Mr J E Thompson
Assistant Coroner for County Durham and Darlington
H.M. Coroner's Office
P.O. Box 274
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DH8 1HG

11 February 2025

Dear Mr Thompson

Regulation 28: Reply to the report to Prevent Future Deaths ('PFD') in relation to Mrs Sylvia Savage

Thank you for your comments at the conclusion of the inquest into the very sad death of the late Mrs Sylvia Savage. This letter sets out a response to the comments and the PFD report directed to the Four Seasons Health Care Group ('the Group').

May I firstly express my condolences to Mrs Savage's family for their loss. Please be assured that the safety of those in our care is the Group's absolute priority.

During the inquest that took place between 9 and 12 December 2024, you heard evidence from the Home's Manager [redacted] and Regional Manager [redacted] about initiatives and measures undertaken at Redwell Hills Care Home ('Redwell' or the 'Home') following the death of Mrs Savage. The Group has supplied information on the following issues:

1. Training of staff at the Home in relation to record-keeping and archiving
2. The Home's falls policy and processes

We now write to give you assurance that further steps have been taken and actions implemented to address the matters raised at the Inquest. These have been incorporated into the ongoing provision of care services at the Home and have been shared more widely across our business as part of our approach to learning and continuous quality improvement.

As an organisation, the Group strives to learn from all incidents affecting our residents or team members. The Group has considered aspects of care service delivery and practice in the Home openly and honestly, and where any lessons learned can be cascaded throughout the wider organisation to improve our overall care quality. The regional team and the senior/executive management team will continue to review your findings and disseminate and implement any consequent recommendations accordingly throughout the organisation.

Our organisation includes a dedicated Quality Team, with responsibility for process improvement, this includes direct support for each home. Regional Managers are regularly present in our care homes and are responsible for facilitation, monitoring and progress checking of change and improvement activity, alongside other members of the regional team.

I have detailed the concerns raised in your PFD report below followed by confirmation of the steps that the Home and Group have taken and will continue to take regarding these concerns.

Matters of concern

"1. There was I heard no clear definition of when to report falls externally & internally – this to me is perhaps the reason why the fall Mrs Savage suffered on 1/2/23 was not recorded internally, all be it CQC were notified on this occasion. The fall on 18/3/23 was not reported to CQC and whilst I understand staff at the care home did not know the outcome of Mrs Savage's treatment in hospital – she left the home by ambulance and did not return. This seems an occurrence worthy of reporting – it strikes me some clearer reporting structure is necessary – timely and accurate reporting both internally and to regulators allows for those concerned to assess the care home and decide on whether there are risks/issues that need addressing and protect residents. I would suggest over reporting is preferable to under reporting."

As set out in the witness statement of [redacted] dated 2 December 2024, the Group strives to learn from all incidents affecting our residents or team members. The Group has considered aspects of care service delivery and practice at the Home and across the Group openly and honestly alongside your expressed concerns.

The Group includes a dedicated Quality Team, with responsibility for process improvement, including direct support for each home. Regional Managers are regularly present in our care homes and are responsible for facilitation, monitoring and progress checking of change and improvement activity, alongside other members of the regional team.

The Clinical Risk Management Policy (also exhibited to [redacted]'s statement) was adopted by the Group in 2021, with a body of supporting material for guidance on falls risk and post-falls management. Falls Awareness training was introduced as part of an induction program to new home starters across the Group from April 2020 and then as mandatory training for all care and clinical team members from April 2021.

A Falls Process Flowchart has formed part of the new system in place after April 2021. Since April 2021, all care and clinical team members must complete falls awareness training, delivered by a learning management system complemented by on-site face to face training.

The Group operates a digital incident management platform (RADAR) which allows team members of all grades to report incidents affecting residents, team members and any visitors to the care home. The system also offers prompts to ensure appropriate categorisation of the incident and to support necessary further actions including referral to external agencies and management by regional support teams.

All Home Managers, Deputy Managers and members of the Group's regional team receive mandatory training on the use of RADAR and how to complete a report and any subsequent investigation.

When reporting a fall, a series of mandatory questions require answers to the following prompts – time and place, personal factors, environmental factors and any potential injury. The system asks for a description of the incident and what action was taken at the time. The team also have the option of uploading statements and pictures to aid an investigation. All incidents reported to RADAR are subject to investigation. The investigation is to be completed within 14 days, although this can be completed sooner if the detail is known to close the investigation or extended if a third party become involved such as the police, safeguarding and CQC. Notifications to local safeguarding teams are completed in line with local safeguarding requirements. CQC notifications are completed in line with CQC statutory notification requirements.

When any incident is reported to RADAR the Home Manager receives a notification via email. Incidents of a high level of seriousness are also alerted to regional and senior team members across the Group.

Each home in the Group is required to complete an incident analysis each month which is produced via the RADAR system, this is then validated during the Regional Manager Provider Validation Review which is carried out each month. This seeks to support consistency of application of Group policy and affords an opportunity for the regional team to address any issues quickly to inform ongoing practice.

A replacement learning management system, “Your Hippo”, a Skills for Care Endorsed Provider, was deployed at the end of 2023. Any new team members joining the business must complete all mandatory training within the first two weeks of commencing employment. Your Hippo uses a blended learning approach which consists of induction, training and shadow shifts to ensure that all colleagues are supported and integrated in the most effective way. During monthly audit visits undertaken by Regional Managers or Regional Support Managers, a selection of training records is reviewed to ensure compliance.

The Group works with external healthcare partners to manage falls risk, including GPs, district nurses and community falls prevention services: the exact resources vary between localities. The new overarching Falls Policy (exhibited to [redacted]'s statement) was adopted by the Group in May 2024, with specific focus on the management of referrals. The Falls Policy was designed to pull together existing documentation and processes regarding falls protocols, flow charts, person centred care planning expectations, risk assessments and risk management procedures. The Falls Policy also includes our expectations regarding what action we expect of our teams of all levels, when a resident experiences a fall.

Whilst we aim to empower residents to sustain and maintain their mobility for as long as possible, the Falls Policy advises our teams to refer falls to external support teams, where needed. When falls are logged to RADAR, prompts ask the team member completing the notification to consider a referral to the local community falls team and review equipment usage.

Falls monitoring is part of the key care indicators analysis produced by the Group’s Incident Analytics Lead and shared with operational team members for review and identification of trends, or emerging risks, to agree action, if any, is required. Further to this, the Group’s Quality Team provides additional support to homes where a high prevalence of falls is identified, which may include visits to the home to discuss actions with the Home Manager. Redwell Hills does not provide nursing care, and the care team works closely with external healthcare partners to support the nursing care needs of residents**.**

Each Home Manager completes monthly trend analysis using RADAR, which allows them to identify any patterns in terms of people, places, times of day etc where falls are more prevalent. This in turn allows the Home Manager the opportunity to review risk reduction measures already in place and identify additional appropriate action such as a referral to external healthcare partners. RADAR also supports oversight by the Regional Manager and other members of Regional Management to ensure that correct practice is embedded and followed, including referrals and reports to relevant external partners and notifications to appropriate regulators. Regional Management visits take place on a regular basis to ensure the completion of all documentation and appropriate escalation of any care needs and this includes a review of selected (at random) care files.

Team members must document any concerns about our residents on RADAR straight away and the Home Manager and Senior Care Assistants carry out spot checks and sitting in on handovers to support this. Refreshed training around RADAR reporting of falls has been introduced within the Group in the last 12 months, in conjunction with the roll-out of the Falls Policy, and the senior team at Redwell Hills has received this via the learning management system.

Residents who are showing any signs of deterioration have physical observations put in place and recorded for monitoring and these will be discussed with the Home Manager or Senior Care Assistant so that referrals may be made to health professionals quickly. Team members are to escalate any concerns as soon as they are noticed. Deteriorating residents are discussed in the daily flash meetings and any actions identified are then followed up by the Home Manager or deputy.

Team members at the Home have been reminded that handovers from one shift to the next must contain details of the resident’s needs, which will include equipment to be used, settings and frequency of aids and appliances, risks in respect of mobility and falls, skin integrity, hygiene, continence, choking, nutrition and support required for each care need and risk identified. Handovers will also identify any incidents such as falls during the shift, including those which may signal a need for a review of risk assessments or a referral to healthcare professionals. The handover which takes place is verbal using a written document as a record of the information shared.

"2. The evidence is clear that the provided sensor mat was not an efficient way of monitoring Mrs Savage when she attempted to mobilise. It was well known in the home that Mrs Savage defeated it's purpose by moving or unplugging it. There seems to have been a lack of thought as to an alternative measure. The wall mounted sensor, for example was seen by the expert as a reasonable measure – the home manager said he could consider them and the regional manager indicated they were used in the company, but not at the care home where Mrs Savage was residing. It seems to me the home should have an armoury of measures to pick from to tailor the needs of the individual resident not just limited to one particular measure. The risk of death is obvious to others if persons at high risk of falls are not known to be moving by those charged with looking after them".

Mrs Savage had been admitted to the Home initially as a temporary placement on 14 December 2022. For new admissions, upon receipt of a referral or enquiry, details about the person to be admitted to our homes will be taken and a pre-admission assessment will be completed. The information obtained at the pre-admission stage will seek to include everything that the home requires to ensure that the needs of the person can be met safely, and to ensure that there is continuity of care, treatment and support for the person, and this information is used to commence formulation of care plans and risk assessments, including mobility needs and falls risk. All risk assessments are to be completed within 12 hours of admission and care plans finalised within 72 hours, these documents are reviewed monthly as a minimum, or as a change in resident need is identified.

Following any hospital stay, when a resident is due to be discharged back to the care home, the Home Manager or senior representative will complete an assessment to establish any change in need, including mobility and falls risk, to be certain that they can still meet those needs. On re-admission to the home, individual risk assessments and care plans are to be reviewed and updated, where required, within a recommended timescale of 12 hours. A series of How to Guides gives additional support to team members in specific clinical and support areas, including a How to Guide on the assessment of falls risk.

We strive to mitigate falls risks whilst recognising that sensory equipment cannot of itself prevent a fall but provides staff a signal of a resident moving or mobilising and a window to attend the area where movement has been detected to assist the resident. Certain incidents may be categorised as a "near miss" as staff have prevented a possible fall from happening and will inform ongoing practice just as a fall in terms of lessons that may be learned.

Residents' wishes are respected as part of the care planning and risk assessment process with a view to ensuring that clear evidence of risk has been explained and understood. Whilst respecting that Mrs Savage's rights to freedom of movement and independence with mobilising were empowered by the team at Redwell Hills, we acknowledge that further assessment of reticence to utilise the sensor equipment in place, and consultation with Mrs Savage's family members, may have further supported the falls management process.

The Group has access to a range of sensor equipment to support the needs of residents, including infrared motion detectors. Sensor mats are often favoured as they alert teams to a resident attempting to mobilise and can be moved with the resident if they choose to sit in lounge areas, for example. Infrared motion detectors can be troublesome for residents who can walk short distances independently as they will ring constantly when the resident is moving around their bedroom and the noise and consequential agitation that may be experienced may lead to further risk of harm or injury. It cannot be said with any certainty that Mrs Savage would have responded better to a different sensor measure, but it is acknowledged that the care provided to Mrs Savage following her falls on 1 February and 18 March 2023 was reactive rather than proactive and that although there were multiple discussions regarding her care, further interventions such as consideration of a wall mounted sensor were not deployed.

Following the concerns noted at the inquest, regional teams have reminded all Home Managers as to the scope of equipment available to them through the Group procurement department, to support falls reduction. This equipment is available to any resident, in accordance with their assessed needs and risk assessment. Regional teams will incorporate this into their regular audit of home practices.

On reflection a focussed meeting with Mrs Savage's family should have taken place and discussion held around her dislike of the sensor mat. A best interest decision could have been made and an informed decision taken on whether it was more detrimental to have the sensor mat in place. In addition, the Home could have discussed and considered infrared motion monitoring equipment as an alternative.

[redacted] recognises the responsibility to take forward the lessons learned, share these with the team and ensure they are implemented and sustained moving forward. An important lesson was communication with residents' families as to the different areas of care needs. Positive dialogue is to be constantly promoted in respect of any areas of concerns of high need, as well as being transparent and person centred at all times.

The Home now operates more positive lines of communication with families, including them in the care decisions and providing as much information possible to support informed decisions, as evidenced in some of the positive feedback the Home has received though Customer Satisfaction Surveys and other ad-hoc review processes.

"3. Mrs Savage's fall in February 2023 was it appears reported to her GP by her daughter and that led to a nurse attending the home to examine her. Staff at the home do not appear to have done so themselves. It is of concern that after a fall the staff within the home should have a mechanism to ensure medical advice is obtained in a timely fashion and that it is documented clearly and not be reliant on family members summoning help for residents themselves when they have become aware of an incident."

As detailed below, a number of courses have been undertaken by the care team at the Home covering refresher training on obtaining professional medical advice promptly in appropriate circumstances.

The Home has adapted practice around falls team referrals sent through the Community Matron, focussing on a wider scope of equipment used to mitigate the risk of falls.

All Home Managers now take part in a Falls Forum attended by Regional Managers and Group management on a monthly basis. Discussion focusses on falls in the Group's homes and what we are doing to mitigate risk and achieve the best, safe support for our residents. This allows best practice to be reinforced and any new initiatives to be cascaded quickly.

All visiting professionals including General Practitioners will now be prompted and requested to complete the Visitors Book on arrival to the Home and to await a member of the team to announce their arrival so that they can be accompanied on all visits by a senior member of the care or clinical team, to ensure that any advice or recommendations can be communicated as needed. Senior Care Assistant staff or a Unit Manager on duty will go with the healthcare practitioner when they attend and review and treat our residents. The Senior Carer will then document information in the Healthcare Professionals Visit form. The information recorded will confirm the time and date of the visit and the name of the practitioner. The practitioner will be asked to verbally agree that the information and details are correct or advise of any changes as necessary or appropriate and the date of the next visit will also be recorded.

All significant visits and communications/conversations with visiting health professionals should be recorded in the visiting professionals' section of the resident care plan in any event, with a carer making an accurate record of the visit and any recommendations or actions and shared in the handovers of any resident who has received a professionals visit that day.

The Home Manager or Deputy Manager will review the Healthcare Professional Visits records during monthly audits and will escalate any concerns immediately.

A Themed Supervision for Senior Carers is now in place which sets out the procedure above. A reminder about the process to all care home staff is contained in the daily Flash meeting template/agenda.

"4. The absence of records has hindered my investigation into Mrs Savage's death. The expert in her evidence made it clear – good recording keeping allows staff to monitor changes in her condition, allows new staff or those returning from time off to reacquaint themselves with residents' condition and allows clinicians to make diagnosis – without access to good records I can see a clear risk to the care of residents. It is also surprising to me the complete reliance on paper records which have in Mrs Savage's case have been lost. I would have expected to see electronic recording of information and electronic storage of it. I note the roll out of this in the company has been paused whilst the company is awaiting sale, and my concern is whether the electronic recording and storage will be implemented – to me immediate access to records of a resident or absence of them creates concern"

We acknowledge the shortcomings in record-keeping at Redwell Hills as addressed in the Home Manager's statement of 1 December 2023. Record-keeping training and guidance has been heavily promoted within the Home since the issues were identified in connection with Mrs Savage's death. All existing clinical and care team members have been required to refresh mandatory courses on record-keeping training. Care plan and documentation training was booked for team members at the Home as a face-to-face course following the incident and has taken place regularly with multiple sessions covering the full care team, the last taking place on 8 August 2024. The courses have covered contemporaneous noting of daily events, professional visits and emerging risks, entries in the Group's incident management system, RADAR, and proper archiving.

A new "How to Guide" for archiving was published and distributed throughout the Group in October 2024, providing clear standards and expectations around the care, storage and safe keeping of records. A training module on the Group's learning management system is also being developed and roll out is expected shortly. This will be additional guidance for the Home's teams in relation to GDPR and the safekeeping and storage of records.

As stated in the Home Manager's statement, the How to Guide for archiving has been shared with the team in group supervisions and confirmed in team meetings. Expectations for storing and archiving paperwork have been confirmed with the team and they are aware as to the importance of accurate record keeping. Additionally:

- Storage is a mandatory agenda item at meetings that are held every six to eight weeks.
- The Home Manager has discussed the lessons learned around this matter in handovers and flash meetings.
- The Senior Care team and Home Manager are completing daily checks of room documentation and the information recorded on that to ensure quality and accurate content.
- On each unit the Home has a filing cabinet for staff to store records at the shift end, then at the end of the month the Senior Care Assistants check files and documents are archived appropriately to ensure a complete history of resident care needs and care delivery. The process has been explained and demonstrated to each member of staff and recorded in supervisions, including on the completion of all daily notes and charts and the required detail to be captured.
- The Home Manager and Regional Management will continue to drive the importance of this documentation to permanent and support staff with knowledge and accountability for record keeping.

Regular monitoring and support are given by the Unit Manager, Home Manager, Deputy Home Manager and Regional Support teams to ensure all care staff understand the importance of effective record-keeping. Senior Care Assistants in the Home check charts for all residents throughout the day and sign the charts in red pen and report any defaults, omissions or errors or matter of concern to the Home Manager or Deputy

Manager on the same day. Daily notes and room charts are also checked by the Home Manager and Deputy on daily walk rounds and at the Flash meeting, where any concerns or information required are discussed and staff reminded to report any concerns to the Home Manager or Deputy in their absence.

Staff at the Home have been reminded that handovers from one shift to the next must contain details of residents' needs, which will include equipment to be used, settings and frequency of aids and appliances, risks in respect of skin integrity, hygiene, continence, choking, mobility and falls and nutrition and support required for each care need and risk identified. Supplementary documentation in use for each resident and the requirement for it to be competed on shift are also highlighted.

Falls and record-keeping awareness remain constant agenda items discussed within the daily flash meetings which are attended by all senior team members and department heads on duty. A daily walk round is completed by the Home Manager and the senior care team and all issues identified are discussed at the next flash meeting or sooner with relevant members of the team as necessary to ensure resident safety. A sample of care plans are checked each month to ensure compliance with the Group's processes

The process for daily record-keeping and storage of records has been explained to each member of the team and recorded in supervision notes, countersigned to confirm understanding. Throughout 2024 the Group rolled-out electronic medicines administration records ('eMAR') as part of continued investment in our homes, notwithstanding a sales process launched in June 2024. The system removes a lot of the paper in the medication process and with live reporting supports improved visibility at home and regional level. This investment in eMAR followed a wholescale Wi-Fi upgrade programme and serves to modernise and digitise a key area of how we work. The Group is piloting electronic care records at several homes as part of continued efforts to digitise intensive manual processes. In the meantime, the importance of proper record-keeping and archiving is a regular agenda item at flash meetings.

Supervisions have been completed with all care team members at the Home, regarding the standard required in respect of completion of care plans, risk assessments and supplementary documents and particularly room-based charts which document (for example) positional changes and food and fluid intake and daily notes updated at each observation. The supervision records also note the importance of recording communications with visiting professionals. As part of the supervision exercise, the importance of completion of all daily notes and charts, to ensure the level of detail is accurate, including details of falls, skin integrity, incontinence, diet, social engagement and mobility was discussed. The areas listed above are revisited regularly at flash meetings.

"5. The evidence I have heard is after Mrs Savage's fall on 1/2/23 and when it became clear the sensor mat was not working as intended – this should have prompted staff to return to the care plans and re-evaluate them – it did not. Indeed, one care home witness stated as Mrs Savage had not had 3 falls in 3 months no change to her plan was needed. Given the second fall Mrs Savage had some weeks later gave her injuries that led to her death this approach appears flawed. Whilst I acknowledge work is ongoing in this area it appears that prompt re-evaluation of the care plans after events such as a fall are necessary to prevent injury and death – I would ask for some reassurance that significant events are captured by staff and in turn their significance is carefully considered and if necessary changes made to care."

All care plans and risk assessments are reviewed monthly as a minimum. Each section of the care plan is to be reviewed more frequently should a change in need be identified or a risk highlighted, for example following a fall or other incident. As regards mobility care plans these should be evaluated following any fall or near miss or if any other change in need is apparent, for example a resident diagnosed with an infection which may impact balance.

We keep under review and if needed update the policies referenced above for all staff providing residential care at the Home and the Group more widely.

Thank you for raising your concerns. I hope that the content of this letter provides sufficient assurance that the Four Seasons Health Care Group takes the concerns raised seriously, has acted following the death of Mrs Savage and has accepted the points raised and continues to work to improve the services we provide. Should you have any questions or concerns or comments, please do not hesitate to contact me directly.

Yours sincerely

[redacted]

[redacted]
Director of Governance and Quality
Four Seasons Health Care Group