Maria Mallaband

Mr Andrew Hetherington
HM Senior Coroner for North Northumberland and Acting Senior
Coroner for South Northumberland
County Hall
Morpeth
Northumberland
NE61 2EF

[redacted]

Dear Sir,

**Inquest into the death of Julie Nolan**

We write to formally respond to your Prevention of Future Deaths (PFD) Report, dated 11 May 2023, received on 25 May 2023 following the sad death of Mrs Julie Nolan. As an organisation, we are ensuring that we learn from the circumstances of Mrs Nolan's death and that appropriate action is taken so that a death does not occur in similar circumstances.

We have reviewed the concerns identified in your PFD report and we shall respond to each of your concerns in turn:

Concern 1: The deceased was a resident at Astor Lodge Care Home. I am concerned there was limited documentation of wound management and pressure care and it is unclear the extent to which wound management and repositioning was provided in line with care plans.

We accept that regretfully we were unable to provide sufficient documentation at the inquest, for which we apologise, this was a consequence of the Home being unable to locate a full set of records for Ms Nolan. Unfortunately the record keeping in respect of the care provided to Ms Nolan fell below the standards we expect across the organisation. We were able to confirm at the inquest, that on the basis of the documentation that had been located, there was evidence of a detailed care plan in relation to Mrs Nolan's wound management and pressure care, however , the Home was unable to provide records to evidence the implementation of these care plans. Evidence was however provided by a Care Practitioner, who was able to confirm that positional changes and wound management did take place.

At the inquest, [redacted] (Group Complaints and Compliance Manager) was able to provide details of the prompt and comprehensive actions which were taken by the company and within the Astor Lodge, once the issue of the missing records was identified. They are summarised below:

1. Senior members of the Regional Management team are currently overseeing operations at Astor Lodge, pending the commencement of our new permanent Care Home Manager (July 2023). The Senior Management team are currently conducting an audit of every resident file to

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ensure that every resident has relevant and appropriate care plans in place, that these plans are being followed and that there is documentary evidence confirming the same. This includes, but is not limited to, care plans for wound management and pressure care.

2. All of the Care Homes across the company are being transitioned to fully electronic records. All Homes are now fully electronic, in relation to medication systems, and we are currently working on transferring all care planning over to the electronic system. In preparation for that transition, the records at Astor Lodge and other Care Homes, where records are currently paper based, are being reformatted to ensure that the paper records mirror the required electronic format and more person centred content of the records held on the electronic system.

3. As part of the change in documentation, skin integrity plans for residents who have wound/pressure damage have been updated, ensuring person centred care and a clear pathway for any required escalation checks are carried out to ensure that, when required, there is timely and appropriate liaison with Tissue Viability Nurses as per company policy. Wounds are also being photographed, as prescribed within the relevant care plan to ensure any wounds are monitored, changes identified and care plans and treatment adjusted accordingly.

4. Every member of staff is required to undertake mandatory training when they commence employment at Astor Lodge, and currently a full refresh of training is taking place. This training incorporates training on wound care and pressure damage and this training is repeated on an annual basis. Checks have been carried out to ensure that appropriate staff within the Home are compliant with their mandatory training to ensure that they have received the most up to date annual wound care and pressure area care training.

5. Following Mrs Nolan’s death, a clinician from the Quality Support Team has been working with staff from Astor Lodge, with care plan and risk assessment training, looking specifically at lessons learned from the clinical issues which arose in Mrs Nolan's case. This training includes, but is not limited to, a discussion around the importance of documentation, evidencing improvements in the safe care and treatment of individuals, how we make referrals to outside healthcare professionals and how we carry out and evidence any action or treatment advised by our community partners.

6. The training reinforces the need for staff to maintain accurate, complete, and detailed records in respect of each resident, with any care or clinical interventions and daily records, being completed throughout the whole of a shift, to reflect each intervention any resident may receive and to ensure that records are current, reflective and completed in a timely manner.

7. Relevant senior staff are also attending RESTORE2 on an ongoing basis (an escalation tool used in care setting to enable early recognition of deterioration) training, which is delivered by inhouse trainers through our Learning and Development team and is available on a rolling monthly basis for staff to book onto. This training includes guidance on acute infections and how to identify signs and symptoms of them, understanding the potential risks of sepsis, including signs and symptoms, and when to seek further advice. Within this training, the importance of baseline observations and the use of the SBAR (Situation, Background, Assessment and Recommendation) tool is also discussed. Any additional training needs identified, will be delivered by our Learning and Development team as required.

8. Senior staff are also receiving react to red training booklet, which includes refresher training on the normal structure and functions of the skin, how pressure ulcers develop, the importance of risk assessments, skin inspection, pressure ulcer prevention, repositioning and the management of existing pressure damage and encouraging personal engagement. This booklet

requires the staff to work through the training materials and then answer questions, at the end to test their knowledge and understanding, and progress being monitored by the Senior members of the Regional Management team .

9. In order to ensure that documentation is being completed correctly, the Senior members of the Regional Management team are responsible for carrying out daily walk arounds, which includes walking around the Home and focusing on key areas of risk and addressing areas that may require further input, such as the home environment and any issues arising around resident care, documentation, staff and COVID 19 compliance. This process was in place at the time Mrs Nolan was a resident, but was not always completed as robustly as we would expect.

10. To ensure that this is being undertaken and to assist with the recording of this process, the walk around form has been made electronic and updated to set out each action the manager needs to complete during the walk around, with the requirement to upload picture evidence of any findings. These walk arounds are now audited as a minimum every week by the Quality Teams, with the results uploaded and available to be reviewed by Regional Director and Quality Excellence Team and action plans are created to address any issues identified.

11. In addition to the walk around, Senior members of the Regional Management team are introducing audits of 10% of care plans within the Home on a monthly basis, to ensure that all documentation and care plans are in place and are in line with company policy. Audits are also being monitored on a monthly basis, through Regional Director visits, which encompass completion of an electronic document (Regional Director Visit Report) to review what audits have been undertaken. This report is also currently being updated to be more prescriptive about the checks required, and include a reference to checking walk arounds and all relevant audits have been undertaken.

12. Any residents identified at risk of pressure damage or other factors such as falling are also reviewed on a weekly basis by the clinical team to ensure that the Senior members of the Regional Management team and staff have full oversight and awareness of any residents that they deem at risk. This ensures areas of focus, such as time pressure damage, serious changes in health status and infections, are reviewed, by the Senior members of the Regional Management team , Quality Excellence Partner and Regional Director, requiring sign off on a weekly basis by the Home manager and on a monthly basis by the Regional Director.

13. Since Mrs Nolan’s death the format of this document has changed to be more prescriptive and will be converted into an electronic form as part of the move to fully electronic records. The Senior members of the Regional Management team are ensuring compliance with this process and completion of this document is also now checked and recorded as part of the monthly Regional Director visits.

14. In addition to the internal quality assurance checks conducted within Astor Lodge as referred to above, the company’s Quality Excellence Team will be conducting random 'spot checks' at the Care Home, on a regular basis. These checks will include ensuring documentation is completed to the required standard, as set out in relevant policy and training. If any issues are identified, as part of the spot checks, an action plan will be prepared to address these, and specific staff will be allocated the action to complete. This is then monitored locally and regionally in respect of action compliance via our quality management system.

15. There is no evidence that Mrs Nolan’s care records were selected as part of this higher level audit, however there is no indication that during Mrs Nolan’s stay there were concerns identified with care plans and records not being completed at Astor Lodge..

16. In terms of the storage of records, we are introducing that each resident's records are signed off at the end of each shift by the nurse in charge and placed into the relevant box for that resident, with a list made of what is contained in each box. Unfortunately, at the time of Mrs Nolan's residency it has come to light that this process for the storage of records was not being followed consistently. The Senior members of the Regional Management team, are currently overseeing the archiving process to ensure that this is being followed correctly and all documents are being organised and filed into allocated boxes that are trackable and can be located via our internal archiving system.

17. In addition the company's Data Protection Officer and Head of Information Governance have been made aware of the past storage issues for future monitoring. A number of checks of services focusing on data storage will occur and heightened awareness sessions are in place to ensure consistent updates and reminders to services on the importance of appropriate document storage and archiving.

18. Since the conclusion of the inquest, a National Webinar has taken place (19 May 2023) attended by all care homes within the organisation, regional quality and director teams along with legal representatives, which discussed the findings at the inquest and amongst other matters, the importance of wound and pressure management. In addition, the need to accurately document any care and treatment required was reinforced to staff as well as a reminder to ensure appropriate storage of documentation and the need to consider escalation to Tissue Viability in a timely way and monitor any deterioration and take photographs of wounds. These webinars have been scheduled on an ongoing basis for a variety of topics.

<u>Concern 2: I am concerned that the Manager and Registered Nurse was the designated nurse for the Care Home for two consecutive days.</u>

As confirmed in the inquest, at the time of Mrs Nolan's death there was a significant COVID outbreak within the Home. Staffing pressures due to COVID meant that unusually the manager was allocated nursing shifts in order to ensure that the Home was operating at a safe level. Whilst the manager was named as the nurse for two consecutive days, this did not mean that she was constantly working throughout this period and instead the requirement was for her to sleep on site, only to be contacted by staff in an emergency.

In this response we have outlined the actions we have already taken, and those which we are in the process of taking. In providing this response to you, we hope that we have conveyed how seriously we have viewed this matter and that we are committed to learning from Mrs Nolan's death.

We trust that this response has answered your concerns, but please do contact me should you have any queries or concerns.

Yours faithfully

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Chief Executive Officer