PrimeLife

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M/s Vanessa McKinlay, HM Assistant Coroner for Birmingham and Solihull
Coroner's Court Steelhouse Lane Birmingham B4 6BJ

By email only to: [redacted]

20 April 2022

Dear M/s McKinlay

Regulation 29 Response to Regulation 28 of the Coroners (Investigations) Regulations 2013
Report to Prevent Future Deaths- Tanworth Court Nursing Home

We make this Regulation 29 response to the Regulation 28 Report to Prevent Future Deaths, received on 22.02.22. We understand the response must contain detail of action taken or proposed to be taken, setting out a timetable for action. Otherwise we must explain why no action is proposed.

We address each MATTER OF CONCERN below.

1. ***Tanworth Court Nursing Home staff reported to the hospital that Mrs Spiby became distressed and ran into collision with a wall when trying to leave her room, before falling to the floor. The origin of this account was unclear from the evidence. No record was made of the incident in the nursing records.***

The following actions have been taken to improve the accuracy of nursing records and reinforce good practice in the recording of incidents within nursing records.

- Defensible Documentation Training for Registered Nurses initiated by Nurse Advisor [redacted]. Training included: NMC Code, Accountability, Effective communication, Examples of good and poor documentation, NMC Hearings and clinical negligence. Training was planned in to be completed by 15.4.22 and actions have been completed with all Tanworth Court nurses.
- Further competency checks are being conducted to ensure continued learning. This will be completed by the nurse advisor/trainer on a regular basis (weekly at present) and will cover a period of 3 months or longer if issues arise from the competency checks. Competency checks will only be ceased if the advisor/trainer is confident that the information has been retained and good practice demonstrated.
- Training to be given to all staff (including nurses) around clear and concise documentation, record keeping training to be re issued (all completed by 18.3.22), the record keeping and documentation policy has been re-issued to all staff via the Relias training system. Training delivered by an external training provider and this was conducted and completed by 18.3.22, by all care staff. The Home management team review nursing records daily and record their

findings on the daily walk around document which also encompasses reviews of all supplementary documentation.

- Any shortcomings in documentation are addressed immediately by the home management team. Conversations with staff are formally recorded within supervisions and any disciplinary action taken, as necessary. Where there is non-compliance found the staff members will be given supervisions and learning sheets will be completed with them to encourage adherence to best practice. Actions in this regard were completed by 18.3.22 as planned.
- Daily spot checks by management of documentation and record keeping are being completed, and recorded to ensure the level of detail is correct. All information contained within the daily records (nurse records and any records made of information pertaining to service users) is triangulated with other supporting documents such as food and fluid charts, incident forms etc. This is applicable to both the nursing and wider care records.
- Monitoring of the documentation is undertaken at the commencement of the day shift (around 8am) and at around 4pm with regular spot checks also being undertaken during the day. This process of monitoring will continue long term and become part of each day's routine activities.
- All nursing and care staff to be aware of Prime Life Accident/Incident Policies and Management of Falls Policy- evidence to be if staff have read and understand these policies. Actions to be completed by 11.4.22 and timeframes met.
- Falls Management including Head Injury Training for all nurses. Training to be delivered by the nurse trainer/advisor and to include: Body Mapping, vital observations including Neuro-observations, ReSTORE2(NEWS2), Accident/Incident forms, care plans, risk assessments, daily notes, communication record – MDT and reducing the risk of falls. Actions to be completed by 22.4.22 (slight amendment to the original action plan in place due to annual leave and sickness amongst the nursing team) with the exception of the clinical lead who is currently on long term sick.
- Falls prevention training to be given to all care staff to aid identifying risks associated with falls, how to minimize the risk of falls and how to support the clients involved in such incidents. Training to be completed by all care staff by 22.4.22 (slight amendment to the original action plan in place due to annual leave and sickness amongst the nursing team). with the exception of the clinical lead who is currently on long term sick.
- Training to be completed with all care staff on how to effectively complete an ABC chart, appropriate assessment of the situation and how to share the information with nurses and senior management. Training to be completed by all nurses by 22.4.22 with the exception of the clinical lead who is currently on long term sick.
- Upon the clinical lead's return we will prioritise the training required for the clinical lead to be completed.

2. No incident form was completed.

The response to point 1 of the MATTERS OF CONCERN provides the majority of our response to point 2 and we refer you to the response to that point. In addition regarding the completion of incident forms we have done the following:

- Nurses to have training/supervision in Incident Form completion including body mapping. Training and supervisions to be undertaken by nurse trainer/advisor and timeframes set to 15.4.22. This has been completed by all nurses with the exception of the clinical lead who is

currently on long term sick. Upon the clinical lead's return we will prioritise the training for the clinical lead to be completed.

3. ***No investigation of the accident or the circumstances giving rise to it was undertaken.***

We have taken the following actions to emphasise the importance of investigating accidents and incidents:

- Senior management undertake daily spot checks to ensure that any incidents are identified, and any subsequent actions are noted and addressed. This is overseen by the regional operational team and home management team. The associate director for elderly services is currently supporting the home 3-4 days per week and is responsible for ensuring governance in this area. Daily spot checks commenced on 18.3.22 and continued oversight and monitoring needed in the future. Monitoring of the documentation will be undertaken at the commencement of the day shift (around 8am) and at around 4pm with regular spot checks also being undertaken during the day. This process of monitoring will continue long term and become part of each day's routine activities.
- Investigations into incidents are undertaken presently if practice within the Home meets the threshold which warrants investigation. There is in place enhanced monitoring of daily activity within the Home and this will encourage timely escalation of matters to a full investigation as necessary.
- Human Resources team to undertake training with senior management to ensure they are aware of their responsibilities with regards to investigations into staff conduct, how to demonstrate equality and fairness to employees, how to reach resolution into inappropriate conduct/competency, the options available for formal action for continued non-compliance etc. Was originally expected to have been completed by 15.4.22 but due to unforeseen circumstances, this timeframe has not been met but will be completed by 22.4.22
- New policy to be devised about how to conduct an effective investigation into poor care practice and any safeguarding incidents. Must be able to demonstrate how to conduct investigations, how to take statements, how to correlate with documentation etc. Following discussion at recent operational board meeting, this policy will be in situ and disseminated to all Prime Life sites by 30.04.22.

4. ***There was no evidence of a commitment to learning from this incident with a view to safeguarding residents in the future.***

We are committed to continually improving as an organisation and safeguarding remains at the top of our list of priorities. Please find attached actions completed to demonstrate our commitment to learning:

- Safeguarding training has been delivered by the internal quality team, this included reportable incidents, incident reports and auditing of incidents. It is now the responsibility of the regional operations team to ensure that any reportable incidents are being sent through to the local authority and other interested parties without delay. The manager's review of incident reports will be completed and overseen by the regional operational team. Training to be delivered by the providers Quality Matters Team. This initial action was completed by 25.3.22.
- Learning and practice reviews after incidents / safeguarding concerns have been completed and can be evidenced. Incident and safeguarding audits to include an action plan of any lessons learned and a clear plan of how learning and practice can be improved. These reviews will be undertaken each month by the home manager with close monitoring and

observation form the regional operational team. All safeguarding concerns will then be disseminated to the Lead Operation Director for monthly collation of the company safeguarding incidents and reflected on the monthly risk matrix which is shared with the Board of Directors.

- A new lessons learned document will be sent to each Prime Life location every month to share both good and bad practice. This will encompass any new documentation/procedure put into place as the result of internal reviews of practice across the group. This will be completed each month by [redacted], lead operational director, to commence 1 May 2022 and monthly thereafter.

Conclusion

As a Provider we are committed to continual improvement and have reflected on the circumstances surrounding the death and the terms of the report issued by the Coroner carefully. We hope that this response adequately addresses the concerns set out in the Regulation 28 report issued on 22.02.22 and demonstrates that action has been taken to address the matters raised therein with further actions in support to embed improvements in the way that care is monitored and delivered at Tanworth Court Nursing Home.

For clarity, the nurse involved in this incident and subsequent coroner's inquest, was suspended from her nursing duties at the home and has since left our employment but has been referred to the NMC for further review.

We hope that the information above in our response assists in assuring the Coroner, the family and the wider public that improvements have been made, embedded and sustained at the service to address the areas of concern set out in the regulation 28 report.

If any further information or clarification is required kindly let us know by return.

Yours sincerely

[redacted]