East London NHS
NHS Foundation Trust

Final: 22.03.18
Approved by Dr Paul Gilluley – Chief Medical Officer on 27.03.18

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Addendum Serious Incident Review Report – [redacted] Datix 56917 STEIS 2016.33770

- **Review panel:** Dr Cathie O'Driscoll - Serious Incident Reviewer
  Ms Daisy Mudoni – Borough Lead Nurse, Luton

Report Author: Dr Cathie O'Driscoll

Introduction

[redacted]

Inaccuracies

- [redacted]
- [redacted]

Reason for Review of the Original Serious Incident Review Process

[redacted]

[redacted]

Methodology

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Additional Documentation Received since the Serious Incident Review

- Police Witness Statement by CSW1 dated 27.12.16. This statement contains the allegation made by [redacted] as previously mentioned
- Police witness statement by another Clinical Support Worker on the mental health ward dated 27.12.16
- Police witness statement by the then mental health ward manager dated 27.12.16 together with a signed drawing by her of the ward layout
- Luton and Dunstable Hospital Emergency Department proforma dated 27.12.16 at 09.41
- From an entry in the electronic case notes of [redacted] dated 29.12.16 at 07.59: "[redacted].
- A copy of the Post Mortem Report on [redacted] dated 04.01.17 which notes [redacted]
- A copy of the forensic toxicology report dated 16.02.17. The toxicology samples tested positive for medications prescribed on the mental health ward and following arrival at Luton and Dunstable Hospital. [redacted]
- A copy of the autopsy and histological reports on the brain dated 27.03.17. [redacted]
- Statement of the Ambulance Emergency Medical Technician who attended the road traffic accident in which [redacted] was involved on 25.12.16 dated 16.09.17
- Coroner's Statement by a Consultant Anaesthetist at Luton and Dunstable Hospital; dated 15.10.17. The statement reads [redacted]
- Coroner's statement by a Consultant in Emergency Medicine at Luton and Dunstable hospital dated 27.02.18 giving the opinion that [redacted]
- Statement by the Nurse on Duty when [redacted] was admitted to the mental health ward in the early hours of the morning on 26.12.16 dated 16.02.18

- Statements by two nurses and a Clinical Support worker covering the night shift on the mental health ward overnight 26/27.12.16 (dated 12.02.18, 17.02.18 and 02.03.18). All statements acknowledge the observations undertaken by the nursing staff and all three staff report having seen [redacted] awake and walking on the ward on the morning of 27.12.16 at the end of their shift (which finished at 08.00)
- A draft statement for the coroner prepared by the then mental health ward manager (undated)

Findings and Opinion

Following perusal of all the new documentation, the SIR panel conclusions are as follows:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

Actions Undertaken on the Mental Health Ward since this Incident

Related to other serious incidents involving the index mental health ward, a series of recommendations and action plans have been implemented in relation to contraband (including illegal street drugs) entering the ward. Considerable efforts have also been made to increase the skill mix of staffing on the ward and to reduce the bed numbers. The

management of informal patients within the directorate has also been comprehensively reviewed to reduce risks during admission. These are referenced in the following action plan.

Action Plan

- Since December 2016, the ward has put in place a twice daily environmental check of the ward for contraband items and additional spot checks

- Since 20.01.17, patients are now being signed in and out of the ward by nursing staff and clinical support workers who are routinely checking them for items such as carrier bags and aluminium cans

- Following serious incident son the ward on 21.06.17 and 01.07.17, staff changes have been made on the ward with the aim of increasing the level of experience of nursing staff and increasing the resource available to the medical staff team.

- In early July 2017, bed numbers on the ward were reduced from 27 to 12 with a gradual increase back to 18. Incremental transfers were agreed one at a time with numbers only moving to 14 on the books by 21.07.17. During the process of increasing bed numbers to 18, the ward only accepted transfers and re-opened to admissions on 03.08.17. The staffing levels remained as they were for 27 beds- 2 qualified and 3 unqualified staff despite lowered inpatient numbers and this was reviewed and decreased to 2 + 2 on nights from 14.07.17. This was reviewed on the 08.08.17 to increase numbers to 2 qualified and 3 unqualified given the increase in patient numbers. The ward has 6 staff (2+4) on days and 5 (2+3) staff on nights

- A recommendation was made following another Serious Incident Review that the Bedfordshire Directorate should develop a detailed plan to review the management of informal patients admitted to the wards, particularly in relation to the development of personalised care plans, risk assessments, leave and the management of intoxication. This was completed in October 2017 under the leadership of the Borough Lead Nurse

Appendix 1

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Serious Incident Review Report

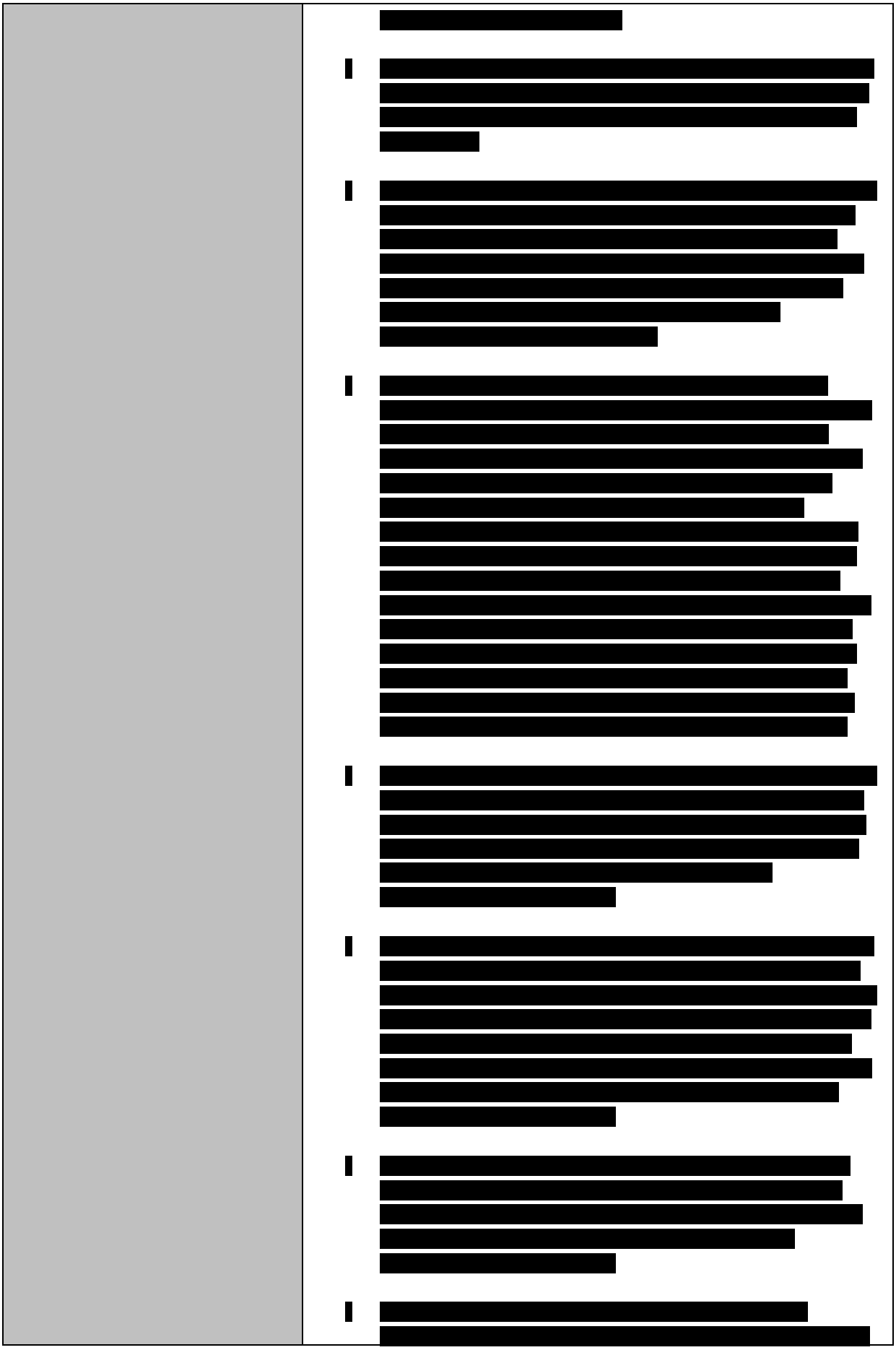
ELFT Datix/STEIS Reference	Datix 56917 STEIS 2016.33770
Incident Date	27.12.16
Incident Synopsis	[redacted]
Date Reported on STEIS	30.12.16
Date Report and Action Plan signed off by the Medical Director	24.03.17
Review Team	• Dr Cathie O'Driscoll - Serious Incident Reviewer

	• Ms Daisy Mudoni – Borough Lead Nurse, Luton • Dr Rhodri David – Consultant Psychiatrist, Tower Hamlets
Review Level	ELFT Level 1a/NPSA Level 2
Report Author/s	• Dr Cathie O'Driscoll – Serious Incident Reviewer
Report Completion Date	24.03.17
Document Version	Final
Executive Approval	Dr Dinesh Sinha – Associate Medical Director for an on behalf of Dr Kevin Cleary – Medical Director
Electronic File Path	K:\Assurance Department\Incidents & SUIs\Level 1a\
Distribution List for the Final Report and/or Executive Summary	1. The Service and Clinical Directors 2. Service and team managers to whom the recommendations and action plan apply 3. The Assurance Department 4. The Serious Incident Review Sub-committee 5. Bedford CCG

Contents: **Page:**

1. Executive Summary

Incident Date	27.12.16
Incident Type	Service User found submerged in bath
Service User Demographics • **Age** • **Gender** • **Ethnicity**	[redacted] [redacted] [redacted]
Directorate	Bedfordshire
Scope of the review	• This review covers the time period between [redacted] 25.12.16 up to and immediately following the incident on 27.12.16 and the subsequent death of the service user on 28.12.16 • It encompasses services provided by the Bedford Crisis Resolution and Home Treatment Team and the Multi-Disciplinary Team from the Bedford In-patient Ward • A further Datix (57527) was completed on 12.01.17 [redacted] No further information was given [redacted]. • [redacted] • The following action was taken: The case was discussed with the MDT including the Service Manager. It was agreed to review local administrative & operational procedures to clarify the current status of individuals on the Team caseload, in order to avoid similar errors in future and to improve communication with other services, service users and families. • Specifically it has been agreed to amend the process of the referral meeting in order to avoid confusion and to review RiO prior to letters being sent out to patients on the waiting list. This will be monitored by the Team Lead. An alert has been sent to the Administration Lead to ensure that administrative staff are aware of the RiO alert giving information of the death of the service user. [redacted]
Involvement and support of patient and/or relatives	• [redacted]



	[redacted]
Notable practice (care and practice that had a positive impact and may provide learning opportunities): **Good Practice (expected standard of care and practice but well executed)**	• No notable practice has been observed during the course of this review • The CRHT nurse who saw the service user on two occasions at Bedford A&E undertook a thorough and well documented review on both occasions • The second on call doctor volunteered to come in to support the second duty doctor on the evening of 26.12.16. She made a thorough assessment, including of risk which was fully documented • From the information available to the panel, it is our understanding that the resuscitation attempt on the service user proceeded very well following his detection. Staff followed all basic life support procedures according to their training, the resuscitation was well managed by the ward manager and all necessary paperwork was present

	by the time the service user was taken to Luton and Dunstable Hospital • Following the incident, the Deputy Director of Nursing (who was not on call) came to the ward to support the ward manager and staff
Care and Service Delivery Problems	**Care Delivery Problems** [redacted]

- [redacted]

CDP3 The Crisis Resolution Team Nurse acknowledges that she telephoned the family on 27.12.16 without being aware of the incident

Service Delivery Problems

SDP1 The experiences of the [redacted] in terms of their interaction with staff on the ward on 26.12.16 have been discussed with and are acknowledged by the ward manager. It is untrue that there are insufficient cups on the ward for them to have been offered a cup of tea and it remains unclear who said this to the service user or whether [redacted] misinterpreted a remark made to [redacted] However the second duty doctor reported at interview that, when she arrived on the ward and met [redacted], she had to ask for them to be given a hot drink which had not yet been provided for them. It is also of concern to the manager that it was not handed over to the night shift that [redacted] of the service user remained on the ward. The panel cannot be assured that these were isolated incidents and not indicative of a wider service need to improve the welcome to new patients and their families on arrival on the ward

SDP2 The failure to check the bag brought to the ward by [redacted] reflects some laxity in respect of searches on this ward which has been identified in an earlier review and for which remedial action has now been instituted

SDP3 At this resuscitation, the bag valve mask was found to be missing from the ward grab bag. This did not cause a

	delay as one was immediately available from the other ward bag. However, the contents of the grab bag are checked every night by staff on the night shift and this finding suggests that this task is not being undertaken as per policy. Furthermore, there had been a previous resuscitation attempt on the ward on the night of 7/8.12 16 and there is no assurance that he bag valve mask had not been missing from that time **SDP4** The second on call doctor came to the ward to assess the service user as appropriate. However, it wasn't clear at interview that there was a shared and consistent view between the second on call doctors and the core trainees and GPVTS doctors on the Luton/Bedford rota about the appropriate circumstances for the middle grade doctors to come in and see patients when they are on call. The panel understand that arrangements are defined for Section 136 and other MHA assessments but otherwise the term step down has been used which suggests a lack of clarity about the role of the on call middle grade doctor **SDP5** When the police visited the ward, they were concerned that the bathroom had not been treated as a crime scene and that staff had cleaned the bathroom following the removal of the service user to hospital
Contributory Factors	[redacted]

	[redacted] **Related to SDP1** The ward in question is very large with 27 beds and an awkward lay out with three separate patient corridors which impede the ability of nursing staff to be fully aware of everything happening on the ward. Sightlines on the ward are very poor and it and its neighbouring ward form a stand-alone unit **Related to SDP2** As a result of the earlier Serious Incident Review the actions already undertaken on the ward in relation to contraband are listed under Section 4.6 **Related to SDP3** ELFT policy regarding the grab bag is that the contents should be checked every night by the night staff on duty. The matron and ward manager should assure compliance with the policy through monthly spot checks At the time of this incident, the panel cannot be assured of compliance with the policy through appropriate and completed documentation. **Related to SDP4** Historically, within the Bedford and Luton Directorates, there has been an expectation that second on call doctors would provide on call cover through telephone advice only. Clarification of expectation of the need for second on call doctors to attend on site has so far been clarified only for Section 136 and other Mental Health Act assessments and there is an identified need for further role clarification **Related to SDP5** None of the ward staff on duty at the time of the incident were aware that the bathroom should be treated as a crime scene until the police authorised otherwise
Root Causes	[redacted]

	[redacted] However, care and service delivery problems have been identified in this case which impeded good quality care, [redacted] Given the difficulty in determining a root cause, the issues of predictability and preventability remain moot at this point
Lessons Learned	• All lessons learned in this review relate to identified care and service delivery problems including the need for admission clerking from both medical and nursing staff to be thorough in relation to physical as well as mental health, [redacted]
Recommendations	**1.** That the Deputy Director of Infection Control and Physical Health Lead Nurse should table a discussion paper at the next meeting of the ELFT Trust wide Physical Health Strategy Group on 17.03.17 to review the incident and timing of physical health checks **2.** That the Clinical Director of Bedford should arrange an audit of completion of physical examination on admission by junior doctors **3.** That the forthcoming Bedford ward away day on 19.04.17 should consider strategies to improve the welcome given to new patients and their families on arrival on the ward **4.** That the forthcoming Bedford ward away day on 19.04.17 should review the ward use of the ELFT diabetic care plan **5.** That the Borough Lead Nurses for Luton and Bedford should develop a strategy and audit tool for ensuring the nightly checks of the grab bags on all their wards **6.** That the Luton and Bedfordshire Training Programme Director and the Clinical Directors for Luton and Bedfordshire should review the on call roles and responsibilities for first on call doctors, second on call doctors and consultants and ensure that these are fully understood and widely disseminated **7.** That the Chief Nurse and Deputy Chief Executive should convene a working group to write ELFT guidelines for nursing staff (especially ward managers and DSNs), on call managers and on call directors on the management of incidents involving unexpected death or serious injury in inpatient settings

Arrangements for shared learning	This report including any recommendations and resulting action plan will be shared with the teams and staff involved, discussed at the local healthcare governance meeting and any learning which applies across the directorate or organisation will be disseminated via the respective communication channels. A feedback meeting has been held on 10.03.17 for those staff involved in the incident and investigation and the relevant senior managers

2. Methodology

2.1	**Level and type of review:** • Single incident review • ELFT Level 1a/NPSA Level 2 (Comprehensive)
2.2	**Standard Terms of Reference:** • To review the initial incident management and support to those involved • To establish the facts and any specific problems to be addressed • To review the care the patient was receiving at the time of the incident • The suitability of that care in view of the client's history and assessed health and social care needs in relation to policy and good practice guidance • The extent to which the care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies • To look for improvements rather than apportion blame • To establish how recurrence may be reduced or eliminated • To formulate SMART recommendations • To provide a report as a record of the investigation process and a means of sharing lessons from the incident **Additional/Specific Terms of Reference** • None identified
2.3	**Scope of the review:** • This review covers the time period between [redacted] 25.12.16 up to and immediately following the incident on 27.12.16 and the subsequent death of the service user on 28.12.16 • It encompasses services provided by the Bedford Crisis resolution and Home Treatment Team and the Multi-Disciplinary Team from the Bedford In-patient Ward • A further Datix 57527 was completed on 12.01.17 [redacted] No further information was given by the caller. • [redacted] • The following action was taken: The case was discussed with the MDT including the Service Manager. It was agreed to review local administrative & operational procedures to clarify the current status of individuals on the Team caseload, in order to avoid similar errors in future and to improve communication with other services, service users and families. • Specifically it has been agreed to amend the process of the referral meeting in order to avoid confusion and to review RiO prior to letters being sent out to patients on the waiting list. This will be monitored by the Team Lead. An alert has been sent to the Administration Lead to ensure that administrative staff are aware of the RiO alert giving information of the death of the service user. The second incident and its management have been escalated to the Director for information and the incident was closed on 22.01.17.
2.4	**Methods used:** • Case note and electronic patient record review

	• Tabular timeline • Staff interviews with the Deputy Director of Nursing, On call Manager, Consultant Psychiatrist and Ward Manager of the ward, the admitting Nurse and admitting Duty Doctor, another Duty Doctor and second on call Doctor who had assessed the service user, a Nurse and four unqualified staff who had been on shift at the time of the incident, a Nurse from the adjacent ward who attended the incident and the Nurse from the CRHT who assessed the service user twice in Bedford A&E • Telephone interview with the GP of the service user. The GP had met [redacted] • Interview with [redacted] of the service user • Advice and consultation with the Deputy Director of Infection Control and Physical Health Lead Nurse • NPSA Contributory Factor Framework and Fishbone Diagram
2.5	**Involvement and support of patient and relatives:** • The Chair of the panel met [redacted]

	[redacted]
2.6	**Involvement and support provided for staff involved:** • Staff interviewed as part of this investigation were given information regarding the serious incident review process, a copy of the Terms of Reference for the review and information regarding the Employment Assistance Scheme which offers free counselling and support to Trust staff in addition to their normal work support structures. • All members of staff interviewed as part of the review were asked about the level of support provided to them after the incident, whether they were satisfied with the support provided and whether it was adequate for their needs. Any concerns about post incident support are recorded in the report by exception as a service delivery problem. • A feedback meeting has been held on 10.03.17 for those staff involved in the incident and investigation and the relevant senior managers
2.7	**Information and evidence gathered:** • Ward Observation Chart (general – hourly observations) from 25.12.16 at 20.00 to 27.12.16 at 19.00 • Ward Handover records from the night to day shift on 26.12.16 and 27.12.16 • 48 hour report completed by the ward manager and dated 28.12.16 • Safeguarding Documentation relating to the decision for a Section 42 review dated between 06.01.17 and 09.01.17 • Timeline created [redacted] • Statement for the Coroner provided by the Speciality Doctor who assessed the service user on the evening of 27.12.16 (undated) • List of questions provided to the Chair of Panel [redacted] given to her on 27.02.17 • Luton Borough Council Safeguarding Enquiry report dated 13.03.17

3. Incident Description, Context and Chronology of Key Events

3.1 Detection of the incident:

[redacted]

3.2 Incident description and consequences:

[redacted]

3.3 Background and context:

- [redacted]

- The Bedford and Mid-Bedfordshire Crisis Resolution / Home Treatment (CRHT) Teams work with a group of patients, who, without this support, would need to be admitted to hospital, or who cannot be discharged from hospital without intensive support. The service enables patients who are in crisis, and not able to function at their normal level, to be supported in their own homes

- The Bedford Acute Inpatient Service is an acute 27-bed male inpatient service that provides 24 hour treatment and care in a safe and therapeutic place. Staff actively engage and involve people who are experiencing acute mental health episodes which cannot be managed in a less restrictive setting, owing to the degree of risk, clinical need or patient choice. Whilst patients receive individualised care and treatment based on their needs the Multi-Disciplinary team work closely with all service users, their families and carers in providing a therapeutic environment which lends itself to our service users' recovery. This ward and an adjacent nine bedded female ward form a stand-alone unit for service users from Bedford and Central Bedfordshire which is however located in Luton

3.4	**Actual effect upon the patient/s and service/s**	Death of in patient service user from unknown cause		
3.5	**Actual severity of the incident** *(e.g. Death)*	Death		
3.6	**Pre-investigation risk assessment**	**A** **Potential Severity** **(1-5)**	**B** **Likelihood of recurrence at that severity** **(1-5)**	**C** **Risk Rating** **(C = A x B)**
		5	2	10
3.7	**Chronology of events:**			
	[redacted]	[redacted]		
	[redacted]	[redacted]		
	[redacted]	[redacted]		

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

4.	Review Findings and Analysis

4.1 **<u>Notable practice</u> *(care and practice that had a positive impact and may provide learning opportunities)*:**

- No notable practice has been observed during the course of this review

<u>Good Practice</u> *(expected standard of care and practice but well executed)*

- The CRHT nurse who saw the service user on two occasions at Bedford A&E undertook a thorough and well documented review on both occasions
- The second on call doctor volunteered to come in to support the second duty doctor on the evening of 26.12.16. She made a thorough assessment, including of risk which was fully documented
- From the information available to the panel, it is our understanding that the resuscitation attempt on the service user proceeded very well following his detection. Staff followed all basic life support procedures according to their training, the resuscitation was well managed by the ward manager and all necessary paperwork was present by the time the service user was taken to Luton and Dunstable Hospital
- Following the incident, the Deputy Director of Nursing (who was not on call) came to the ward to support the ward manager and staff

(Include overall comment on care planning and risk management either in 4.1 or in 4.2) The panel have identified several concerns about the care of the service user while on the ward and these together with concerns about the interaction with the family of the service user are detailed in the following section

Additionally, the panel have been asked [redacted] to consider various hypotheses of concern to them. Some [redacted] concerns relate to identified care and service delivery problems but for other questions, the panel feel that the available evidence does not substantiate the concerns:

- [redacted]

[redacted]

[redacted]

<table>
<tr><td></td><td>[redacted]

[redacted] [redacted]

[redacted]

[redacted] [redacted]

[redacted]</td></tr>
<tr><td>4.2</td><td><u>Care and Service Delivery Problems</u> (something that should have happened didn’t or something happened that shouldn’t have happened):

Care Delivery Problems

[redacted]
[redacted] [redacted]
[redacted] [redacted]
[redacted] [redacted]
[redacted] [redacted]
[redacted]
[redacted] [redacted]</td></tr>
</table>

[redacted]

Service Delivery Problems

SDP1 The experiences [redacted] in terms of their interaction with staff on the ward on 26.12.16 have been discussed with and are acknowledged by the ward manager. It is untrue that there are insufficient cups on the ward for them to have been offered a cup of tea and it remains unclear who said this to the service user or whether he misinterpreted a remark made to him. However the second duty doctor reported at interview that, when she arrived on the ward [redacted], she had to ask for them to be given a hot drink which had not yet been provided for them. It is also of concern to the manager that it was not handed over to the night shift [redacted] remained on the ward. The panel cannot be assured that these were isolated incidents and not indicative of a wider service need to improve the welcome to new patients and their families on arrival on the ward

	SDP2 The failure to check the bag brought to the ward [redacted] reflects some laxity in respect of searches on this ward which has been identified in an earlier review and for which remedial action has now been instituted **SDP3** At this resuscitation, the bag valve mask was found to be missing from the ward grab bag. This did not cause a delay as one was immediately available from the other ward bag. However, the contents of the grab bag are checked every night by staff on the night shift and this finding suggests that this task is not being undertaken as per policy. Furthermore, there had been a previous resuscitation attempt on the ward on the night of 7/8.12 16 and there is no assurance that he bag valve mask had not been missing from that time **SDP4** The second on call doctor came to the ward to assess the service user as appropriate. However, it wasn't clear at interview that there was a shared and consistent view between the second on call doctors and the core trainees and GPVTS doctors on the Luton/Bedford rota about the appropriate circumstances for the middle grade doctors to come in and see patients when they are on call. The panel understand that arrangements are defined for Section 136 and other MHA assessments but otherwise the term step down has been used which suggests a lack of clarity about the role of the on call middle grade doctor **SDP5** When the police visited the ward, they were concerned that the bathroom had not been treated as a crime scene and that staff had cleaned the bathroom following the removal of the service user to hospital
4.3	**<u>Contributory factors</u> *(influential and causal factors for each identified care and service delivery problem)*:** **Related to CDP1** [redacted] **Related to CDP2** [redacted] A Band 7 nurse with expertise in physical health care has recently been appointed following a previous resignation in October 2016 but this service is only available in working hours. Access to ELFT nursing staff with specialist physical health expertise was not available at the time of this incident except through telephone contact available but not yet being widely accessed by the wards. **Related to CDP3** The CRHT nurse was working night shifts at this time. She had

	checked the electronic patient record before going off duty on the morning of 27.12.16. At that time, details of the incident had not yet been written up on RiO, the electronic patient record. The nurse telephoned [redacted] when she came back on duty that evening without first rechecking RiO. She acknowledges the error and has reflected on changing her practice to ensure that the same mistake will not recur. **Related to SDP1** The ward in question is very large with 27 beds and an awkward lay out with three separate patient corridors which impede the ability of nursing staff to be fully aware of everything happening on the ward. Sightlines on the ward are very poor and it and its neighbouring ward form a stand-alone unit. **Related to SDP2** As a result of the earlier Serious Incident Review the actions already undertaken on the ward in relation to contraband are listed under Section 4.6. **Related to SDP3** ELFT policy regarding the grab bag is that the contents should be checked every night by the night staff on duty. The matron and ward manager should assure compliance with the policy through monthly spot checks At the time of this incident, the panel cannot be assured of compliance with the policy through appropriate and completed documentation. **Related to SDP4** Historically, within the Bedford and Luton Directorates, there has been an expectation that second on call doctors would provide on call cover through telephone advice only. Clarification of expectation of the need for second on call doctors to attend on site has so far been clarified only for Section 136 and other Mental Health Act assessments and there is an identified need for further role clarification. **Related to SDP5** None of the ward staff on duty at the time of the incident were aware that the bathroom should be treated as a crime scene until the police authorised otherwise.
4.4	**<u>Root causes</u> *(contributory factors that are causal to the incident)*:** ***(include comment on predictability/preventability)*** [redacted]
4.5	**<u>Lessons learned</u> *(key safer practice issues identified that did not materially contribute to the incident)*:**

	All lessons learned in this review relate to identified care and service delivery problems including the need for admission clerking from both medical and nursing staff to be thorough in relation to physical as well as mental health, [redacted] and the need to properly welcome new patients and their families to the ward
4.6	**<u>Action taken since the incident which relates to any contributory factors, root causes and recommendations</u>:** • A resuscitation officer has been contracted by ELFT spending one day a month in each directorate and has been in post since October 2016 • Since December 2016, the Bedford ward has put in place a twice daily environmental check of the ward for contraband items and additional spot checks • Following this incident, the Deputy Director of Infection Control and Physical Health Lead Nurse immediately arranged for a supply of bag valve masks to be delivered to the ward • Since 20.01.17, patients are now being signed in and out of the ward by nursing staff and clinical support workers who are routinely checking them for items such as carrier bags and aluminium cans • Staff on the ward are participating in the following Nurse development programmes: - Band 2 Development Programme running from January to March 2017 - Band 4 Development Programme running from January to March 2017 -Band 6 Development Programme running from January to March 2017 -Band 5 Development Programme is due to commence in April 2017 and nurses from the ward have been put forward for this. The Deputy Director of Nursing has ensured that these development programmes contain modules on physical health care • All ELFT band 6 and above senior inpatient nurses are required to attend annual immediate life support (ILS) training. Since January 2017 it has been agreed that in stand-alone units all staff band 4 and above will be trained to ILS level. Seven nurses from the ward undertook Intermediate Life Support Training on 11.01.17. Further training dates are currently being arranged with the aim that all staff at Band 4 and above will receive this training as the two adjacent wards comprise a stand-alone unit • The Deputy Medical Director for Luton and Bedfordshire is convening and chairing a Physical Health Strategy Group for the two directorates. The first meeting took place in February 2017 and the group will meet every two months • On 28.02.17, a presentation was delivered to the Bedfordshire CCG on measures taken within the directorates to address the physical health of service users and identifying next steps including addressing the gaps in physical healthcare provision for ELFT service users • As of 13.03.17, it has been agreed by the Bedford Ward that all visits will take place as far as possible in the ward dining area which is provided with soft

	furniture and tea and coffee facilities and with good visibility for nursing staff • From 02.04.17, a Band 7 Physical Health Nurse will be in post to support the Bedford and Luton Directorates • [redacted] • [redacted] • [redacted]
4.7	**<u>Recommendations</u>:** **1.** That the Deputy Director of Infection Control and Physical Health Lead Nurse should discuss the incident at the next meeting of the ELFT Trust wide Physical Health Strategy Group on 17.03.17 to discuss whether the physical health policy requires amendment **2.** That the Clinical Director of Bedford should arrange an audit of completion of physical examination on admission by junior doctors **3.** That the forthcoming Bedford ward away day on 19.04.17 should consider strategies to improve the welcome given to new patients and their families on arrival on the ward **4.** That the forthcoming Bedford ward away day on 19.04.17 should review the ward use of the ELFT diabetic care plan **5.** That the Borough Lead Nurses for Luton and Bedford should develop a strategy and audit tool for ensuring the nightly checks of the grab bags on all their wards **6.** That the Luton and Bedfordshire Training Programme Director and the Clinical Directors for Luton and Bedfordshire should review the on call roles and responsibilities for first on call doctors, second on call doctors and consultants and ensure that these are fully understood and widely disseminated **7.** That the Chief Nurse and Deputy Chief Executive should convene a working group to write ELFT guidelines for nursing staff (especially ward managers and DSNs), on call managers and on call directors on the management of incidents involving unexpected death or serious injury in inpatient settings

Action Plan	**5.**

Reference: Datix 56917 STEIS 2016/33770 Date created: 24.03.17 Final date for review: 31.10.17

Serious Incident Reviewers To Complete			**Managers To Complete**			**Action Plan Reviewer To Complete**	
Issue Identified (Reference to Contributory Factors and Root Causes)	**Recommendation**	**Level of Recommendation (Individual Team Directorate Organisation)**	**Actions To Be Taken**	**By Whom**	**By When**	**Outcome**	**Completion Sign-off**
	Action Plan to be checked for completion in six months' time (either by Assurance department for 1a or directorate for 1b)	Organisation	Check of Action Plan	Mrs Chris Kitchener – Associate Director of Assurance	31.10.17		
	Check that feedback has been given to family, patient, and other agencies by 10 days following sign off	Individual	Feedback given [redacted] and GP of the service user	Dr Cathie O'Driscoll – Serious Incident Reviewer	30.04.17 (following sign off at the ELFT Trust Board Meeting on 27.04.17)		
Related to CDP1	1.That the Deputy Director of Infection Control and Physical Health Lead Nurse should discuss the incident at the next meeting of the ELFT Trust wide Physical Health Strategy Group on 17.03.17 to discuss whether the physical health policy requires amendment	Organisation	Discussion of incident at Physical Health Strategy Group	Ms Carol Shannon - Deputy Director of Infection Control and Physical Health Lead Nurse	17.03.17		
Related to CDP1	2.That the Clinical Director of Bedford should arrange an audit of completion of	Directorate	Audit of physical examination on admission completed and remediation plan in place if necessary	Dr Zelpha Kittler – Clinical	31.03.17		

Serious Incident Reviewers To Complete			Managers To Complete			Action Plan Reviewer To Complete	
Issue Identified (Reference to Contributory Factors and Root Causes)	**Recommendation**	**Level of Recommendation (Individual Team Directorate Organisation)**	**Actions To Be Taken**	**By Whom**	**By When**	**Outcome**	**Completion Sign-off**
	physical examination on admission by junior doctors			Director Bedfordshire			
Related to SDP1	3.That the forthcoming Bedford ward away day on 19.04.17 should consider strategies to improve the welcome given to new patients and their families on arrival on the ward	Team	Discussion and strategy formulated at away day	Mr Ashick Hossany - Interim Modern Matron and Ms Stacey Wimbleton -, Ward Manager	19.04.17		
Related to CDP2	4. [redacted]	Team	Discussion and strategy formulated at away day	Mr Ashick Hossany - Interim Modern Matron and Ms Stacey Wimbleton - Ward Manager	19.04.17		
Related to SDP3	5.That the Borough Lead Nurses for Luton and Bedford should develop a strategy and audit tool for ensuring the nightly checks of the grab bags on all their wards	Directorates	Strategy developed and audit tool in place with audit timetable	Ms Daisy Mudoni - Borough Lead Nurse Luton and Ms Sasha Singh – Borough Lead Nurse Bedford	31.05.17		
Related to SDP4	6.That the Luton and Bedfordshire Training Programme Director and the Clinical Directors for Luton and Bedfordshire	Directorates	Updated guidelines agreed and disseminated	Dr David Middleton – TPD Luton and Bedfordshire,	31.07.17		

Serious Incident Reviewers To Complete			Managers To Complete			Action Plan Reviewer To Complete	
Issue Identified (Reference to Contributory Factors and Root Causes)	**Recommendation**	**Level of Recommendation (Individual Team Directorate Organisation)**	**Actions To Be Taken**	**By Whom**	**By When**	**Outcome**	**Completion Sign-off**
	should review the on call roles and responsibilities for first on call doctors, second on call doctors and consultants and ensure that these are fully understood and widely disseminated			Dr Farid Jabbar, Clinical Director Luton and Dr Zelpha Kittler, Clinical Director Bedford			
Related to SDP5	7.That the Chief Nurse and Deputy Chief Executive should convene a working group to write ELFT guidelines for nursing staff (especially ward managers and DSNs), on call managers and on call directors on the management of incidents involving unexpected death or serious injury in inpatient settings	Organisation	Guidelines developed, agreed and disseminated to the relevant staff	Professor Jonathan Warren - Chief Nurse and Deputy Chief Executive	31.07.17		
Actions Already Undertaken							
	- A resuscitation officer has been contracted by ELFT spending one day a month in each directorate and has been in post since October 2016		Completed				
	- Since December 2016, the Bedford ward has put in place a twice daily environmental check of the		Completed				

Serious Incident Reviewers To Complete			Managers To Complete			Action Plan Reviewer To Complete	
Issue Identified (Reference to Contributory Factors and Root Causes)	**Recommendation**	**Level of Recommendation (Individual Team Directorate Organisation)**	**Actions To Be Taken**	**By Whom**	**By When**	**Outcome**	**Completion Sign-off**
	ward for contraband items and additional spot checks						
	- Following this incident, the Deputy Director of Infection Control and Physical Health Lead Nurse immediately arranged for a supply of bag valve masks to be delivered to the ward		Completed				
	- Since 20.01.17, patients are now being signed in and out of the ward by nursing staff and clinical support workers who are routinely checking them for items such as carrier bags and aluminium cans		Completed				
	- Staff on the ward are participating in the following Nurse development programmes: - Band 2 Development Programme running from January to March 2017 - Band 4 Development Programme running from January to March 2017 -Band 6 Development Programme running from January to March 2017 -Band 5 Development Programme is due to commence in April 2017 and nurses from the ward		Dates as given				

Serious Incident Reviewers To Complete			Managers To Complete			Action Plan Reviewer To Complete	
Issue Identified (Reference to Contributory Factors and Root Causes)	**Recommendation**	**Level of Recommendation (Individual Team Directorate Organisation)**	**Actions To Be Taken**	**By Whom**	**By When**	**Outcome**	**Completion Sign-off**
	have been put forward for this. -The Deputy Director of Nursing has ensured that these development programmes contain modules on physical health care						
	-All ELFT band 6 and above senior inpatient nurses are required to attend annual immediate life support (ILS) training. Since January 2017 it has been agreed that in stand-alone units all staff band 4 and above will be trained to ILS level. Seven nurses from the ward undertook Intermediate Life Support Training on 11.01.17. Further training dates are currently being arranged with the aim that all staff at Band 4 and above will receive this training as the two adjacent wards comprise a stand-alone unit		Commenced January 2017 and ongoing				
	- The Deputy Medical Director for Luton and Bedfordshire is convening and chairing a Physical Health Strategy Group for the two directorates. The first meeting took place in		Commenced February 2017 and ongoing				

Serious Incident Reviewers To Complete			Managers To Complete			Action Plan Reviewer To Complete	
Issue Identified (Reference to Contributory Factors and Root Causes)	**Recommendation**	**Level of Recommendation (Individual Team Directorate Organisation)**	**Actions To Be Taken**	**By Whom**	**By When**	**Outcome**	**Completion Sign-off**
	February 2017 and the group will meet every two months						
	- On 28.02.17, a presentation was delivered to the Bedfordshire CCG on measures taken within the directorates to address the physical health of service users and identifying next steps including addressing the gaps in physical healthcare provision for ELFT service users		Completed				
	- As of 13.03.17, it has been agreed by the Bedford Ward that all visits will take place as far as possible in the ward dining area which is provided with soft furniture and tea and coffee facilities and with good visibility for nursing staff		Completed				
	- From 02.04.17, a Band 7 Physical Health Nurse will be in post to support the Bedford and Luton Directorates		Commencing 02.04.17				
	- A proposal is due to be resubmitted to the April Meetings of both the Bedford and Luton Directorate Management		Agreed for April 2017 DMT meetings				

Serious Incident Reviewers To Complete			Managers To Complete			Action Plan Reviewer To Complete	
Issue Identified (Reference to Contributory Factors and Root Causes)	**Recommendation**	**Level of Recommendation (Individual Team Directorate Organisation)**	**Actions To Be Taken**	**By Whom**	**By When**	**Outcome**	**Completion Sign-off**
	[redacted]						
	- The borough director has agreed that diabetes training will be delivered in April and May to all wards in Bedford		Dates as given				
	- The ELFT Diabetes Nursing Team has written a protocol for the management of hyperglycaemia which will be ratified at the next Quality Committee Meeting on 19.04.17		Dates as given				

Appendix 2

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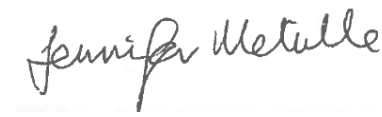

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