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Ms J Russell-Mitra HM Assistant Coroner for the County of Surrey
HM Coroner's Court
Station Approach
Woking
Surrey, GU22 7AP

BY EMAIL ONLY

28 April 2022

Dear Ms Russell-Mitra

Inquest touching the death of Michael Humphries

Response to the Regulation 28 Report – Action to Prevent Future Deaths

We write in response to your Regulation 28 Report dated 7 March 2022, following conclusion of the inquest into the death of Michael Humphries. Firstly, we would like to express once again how saddened we were by Mr Humphries' death and extend our deepest condolences to Mr Humphries' family.

Background

The inquest into Mr Humphries' death was concluded on 30 April 2021, and you gave your conclusion in court on 10 May 2021. Following conclusion on 10 May, you went on to share that you considered your duty was invoked under paragraph 7 of Schedule 5 Coroners and Justice Act 2009, but you did not at that stage say to whom a Regulation 28 report might be issued. We heard nothing further, and we were not asked to supply any further evidence, until the Regulation 28 report was received by email on 17 March 2022.

Mr Humphries passed away on 30 April 2019, and Tadworth Grove moved quickly and took action to investigate and identify how Mr Humphries came to acquire a serious pressure injury on his leg. Our own initial investigations led us to identify opportunities for learning and Tadworth Grove took immediate steps to identify lessons learned and action recommendations arising as a result of our investigation. Ultimately, the inquest concluded as a natural causes death and Mr Humphries cause of death was not linked to wound care, or the pressure injuries which he had acquired whilst he was a resident at Tadworth Grove.

Actions taken following Mr Humphries death

We wish to assure you that Tadworth Grove took immediate action following Mr Humphries death in March 2019 and has continued to improve in the areas highlighted in your Regulation 28 report.

During the inquest, evidence was heard from [redacted], who at the time held the post of Regional Director for the region, as to the actions taken and improvements made at Tadworth Grove. We have attached a copy of [redacted] witness statement which was included within the disclosure bundle.

We have also attached a copy of our new wound care re-assessment documents which further illustrates the changes that we have made, at an organisational level, and we are currently undertaking a further review of our wound care policy to incorporate relevant resources from the National Wound Care Strategy recommendations.

Response to specific concerns

We have set out below, our responses to the specific concerns your raised in your Regulation 28 Report. We should also inform you that this information on actions taken has already been shared with CQC, who, on receipt of your Regulation 28 Report, requested a response and assurances to be provided to them by 1 April 2022.

Matter of Concern 1.
T-bar cushion arrived with Michael without any information on its proper use.
Documents are poorly filled in and incorrect information has been recorded. This has made it more difficult to chart the progress of this wound**.**

Actions taken at the time and following Root Cause Analysis Investigation ("RCA"):

- Following our internal analysis, we immediately reinforced with all our staff and nurses at Tadworth Grove that it was their responsibility to obtain information and instructions for any equipment issued by a 3rd party for resident's use and to ensure that any instructions received are carried out and reflected in the care plans.
    - These communication events took the form of:
        - Meetings minutes
        - Handovers
        - Daily Huddles
        - Supervision records
        - Clinical Risk Meetings
- We reminded staff (within the meetings as above) to ensure that any instructions from visiting professionals are and were transcribed or documented within the resident care plan, and to seek medical advice immediately should they encounter any difficulty.
- The Nursing staff were reminded (within the meetings as above) that it is their responsibility to ensure that a copy of transfer notes are retained within the home when a resident is admitted to hospital.
- We re-iterated the importance of residents' feet being checked during personal care and when repositioning to ensure that feet/toes are not touching the bedboard and if necessary, the use of a bed extension to be explored.
- It was re-enforced that Residents should also be checked to ensure that they are not slipping down in the bed when the head rest is raised, where this the case, the foot of the bed can also be raised too to reduce risk.
- Nurses have received Skin Integrity Training. All the Registered Nurses at Tadworth received refresher training. If wounds are identified by Agency nurses, the Clinical Deputy or another Bupa nurse are to provide oversight and assurance by checking the grade recorded.
- Any decision by residents deemed to be unwise (by staff) should (with consent) be discussed with the Next of Kin/Residents representative to ensure good lines of communication and expectations are met (It was established that at times, Mr Humphries preferred not to be repositioned).
- An agreement was made that the care home would supply pressure relieving equipment such as "Liverpool Booties" for resident's feet if the resident is unable to reposition and is nursed on an air mattress.
- A local agreement was made for residents with pressure wounds to be included in the GP weekly round fortnightly for review unless concerns are identified before. This has already been agreed with the GP following the quarterly meeting held with the surgery on 21st May 2019.

Organisational Learnings: (including Pressure Area Care)

- All of the above actions were checked for completion and were also shared with the wider team in the region.
- As an organisation, trends were / are monitored, and lessons learned are escalated where appropriate to the organisation as a whole. The initial response within lessons learned would be to:
    - fix it first (resolution for the resident)
    - local learnings (service level agreements and change)
    - wider organisational learnings (policy and practice guidance)
- The Managing Director and Head of Operational Quality attend a monthly quality review with the Director of Risk & Governance and Operations Director to provide assurance regarding oversight and actions taken to improve the quality metrics across the business.

Matter of Concern 2.

I have seen the documentation from the care home where the wound tracking documents are poorly filled in and incorrect information has been recorded. This has made it more difficult to chart the progress of this wound**.**

Actions taken at the time and following RCA:

- As a management team, we:
    - Took care to monitor whether the actions taken, and lessons learned had been embedded through the Monthly Home Review audit.
    - Monthly Quality Care Metrics trends are routinely reviewed through internal and external Quality Monitoring inspections.
    - Internal inspections are carried out by our Risk and Governance Inspectors.
    - Local Authority or Continuing Healthcare Quality Monitoring Inspections continue as per local agreement.
- We reinforced the consistent recording of care planning and shift handovers using the "Operational Essentials" (now Resident Essentials) framework which is the Bupa Care Services Quality Assurance Framework. This framework is used to record information and prompt audits and checks of operational aspects of running a care home.
- Nursing staff were reminded that it is their responsibility to ensure that all resident wounds are photographed at least weekly or if any changes occur, and that they should report all wounds and wound updates to the Home Manager so that appropriate care and equipment can be agreed.
- The Home Manager is to ensure that all incidents are logged on the internal "Datix" incident database.
- We reinforced with Nurses at the Weekly Clinical Risk Meetings that any significant deterioration in a resident's wound should be immediately reported to the Tissue Viability Nurse (TVN) or GP.

Organisational Learnings:

- Following evidence given by [redacted] during the inquest, [redacted] submitted a wound care plan tracker, that could be used in line with our wound care policies and protocols which Bupa has taken on board nationally and updated the wound care plan tracker and we are currently implementing this - we notified the coroner that this would be implemented as part of lessons learned.
- The Managing Director and Head of Operational Quality attend a monthly quality review with the Director of Risk & Governance and Operations Director to provide assurance regarding oversight and actions taken to improve the quality metrics across the business

Matter of Concern 3.

Wound care knowledge was not adequate.

Actions taken at the time and following RCA:

- All Nursing and Care colleagues received refresher training in skin integrity management delivered by the Community Tissue Viability Nurse on 20 August 2019, (previous training was completed on 10 October 2018).

- We ensured that the Registered Nurses all had easy access to:
    - Care Plan Guidance material,
    - Sepsis Risk Ratification Tool,
    - Restore 2 documentation,
    - Policies relating to skin integrity, Pressure Ulcer (PU) and Wound Management
    - Resident Discharge and Transfer Form.
- We ensured that nurses understood the necessity to take photos of any wound within the home at least monthly or more frequently if deterioration is noticed.
- The home maintains Care Policy Document Folders which are updated regularly with Quarterly checklists provided to the home. The latest version of all documents is also accessible through Bupa Care Services intranet "One Place" which all the Nurses can access through the computers in the Nurses Stations.
- We provided evidence of nurses' training from Bupa, along with any training updates received from the TVN, and this has continued since 2019.
- We also provided evidence that the nurses had training in 2018 prior to this incident, but we acknowledged the gap in the training delivered, and:
    - All had refresher training from Bupa,
    - Additional training was provided by the TVN service.
    - Monthly updates are received via the TVN via newsletter and meeting via TEAMS.
    - Access to the wound care presentations at Care Home Forums was arranged by CCG.

Organisational Learnings:

- All of the above actions have been checked for completion and have also been shared with the wider team in the region.
- As an organisation, trends are monitored, and lessons learned are cascaded where appropriate to the organisation.
- Every month the Risk & Governance team produce a retrospective quality metrics pack for each Home Manager (HM) in the business.
    - The report contains details of all Pressure Ulcers (PU) in their homes, including the number and severity of the PU and whether these were acquired in home or before admission.
- Once the quality metrics report is received, the HM produces a report for their Regional Director (RD) identifying interventions taken to support residents with PU in their home such as frequency of dressing changes, equipment in use, support by specialists such as TVN, GP & dietetics and the progress of the wound/s.
    - The RD discusses the interventions recorded with the HM, investigates and resolves any anomalies.
    - Consideration is given if additional support is required such as a Quality Manager visit.
    - Provision of training or equipment review in preparation for the quality review with the Managing Director (MD) and Head of Operational Quality.
- The monthly quality review between the RD, MD and Head of Operational Quality focusses on emerging trends/themes in the homes. Where more serious PU have been identified as occurring in the home, the required Root Cause Analysis (RCA) and Lessons Learned (LL) are discussed and recommendations to share LL throughout the business are made.
- Where concern persists regarding the management of PU:
    - They will be discussed with the RD at the quality improvement to drive improved performance.
    - The RD is responsible for ensuring that the required remedial actions are completed.
- The MD and Head of Operational Quality attends a monthly quality review with the Director of Risk & Governance and Operations Director to provide assurances regarding oversight and actions taken to improve the quality metrics across the business

Matter of Concern 4.

Provision of correct dressings not available to non-TVN professionals.

Actions taken at the time and following RCA:

- Through Clinical Risk Meetings, Nurses have been reminded that it is their responsibility to dress wounds in accordance with the resident's specific Wound Care Plan and to ensure that any Wound Care is documented in Evaluation and Re-assessment forms. Any concerns to be immediately escalated to the Home Manager/TVN/GP as appropriate.

Organisational Learnings:

- All of the above actions have been checked for completion and have also been shared with the wider team in the region.
- As an organisation, trends are monitored, and lessons learned are cascaded where appropriate to the organisation as a whole.
- The MD and Head of Operational Quality attend a monthly quality review with the Director of Risk & Governance and Operations Director to provide assurance regarding oversight and actions taken to improve the quality metrics across the business

Matter of Concern 5.

Referral system with TVNs was not useful in Michael's case. Initial consultation by telephone was unable to identify issues that would have assisted wound care.

Actions taken at the time and following RCA:

- All referrals to the TVN are now notified by email. Prior to this, the original referral system was via fax. We had moved on from the original referral system via fax by the time of the inquest hearing, and this was explained at the inquest, and we provided evidence of a referral being made by email and the submissions of digital photographic evidence. We submitted examples of evidence of wounds and anonymised emails of TVN instructions to the nurses. This has been a better system and more efficient and we have continued with this process which requires that:
    - Nurses should inform the TVN by email of any wound deterioration the same day that it is identified.
    - Where a TVN opinion has been sought and has not been possible, consideration should be given to the additional risk posed by the non-attendance of TVN's. In such circumstances alternative sources of internal (Bupa Clinical Specialists) and external (District Nursing Teams and GP) advice should be sought.
- In relation to the provision of dressings available to non TVN professionals, access to these dressings will remain within the control of TVN specialists. When referrals are made to manage high risk clinical wounds, these high risk dressings need to be prescribed by the TVN and the Tadworth Grove nurses can continue ordering non high risk dressings regimes to manage low risk wound care within the home.

Organisational Learnings:

- All of the above actions have been checked for completion and have also been shared with the wider team in the region.
- As an organisation, trends are monitored, and lessons learned are escalated where appropriate to the organisation.
- The MD and Head of Operational Quality attend a monthly quality review with the Director of Risk & Governance and Operations Director to provide assurance regarding oversight and actions taken to improve the quality metrics across the business

Matter of Concern 6.

Information may be useful to National Wound Care Strategy.

Actions taken:

• At the inquest [redacted] explained that the wound care issues experienced at Tadworth Grove were not unique to this service, and were significant at a national level, and discussions were held on the on-going consultation towards policy/strategy. • As a result of these lessons learned and reflections, the wider organisation amended our wound care tracking document and policies to ensure lessons are learned across the Bupa portfolio.
Organisational Learnings: • Our Bupa Care Services Policies are aligned with and reviewed in light of changes to The National Wound Care Strategy. • The Managing Director and Head of Operational Quality attend a monthly quality review with the Director of Risk &Governance and Operations Director to provide assurance regarding oversight and actions taken to improve the quality metrics across the business

In addition to the concerns you raised in your Regulation 28 Report, we wish to assure you that Tadworth Grove and Bupa continue to foster a culture of continuous improvement and learning, to ensure that lessons learned are embedded. The Regional Director allocated to Tadworth Grove continues to undertake a Monthly Operational Assurances Audit (MOAA) each month. This audit includes:

- A check of the monthly metrics report to ensure analysis of all metric indicators is completed using metrics and Datix, that this is recorded in the metrics report and there is evidence of action being taken to address trends.

- The care plans of at least 2 high risk residents, which could be residents with Pressure Ulcers, are evaluated to check all sections are completed comprehensively, are person centred and up to date.

Audits are sent to Risk & Governance and Operations, so that the business has oversight of all homes performance against these benchmarks every month.

We hope that this response provides assurance that Tadworth Grove and Bupa as an organisation have taken extensive steps to learn lessons from Mr Humphries' tragic death. We have made significant improvements and will continue to ensure improvements and changes are embedded, addressing and mitigating risks to residents.

Yours sincerely

[redacted] [redacted]

Operations Direction, Bupa Care Services Registered Manager, Tadworth Grove