Friday 25th April 2025

Response for June Phillips

1.The documentation following a resident having a fall in the home is as follows the falls risk assessment (screening for tools part one and part two) are updated within 24 hours this is then followed through and documented within the care records. A root analysis tool along with an incident investigation form has now been implemented.

2. Body maps are in situ for resident who have sustained injuries and are updated daily, and photographs are taken of the wounds/injuries as evidence and are attached to the individual care plans.

3. Where the resident has a fall and sustains an injury a plan a care is put in place. The accident form is completed at the time of the fall and family notified. In the event of the resident sustaining an injury and, on a blood thinner 999 is called and documented. It is also the case following a fall and no apparent injury is identified 999 is also called when the resident is prescribed blood thinning medication.

4. GP's on weekly ward round from Northbrook Surgery have now implemented for good practice a detailed summary of their findings and outcomes for each resident and forward this information by email to the Care Home following the ward round. This Information is transferred onto each residents individual personalised care plan. This information is clear and transparent to all and avoids misunderstandings.

5. Professional i.e. social workers, best interest assessors are asked to document their findings directly on to the individuals personalised care plan. This again avoids miscommunication and clear and transparent understanding of the outcome.

6. Each staff member within the care home has received a supervision. It is recorded and discussed within the supervision the importance of reporting and recording in an accurate and timely manner. All supervisions as of February 2025 and before this time reflects this discussion

7. Staff meetings have been held following June Phillips fall where it has been discussed the importance of documenting and reporting accurately and timely. A Staff meeting took place as of 11th March 2025 to inform the staff of the Coroners Court hearing regarding June Phillips and to discuss the importance of completing an accurate assessment of each accident and incident and also reacting promptly and in accordance to policy and updated guidance.

8. Following the fall of June Phillips, we updated our policy regarding residents who sustain a head injury and are on a blood thinner medication 999 is called, but as

lessons learnt a resident on a blood thinner medication who falls regardless of a apparent injury 999 is now called for good practice.

9. Residents who fall regardless of been on a blood thinner medication and have no apparent or visual injuries 111 is called for advice.

10. Falls are reported to safeguarding and followed by a CQC notification.

11. A resident who sustains two or more falls is referred to the fall's clinic and 3 falls within a 3-month period regardless of any injury are referred to safeguarding and a notification to CQC.

12. All staff are receiving refresher first aid training along with manual handling training. As of March 2025, all staff are receiving their refresher first aid training this is ongoing. Also, refresher Manual handling training.

13. The manager has joined a managers support group on social media which has proved to be very informative. The manager is also attending registered managers forums which again as proved very empowering.

14. We have implemented a lead of documentation who is responsible for checking and over seeing i.e. falls and risk assessments. All accidents are audited monthly and responded to accordingly and in a timely manner.

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Care Home Manager