Date: 27th April 2022

NHS
Mersey Care
NHS Foundation Trust
Community and Mental Health Services

Mersey Care NHS Foundation Trust
V7 Building
Kings Business Park
Prescot, Merseyside
L34 1PJ

Dear Mr Rebello,

Re: Sarah Louise Doyle (deceased) Regulation 28 Report dated 4 March 2022

I write under Regulation 29 in response to your Regulation 28 Report dated 4 March 2022 in relation to concerns arising out of the death of Sarah Louise Doyle, 5 days earlier, on 27 February 2022. The inquest has not yet been listed.

The Trust always takes the death of any service users seriously and is keen to learn lessons where possible. I can confirm that your report has already been shared in the Trust Wide Executive Safety Huddle which is attended by Trust Executives and representatives from each clinical Division and also via Divisional Safety Huddle meetings. Safety Huddles are weekly meetings held at both a Trust Wide and Divisional level and have in attendance clinical and other professional managers from each service area. The purpose of the meetings is to highlight any new safety issues, incident trends or immediate learning to be shared.

The concern you identified in your report was that the five minute observations of Sarah were recorded exactly on each five minute interval and that these observations were covered by one signature with a downward arrow.

I can confirm that in relation to supportive observations the following actions are already either complete or well underway:

1. Urgent instructions have already been given via the Associate Director of Nursing and Patient Experience as to the use of and recording of intermittent observations, which is in addition to the Trust Supportive Observation Policy.

2. On March the 8th 2022 the Regulation 28 was discussed at the local division safety huddle with all inpatient Matrons present. An immediate action was for them to discuss with their

respective ward managers the need to ensure changes in the language used to describe level 2 observations to support more accurate recording. The discussions confirmed intermittent observations should take place within each 5, 10 or 15 minute 'windows', rather than saying that they are 5, 10 or 15 min checks (as they won't be taking place at exactly those timed intervals).

3. A further Senior Leadership Team meeting was held on 14th March 2022 to ensure oversight of what was required and timescales for completion. The Inpatient Matrons were given until 25th March 2022 to ensure the changes in recording of observations to unpredictable times was rolled about and discussions held across all staff groups in each inpatient ward. This has been completed.

4. A local audit has been developed with Inpatient Matrons to check and provide assurance that recording the actual time service users were checked is taking place, as opposed to rounding to the nearest 5-minute time window. As additional assurance, spot checks are being undertaken by the Senior Leadership Team and Inpatient Matron/ Ward Manager group.

5. Inpatient Multi Disciplinary teams have been reminded that if it is deemed clinically appropriate for a service user to remain on 5-minute unpredictable times, that a clear rationale is given in the clinical notes as to why this is required and not a full level 3 one to one observation. Ward Managers and Inpatient Matrons are overseeing this.

6. Inpatient staff are required to have yearly competence assessments regarding supportive observations. All of the staff on the wards in Clock View will have had their yearly competency updated on the supportive observation policy and will have been observed in practice carrying out at least 2 supportive observations checks by the end of April 2022. All of the other wards across Local Division will be completed by the end of May 2022.

7. The Senior Leadership Team, Inpatient Matrons and Ward Managers have carried out spot checks on supportive observation forms and immediately challenge poor/inaccurate record keeping. Inpatient Matrons are also doing extra "dip audits" on observations records to

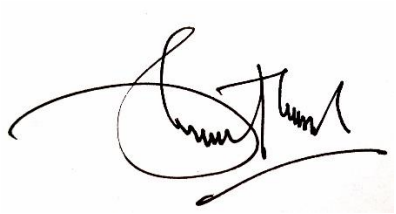
specifically review the timings of supportive observations to ensure these are random within the time 'window' rather than specific to the 5 minutes.

8. It is part of the role for the Nurse in Charge of each shift to carry out random checks of documents and the ward environment throughout the shift.

9. The Trust has reviewed the existing Ward Assurance Audit in relation to supportive observations. An interim change to recording has been made ahead of a scheduled electronic system going live in May 2022 which will reflect the need for supportive observations to be at unpredictable intervals. These audits are taking place weekly, and the highlights are shared in safety huddles and at divisional clinical meetings.

I hope that this letter assists in explaining the actions that the Trust have already taken in the immediate period following Sarah's sad death to address the specific concerns raised in your report.

I can confirm that the Trust is in the process of carrying out a review into Sarah's death and will share this report with you as well as actions proposed and taken as a result of it. A number of wider actions have already been commenced on a trust wide footprint which can be shared at the future inquest hearing.



Dr [redacted]
Consultant Forensic Psychiatrist
Deputy Chief Medical Officer – Patient Safety and Quality
Director of Patient Safety

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