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Patricia Harding
Senior Coroner
Mid Kent and Medway

6th May 2016

Dear Madam,

Response to Regulation 28: Report to prevent future deaths (1)

I am writing in response to the Regulation 28: Report to prevent future deaths (1) to set out the actions taken in response and additionally proposed to be taken following the death of Lillian Hursall.

The Matters of Concern are:

1. The mechanism to hold the cotsides (bedrails) in a vertical position comprise a retaining bolt in a sliding vertical rail which engages with a corresponding hole in a static rail. Whilst the mechanism operates safely when the mechanism is properly engaged which is established by an audible click, staff at the care home had experienced occasions when the cotsides retaining button had not been fully engaged when the cotside had been raised to prevent a resident falling from bed rendering the cotside unstable and at risk of lowering inadvertently.
2. Nursing and healthcare staff moved a patient onto her back and placed a pillow under her head when the patient had suffered a significant uncontrolled fall onto her face and the extent of her injuries had not been assessed. It was known at the time that this happened that she had suffered a head trauma as she had a bleeding injury to her forehead, she had additionally suffered a subdural haematoma and had fractures to her cervical vertebra.

Having considered the findings of the coroner we have taken the following actions immediately:

- A programme of re-training in first aid has been commenced and will be completed by the 1st June 2016. The training is delivered via City and Guilds accredited learning and via a competency based workbook for all the care staff, this is monitored for compliance by the Head of Quality and Compliance.
- A programme of moving and handling re-training has been commenced and will be completed by the 1st June 2016, this is carried out in the blended approach of e-learning and via competency based workbooks for all staff delivering care.
- A programme of health and safety retraining has been commenced and will be completed by the 1st June 2016. This is been done via City and Guilds accredited training and competency based workbooks which are independently invigilated.
- A thorough system of bedrail audits has been introduced to ensure all bedrails lock with an audible click into the safety bracket. This entails an audit via the maintenance operative to check for safety and security which is then rechecked by the home manager.
- Staff have been re-educated in bed rail use in order to ensure the locking mechanism is properly engaged. This was done via a process of direct supervisions.

- Staff have received health and safety briefings in daily meetings to reiterate the potential dangers of not ensuring bed rails are locked in position. This is recorded via staff meeting minutes and direct supervisions.
- All staff have been advised that following a fall no person should be moved until a full assessment by a suitably trained person has been carried out.

Should the coroner require additional information in respect of the actions taken or planned please do not hesitate to get in touch with me.

Yours Sincerely

[redacted]
Chief Operating Officer
For and on behalf of Ranc Care Homes Limited