Ms Rachel Syed
HM Assistant Coroner,
Manchester West
HM Coroners Court
Paderborn House
Howell Croft North
Bolton
BL1 1QY

Our reference:	SBaker/R28
Your reference:	RRS/SBR/S.BAKER
Please ask for:	Joanne Willmott
Extension:	89451
Direct line:	01942 489451
Date:	27th January 2020

Sydney Baker - Deceased

Dear Ms Rachel Syed

I write to you in response to your correspondence dated the 2nd December 2019 regarding Sidney Baker – Deceased, and the enclosed Regulation 28 report to prevent future deaths.

Sidney Baker was a resident at Barley Brook, a residential care home delivered by the provider Rosewood Healthcare Group. Wigan Council purchase services from the provider on a spot purchase arrangement.

Wigan Council is responsible for quality assuring the care homes delivering services within the Wigan borough. The Council has a team of Quality Performance Officers who perform proactive visits to services, which can be either announced or unannounced. They will also investigate any complaints and support any Section 42 safeguarding enquiries.

The concerns identified in your Regulation 28 report closely reflect concerns highlighted and addressed during the Section 42 safeguarding enquiry and subsequent case conference. This being the case I would like to demonstrate that Wigan Council have acted in accordance with the Care Act 2014 to support the provider in making necessary changes.

On the 12th August 2019 a case conference took place following the Section 42 safeguarding enquiry. The outcome of this case conference resulted in the development of a protection plan which clearly defined Wigan Councils expectations regarding several aspects of the service delivery at Barley Brook, including those raised within the Regulation 28 report. Wigan Council have monitored the service delivery against the documented actions to ensure that the concerns have been addressed.

We write to assure you that such changes have led to improvements within the provider's service resulting in better care and support and contemporaneous record keeping.

Please reply to: Joanne Willmott
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Between the 11th July 2019 and 16th January 2020, a total of 9 monitoring and support visits have taken place at Barley Brook. This involves the Quality Performance Officers from Wigan Council visiting the service and scrutinising service delivery and making recommendations to ensure that the service is not only compliant with the Care Quality Commissions regulations but that best practice and innovation is instilled into all areas.

The concerns raised in the Regulation 28 Report are as follows:

Concern 1: There were no contemporaneous documents that a Dieticians or a Falls Team referral had been made by the Care Home personnel in question.

Concern2: There were concerns that entries contained in Mr Bakers care plan were incorrect, including vital information contained on his weight monitoring sheet. Furthermore, the general quality of record keeping was poor.

We can confirm that the following actions have been taken to address both concerns as follows:

Council's considerations and investigation:
Following Mr Baker's death, several monitoring and support visits took place at Barely Brook. We considered a sample of referrals that had been made in respect of current residents. Wigan Council can confirm that the recording of referrals of any kind (including dietician and falls team, and referrals to the Later Life and Memory Team) has improved. Barley Brook has demonstrated they are now keeping contemporaneous records and documentation.

Body map charts are now included in residents' rooms to complete should an incident occur. This ensures body maps are contemporaneous and not completed retrospectively.

Sending referrals via fax:
Where a referral is sent via fax, the referral form is signed and dated at the point of submission. Following this a phone call is made to ensure that it has been received by the intended recipient. A copy is held on the individuals file and the action of a referral being made is appropriately documented in the persons health professionals log within the Care Docs system at the time the referral is confirmed as being received. It is the dietician service that requires referrals to come through via fax. Other supporting health services will accept referrals via email, in these instances a copy of the referral is printed off and held on the individuals care file and is complimented by adding to the the individual's health professionals log.

Such actions ensure a comprehensive chronological log of all health professional liaison and interventions. The Care Docs system contains several filters that can be applied by the person using it. This functionality assists the Registered Manager, Regional Manager and provides the aligned Quality Performance Officer with a platform that is easy to review and audit.

Safeguarding referrals:
The Registered Manager has become more proactive in ensuring safeguarding referrals are submitted to Wigan Council, which includes falls, both witnessed and unwitnessed. If a person has fallen, witnessed or unwitnessed and no injury has been sustained the provider is still required to submit a Tier Two referral to their Quality Performance Officer.

A referral will detail what has happened, the initial response to the incident and the plans put in place to mitigate the chances of reoccurrence. The Quality Performance Officer will then respond to the referral with any recommendations and further actions and look at previous referrals to identify patterns or trends. The requirement to comply with this process has been reinforced with the manager at Barley Brook to ensure comprehensive and consistent implementation.

Unfortunately, the process had not been followed in Mr Baker's case but the above demonstrates that steps have been taken to ensure this omission does not occur again.

Wigan Council have offered training to the provider to support with this process. The staff at Barley Brook are due to receive "Tier Training" from Wigan Council which all staff will be taking part in. This will assist the staff moving forward in ensuring that referrals are made in a timely manner and incidents are recorded contemporaneously on a resident's records. Wigan Council will monitor attendance at the training and the impact that this has on practice.

The Registered Manager has demonstrated that they undertake a monthly falls audit to identify trends and patterns across falls that have occurred. Her review considers the time of day the falls have taken place, the activity taking place at the time of fall and location. Following this audit, the Registered Manager will consider the actions required, which may include a referral to the falls team.

I can confirm that since the 24th June 2019 to present a total of seven referrals have been made specifically relating to falls which demonstrates the positive action taken and further understanding of the importance of record keeping.

Weight monitoring and documentation:
The Deputy Manager at Barley Brook is the person responsible for recording and documenting information regarding weight monitoring and management. All residents at Barley Brook are routinely weighed on a monthly basis. Weighing may take place more frequently if required by an individual's care plan. The Registered Manager during a monthly audit routinely checks that weight monitoring is up to date and recorded appropriately. Documenting a new resident's weight is also part of the admissions process. Should a person's weight drop significantly, a referral will be made to the dietician team as appropriate when considering a resident's MUST score.

Wigan Council looked at a sample of care plans during support visits which took place on 26.09.2019, 10.10.2019 and 16.01.2019. Upon considering the plans, Wigan Council are satisfied that the provider uses the individual's weight to inform their MUST score (Malnutrition Universal Screening Tool). This enables the Deputy Manager to identify and categorise a resident's risk status as either low, medium or high. The Deputy Manager will make the necessary referrals and undertake the appropriate actions aligned to each score.

The referral and documentation processes have improved.

After considering a sample of care files during support visits, Wigan Council can confirm that the provider has also undertaken other actions such as revised the supplementary care chart. This is used to monitor an individual's food and fluid intake. The charts are completed first-hand by the care staff that have been supporting individuals with mealtimes and is completed after each meal to ensure that records are both factual and contemporaneous.

The charts do not simply say 'ate full meal' or 'drank two cups of tea'. It is specific in the amounts eaten and drank and includes guideline intake amounts. Other supplementary care charts have been reviewed also including but not exclusive to positional changes.

The recording of any care delivery or significant events is now performed by the individuals delivering the care and support. Records are no longer solely updated by Senior Carers on site. This reduces the risk of inaccurate record keeping and ensures the recording of information is contemporaneous as the records are updated at the time incidents and events occur by the person who is witness to the event or incident.

All care staff now have access to the online Care Docs system used by the service and each staff member has their own log in details.

Entries are both digitally stamped with the persons log in ID, time and date.

During Wigan Council's support visits on 26.09.2019, 10.10.2019 and 16.01.2019, several care plans were analysed, and Wigan Council can confirm that record keeping has improved due to the above actions being taken and implemented.

During our support visits to the service we have considered a sample of the monthly care plan audits performed by the Registered Manager. These audits show that weights are being monitored and recorded appropriately. The Regional Manager also audits a sample of care plan files during their monthly visits to the service. The above ensures a triple layered approach to quality assurance and scrutiny of practices within the service.

Wigan Council consider that the above actions demonstrate the provider's commitment to ensuring contemporaneous record keeping is consistent and care plans accurately reflect the care that an individual requires.

Training:
We visited the provider on 16 January 2020 and scrutinised the training programme at Barley Brook. Wigan Council recommended that the provider sources training for all staff in both effective record keeping and dementia and nutrition. Wigan Council consider that such training is necessary to ensure that all staff team members recognise the importance of good record keeping, their role within this and the what the consequences of poor record keeping can be. The training in relation to dementia and nutrition will provide staff with a deeper understanding in order to deliver a more person-centred service. The training will provide learning such as how dementia can affect a person intake including managing weight loss, changes in food taste and preferences that can occur and methods in which to increase a person's intake. The response to these recommendations will be monitored by Wigan Council to measure the uptake and impact that learning has had on service user experiences.

Conclusion

Moving forward Wigan Council will continue to monitor, support and constructively challenge the service delivery within Barley Brook to ensure that individuals residing within the services do not share the experiences of Mr. Sidney Baker.

Specifically, we will continue to monitor the changes that have taken place as detailed above. This includes monitoring the effective record keeping and ensure that referrals made in a timely manner to supporting health professionals are effective.

We will be coordinating bimonthly monitoring visits aligned with the visits of the Regional Manager for the next six months; this will ensure that the quality and positive steps taken continues.

The Care Quality Commission have recently inspected the service. The inspection report has yet to be published but upon publication we will review its content and scale our support to the service accordingly.

I have endeavoured to provide you with as much detail as possible regarding both actions already taken and actions to be performed moving forward but should you require any further information or have any questions regarding the above please do not hesitate to contact me.

Yours sincerely

Joanne Willmott
Director of Homes and Communities
Wigan Council