Activecare Ltd
T/A Westwood Hall Nursing Home,
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David Lewis
Assistant Coroner for Liverpool and The Wirral

By e-mail only

30 January 2026

Dear Mr Lewis,

Inquest Touching the Death of Dorothy Ann Macdonald

Thank you for your Regulation 28 report of 17 December 2025 following the Inquest into the death of Dorothy Ann Macdonald (hereinafter "Mrs Macdonald"). I am responding on behalf of both Activecare Ltd t/a Westwood Hall Nursing Home (hereinafter "the Home") and the overall care provider, Springcare Limited.

I know that you will share a copy of this response with Mrs Macdonald's family, and I would like to take this opportunity to express my condolences for their loss.

Concerns Raised

In your Regulation 28 report you raised the following concerns with regards to the Home:

- That staff had incorrectly assessed and documented Mrs Macdonald's risk of falling as being at 'low' and later 'medium' likelihood, and that they had also underestimated the likely impact of the harm resulting in an understated overall risk score;

- That falls risk training was not effective and/or being adopted properly by those staff members responsible for undertaking falls risk assessments; and

- That there had been a failure to refer to the Falls Team in accordance with the Falls Policy

In light of the above concerns you have sought clarification as to the steps which are being taken to ensure that all relevant staff have received, understood and consistently act upon suitable and sufficient training in the assessment of falls risk. You have further asked for clarification as to how the Home will satisfy itself:

a) that all relevant staff have received, understood and consistently act upon suitable and sufficient education about the circumstances in which, and how, a referral to the falls team should be made; and

b) that the service is sufficiently responsive and effective in responding to requests for its specialist input.

Response

At the outset I would like to reassure you that we have reflected seriously upon the contents of your Report, both within the Home and across the broader service, and that we welcome the opportunity to identify learnings, as well the opportunity to both improve the quality of our care provision and strengthen the existing policies and procedures where appropriate.

Assessment and Documentation of Falls Risk

I acknowledge that Mrs Macdonald was initially assessed by the deputy manager at the Home as being at low risk of falls. This assessment was made on the basis she did not have a falls history, and it was understood and anticipated that she would not be very independently mobile. Whilst we do not consider that it was unreasonable for the deputy manager to initially assess the risk as low on the limited information available at that time, I accept that there may be a limited range of opinion in this regard which could include Mrs Macdonald being deemed at a higher level of risk in view of her frailty, dementia and potential for a serious adverse outcome in the event of a fall.

Despite the initial assessment of the falls risk as low, Mrs Macdonald was placed on a system of hourly checks from the outset in order to monitor her. Within days of her arrival at Westwood Hall and prior to any falls occurring, it was quickly ascertained that Mrs Macdonald was in fact capable of mobilising independently and was doing so. Staff accordingly identified that her overall falls risk was correspondingly significantly higher than first thought. Consequently, the frequency of the safety checks was immediately increased to every 30 minutes, and the use of a bed/chair sensor pad was implemented.

These risk prevention measures, which were appropriate for someone with a high to very high risk of falls, were clearly documented in the care notes ensuring that all staff caring for Mrs Macdonald were fully aware of the increased and significant risk and the mitigation measures in place. The relevant risk assessments and care plans for Mrs Macdonald were reviewed and updated to reflect these additional enhanced measures. However, it is acknowledged and accepted that, due to an administrative oversight, staff omitted to also amend the numerical risk rating on the electronic record system.

After each of Mrs Macdonald's subsequent falls staff reviewed the measures already in place to determine whether any additional steps could be taken. Mrs Macdonald was

respectively: i) moved to a room affording increased visibility to staff, ii) provided with a raised toilet seat to assist her in getting on and off the toilet, and iii) had her recliner chair swapped for an ordinary armchair at the family's request. These measures were also documented and recorded in the care plans and notes.

I would therefore respectfully contend that Mrs Macdonald's risk of falls was appropriately assessed, monitored, reviewed and identified as high prior to any falls occurring. I do accept that the numerical overall risk rating was not correctly updated on the electronic record system to reflect the identified increased risk, however, this omission had no practical impact on the care which was actually provided to Mrs Macdonald or the risk reduction measures which were put in place. These were comprehensive and entirely appropriate in all the circumstances and I note your findings in that regard.

I would respectfully submit that this was a discreet error of documentation, not one of risk assessment or care provision, and is not reflective of general failings or inadequacies in falls risk assessment at Westwood Hall. I am furthermore confident that all of the residents at Westwood Hall have had their falls risks assessed and correctly identified, that they all have appropriate falls prevention measures in place, and that these are clearly documented in the care records.

To ensure this is the case we have undertaken a review of all residents' care plans and documented risk scores to ensure that these numbers correctly reflect the identified falls risks. We have also provided refresher training to the relevant staff to ensure that these risk scores are appropriately adjusted on the system when risk assessments and care plans are reviewed and updated. This has been documented as a supervision.

Training

I can confirm that the staff who are responsible for assessing and reviewing residents' falls risk at Westwood Hall have been sufficiently and suitably trained. They understand and consistently act on this training, in conjunction with their clinical judgement and experience, so that a resident's risk of falls is assessed, monitored and reviewed with increased risks promptly identified and responded to. I enclose key training documents for your reference.

I would furthermore like to reassure you that Springcare undertake monthly reviews and audits of residents' care across its whole provision in order to identify any relevant trends, patterns or areas where the provision can be bolstered and enhanced.

Referrals to the Falls Team

Springcare are currently reviewing their Falls Policy to determine whether further, more specific guidance can be included regarding when and in what circumstances a referral to the Falls Team should be made.

It is necessary to consider that residents' frequency of and propensity for falls can vary extensively based on their individual situations and capabilities, and that a single set of guidelines or prescribed course of action may therefore not be appropriate in every circumstance. It is also necessary to take into account the fact that not all areas offer a Falls Service to which referrals can be made. Efforts are, however, being made to identify a broad-brush approach which managers can adopt, in conjunction with their own clinical judgement and/or advice from GPs or other external medical professionals.

In the interim and in response to the concerns raised, Westwood Hall has adopted the approach of referring any resident who has fallen, regardless of the circumstances, to the Falls Team. Staff have been made aware of this new approach.

Neither Westwood Hall nor Springcare is in a position to ensure that a Falls Service, a third-party service, is sufficiently and effectively responding to requests for its specialist input. Westwood Hall are, however, implementing a system whereby any referrals made to the Falls Team are chased up after 2 and 4 weeks respectively where no response has been received, and that these chasers are documented in the resident's care records.

Thank you again for bringing your concerns to my attention. I trust that this response provides assurance that appropriate action is being taken to address those concerns.

Yours sincerely,

Operations Manager
Springcare Limited