Incidents were previously dealt with through investigations, however we have developed the above policy to add greater structure in our process.
- If any family member, carer or professional had concerns we would now escalate to GP/Out of Hours service or Paramedic, even if the Registered Nurse's observations show no concerns.
- We have also changed our admissions policy for young people that have had surgery. We now require a post-operative multi-disciplinary meeting that sets out how to care for the young person going forward and the complications we could encounter. If the risk exceeds our capabilities then we would respectfully decline a young person's stay, until our staff are adequately trained .

2) i. <u>Registered Nurses and Carers at EAM lack the ability to identify, recognise and act upon the deteriorating patient</u>

- We have person centred care plans which highlight all care needs and are updated at least six monthly or as care changes arise. These are done in collaboration with families and professionals involved in a young person's care.

- Staff have undertaken clinical observation training.

- Nurse managers/seniors have received accredited train the trainer presentation skills course and have had training to deliver accredited clinical observations training ourselves. This will ensure it is delivered to staff at times that suit our needs, enabling more staff to access training.

2) ii. <u>Registered Nurses and Carers at EAM did not escalate for medical review</u>

- There is now an updated When to Seek Medical Advice policy that staff have read and signed which advices when to seek medical help and to listen to family concerns.

- Discussions are being held with our local GP practice in regards to one GP being assigned to EAM so there is more continuity from the GP practice.

2) iii. <u>Registered Nurses and Carers at EAM demonstrated a poor standard of basic (physiological) observation and monitoring</u>

- All staff have now had formal training in clinical observations. Staff also receive basic resuscitation training which is additional to the clinical observation training.

- Nurse Managers have received accredited training to undertake clinical observation training to deliver to all staff. This allows the training to be delivered at times that can include both staff on day shifts and those on night shifts

- Hospital admission/discharge policy updated with 'When to Seek Medical Advice' now included in the policy.

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2) iiii. <u>Registered Nurses and Carers at EAM failed to read and use the care records appropriately (in particular the RN did not read important/critical entries on the 9th at all)</u>

- At the start of each shift, the nurse or senior who is running the shifts allocates each child/young person to a staff member. That staff member (or members, as they work in pairs) will be in charge of undertaking all care needs for the young person and completing any records for them. They will also verbally update the nurse/senior throughout the day of where they are up to.

- Staff record notes at regular intervals during the day, for the young person they are allocated. This includes writing in their daily evaluations of all cares provided.

- We have a new system for handovers which incorporates more thorough reading of the daily evaluation sheets written. Staff shift times have changed, to allow 30 minutes for handover, instead of the previous 15 minutes. Staff come in, and are asked to read at least the previous 48 hours of notes before handover. Staff then sign in the diary to confirm they have read and understood all the entries. This means that staff know what has happened with all young people, as well as receiving a handover of main events. This is now incorporated into the handover.

- We have also introduced lunchtime handovers. After staff have had lunch, they now give handovers of where they are up to, what they still need to do, so that the nurse and carers remain up to date on what has happened up to that point.

- Nurses and seniors who record entries in their note pads, for example phone call messages, conversations with families and professionals they may take, now have a hardback book and this will be archived so they can be retrieved if need be in the future. Previous practice had been to shred the paperwork at the end of the shift. Staff also aware if writing in retrospect to write the reason why and this has been incorporated into our Record keeping policy.

3) <u>CQC inspection- insufficient action has been taken with regard to the recommendations made within the last CQC inspection</u>

- The CQC inspection in October 2017 was post LH stays at EAM.

- Following the CQC report dated Oct 2017, EAM has completed an action plan which CQC is aware of as the Directors initiated a meeting with CQC. We have also had several meetings with Trafford Commissioners to ensure that we are working towards our actions. Our action plan is fully detailed to

demonstrate progress. Trafford Council's Commissioning Team are working with EAM to ensure outcomes are within timescales.

We have taken the Regulation 28 very seriously and have put into place what we feel would prevent a further death. I hope that what we have implemented offers reassurance that we have taken this very seriously. We understand that this is not the conclusion but the beginning of a revised and more structured working practice intended to protect all of the young people that we care for.

Yours sincerely

[redacted]

[redacted] RGN, RSCN, MSc Child Studies, BSc (Hons) Children's Community Specialist Practitioner, Founder/Director