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Ms Katy Skerrett
HM Senior Coroner for Gloucestershire
Gloucestershire Coroner's Court
Coronium Avenue
Barnwood
Gloucester GL4 3DJ

05 May 2017

Dear Ms Skerrett,

Daphne Cherry deceased – Prevention of Future Deaths report

We write further to your letter of 15 March, 2017, and in particular the Prevention of Future Deaths report issued following Mrs Cherry's Inquest. As you know, Care UK had already put in place a number of changes following Mrs Cherry's death but welcomes the opportunity to consider further improvements.

We note that you are concerned whether staff at Sandfields Care Home are able to identify when a medical concern should be escalated and a review sought. The actions we have taken are as follows.

As a preliminary point, Sandfields employs a number of registered nurses and there is always at least one on duty at any given time. As the Coroner will be aware, nurses undergo extensive professional training which would cover recognition of the clinical symptoms exhibited by a deteriorating resident. Care UK has nonetheless taken further action both to supplement this professional knowledge of our nurses, and also to train the rest of the Sandfields staff (including those who are non-clinically trained) in recognising deteriorating residents.

The home manager, deputy home manager and the home's unit leaders have all undergone training in *'Early recognition of the sick and deteriorating patient'*, which has been provided by the Care Home Support team based at Gloucestershire Care Services NHS Trust. In essence, they are an NHS service funded jointly by Health and Social Care, and they provide education and training to care homes across Gloucestershire. They work closely with key stakeholders in the sector, including the CQC and CHC. We enclose a link to their website, should the Coroner need any further information:

https://www.glos-care.nhs.uk/our-services/specialist-care/care-home-support

We are awaiting further dates for training sessions to be released by the Care Home Support team, and as soon as they have been made available then all shift leaders will be booked onto upcoming sessions. We expect the dates to be released in the next couple of weeks.

Alongside this, and in order to augment the training, the unit leaders have been specifically tasked, in conjunction with the Care UK governance team, with cascading the principles of the

training to the shift leaders. This is to ensure that staff are brought up to speed as soon as possible, and not simply waiting for the further Care Home Support training dates. Unit leaders will meet with shift leaders on a one-to-one basis to take them through the principles. These meetings are to have taken place by 15 May, 2017. Once this phase is complete, one of the unit leaders will also be responsible for training the remaining care home staff. This process will be completed by the end of June 2017 and will capture all staff working in the home. The principles will also be reinforced on an ongoing basis as part of individual staff supervision.

The net result of the above actions is that all staff within the home will have received training in recognition of deteriorating residents by the end of June 2017. We have not limited this process to clinical staff, as we consider it is important that all staff are able to recognise an unwell resident and understand what to do.

In terms of the training itself, it includes an escalation numbering system to alert staff to the seriousness of the resident's condition, otherwise known as the 'National Early Warning Score', (or 'NEWS'). This provides an algorithm by which six physical parameters are measured and given a score. The overall score then provides staff with a clear indication as to what type of response is required to each clinical scenario, so whether this is a call to the 111 service, a GP or an ambulance.

The training also incorporates understanding "SBAR" - i.e. Situation, Background, Assessment and Recommendation. This is an action list used as an aide memoire for staff relating information to 111/GP services. Sandfields keeps a copy of the list next to the telephones so that it prompts staff when they are speaking to other medical teams. It encompasses:

S - Situation (a concise statement of the problem)

B - Background (pertinent and brief information related to the situation)

A - Assessment (analysis and considerations of options — what you found/think)

R - Recommendation (action requested/recommended — what you want)

We recognise that it is important to also monitor the efficacy of training and knowledge-building, and this is the responsibility of the home manager and deputy home manager. One of them will be on duty at any one time, including evenings and weekends. There is therefore 24/7 management coverage. As we mentioned above, there is also always a nurse on duty.

In order to check that staff are responding appropriately to resident's clinical needs, it is their responsibility to discuss unwell residents with the manager or the deputy during daily meetings and walkarounds. This includes an outline of the clinical presentation, and the actions taken by that member of staff in response. If it is during the weekday core hours, then staff should approach the manager to discuss a resident. If it is during the evening or early hours of the morning then they should escalate to the nurse in charge who, in turn, is expected to contact the on-call manager if unsure about what to do. At weekends, the on-call manager telephones the home to discuss unwell residents in order to ensure appropriate actions have been taken.

This process provides effective scrutiny of the staff's decision-making, and reinforces any learning points. It is effectively an ongoing audit process, to ensure safe care to residents. It is not an additional step in the process which might cause delay as staff have to check with us before taking action. It is about oversight of the decisions that have been made by staff, and if there is an emergency then they are expected to contact the appropriate services without delay.

In addition to the Coroner, we have also been liaising with the CQC in relation to the changes which have been made within Sandfields. In particular, we outlined those changes described above and we received correspondence in response from our local CQC inspector, Vicky Dale, on 4 May 2017, stating that:

"I have made a note of your comments and can see that action has been taken to ensure staff are skilled and competent to recognise and escalate concerns when a person's health deteriorates and that processes have been implemented to support the staff training and expected standards of care."

We are therefore confident that we have implemented a robust series of improvements, which will result in staff understanding and responding to the clinical needs of an unwell and deteriorating resident.

Yours sincerely,

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Sandfields home manager