Cardinal Healthcare

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Mr David Reed

HM Senior Coroner for Worcestershire

Response to Regulation 28 Prevention of Future Deaths Report
Regarding the Death of Mr. Alfred Edward Sparrow
Cardinal Healthcare - The Meadows Nursing Home

We are writing in response to the Regulation 28 Prevention of Future Deaths report issued following the inquest into Mr Sparrow's death. We take the coroner's concerns very seriously and have conducted a thorough review of our practices and processes. Below, we address each concern in detail, outline the actions taken, and propose future improvements, all informed by reflective practice and lessons learned from this case.

1. Concern Regarding Mealtime Assistance

The coroner's first concern revolves around the care provided to Mr Sparrow during mealtimes. His care plan at his previous care home specified that he required full assistance with food and fluid intake due to his diagnosis of vascular dementia. However, care notes documenting his food and fluid intake did not clearly indicate whether he was being assisted, raising concerns that Mr Sparrow might not always have received the assistance required, potentially putting his health at risk.

Our thoughts on the Issue

His care plan was assessed when Mr Sparrow was admitted to The Meadows Nursing Home on 11 September 2023. We concluded that, while he had a diagnosis of vascular dementia and his previous home had recorded that he required full assistance with eating, he still demonstrated some ability to feed himself. Encouraging independence was essential to maintaining Mr Spar-

row's dignity and preventing deskilling, which his daughter confirmed in her statement: "My father was moved into The Meadows Care Home on the 11th of September 2023. He was alert and able to feed and drink unassisted."

However, we acknowledge that while our intentions were to respect his dignity and foster independence, our documentation needed to reflect this nuanced approach fully. The failure to explicitly record whether staff assisted Mr Sparrow during meals created uncertainty. This omission highlights where we must improve our practices to ensure transparency and clarity in care records.

Actions Taken and Future Improvements

Care Plan and Documentation Review: A full review of all resident care plans is underway to ensure they accurately reflect each resident's needs and any changes in their condition. In Mr Sparrow's case, we now realise that his ability to feed himself may have fluctuated, and such fluctuations should be recorded better in care notes.

Training in Person-Centered Documentation: All staff receive additional training to improve their documentation of the level of assistance provided during meals. It is critical that staff not only record food and fluid intake but also specify the level of support provided to the resident, whether full assistance or encouragement.

Implementation of Care Vision: We are in the final stages of contracting a new care planning system, Care Vision, which we hope will be fully operational by January 2025. Care Vision will prompt staff in real time to record food and fluid intake and flag incomplete entries to the management team. This system will ensure that detailed, accurate information about the level of assistance provided is recorded at the point of care.

Spot Checks through the "Resident of the Day" System: Until Care Vision is fully implemented, the home manager will conduct daily spot checks of care notes as part of the "Resident of the Day" system. These checks will help identify any documentation gaps and ensure corrective actions are taken where necessary.

Recruitment of new full-time clinical lead: We have recently recruited a full-time clinical lead at The Meadows, who is now part of our management team. The introduction of this Clinical Lead will allow the Home Manager to focus more on overseeing the overall operations of the home and strategic planning while ensuring a more effective delegation of clinical responsibilities. The Clinical Lead will provide enhanced support to nursing staff, ensuring that care plans, including mealtime assistance, are regularly reviewed and accurately documented. This addition to the management team will ensure that care is delivered according to each resident's needs and that documentation standards are rigorously upheld.

2. Concern Regarding Inaccurate Record of Fluid Intake

The coroner's second concern is a false entry in Mr Sparrow's care notes. The entry indicated that Mr Sparrow had consumed 200ml of tea at 20:30 on 1st December 2023, which was two hours after he had passed away. This raised serious concerns about the accuracy of care records and the possibility that staff were documenting care actions retrospectively, potentially compromising the safety and well-being of residents.

Our Thoughts on the Issue

While we acknowledge the inaccuracy of the 20:30 entry, we believe it was the result of late documentation rather than intentional falsification. Staff members sometimes input care notes after their shifts when using our current care planning system, Fusion, which does not prompt staff to document care in real-time. Care and resident safety tend to be prioritised over administrative tasks, occasionally leading to delays in notetaking.

However, we agree that this practice is unacceptable, and the incident has exposed an important weakness in our system that must be addressed immediately. The late entry of care notes is a known issue that can lead to mistakes, as demonstrated in Mr Sparrow's case, where a staff member from the day shift inputted the 20:30 entry after their shift.

Actions Taken and Future Improvements

Implementation of Care Vision: The new care planning system, Care Vision, will prompt staff to document care activities, including food and fluid intake, at the point of care. This system will flag if records are not completed in a timely manner, and managers will be alerted to any incomplete or delayed entries. Care Vision will be fully operational by January 2025.

Reflective Practice and Staff Accountability: All staff have already participated in reflective practice sessions, which focus on the importance of timely and accurate documentation. During these sessions, staff discussed the impact of inaccurate entries on resident safety and the legal and ethical responsibilities they carry in their role. In the future, staff who fail to complete documentation in real time will be subject to disciplinary action.

Spot Checks and Monitoring: In the interim, the home manager will continue to use the "Resident of the Day" system to review daily care notes and ensure that staff complete documentation accurately and in a timely manner. This system provides an immediate layer of oversight while we await the full implementation of Care Vision.

Supervision and Mentorship: Senior staff mentor new staff members to ensure they know the importance of recording notes promptly. We will also ensure that staff have the time and support needed to document care without feeling pressured by other duties.

3. Concern Regarding Oversight in Investigation

The third concern relates to the internal investigation conducted by the manager of The Meadows Nursing Home, [redacted], following Mr Sparrow's death. While reviewing his care plan and care notes and speaking to staff, Mrs Hawkins did not identify the false entry made on 1st December 2023. The coroner expressed concern that this oversight could have delayed identifying the issues raised in concerns 1 and 2.

Our Thoughts on the Issue

The investigation into Mr Sparrow's death was initiated by the Care Quality Commission (CQC) in December 2023. Ms. Hawkins conducted a thorough review based on the information available. Her investigation report was submitted to CQC, the local authority (Kerion), and the safeguarding team, all of whom reviewed the findings and raised no concerns. The safeguarding team ultmate-

ly closed the case with a single recommendation: to ensure that a duty of candor was exercised with Mr Sparrow's family.

Although the error regarding the 20:30 entry was not identified during this investigation, we believe it was an unfortunate oversight rather than a failure of the investigation process. Multiple commissioning and compliance teams reviewed the evidence, and none flagged the error. However, we recognise that this oversight highlights the need for more rigorous review processes and enhanced investigative procedures.

Actions Taken and Future Improvements

Improved Investigative Procedures: Moving forward, all internal investigations will involve a multi-layered review process, ensuring that senior management reviews the findings before reports are finalised. This additional oversight could help prevent essential details from being overlooked.

Training for Managers: All home managers, including [redacted] will receive further training on conducting investigations, with a specific focus on reviewing care documentation and identifying discrepancies. This training will ensure that managers are equipped to identify and address potential issues more effectively in the future.

Collaborative Reviews with External Bodies: We will continue to work closely with external agencies such as CQC, the local authority, and the safeguarding team to ensure thorough, collaborative reviews of all future investigations. This will allow for multiple perspectives and additional oversight, reducing the likelihood of errors being missed.

Reflective Practice on Investigation Processes: Reflective practice sessions have been held with management to evaluate the investigation into Mr Sparrow's care. These sessions have identified several areas for improvement, including more careful scrutiny of care notes and more transparent communication between staff and management.

Patterns and Areas for Improvement

Upon reviewing all three concerns, we have identified several common patterns:

Documentation: A recurring theme in concerns 1 and 2 is the importance of accurate and timely documentation. Staff must record what care is provided and how it is delivered, including specific details such as the level of assistance during meals.

Systemic Oversight: Concern 3 highlights the need for stronger internal and external oversight during investigations. The failure to detect the entry in Mr Sparrow's care notes occurred within The Meadows and during multiple external reviews. This could suggest a need for better communication and collaboration with external agencies.

Technology: Concerns 1 and 2 reveal the limitations of our current care planning system, Fusion. The absence of real-time prompts for staff to record care activities increases the likelihood of late entries, which in turn can lead to inaccuracies. Implementing Care Vision will address this issue directly by ensuring care is recorded at the point of delivery.

Reflective Practice: We have conducted reflective practice sessions with our staff and management team, focusing on the lessons learned from Mr. Sparrow's case. These sessions have been

Instrumental in identifying areas for improvement and reinforcing the importance of accurate documentation, timely reporting, and thorough investigations. We are committed to fostering a culture of continuous learning and accountability within our team.

Conclusion

The Meadows Nursing Home is deeply committed to addressing the concerns raised in the Regulation 28 report and ensuring that we provide our residents with the highest standard of care. The steps we are taking—implementing Care Vision, enhancing our documentation practices, improving investigative procedures, and conducting reflective practice sessions—demonstrate our dedication to learning from this incident and preventing future occurrences.

We recognise that the key to our improvement lies not only in the systems we implement but also in the invaluable feedback from our staff. Their insights and experiences are crucial in shaping our practices and ensuring that we continually evolve to meet the needs of our residents. We are fostering a culture of open communication and collaboration where every team member feels empowered to contribute to our shared goal of excellence in care.

While we acknowledge the mistakes made in this case, we firmly believe that the changes we are implementing will significantly enhance our processes and ensure that our residents receive the care they need and deserve. We extend our sincere condolences to Mr Sparrow's family and remain committed to acting on the coroner's recommendations as we strive to continuously improve our care practices.

We extend our sincere condolences to Mr Sparrow's family and are committed to acting on the coroner's recommendations.

Action Plan: Response to Regulation 28 Prevention of Future Deaths Report (Mr. Sparrow)

Objective: To address the coroner's concerns regarding Mr. Sparrow's death and implement necessary improvements to ensure the highest standard of care at The Meadows Nursing Home.

1. Care Plan and Documentation Review

Action:

- Complete a full review of all resident care plans to ensure they accurately reflect the needs and care provided.
- Implement consistent documentation practices for fluctuating levels of assistance, especially during mealtimes.
- **Responsible Person:** Home Manager / Clinical Lead
  Timeline:
- Care plan review completed by **15th October 2024**
- Ongoing documentation checks: **From 16th October 2024**

2. Training on Person-Centered Documentation

Action:

Provide training to all staff on accurate and detailed documentation, especially regarding levels of mealtime assistance.

Ensure training covers the ethical and legal responsibilities of real-time documentation.

Responsible Person: Clinical Lead / Training Coordinator
Timeline:

- Training sessions to be completed by: **30th October 2024**
- Follow-up competency assessments: **By 15th November 2024**

3. Implementation of Care Vision System

Action:

- Finalise the contract and implement Care Vision, a new care planning system that prompts real-time documentation.
- Ensure all staff are trained on using the new system effectively.

Responsible Person: IT Department / Home Manager
Timeline:

- Full implementation by **31st January 2025**
- Staff training on Care Vision completed by **15th February 2025**

4. "Resident of the Day" Spot Checks

Action:

- Continue daily spot checks of care notes until the Care Vision system is fully operational.
- Focus on identifying gaps in documentation and taking immediate corrective action.

Responsible Person: Home Manager
Timeline:

- Daily checks are to be conducted **immediately**, starting **25th September 2024**
- Continue until Care Vision is operational: **Until 31st January 2025**

5. Recruitment of Full-Time Clinical Lead

Action:

- Ensure the Clinical Lead monitors the accuracy of care plans, documentation, and mealtime assistance.
- Assign clear clinical responsibilities to the new lead for oversight of resident care.

Responsible Person: Home Manager
Timeline:

- Clinical Lead in full operational role: **Already recruited, ongoing monitoring**

6. Addressing Late Documentation

Action:

- Implement an interim system of manual reminders to staff to ensure timely documentation until Care Vision is operational.
- Immediate disciplinary action should be taken against staff members failing to document care in real-time.

Responsible Person: Clinical Lead / Home Manager
Timeline:

- Manual reminder system active: **Immediate**
- Monitoring via "Resident of the Day" system: **Ongoing**

7. Staff Reflective Practice on Documentation and Accountability

Action:

- Continue reflective practice sessions for all staff to emphasise the importance of accurate and timely documentation.
- Introduce further reflective practice specifically for those involved in Mr. Sparrow's care.

Responsible Person: Home Manager / Clinical Lead
Timeline:

- Reflective practice sessions: **Monthly, starting 10th October 2024**

8. Improved Investigation Procedures

Action:

- Introduce a multi-layered review process for internal investigations to prevent oversights.
- Train all managers on thorough documentation review and the investigation process.

Responsible Person: Operations Manager / Home Manager
Timeline:

- New review procedure established by: **30th November 2024**
- Manager training completed by **15th December 2024**

9. Collaborative Reviews with External Bodies

Action:

- Strengthen collaboration with external bodies like CQC and the safeguarding team during future investigations.

Responsible Person: Home Manager / Compliance Manager
Timeline:

- Initiate collaboration framework by **1st October 2024**
- Ongoing for future investigations

10. Supervision and Mentorship for New Staff

Action:

- Assign senior staff to mentor and supervise new staff, ensuring they understand the importance of prompt and accurate documentation.
- Implement ongoing mentorship to foster accountability.

Responsible Person: Clinical Lead
Timeline:

- Mentorship program to begin: **Immediately**, from **25th September 2024**

Conclusion:

This action plan ensures timely and effective improvements to address the coroner's concerns, focusing on enhancing documentation accuracy, staff accountability, and care quality. We will monitor progress regularly and adjust timelines as necessary to ensure all actions are completed on schedule.

[redacted]

[redacted]

Director