Runwood Homes PLC
Windmill House
14 Browick Road
Wymondham
Norfolk
NR18 0QW

19 January 2023

Dear Her Majesty's Coroner

Re: Prevention of future deaths report – Windmill House.

Care plans being prepared without input from family.

New pre admission form has been developed and now includes detailed information regarding resident and family input, all pre admissions will be completed in person and not over the phone, families will be involved as part of the pre-admission process irrespective of resident capacity as long as the resident with capacity consents, this will be documented on the form.

New residents' risk assessments will be completed in co-ordination within 24 hours and care plans within 7 days, although priority will be given within the first 6 hours to the highest risks to residents, e.g. choking, falls, pressure ulcers, evacuation during a fire, nutrition/hydration and any other specific ones such as pain, epilepsy, diabetes, moving and handling, absconding. This will allow staff to be able to assess the resident and gain further knowledge of their needs. All families will be invited to attend after 6 weeks to review these and then sign, these will be followed up monthly during the "Resident Of The Day" process and a full review will be undertaken at 6 months of the resident's care plan and risk assessments, or if needs change they will be reviewed sooner.

Care plans being developed through cutting and pasting from other residents care plans.

All care staff have now completed further training on the electronic care plan system, all care staff are fully trained in making sure care plans are developed for the individual and nothing is to be copied and pasted from others' care plans. This is being regularly reviewed by the senior team through auditing, and reviewed again monthly during the resident of the day process.

Care plans containing several inaccuracies.

Again through a thorough pre admission assessment and training delivered on developing person centred care plans, any potential for inaccuracies is being closely monitored by the senior team as documented above. All new residents admitted to the home are being weighed weekly for the first 4 weeks of their stay, this allows us to monitor residents' dietary needs closely and to ensure that these are being met, and to assess whether any further input is needed from multi-disciplinary teams.

Developing care plans for residents with a diagnosis of diabetes

Further to the inquest, all residents with a diagnosis of diabetes, whether it be tablet or diet control, are now having their blood sugars monitored via the GP practice and these residents are having their bloods taken every 3-6 months. All care plans are now person centred to the individual with how staff should respond to a resident who maybe experiencing hypo/hyperglycaemic episodes, and they better reflect the residents dietary requirements. As part of the process of reviewing care plans for residents with diabetes, advice was obtained from the catering and hospitality lead, who also worked closely with a nutritionist on the menus for the care home, which included advice related to menus for residents with diabetes.

These menus are now discussed at the monthly nutritional meeting with the senior staff and head chef, these meetings are minuted and given to the teams, including the kitchen, to ensure that the information is well communicated.

Concerns over fluid intake and how this was monitored and documented.

All residents' care plans are developed with the individual, information gained from the residents' pre admission assessment and information gained from the resident and their family allows us to gain information regarding what their fluid intake has been like and also through fluid charts for the first four weeks, allows us to monitor fluid intake. Hydration trolleys are in effect at the home, one each shift one person is allocated to be responsible for ensuring that residents' fluid intake is monitored and documented accurately. This was discussed at the care plan training and how to accurately record fluid intake. All staff are required to ensure that they record intake in millilitres, "mls" in all entries so that the electronic care record system automatically picks up the intake and calculates it. Fluid intake is monitored daily by the Care Team Leader (CTL) with a further overview by the Deputy Home manager. The care team are reporting to the senior team any concerns relating to residents' fluid intake. Staff determine residents' fluid intake by the size of the cup in mls, how much has been offered and then drank.

PRN medication not given as stated on the discharge letter from the hospital

All senior care staff have to record all medication received into the home and two staff are required to check and sign in medication on the medication administration record (MAR) chart. This follows the medication policy and procedure, any concerns over documentation when a person is discharged from a hospital are followed up with the hospital, and if admitted from the community, the resident's GP will be contacted to confirm any queries with prescriptions.

All as required (PRN) medication has a protocol produced that is person centred. For any resident that has a cognitive impairment and is unable to verbalise pain, staff will assess whether they are or are not in pain by using facial expressions, body language or a pain assessment tool to gain this information and act on the information obtained.

PRN medications are documented in the residents care plan, along with regular medication, so all senior staff that are medication trained will have this knowledge when administering medication, all senior staff have been completing extra medication training to develop their skills.

Care plans not being audited and reviewed by senior team

A percentage of care plans are being audited monthly, the Regional Director and deputy home manager, review care plans monthly as part of the "Resident Of The Day" process.

Staff are ensuring that all care plans are accurate and person centred and individualised to residents' personal needs.

Lessons learnt have been completed and reviewed, regular staff and care team leaders meetings have been held to communicate these changes, and also 1:1 supervisions have been held.

Lessons learnt no evidence of implementation and nutrition/hydration records not regularly audited.

Any findings from concerns raised have a lessons learnt in place, these are then discussed at flash meetings, 1:1's if applicable, and given to the team to read and sign.

Food/fluid charts are being reviewed daily by the CTL, any concerns are then discussed with the team at handover and fed back to them, the CTL also reviews the electronic care record system to ensure that this is being recorded effectively and accurately. Any concerns that this is not being followed is raised to the deputy home manager and communicated back to the Regional Director.

Yours Sincerely,

[redacted]

[redacted]
Regional Director
[redacted]