Response to coroners concerns Nuffield

Mr Farrington passed away on the 21st June 2016 which is some 18 months ago now.

We have initially provided evidence from external agencies of the changes that have happened in this time and then specifically answered the questions raised following the inquest.

We believe that the evidence provided shows that following the improvement plan there are now structures and processes in place to avoid such situations and that these are now embedded in the culture of the home.

In the period following June 2016 there has been a considerable amount of work completed with the Surrey Downs Clinical Commissioning group and their report from 2017 states the following;

On the day of the visit we sampled 3 care files, one of which was the deceased and part of the LSE. The focus was on Wound and Tissue viability within the care plan.

We looked at:

- Wound Care plans
- Wound continuation monitoring charts
- Tissue Viability Care plans
- Tissue continuation monitoring charts

We were told and shown by the manager that the home operates a computerised system to record care plans. The wound and tissue care plan are generated from the computer programme. Both the wound and tissue continuation monitoring charts were written by hand.

The home manager explained the home would complete a wound and tissue viability care plan if the skin was broken and if a dressing had to be used. Wound and tissue continuation monitoring charts would be in place to monitor the area, and to demonstrate that correct treatment had been given in line with professional recommendation that would appear within the care plan.

On one file there were 4 wound care plans in place. They had been regularly reviewed, hence there were several versions for the same wound. The care plan had been updated either when the wound had changed its grade or if a professional such as the tissue viability nurse had visited.

A follow up visit was made on 17th October to look at the improvements made around Care Planning in relationship to Wound Care.

The wound care plans had greatly improved the information was well laid out and there was clear instructions to staff how any wound needed to be treatment and what materials to use.

We were shown a folder that was well presented of all the wounds including pressure sores and skin tears on the top unit.

The home had put in place a formal wound assessment plan that gave staff an aid memoir to all the areas they should be considering when recording progress of a wound.

We were able to see an audit that the manager had completed looking at all the wound care plans.

We were also inspected by CQC on the 12th July 2017 and their inspection report states:

"there were up to date risk assessments in place for those who may be at risk of falling or developing pressure sores. These were reviewed regularly. One person who was at risk of developing a pressure sore had been placed had been placed on an air mattress to reduce the likelihood of this which was regularly checked. Incidents and accidents were now being reviewed and action taken to address and regular patterns or trends that may be identified.

1,

a) Since this time we have put in place a new auditing system with close support from the local quality development team from East Surrey, this has been developed over the past year and has been met with positive feedback from the local team.

   The manager carries out weekly wound audits which are then audited monthly by the General manager. There is also a monthly managers audit which includes care plans and this ensures that the care plans are current relevant and evidence based, any issues identified then lead to an action plan that is audited during the next month.

b) As part of the monthly audit completed by the manager and sent to the senior management team who then audit this using random samples during very regular visits the daily recordings such as care notes and turning charts are checked for accuracy and relevance.

c) The information given to cqc was that the tissue viability nurse had been involved and the measures described above are in place to ensure that the advice given is followed or that clear rationale is given when there is a departure from the advice, (in this instance we would be asking the relevant professional to endorse the changes or departures made).

d) The auditing process that has been actioned since these events are part of the process to ensure that advice given is followed or clear rationale given when other methods are employed.

e) Part of the audit process is reviewing care plans and would ensure that the action given in the care plan is followed.

2, There was no tissue viability nurse for an extended period of time which was not acceptable there had not been any acceptable replacement provision provided. In future the service will give consideration to raising this as a safeguarding concern.

3, We would not be able to dictate what action cqc will take but the governance improvements we have put in place are designed to ensure that the care provided is based upon evidence and has been audited by both the staff within the home and the SMT.

4, When CQC are carrying out an inspection they always ensure that there is a sign displayed for families and visitors to make them aware of the inspection.

Staff are aware that when discussions are held with family members this should be documented in the appropriate notes to provide evidence that this has occurred and further it should also be documented if the service user has indicated that they do not wish for any information to be shared.

5, We were asked for and provided a chronology of events, at no point were we asked for anything further by Surrey Adult Safeguarding. We did not initially carry out an internal investigation as we would usually be advised not to while any further investigations such as police investigations or open safeguarding reviews are completed. It is standard practice that this would be the case, however the increased governance processes we have put in place has been designed implemented and reviewed successfully to avoid similar situations in the future.

It is to be hoped that the change in processes within the local authority will mean that in future where appropriate families will have an increased involvement but this is not something we would be able to action.

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