Qualia Care
(in administration)

Drakes Court
302 Alcester Road
Wythall
Birmingham
B47 6JR

[redacted]

HM Coroner Manchester South
Coroner's Court
1 Mount Tabour Street
Stockport
SK1 3AG

Date: 4 November 2024

Dear Sirs,

Re: Regulation 28 Report into the death of James Astley

We write further to your report made under Regulation 28 of the Coroners and Justice Act 2009 dated 10 September 2024.

At the outset we, and everyone at Downshaw Lodge ('The Home'), would like to express our condolences to Mr Astley's family and friends on their loss.

Please take this as our formal response to the concerns raised by His Majesty's Senior Coroner, Alison Mutch OBE, regarding:

- the quality of record keeping and, in particular, that relating to fluid and nutrition documentation at The Home; and
- understanding of the MUST system to inform the delivery of care at the Home.

We confirm that steps and actions have been taken by the Home to address these concerns as is outlined below.

By way of background, the Registered Manager commenced employment at the Home in early December 2023 following an induction into the service. In December 2023, the Regional Manager identified a need for improvement in the completion of documentation by staff, and an action plan was developed. Due to the concerns identified, a Quality Manager subsequently completed an internal IMPACT audit in January 2024.

The key areas of concern highlighted in the internal IMPACT audit were:

- Food intake records were generally completed well, but where pureed meals were provided, they lacked details about the meal contents. A general term, "blended meal", was used instead of specifying the ingredients.
- There was limited evaluation of food and fluid intake records to ensure that residents had adequate nutritional intake and were receiving a varied diet.

- Whilst the majority of assessments were completed correctly, a nutrition risk assessment, a Waterlow assessment, and a MUST were noted to have been scored incorrectly.

Actions taken to address concerns:

Following the audit, and prior to service of the Regulation 28 report, the Home implemented several measures to improve record-keeping and ensure that the errors identified do not recur. Further detail is provided below.

Additionally, regular meetings have taken place with multiple agencies to discuss The Home's progress and share information. These meetings occur monthly and include the following attendees: the Team Manager of Tamside (who chairs the meeting), the Home Manager, the Regional Manager, the Clinical Lead for Continuing Healthcare and Neuro Rehabilitation, Individualised Commissioning Nurses, the Head of Individualised Commissioning and Quality Improvement, the Safeguarding Lead, representatives from Digital Health, District Nurses, the Infection Prevention Officer, and the Contract Performance Officer.

The agenda for these meetings includes the following:

1. Updates on the agreed priority areas.
2. Update on administration.
3. Feedback from reviews and visits conducted by each stakeholder, focusing on the agreed priorities and any new issues identified.
4. Input from residents, caregivers, and families.
5. Commissioning updates regarding visits and communication with the provider about any concerns.
6. Updates on Care Quality Commission (CQC) notifications.
7. Updates on communication strategies.
8. Decisions on further actions required or recommendations, including the escalation or de-escalation of issues.

MUST Training and Competency:

On 31 January 2024, all nurses and senior staff completed a mandatory training workshop on the Malnutrition Universal Screening Tool (MUST). The training covered the correct calculation of MUST scores using the BAPEN calculator. Evidence of attendance, course details, and syllabus are attached for the benefit of HM Coroner as Exhibit SA/1. We are pleased to report that the current staff team has been open to learning and has demonstrated a strong commitment to improving their documentation.

Nutritional Monitoring:

At the end of January 2024, the Registered Manager conducted a full nutritional analysis of all residents' weights. Any resident experiencing significant weight loss was flagged, and their care plan updated. A copy of the Resident MUST Care Plan is attached for the benefit of HM Coroner as Exhibit SA/2.

Since January 2024, at the end of each month, the Registered Manager is provided with a report on residents' weight. Again, any resident experiencing significant weight loss is flagged, and their care plan updated. An example of the monthly report is attached for the benefit of HM Coroner as Exhibit SA/3.

The Chef at The Home is kept appraised of changes to resident care plans in order that action can be taken to meet the nutritional needs of residents identified as being at risk. This includes, for example, fortifying food or preparing tailored meals.

Staff at the Home have ready access to all resident care plans and the Registered Manager also conducts daily walkarounds to ensure that care plans, including nutritional needs, are being adhered to.

Regional Manager's Oversight:

Weekly visits to the Home have been conducted since January 2024 (an continue as at today's date) by the Regional Manager, [redacted], to ensure that nutritional monitoring arrangements are being effectively implemented. These visits involve reviewing high-risk residents' MUST scores, ensuring they are accurately calculated, and verifying that care plans contain appropriate detail for managing residents' dietary needs.

Training and Compliance

All staff have undergone comprehensive training in key areas:

- Fluid and Nutrition Training: This course covers the principles of hydration, nutrition, and food safety and ensures that staff understand how to provide adequate nutrition in line with care plans.
- Documentation and Record-Keeping Training: This course reinforces the importance of accuracy, clarity, and completeness in documentation.
- MUST Training: as detailed above. Refresher training will be completed annually at the home for all new starters.

The above training programs ensure that staff members accurately document dietary and fluid intake, escalate concerns about significant weight loss, and follow the appropriate procedures to mitigate risks, such as referring residents to a dietician when necessary. The courses also include guidance on the completion of the 'Resident 7-day Booklet' which documents the following criteria in accordance with the individuals' identified risks:

- Dietary intake
- choking risk
- IDDSI level
- Review of food intake
- Fluid intake
- Target: … mls
- Review of fluid intake
- Review of output
- Handovers

All staff have now completed the training courses detailed above, and as such, we are confident they are competent and understand the level of detail required when completing fluid and nutrition intake charts. The staff also understand how to escalate when a resident experiences a significant weight loss by reporting to the Registered Manager and considering the fortification of food or a referral to a Dietician. This is evidenced through frequent 'dip-sampling' of care records which confirm records are now completed correctly to the required standard.

A list of all training courses provided to staff is detailed in the Training Matrix which is provided for the benefit of HM Coroner as Exhibit SA/4.

Oversight and Additional Improvements:

Since the death of Mr. Astley, we have introduced further improvements to enhance The Home's performance:

- Regular spot checks and 'dip-sampling' of care records are now conducted by the management team. This process ensures compliance with documentation standards and identifies any need for additional staff training.
- Fluid and food intake charts are closely monitored, and detailed handovers take place at every shift change so as to ensure no gaps in communication.
- Enhanced communication between care staff and kitchen teams has improved the quality and variety of food provided to residents, with specific attention given to residents identified as at risk.
- The outcome of the Inquest into the death of Mr. Astley has been shared with the staff team.

Conclusion

We are committed to ensuring the highest standards of care and have taken substantial measures to address the concerns identified during the January 2024 IMPACT audit and those raised by the Senior Coroner. These include improved staff training, regular reviews of documentation, and enhanced oversight processes.

The steps we have implemented are intended to prevent a recurrence of the issues observed in Mr. Astley's case. We firmly believe that these improvements will enhance the quality of care provided at The Home and ensure that our residents receive safe and effective care.

We hope this correspondence provides reassurance to the Coroner and Mr. Astley's family that the issues identified have been comprehensively addressed and that we are dedicated to continuous improvement in service quality.

Kind regards,

[redacted]

[redacted]

Managing Director, for and on behalf of Qualia Care Limited (In Administration)