Regulation 28: Report to Prevent Future Deaths

Purpose

The purpose of this document is to outline the actions that will or have been implemented to address the Matters of Concern identified by Ian Singleton, Assistant Coroner for Wiltshire and Swindon; as an outcome of the inquest into the death of Mr William Edward Marson.

Background

An investigation was held into the death of William Edward Marson who was a resident at Sutton Veny House Nursing Home during 2015. The Assistant Coroner determined as an outcome of hearing witness evidence at the inquest that there were several areas of concern, these included:

- The staff on duty had not been adequately trained if at all in the use of the ventilator.
- The staff were not aware of the existence of a User's Manual or its location.
- The information printed off from the User's Manual did not include details of how to determine whether the ventilator was functioning correctly or how to recognise and rectify faults.

The Assistant Coroner therefore determined that further action needed to be initiated by Sutton Veny House Nursing Home to ensure the safety of residents in the future.

This document therefore outlines the current position and actions that would be initiated in the event that a resident required either specialist equipment or interventions to support their medical condition or care needs in the future.

Current Position

There are currently no residents within the home who require assisted ventilation or other equipment that could be categorised as outside of the normal range that one would expect to find within a Nursing Home.

The home also has a new Home Manager who understands the importance of ensuring that the staff within the home attain the requisite level of clinical competence required to deliver safe and effective care to residents.

The Home Manager regularly monitors and audits the standard of care delivery against a suite of specified corporate audits to ensure that high quality care is maintained.

The Home Manager in collaboration with other members of the Sutton Veny House team has developed an ethos of continuous quality improvement to ensure that all aspects of care are reviewed on a regular basis. Team members are encouraged to make recommendations on areas for improvement and actively participate in supporting implementation into practice.

The quality and comprehensiveness of the resident's initial and ongoing assessment and care plan documentation has been improved. The Deputy Manager audits the contents of these documents on a monthly basis and also advises and supports her registered nurse colleagues in the development of their skills in this area.

The workforce establishment and skill mix within the home has been reviewed, revised and membership of the team has been refreshed.

Team members are encouraged to participate in further development of their knowledge and skills and update training / education. There are several initiatives within the home to support knowledge and skill development including individual registered nurse team members assuming lead responsibility for a specialist area of clinical interest, Display of Education Topic of the Month information, apprenticeships, Care Certificate and NVQ training for care team members as well as online and delivered mandatory / statutory training. All team members receive regular supervision and monitoring, support and feedback relating to their work performance.

Future Process for a Resident Requiring Specialist Intervention.

In the event of a resident either being admitted or unexpectedly requiring specialist intervention then the following process would be initiated:

- A comprehensive assessment of the stability of the resident's medical condition, the feasibility of meeting their care and specialist intervention management needs safely within the home environment would be conducted.
- A medical management plan would be established with the GP or the resident's specialist medical consultant detailing the parameters for safe working associated with the specialist intervention, trigger alert factors and associated escalation plan.
- The GP would be requested to flag on their system that the resident was receiving a specialist intervention to alert other members of the practice and / or Out of Hours service if they receive a call from the home for advice or assistance.
- A detailed care plan outlining the care and management of the resident and any equipment relating to the specialist intervention would be formulated which would also include the parameters for registered nurse and care team member's involvement in the management of the resident. This care plan would also include sign posting information to the relevant resources available to the practitioner to support safe management of the resident.
- The resident would not be admitted until all appropriate team members had received training in the use of the equipment. This would include normal use of the equipment, hints and tips for addressing minor faults, contact details if there was a major problem with the equipment and contingency arrangements to keep the resident safe during a major equipment failure event.
- If the resident was already residing in the home then a risk assessment would be conducted to ascertain the safety measures that would need to be implemented to support the resident whilst the team were trained. This may include the resident having one to one support from a specialist until such time as the team were trained and deemed competent.
- A named specialist would be identified to support team members until they were competent and confident in the use of the specialist equipment.
- Evidence based clinical competencies associated with the management and use of the equipment would be adapted and adopted for use with the specific resident and utilised for assessing the competence of individual team members.
- A list of team members authorised to operate the equipment or manage the specific specialist intervention would be formulated and displayed in the Nurses Station and the Managers Office to provide easy access to this information for other team members or health care professionals from the wider healthcare community.
- 24 hour contact details for specialist support would be obtained and documented in the resident's Care Plan and Room Folders as well as on the residents Care Docs record. If appropriate this information may also be attached to the equipment in use.

- An on call rota of senior team members familiar with the use of the equipment would be established to support more junior team members with queries, issues or support in the use of the equipment.
- A user friendly version of the equipment manual as well as the full manual would be devised and team members would be notified of the location of these documents. The location of this information would also be documented on the residents electronic and hard copy records.
- The settings or range of settings would be clearly displayed in the residents room folder and an associated record signature sheet for checking the settings would be formulated and placed in the residents room or if required in an equipment specific folder in the residents room.
- A risk assessment would be devised and a copy placed in the resident's room folder as well as in the homes main risk assessment folder.
- Policies and procedures relating to the use of the equipment would be formulated if there were no generic ones from the manufacturer of the equipment that could be adapted and adopted for use within the home.
- Clinical best practice evidence would be sourced and displayed on the Homes Education Board and may also be supplied to individual team members if deemed appropriate.
- All team members would be encouraged to raise any concerns or issues they had encountered with use of the equipment in the regular team meetings, handover sessions or directly with the Home Manager.
- The Home Manager in partnership with senior clinical colleagues within the team as well as relevant members of the medical team, equipment supplier representative, the resident and family would monitor and conduct regular reviews and revisions to the residents management to ensure that the resident continued to receive safe and effective management and care delivery.

Process Implementation

It is anticipated that implementation of this process will serve to prevent a repeat of the issues and address the concerns that have been raised by the Assistant Coroner for Wiltshire and Swindon associated with the care that Mr William Edward Marson received during the evening of the 18th June 2015.

As an organisation, Avon Care Home is committed to providing excellent care and is disappointed that during the events of that evening the care of Mr Marson did not meet the high standards that are expected for the group's residents.

The learning from this incident will be shared with the Home Managers from all the homes associated with the group at a Home Managers meeting scheduled for the 14th December 2016. Immediately after this meeting it will be expected that the process detailed above is communicated and implemented across all Avon Care Homes. A process checklist and flow chart will also be formulated for use to support the future planning for any resident requiring specialist intervention or management who may be admitted into any of the group's homes.

The flow chart will be displayed within each home in a suitable location for easy access to all senior team members as a quick and simple reference relating to the process. Copies of the checklist will be made available to all Home Managers following the Home Managers meeting in December.