Introduction:

Following the tragic death of TB and the subsequent Coroner's inquest, it was ordered that we, as the resident's care provider, submit our plan of necessary actions in order to eliminate the risk of future such occurrence. I therefore set out below our itinerary of actions taken, those actions which are currently in progress and our proposed future actions. Although systems and processes were in place for the updating of care plans and hospital passports, we acknowledge that in this very sad case these were not followed, because of this a more robust system was implemented. These are as follows:

Actions taken

- Hospital passports are checked by two members of senior staff weekly.
- Care Plans are updated monthly or when any changes to care are required by a senior member of management.
- Implementation of hospital passport checklist
- Northwest Ambulance service to sign hospital checklist to say information has been passed over.
- Provider contacted Northwest Ambulance Service to discuss hospital checklist implemented due to ambulance staff being reluctant to sign receipt of the documents, meeting held with Stuart Hall NWAS, Alison Ricchiuti. Fylde Coast Care Home Lead and Lisa Wright Care Home Administrator to discuss.

Actions currently being taken

- Digital Care Records are in the process of being implemented.
- Staff are currently being trained in the use of the digital care system.
- Senior management inputting all residents' details to ensure concise accurate information is inputted, this is checked by a second person.
- We have signed up to a Registered Managers Forum to share views and information to improve our service.

Future actions

- See attached document outlining the suggested implementation of "Urgent transfer from care home to hospital" document.

Conclusion:

It is my sincere belief that with the implementation of the above listed actions, there is a minimum likelihood of the recurrence of the type of death suffered by our resident, TB. I believe that where there is more than one agency involved in the care of a resident from a care home, it is vitally important that all parties act collaboratively to ensure the safety and wellbeing of that resident. As illustrated above, I believe the initiative to be jointly undertaken between ourselves, other care providers and the local ambulance service provides critical assurances regarding the safety of residents. The other measures which we have undertaken contribute significantly towards the minimisation of risk similarly.

In summary, I believe that by the implementation of each of the actions as set out above, we provide maximum assurance of the safety to our residents, particularly at the most vulnerable moments. The lessons learned from this tragic event are substantial, and I believe that we have now addressed each aspect of risk, although we continue to learn and react accordingly and appropriately.