Inquest of Lilian Shearing 13/09/2022

Regulation 28 – Tanglewood Cloverleaf Care Home

Training

It is three years since Mrs LS death and the monitoring and auditing processes within all Tanglewood homes has been enhanced significantly. Throughout the pandemic, work has been ongoing to continue to provide essential training. A new platform for e-learning was introduced which enabled team members, both newly employed and established, to access ongoing training throughout this period. There has been a continued focus on the importance of nutrition and hydration and how we support residents in all stages of their later life and what we can do in the event of the individual declining adequate nutritional and fluid intake required to sustain life. A care plan manager has been employed to oversee the care plans and content in all homes ensuring the standard of documentation is consistent, this person also provides training to all care teams to ensure the process is understood. Regular audits are completed for each home with action plans for completion where identified. These actions are followed up, checked for completion and verified.

Policy & Procedure

We have reviewed the content of the Nutrition & Hydration policy and amended the content to include current practice of monitoring and recording all intake (see appendix 1), how we support the resident who may be reluctant to accept food and fluids especially at end of life, and the importance of recording if a resident declines assistance or intervention. What we do if a residents daily fluid target appears excessive and is not consistently achieved over a 7-day period and how we manage and record the discussions with the GP and family members in relation to this.

Admissions to Tanglewood homes

The outcome of Mrs LS inquest was discussed at a manager's meeting on 27th September 2022, an overview was provided from the point of transfer to the home, we reviewed the pre-assessment information available to the home which was very comprehensive and the fact that two members of staff accompanied Mrs LS on the transfer to ensure information was relayed to the team at the home.

We have set up the admission process over two time frames the first being 24-hours to complete key documents, this can be done using a pre-assessment document and additional information from family members – a nutrition & hydration assessment is included – and the formulation of the remainder of the care plan within 7-days as this is a live document that will continually evolve. In addition to written referrals or transfer documents, residents and their families are actively involved in providing information which enables us to provide consistent, holistic care for the individual.

Daily oversight – all homes

Each Tanglewood home completes a daily clinical oversight and operational report, this has been developed and implemented during the past year. It gives the Directors a complete overview of all allocated services, the documents are saved down each day and reviewed by the registered manager of the home and the regional manager, with actions carried forward to ensure nothing is missed (An example copy of this has been attached as Appendix 2).

We have improved communication with family members by completing Resident of the Day records – this ensures we are contacting next of kin/POA to discuss the individuals wellbeing each month in line with this process. Changes to a person's health is communicated to the family as soon as it is identified with additional information being added to the care plan. GP referrals are made through direct contact with the surgery or through Ask My GP.

The resident of the day forms are checked and signed off daily by the Home manager and Regional Manager and any follow up is recorded.

Ongoing regulatory visits to all homes by the Regional Compliance Managers

Each Regional Manager has a portfolio of a maximum 4 homes, we are responsible for supporting the managers in all areas of compliance to ensure the standards and practices are consistent across the group. As part of the discussion and outcome surrounding the events prior to Mrs LS' admission to the home and subsequent concerns relating to her condition prior to hospital admission we have very carefully considered lessons learned which we have taken forward as a group.

Feedback has been given from a recent inquest on 12/10/2022 (WH – a late resident at another Tanglewood home) whereby it was commented on by the coroner about the recording of all fluids given and offered to the resident, it was evident from the records that even when refused – it was documented – this is a direct result of the ongoing focus on the importance of recording all incidences of acceptance and refusal of care interventions.

Lessons learned

- On admission – ensure all information/transfer documents have been read and understood – staff are to complete 24-hour records and proceed with formulating the live care plan over the following 7-days as per process
- Ensure that any risk assessments required are completed to ensure minimal risk to the person
- Ensure any daily charts required are activated from the admission date e.g., ADL's, food & fluid intake
- Ensure that resident families/representatives are informed of any changes in their health promptly to enable them to visit the home or attend at hospital – staff to record all contact made
- Discuss the information/documentation available with the resident and/or their representative to ensure all areas of concern are covered
- Ensure ALL communications/discussion held are recorded on the relevant form on the electronic care plan system (iCare or PCS)
- Ensure that ALL referrals to external agencies are actioned and followed up timely with all communication recorded on the care plan system
- Ensure the resident and/or their representatives are kept informed of ALL requests/referrals including dates of appointments or visits
- Ongoing face-to-face staff training within the homes to embed the importance of maintaining records and documentation to provide evidence of care provided
- Ongoing staff training within the homes to ensure that all nutritional and fluid intake is recorded even if declined as we are unable to force residents to take food & fluids if they refuse
- The provision of a Nutrition & Fluid Information Folder for each home which will be included in home meeting discussion and available for team members to access for future information, this will be added to as we move forward

Outcomes

We have identified the following as part of the review surrounding this review

- Improved communications between homes and families/representatives
- Fewer complaints regarding care due to more frequent contact with families / representatives
- Improved record keeping and documentation – this is an ongoing process which includes all new & established employees
- Daily clinical oversight and resident of the day records have provided the senior management team with a clearer overview of all services

Shared information

All Tanglewood homes have received the information pack that has been submitted to the coroner as evidence of the progress that has been made and sustained during the past 3-years