Accurate Document

Avenue House
NURSING & CARE HOME

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24th May 2018

Dear Ms A. Pember & Mr H. Shah

Thank you for your report in relation to the death of Mrs Rich. I outline below our response to your matters of concern and what actions we have already taken in relation to them:

A) Our pre-assessment was completed by a previous manager and we believe it is likely that the previous falls were not disclosed to her at the pre-assessment stage prior to Mrs Rich's admission. In addition, there was nothing in Mrs Rich's pre-assessment or care plan to indicate that the family had ever informed the home of Mrs Rich's previous falls. Ultimately we have to rely on the honesty and full disclosure by residents (if they have capacity), relatives and other professionals.

B) The management of the home followed the company's policy about making a referral after three falls (that it was aware of). We believe the company's policy is reasonable and is common across the care home industry. However, if the home had been informed of Mrs Rich's previous falls, and her previous referrals to the falls team, the home would have referred Mrs Rich sooner under this reasonable and balanced policy. The Coroner should also note that the home has recently referred residents, who have had 3 or 4 falls to the Falls Team, and even after this number of falls, the Falls Team have made the decision not to get involved in the management of these residents' falls.

C) The management of the home completed the falls risk assessment and action plan and sent this by post, albeit not by the fax facility. There was a copy of this in the resident's file for reference. There was no information in the resident's file to say that the falls team hadn't received this information. Mrs Rich had also been referred to the Falls Team prior to admission to Avenue House and again this was not followed up by the Falls Team. Once falls risk action plans are received by the falls team, they do not typically give the home even a rough estimate of how long it will be before it is followed up and the resident is seen. Therefore the care home simply has to wait for the Falls' Team's input.

Although we believe we followed normal and reasonable procedures in this case, in future to further mitigate against shortcomings of the Falls Team, we will contact the them after sending them referrals and action plans. This will be done to ensure that the Falls Team have received them and to find out what action they intend to take. All contact will be recorded in our residents' care plans under the visiting professionals' information section.

D) The home was never recommended to put in place any additional equipment for Mrs Rich, such as a bed sensor mat. However, despite most of Mrs Rich's falls not being when she got

out of bed, she did have a sensor mat on the floor by her bed, which did alert staff if she was up and walking around her bedroom. A floor based sensor mat is the normal equipment used in care homes for residents at risk of falls. Bed sensor mats are extremely rare and we believe do not offer any advantages over floor based pressure mats. Mrs Rich also had falls in the communal areas of the home and unfortunately no equipment could safely be used to reduce the likelihood of these. However, staff were aware of her high falls risk, and did monitor her when mobilising independently with her frame.

I hope you will deem the above responses and proposed actions reasonable in the circumstances. Please don't hesitate to let me know if you need any further information.

Yours sincerely

[redacted]
Peripatetic Support Manager