North West Boroughs Healthcare
NHS Foundation Trust

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13 December 2019

Private and Confidential

Rachel J Galloway
HM Assistant Coroner
HM Coroner's Court
Paderborn House
Howell Croft North
Bolton
BL1 1QY

Dear Ms. Galloway

Re: Lauren Victoria Finch

Thank you for your letter of 21 October 2019 following the inquest touching the death of Lauren Victoria Finch. We understand the concerns that you have raised in respect of your findings at inquest and hope that the following information will provide some assurance about the proactive steps the Trust has taken in response to these concerns.

You identified a lack of compliance with the Trust observation and engagement policy, namely that Nurse Managers, Nurses and Health Care Assistants on the Westleigh ward were not aware of the requirements of the policy when completing increased levels of observation.

I can now advise you that the following action has been undertaken.

- A training package has been developed to support face to face refresher training for all Nursing staff and Health Care Assistants. This training not only reminds clinicians of the correct procedure when completing therapeutic observations, but will use case studies to discuss various scenarios in how this policy should be applied in clinical practice. This training is to be delivered to all Nursing staff (including health care assistants) working at Atherleigh Park during December 2019.

- A communication has been sent from the Assistant Clinical Director to all Nursing staff and Health Care Assistants working at Atherleigh Park in respect of the points of learning from Lauren's sad death. This correspondence has stipulated the specific requirement of staggering the times of checking a patient, in line with the policy. This is in order to ensure that where therapeutic

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observations are in place for the purpose of reducing risk of suicide or self-harm, there is not a predictable pattern of observation that may reduce the risk reducing impact of this intervention. The introduction of e-observations, early next year, will mean that the exact time observations are taken will be immediately populated on the electronic care record. This will mean a regular audit can be obtained to provide assurance that the requirements of the policy have been fulfilled. This audit will be completed each month and the results will be discussed at the local quality safety and safeguarding group for assurance purposes. The introduction of e-observations is a joint undertaking between our trust and Mersey Care NHS Foundation Trust, with Atherleigh Park targeted as a priority in the rollout of the project.

You also identify concerns in respect of the practice of the Deputy Ward Manager. This specifically related to the Deputy Manager confirming that she was not checking that observations were carried out in line with Trust Policy on the ward.

- Following the inquest, the Assistant Clinical Director completed a reflective session with the Deputy Ward Manager in respect of the number of concerns identified. This session included a discussion about the requirements of the policy when completing 10 minute observation checks. The Deputy Ward manager will also attend the refresher training previously described. In addition to this, the new ward manager on Westleigh Ward is supporting this ongoing reflection in supervision to ensure that policies are adhered to, and the Deputy Manager is fulfilling the quality assurance elements of her role.

- Additionally, the operational manager is completing regular audits, in order to identify any gaps in compliance with the policy. A baseline audit was completed in November 2019 and this will be repeated each month. This is reported into the Borough senior leadership team meeting for assurance.

You note that The Trust carried out an investigation following the death of Lauren. It was of concern that the lead investigator (who gave evidence at the inquest) did not understand the Observation Policy.

- The lead investigator has reflected on the evidence provided at inquest and has acknowledged that although he was able to demonstrate some understanding of the observation policy he did not articulate this by the example provided. The investigation lead has reflected on his description realising that his calculation of timing would have indicated none compliance with the observation policy. The investigator has revisited the policy to further his understanding.

- Lead investigators are supported during the course of investigations by assigned clinical experts. The Trust has developed a standard suite of terms of reference which are to be considered as part of a serious incident investigation; this includes to assess if care delivered was concordant with evidence based practice, NICE guidance, policies and procedures.

Lastly, you highlight that Progress notes were not always made contemporaneously. At times, there was a delay exceeding 24 hours. We fully appreciate the potential clinical risk that this delay may cause.
In respect of this issue:

- The operational manager will conduct a monthly audit of our electronic clinical record (RIO) to identify patterns of delayed record keeping, in order for appropriate actions to be taken to improve standards that fall short of the Trusts record keeping policy.

- This issue will also be covered in the face to face training relating to the observation and engagement policy.

If I can be of any further assistance or you require further information about the steps we have taken, please contact me.

Yours sincerely

Simon Barber
Chief Executive

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