30 March 2023

David Donald William Reid
HM Senior Coroner for Worcestershire
Coroners Court
Martins Way
Stourport on Severn
Worcestershire
DY13 8UN

Dear Mr Reid

Regulation 28: Report to prevent future deaths in relation to Bridget Gormley

I am responding to the Regulation 28 Report issued on 9 February 2023 following the inquest into the death of Bridget Gormley on 31 July 2022. The inquest concluded on 8 February 2023.

Barchester Healthcare ('Barchester') deeply regrets the death of Mrs Bridget Gormley and the distress this has caused her family.

Following this very sad incident we have made a number of changes to the provision of care and services at Latimer Court, and these have been adopted across the organisation in other services and divisions where appropriate. For the purpose of this response, we have considered the concerns raised by you and where possible we have grouped together details of assurance measures where these appear to deal with more than one area of concern. Whilst it is unlikely that the matters referred to below would have affected the outcome for Mrs Gormley, there are matters of practice identified where the need for improvement has been recognised and dealt with.

(1) **During the course of her evidence, the inquest heard that Mrs. Gormley had suffered four falls at Latimer Court between 31 March 2022 and 4 April 2022, and a further four falls between 12 July 2022 and 17 July 2022. Latimer Court's registered home manager, [redacted], conceded in her evidence that neither Mrs. Gormley's Falls Risk Assessment document, nor her Falls Care plan document were updated following any of these falls, and that they should have been so updated. This meant that:**

(a) **Staff at Latimer Court who were looking after Mrs. Gormley may not have been aware that she presented an increased risk of suffering a fall; and**

(b) **Measures to mitigate that increased risk were not considered. Such measures could have included:**

(i) **Asking a GP to refer Mrs. Gormley to the falls clinic.**

(ii) **Placing a sensor mat by her bed or chair, to alert staff to when she was mobilising.**

(iii) **Referring her to Occupational Therapy for mobility aids such as a walking stick or frame.**

(iv) **Briefing staff at Latimer Court to intervene whenever Mrs. Gormley was seen mobilising by herself, and to offer her assistance.**

(2) [redacted] **was unable to explain why these important documents had not been updated as they should have been by staff at Latimer Court. There is therefore concern that staff at Latimer Court did not, and may still not understand their duties and responsibilities to update residents' documentation in such circumstances**

I have addressed the concerns below:

Falls Management

(a) At Barchester Healthcare, all residents care plans are reviewed by the senior carer in a residential home every month or when anything significant changes in their care or support requirements such as a fall. This process is then audited and assured by the unit General Manager via the *resident of the day* process of checking up on care planning. Care plans may also be updated following the daily clinical meeting led by the care home clinical lead which is often the Deputy Manager. At this meeting residents who may have fallen, been unwell or been to hospital are discussed in more detail. All incident forms from the previous 24 hours are noted as incidents for review and prompt the General Manager to cascade relevant information and support to the home team. Appropriate actions will be discussed and documented including the need to make staff aware of any increased risk to the resident and extra vigilance and/or assistance as necessary. Both processes are documented daily, and records kept which are themselves reviewed by the Regional Director and the Quality Assurance Team. As part of the processes there is a record of discussions and where appropriate a record of any request submitted to the commissioners of care i.e., Local Authority, Clinical Commissioning Group, Integrated Care Board and/or Next of Kin and evidence of the outcome of those discussions. Referrals to GP, Falls Team and Occupational Therapist are considered. There is also reflection on duty of candour obligations and reporting to family, CQC and Safeguarding Vulnerable Adults. As part of the *resident of the day* process there will be a review of medication and a formal request for a GP review of medication evidenced where it is considered that medication may be a contributing factor to falls.

(b) Care Plan reviews also take place 6 weeks following admission and every 6 months; the care review process involves the resident and, where they lack capacity, their family. Checking these documents forms part of the Regional Director monthly home visit and Barchester's Quality Improvement Team carry out audit to make sure that this is being done.

(c) Following any fall or found on floor incident the falls risk assessment should be reviewed and the falls diary completed. The falls care plan should be updated accordingly and referrals made as appropriate.

(d) The incidents involving Mrs Gormley had been captured on the accident and incident reports, but the care plan review process had not apparently picked up the need to review and where necessary update the falls documentation. Incident reporting is required to be

entered onto the clinical governance system within 24 hours. To address this, we have amended our monthly clinical governance meeting requirements to include a review of falls for any one individual and their falls history. These meetings are minuted and require discussion of residents having a fall or found on the floor in line with Barchester's Falls Management Policy to ensure that all measures are in place to mitigate the risk of further falls and that the relevant Healthcare Professionals and equipment is accessed and utilised. We have also introduced a regional falls champion forum, chaired by our Divisional clinical lead nurses. This will have an emphasis on prevention but also include reviews of individuals who have fallen, and the documentation required to support them and plan for their needs.

(e) Barchester's Director of Nursing has undertaken a review of policies, processes and procedures in relation to falls and falls management. The Barchester Healthcare policy for Falls Management has been subsequently updated and this update has been shared by the General Manager of Latimer Court with the home team, specifically the senior carer team whose responsibility it is to manage falls.

(f) Barchester Healthcare have also now developed and introduced a specific Post Falls Assessment Tool to aid with the assessment of a resident following a fall or found on floor incident. This assessment process explores pain, any bruising or wounds and any changes in limb movement or walking. It also makes clear the process and frequency of observations and escalation should there be a change from a resident's baseline.

(g) Appendix 3 of the Barchester Falls Management Policy sets out a flow chart for immediate action following a fall or finding someone on the floor. This appendix is displayed in the care stations in the home for ease of reference for the senior care team and is intended to seek to ensure that due process is followed in each case.

(h) Barchester Healthcare have worked with RoSPA in the Falls Fighter campaign with the aim to raise awareness of falls. This has involved training across Barchester's homes and cascading to team members and will continue as part of the 'Falls Fighters' campaign. Falls Fighters attend the monthly Clinical Governance meetings.

(i) As an organisation we take our responsibilities and the duties and responsibilities of our staff very seriously. Robust documentation is an important tool in care planning and communication. We do not assume that all staff approach the completion of documentation as mandated by the organisation in a comprehensive and timely manner although that is our expectation. We recognise that reinforcing the importance of good documentation and the processes that will flow from that is a key foundation stone in our approach to mitigating risk for our residents and person-centred care planning.

Latimer Court

(j) As part of the lessons learnt as identified by the General Manager at Latimer Court it was highlighted that staff required further training from the organisation's Clinical Development Nurse in the approach to and completion of documentation. Specifically, when to complete documentation and the requisite detail to be included in the entries into documentation. Following completion of the inquest and receipt of the Regulation 28 Report, the Managing and Regional Directors have made arrangements for further refresher training to be delivered at Latimer Court with follow up by the Regional Manager and Quality

Assurance Team. This will take place over the next 6 weeks and will be repeated at intervals as necessary. As part of the training delivered, the specific concerns arising out of this case will be used as a case study to demonstrate how the updating of documentation may lead to measures to mitigate increased risk. There will be an additional emphasis on the requirement to maintain robust handover documentation on a daily and weekly basis.

(k) As part of lessons learnt it is recognised by the General Manager at Latimer Court that staff require further training on the Barchester Falls Management Policy. If staff had followed the policy in this case, they would have followed the prompts to ensure that every aspect of the risk review was undertaken along with the immediate action following a fall or found on the floor incident. This includes consideration of the environmental orientation tool which should be completed preadmission and on admission and revisited following a fall. The Managing and Regional Directors have therefore made arrangements for further refresher training to be delivered at Latimer Court with follow up by the Regional Director and Quality Assurance Team. This will take place with the documentation training over the next 6 weeks and will be repeated as necessary. Any checklists or prompts to be used at Latimer Court by the home team will be developed in liaison with the Clinical Development Nurse and will follow the requirements of the Falls Management Policy as to actions to be taken. As part of the training staff will be required to review the environment in which the residents live, practice writing risk assessments and consider how residents needs and risks may change and to develop professional curiosity about residents' presentation and any referrals and actions that should flow from a falls incident.

(l) The training referred to will be attended by all staff at Latimer Court including the General Manager.

(m) Finally, the General Manager at Latimer Court is being provided with increased support by the Managing and Regional Directors and the Clinical Development Nurse whilst the further refresher training is embedded, and a permanent Deputy Manager has been recruited to support the General Manager and the team at Latimer Court going forward.

Thank you for raising your concerns. I hope that the content of this letter provides sufficient assurance that Barchester Healthcare take the concerns raised seriously, has taken action following the death of Mrs Bridget Gormley and has accepted the points raised and continues to work to improve the service we provide. Should you have any questions or concerns or comments, please do not hesitate to contact me directly.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer
Barchester Healthcare