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For the attention of
Mr Cousins
HM Coroner for Blackpool and Fylde
PO Box 1066
Corporation Street
Blackpool
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Email to: [redacted]

22 July 2025

Dear Sir,

Inquest touching the death of Mr Keith Ineson
Regulation 28: Report to Prevent Future Deaths

I write on behalf of Barchester Healthcare (the owners of Glenroyd Care Home) to respond to the matter of concern raised by the Learned Coroner in the Prevention of Future Death Report (PFD) issued on 27 May 2025. The PFD was issued subsequent to the conclusion of the inquest into Mr Keith Ineson which concluded on 23 May 2025 at Blackpool Coroner's Court.

Mr Ineson very sadly died in hospital after a choking incident. He was in hospital where he was recovering from surgery performed subsequent, to a fall at Glenroyd Care home.

The concern raised by the Learned Coroner related to the recording of observations. The Coroner confirmed that there was no evidence that observations had **not** taken place but that recording of observations was inadequate. In particular the PFD provides:

It was noted in the evidence, that the observation scores taken for Mr Ineson following his fall had not all been recorded in Mr Ineson's care notes. This left a gap in the evidence as to reviewing the need for escalation to medical services after the fall. and

I could not identify changes to the record keeping system though, and as such found that the issue around the absence of recording observation scores following a fall gave rise to a risk of further death. This was because the record keeping was inaccurate, contained gaps in the information, and engaged my duty under paragraph 7, Schedule

5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

At the inquest the Learned Coroner heard evidence that observations had been carried out after the fall and that staff had escalated concerns to the out of hours service and general practitioner. Nevertheless, as stated above the system of recording was unclear and at times absent.

Whilst the Coroner has asked for an explanation regarding the recording of observations Barchester Healthcare wishes to set out its holistic actions which go wider than the concern in the PFD. Barchester Healthcare, were already embarking on the investment into a new digital system for observations, which coincided with the inquest. This will also be set out in detail below.

Barchester Healthcare wishes to reassure the Coroner that it is committed to learning from mistakes and experience and to encourage sharing of incidents in an open and transparent way with staff in a "no blame" culture as appropriate. Barchester Healthcare takes these issues very seriously and consistently strives for improvement.

On that basis It was deemed necessary by the organisation to conduct an investigation into how the events were recorded by staff following Mr Ineson's fall on 26 April 2024.Barchester Healthcare has carefully considered the matter giving rise to the concern in the PFD regarding the staff's recording of observations at Glenroyd Care Home.

Following the Inquest, Barchester revisited the issue of recording of all resident interactions and observations to ensure this is undertaken clearly, consistently and contemporaneously. We acknowledge that there was a need to improve the accuracy and regularity of record keeping. We have taken appropriate action in relation to training and technology to ensure that all interactions with patients are recorded.

Training

Additional training following the incident has taken place reinforce the need for appropriate responsiveness to incidents, as well as the need or clear documentation at all times. We have focused on documentation after events to ensure that staff are clear about following the established guidance for escalation after falls. Actions and lessons learned from this have led to specific training in targeted areas. Barchester Healthcare considers that on this occasion staff did escalate matters appropriately as in the evidence given, but we have taken the opportunity to share this sad case with staff to embed the actions that must be taken after an incident and the way that observations should be carried out and recorded We are confident that by implementing our new digital system as well as further reinforcement training staff are clear about the necessity for accurate and detailed recording (including observations).

In addition, the members of staff involved in the incident attended a Moving & Handling refresher training day with an Operational Trainer on 3rd June 2024. The moving and

handling refreshers are routinely completed yearly with every staff member and are part of the three-day refresher. This includes what to do after a fall.

This training is also supported with e-learning, as well as specific practical training completed by the Operational Trainers on the refresher sessions with slide sheets, equipment as well as a session within the refresher where staff have the chance to discuss more complex cases to learn the best way to support someone with more complexities with moving and handling to mitigate against falls happening in the first place.

Digital Care Planning System

The Learned Coroner will recall that in addition to the actions undertaken which were set out in the action plan submitted prior to the inquest, [redacted], the Registered Manager of Glenroyd Care Home explained that Barchester has implemented a new digital care planning system called EnabLE which provides Barchester healthcare services with the ability to set up planned post fall interaction scheduled observations that can be recorded **at the point of care** to ensure accuracy and eliminate the risk of absent recordings. The system is relatively new, and we have completed some additional training with staff and themed supervisions, to ensure they know how to add to the scheduled observations. We are auditing the use of the systems – see below.

In the event that a resident falls or is found on the floor, the electronic recording provides system alerts to be set up to highlight the interactions that **must** be completed by way of a post fall assessment which includes:

- Pain level assessment
- Visual skin checks and any changes with wounds
- BP monitoring, heart rate monitoring and respiration monitoring
- Any changes to mobility.

This system also has a section for the recording of notes which are sent to the handover team to inform them of any changes. This allows for very effective communication – both written and oral updates on a service user's status.

The post falls observations that are on the digital system set out all the matters that must be included such as details of the incident, the resident's wellbeing, and confirmation that the detailed observations have been completed. Therefore, the events before, during and after a patient's fall will be entirely accurate and there will be less opportunity for there to be gaps in a patient's record.

All staff have had in depth training on this digital system, and continue to have support sessions from a Senior General Manager for the region. A General Manager from another Barchester home is an EnabLE champion for the region and will be in the

home weekly for the next month providing support for the in-depth training being rolled out as well as drop-in sessions for the existing team who are already trained.

These sessions so far have involved the completed supervisions for individuals around falls, and actions taken including the detailed documentation to be completed after a fall which includes:

- Falls diary
- Multifactorial falls risk assessment
- Moving and handling support plan review
- Risk assessments related to that individual to be reviewed, healthcare professional records
- Observations (captured on post falls)
- Conversations with next of kin

In addition to the training programme and support staff are provided with an added prompt sheet to support them in the completion of documentation. This is part of a "belt and braces" approach to training.

As part of the continuing programme of learning the region's EnabLE champion who supports the home with EnabLE will continue with the provision of drop-in sessions, documentation audit and will continue to monitor remotely for any trends in learning needed around the digital system to ensure adherence to the actions triggered in the new system.

NEWS2 Observation Records

Our new digital system limits any opportunities missing entries in relation to observations. Our observations are recorded on the digital system in a NEWS2 (National Early Warning Score) observation record, rather than manually written. The training for this has been completed in the home, and we also have oversight by the regional Clinical Development Nurse who supports all her homes monthly and looks at the system to make sure everything is recorded as it should be.

The training statistics for the home are 100% for NEWS2 in the home which ensures the accuracy, frequency and consistency of recording observations. Every Nurse, Senior carer and Care Practitioner has completed NEWS2 training, and three new bank nurses are in the process of completing their induction of which NEWS2 is part of the process. All NEWS2 training is completed on induction into the home, we have checked the recorded dates of NEWS2 training, and the dates have been recorded in the Learning Management system.

The new care planning digital system has also been refreshed when starting this new system and has guidance sheets on the NEWS2 interaction attached for reference for

staff to access ‘at the point of care’. The training which the staff have received assures limited risk for observations to be absent.

All Senior carers, Care Practitioners and Nurses in the home have completed the RESTORE, NEWS2 and Sepsis training and completed a themed supervision for recognising deteriorating adults in their care. Senior carers attend the senior care programme which contains all workshops which discuss and teach over clinical deterioration, observations, medication management how to safely be in charge of a residential community.

Further, lessons learned as stated above, include correct moving & handling techniques. The falls policy has been reviewed by all clinical staff to ensure that everyone is aware of the policy and procedure following a fall (supported by the NEWS2 and RESTORE training above) therefore any need for escalation to medical services following a patient’s fall will be abundantly clear. The prompt sheets and guides created give an oversight of completion and can be checked by management, thereby mitigating the risk of the recording of inaccurate and irregular observations.

We take all concerns raised extremely seriously and wish to reiterate that the health, safety and wellbeing of our residents is of paramount concern. We hope this explanation offers reassurance that the risks of recurrence of the issue identified in the PFD have been mitigated in so far as possible.

We offer our condolences to Mr Ineson’s family and friends for their loss.

Yours faithfully

[redacted]

[redacted]
Director of Nursing and Dementia