By email only

4 December 2023

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HM Assistant Coroner Marilyn Whittle

Office of HM Coroner

The Medico-Legal Centre

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Dear Ms Whittle

Inquest of Mrs Norma Kyte: Regulation 28 Prevention of Future Deaths Report

I write in response the Prevention of Future Deaths Report, issued on 12 October 2023 following conclusion of the inquest into the death of Mrs Norma Kyte.

I would like to express my condolences again to Mrs Kyte's family. We were all deeply saddened by Mrs Kyte's death and although nothing will change what has happened, we are committed to making necessary improvements in practice at Broomcroft Care Home ("the Home").

Since the conclusion of the inquest on 6 October 2023, my colleague has spoken with Mrs Kyte's family. I believe this is an important part of responding to what happened. The family have been very clear with us in that they also need to feel assured that actions have been taken to mitigate the risk of this happening again in the future.

We have listened to concerns raised, we have acted upon them, and we will continue to do so, so that we can be sure that improvements in practice around the use of sensor mats in the Home is embedded and fully understood.

I have set out the concerns you raised below, together with details around actions that we have either taken already or we are working to complete at the time of this response.

Coroner's Concerns

(1) The sensory mats being used on the floor next to the bedside are significantly smaller than the bed and will only trigger when directly stood upon. If a patient gets out of bed in a place not covered by the mat this will not trigger a response from the care home staff and they will be unaware the patient is trying to move or has fallen.

(2) The sensory mats may not be being used in accordance with manufacturer's instructions.

Response

The sensor mat which was in place in Mrs Kyte's room was not an appropriate type or size to place on top of a crash mat on the floor.

Although the sensor mat had been activated by Mrs Kyte earlier that night, it did not activate when she was found on the floor of her bedroom in the early hours of 2 May 2023. We could not be sure why this was, but it is possible that this may have been due to:

- the size of the sensor mat
- not being of a type recommended for use on the floor/on top of a crash mat.

Initial investigations into the fall did not identify that an incorrect sensor mat had been in use in Mrs Kyte's room. It is likely that the sensor mat which had been placed on the crash mat on the floor of Mrs Kyte's room was of a size and type recommended for use on a chair or wheelchair seat.

Further investigations identified an issue within the Home as to different types of sensor mat. There was insufficient understanding of new sensor mats which had been acquired around April 2023, shortly before Mrs Kyte's fall on 2 May.

Some staff within the Home had misunderstood the recommended use for the new mats. The sensor mats had not been ordered from Bupa's standard Clinical Equipment Guide, as they should have been. Bupa's Clinical Equipment Guide, which is available to all Bupa Care Homes and Richmond Villages, is clear and concise, with clear pictures and descriptions of equipment.

Actions taken

Since the inquest concluded, we have taken swift action in the Home, to ensure that any current risks are identified and addressed and to ensure that staff feel confident in the use of sensor mats. This included:

1. Audit of all sensor mats in the Home

An audit of all sensor mats within the Home was completed by 18 October 2023, and this remains on-going (as residents and their needs change).

We ensured that the Home has access to appropriate sensor mats, which includes those recommended for use on a chair/seat and those which are recommended for use on the floor (or for use in conjunction with a crash mat).

All mats within the Home were tested to ensure that they are in good working order and repair. We have also ensured that there is a daily check in each residents planned care to ensure the sensor mats are working and placed correctly. This can be audited from the PCS (electronic records) system. We have also added a visual check of sensor mats in the Home to the manager daily walkaround.

2. Audit of all residents' care plans within the Home

We have reviewed all resident care plans, to ensure that the need for a sensor mat is correctly identified, and that where needed, residents have the correct sensor mat allocated to them, which may mean more than one type of sensor mat is required.

Care plans will be reviewed monthly or following a fall (in line with policy) to ensure they remain relevant to a resident's needs.

3. Reminder to all staff to order equipment via the Bupa Clinical Equipment Guide

The Clinical Equipment Guide is clear and concise. It includes a full description of types of sensor mat, a diagram or picture of each mat, and their recommended use.

We took the opportunity to remind all Bupa Care Homes that equipment should be ordered via the Clinical Equipment catalogue. This eliminates the likelihood of confusion or misunderstanding as to recommended use for different types of sensor mat.

4. Ensuring that where the need for a sensor mat is required, it is clearly recorded in care plans

During our investigation into what happened, we were unable to say with absolute certainty where the sensor mat had been placed on the night of Mrs Kyte's fall, because this information had not been recorded in the care plan.

All residents who are high risk of falls require an additional plan of care. We ensured that each additional plan of care includes:

- details of whether or not the resident requires a sensor mat;
- if so, what type this is; and
- where it should be positioned.

5. **Training and 1:1 sessions with staff**

In addition to the information about sensor mat use that we have included in resident care plans, we are in the process of completing 1:1 sessions with all staff to cover the importance of not only the equipment itself, but the correct use of it.

We also arranged for nursing staff to receive in-person falls training from our in-house training team. Training took place at the Home during the week of 13 November and will continue, to ensure that anyone who was not able to attend a session during that week, receives training at the next opportunity.

We are committed to embedding improvements within the Home. On-going assurance will be supported by the monthly audit of the Home, which is completed by a Regional Director or a member of the Quality Assurance team.

I am sorry that you had to raise these concerns. I can assure you that your report has been taken seriously and I hope this letter provides suitable assurance to you and Mrs Kyte's family that prompt action has been taken to make necessary changes and improvements within the Home.

Please do not hesitate to contact me should you have any questions or concerns.

Yours sincerely

[redacted]

Director of Risk & Governance
Bupa Care Services UK