

13th March 2025

Miss. Sarah Wood,
Assistant Coroner,
Coroner's Court,
The Council House,
Old Market Square,
Nottingham,
NG1 2DT.

Dear Miss. Wood,

**REF: Response to Regulation 28 Report to Prevent Future Deaths
Mr Ronald Colin Nelson (Deceased)**

On behalf of Mulberry Healthcare Ltd, I am writing in connection with the Regulation 28 report which was issued in connection with the death of Mr Ronald Nelson, who was resident of Mulberry Court Care Home ('Mulberry Court/the Home'). I would like to express my deepest condolences to Mr Nelson's family and friends.

Introduction

The Company and its staff strive to deliver the highest level of care to all residents. Prior to and during the course of the Inquest, the Registered Manager provided evidence to assist the Coroner's enquiry and to explain the care and treatment provided to Mr Nelson, specifically with regard to protecting his skin integrity and providing appropriate pressure management. The Registered Manager provided an open and candid account and explained the changes that were implemented following Mr Nelson's death to further strengthen care recording and compliance with care plans. A Regulation 28 report was however issued on 15 January 2026, which raised concerns about poor record keeping and compliance with care plans.

The Company has fully taken on board the concerns raised by the Coroner and is committed to taking any necessary steps to improve resident safety. The actions that were implemented following Mr Nelson's death, and actions taken post inquest to address these issues are set out below.



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Notwithstanding the Company's acceptance of the Coroner's findings that there were omissions in care records and compliance with the care records, we have reviewed the Coroner's judgement and make the following observations;

- Following Mr Nelson's first admission to NUH, Mr Nelson's sacral area was not photographed by staff at NUH until 19.17 hours on 22 October 2024, nearly an hour and half after he left Mulberry Court. At this point the records state that Mr Nelson had a Grade 2 pressure wound to the right buttock and SDTI to the left buttock. A Grade 2 pressure wound and SDTI can develop in under 1 hour in high-risk individuals (which Mr Nelson was), particularly if no pressure area relief is given, for example if he remained on a stretcher or trolley.
- We note that the Coroner found the Home's notes contradictory and suggests that they were misleading. However, to clarify, the descriptions of 'redness', 'sore' and 'skin intact' are all consistent statements to describe skin that is not broken down. These descriptions are consistent with a Grade 1 pressure wound. A Grade 2 pressure wound is where the outer surface of the skin is damaged and the skin is broken down.
- Whilst in the care of NUH, it is recorded that on 25 October 2024, Mr Nelson developed a Grade 2 pressure wound of the left buttock and a Grade 2 pressure wound of the sacrum. These were new wounds that not recorded in NUH's records when Mr Nelson was admitted to the Ward on 22 October 2024. The SDTI was described by staff at NUH as 'evolving'.
- Mr Nelson was reviewed by his GP on 16 December 2024, who reported that the pressure area was improving, with some areas of healing on the edges, suggesting that the plan of care was appropriate.
- When Mr Nelson was admitted to NUH on 16 December 2024, NUH's records record that a skin assessment carried out on 17 December at 05.33am and recorded that the pressure wound was reviewed on admission and was Grade 3. A further review carried out on 17 December 2024 at 07.19am again confirmed the pressure wound to be Grade 3. When Mr Nelson was transferred to the ward at and reassessed at 22.41pm, the pressure wound was assessed and at this stage was Category 4.
- As acknowledged by the Coroner, Mr Nelson had a number of comorbidities which impacted on his skin integrity and the healing process, including poor nutritional intake, weight loss, urinary and faecal incontinence (which resulted in more frequent dressing changes, lessening their efficacy), and prescribed medication.

Action taken in response to the Regulation 28 Report:

We have undertaken a review of the care delivery at Mulberry Court Care Home. This was independently led by a Manager from one of other services. Following this review, we prepared a service improvement plan (SIP). A copy of the SIP is attached at **Annex A**. The SIP was shared with both the CQC and ICB.

All actions listed on the SIP have been completed.

Dealing with the Coroner's specific concerns we have taken the following action:

1. All staff were briefed regarding the Inquest and the Coroner's findings and made aware of the concerns identified and informed of the action the Company was taking to address the Coroner's concerns.
2. Every service user's relative was contacted and provided with details of the Coroner's findings and informed of the action the Company was taking to address the Coroner's concerns. Families were offered the opportunity to for face-to-face meetings.
3. Clinical and medication competencies were carried out to ensure that staff were competent to run the shift.
4. We reviewed the Transfer to Hospital and provided further guidance to the staff about completion of the pack to ensure it contains all relevant information for the resident.. The Transfer to Hospital pack ensures that the Hospital is provided with accurate information about a residents condition at the point of admission to hospital (including skin integrity and any concerns about skin breakdown). Compliance with the Transfer to Hospital pack is being reviewed on a weekly basis for a period of 6 months to ensure compliance.
5. We reviewed the Transfer Back Hospital pack to ensure it remains fit for purpose and Nurses have been trained on its use. Compliance with the Transfer back Hospital pack is being reviewed on a weekly basis for a period of 6 months to ensure compliance. Use of the Transfer Back from Hospital back is compulsory. The Pack requires;
 - a. Review of key documentation on return from hospital, including; body map, skin integrity check and documenting any areas of concern or skin breakdown, weight check, physical observations.
 - b. Review and upload of the discharge summary onto Nourish and copy sent to the Registered Manager (RM) and Clinical Services Manager (CSM) for review.

6. We reviewed the Wound Care Plans to ensure that they were fit for purpose, including the escalation process and that they were being used correctly and consistently by staff. Staff have been instructed to ensure;
 - a. Each wound has an individual care plan and wound assessment in Nourish Care Planning system and wounds are not consolidated.
 - b. All wound photos have the measurements, date, name, body part, etc visible in the photo.
 - c. All wounds are documented on the wound tracker which is sent to the RM and CSM weekly for review and to ensure oversight.
 - d. All letters from the Tissue Viability Nurse (TVN) and dietician are uploaded into the correct care plan on the Nourish system. The care plan also details any instructions given by the TVN, including dressings & regime and any external health professionals to be contacted e.g., dieticians.
 - e. The TVN service has been informed that all instructions must be in writing and will not be accepted if given verbally.
 - f. A body map is completed for each individual wound or skin change on Nourish. Body maps are produced daily for all high-risk residents and are reviewed by Clinical Lead and Home Manager. Body maps are produced weekly for all residents and are reviewed by Clinical Lead and Home Manager.

7. We have reviewed communication process to ensure that staff are up to date with residents care requirements and changes in care need. We have reviewed our current processes to ensure that they are followed by staff. This includes;
 - a. A detailed handover is held at the start of each shift. This will be for all the care team allocated to that shift. The Nurse in Charge (NIC) will give a summary of the last 24 hours.
 - b. All residents are discussed at the handover. The NIC checks with all staff on shift before writing up the handover to ensure the information is reflective and up to date. This is in addition to the information recorded on the Nourish care planning system.



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- c. The handover template has been reviewed and redrafted. It includes;
 - i. High risk information
 - ii. AM / PM handover
 - iii. Supplementary Reviews
 - d. A daily huddle is undertaken in addition to the handover meeting at the start of the shift. All staff on shift are asked for an update on what they have noticed during their shift. Specific information includes; any skin changes, urine colour / odours, skin changes, residents not their usual self- etc. This is documented by the NIC or SCA every day at 10:30am & 15:30pm. Any concerns noted are to be checked by the NIC.
 - e. A daily meeting is carried out every day at 11am with the NIC of each floor, maintenance, catering, CSM, HR and the Home Manager.
 - f. All staff on shift are required to sign a “Read & Understood” document to state they are aware of what is currently being discussed in the daily meetings.
8. We have reviewed whether the current care planning systems is effective and have implemented a new auditing system to ensure that care plans are up to date, reflect residents’ needs, are understood by staff and are followed. This includes;
- a. An effective care plan audit was devised for the home and staff trained on its use.
 - b. All care plans are evaluated effectively to reflect the information in the care plan has been reviewed. This is completed following any changes in presentation/need, or monthly as part of Resident of the Day
 - c. All residents care plans will be subject to full audit following readmission and then periodically.
 - d. All residents have a Resident of the Day completed every month. This is a full evaluation of the care plan and all risk assessments
 - e. The nursing team have regular clinical supervisions carried out and independently verified

9. We have reviewed how repositioning of residents is planned and recorded to ensure that it is person centred for the individual and addresses potential risk of harm. We have implemented further processes to make this more robust and ensure that there is appropriate oversight. This includes;
 - a. All repositioning times are set as an interaction on the individual timeline for the resident on the Nourish Care Planning system, setting out the intervals required between turns and the position.
 - b. All repositioning must be documented within the individuals care plan in the relevant sections, Skin Integrity, Wounds.
 - c. All care plans are evaluated to ensure that they effectively reflect the information in the care plan has been reviewed. This is completed following any changes or monthly as part of Resident of the Day evaluation.
 - d. The recording of repositioning and oversight has been strengthened has been addressed by staff utilising the full functionality of the Nourish Care Planning system. This is set out in more detail below.

10. We have a robust electronic care planning system that when staff use its full functionality it can effectively support staff to provide prompts to staff when care interventions are due, ensure that time critical care interventions are met, and alerts are triggered to senior managers if any care intervention is missed. The system also provides the NIC and RM with effective oversight of care delivery staff utilise the full functionality of Nourish and that the system is used consistently in accordance with the Company procedures. This includes;
 - a. Each resident's personalised interactions have been reviewed and set up on Nourish to ensure they are reflective of all their care needs.
 - b. Personalised prompts are set on the Nourish system to ensure that critical interventions are met.
 - c. For time critical interventions (for example repositioning) alarms are set to alert the NIC or RM if the intervention has not taken place.
 - d. The RM and CIM have oversight of the Nourish system to ensure that repositioning has been completed correctly and this is monitored throughout the day.



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- e. Any paper documents that are required are evaluated and uploaded on to Nourish into the relevant section of the care plan.
- f. A professionals / relatives log to be implemented on the electronic care plan
- g. All information must be documented on Nourish. Any paper documents that are required are evaluated and uploaded on to Nourish.

All staff have received training to support of the systems and process, including the Nourish care planning system to ensure that have the skills and competence to follow the Company's procedures. Oversight is maintained through the Company's oversight and governance policies.

As stated above all actions have been completed.

The Coroner raised concerns that issues may recur in the future. We wish to reassure the Coroner that the systems that have been put in place since Mr Nelson's death are robust and the Company is fully committed to ensure that compliance is maintained. This has been verified by our external regulators.

External Assurance

We should also highlight that the CQC carried out an inspection on 17 and 18 February 2026. Whilst the final report is awaited we have received written feedback, and this is attached at **Annex B**.

The CQC reported that they found no serious issues or concern within the service. With regard the specific areas of highlighted by the Coroner in her judgement, (assessment of risk continuity of care, assessing need and managing risk including pressure areas, and care recording) the CQC reported;

Managing people to manage risks

Risks were assessed and managed in line with people's needs, supported by training and monitoring systems. Alerts and reviews helped ensure interventions were delivered as planned, including positional changes.

Safe systems, pathways and transitions

Systems supported continuity of care and safe transitions, including timely referrals and information sharing with partners. Care plans were reviewed following hospital discharge and processes were in place to share information in the event of an emergency hospital admission.

Assessing needs

People's needs were assessed and reviewed using recognised tools, with detailed and personalised care plans. Additional guidance supported staff to manage key risks including nutrition and hydration and skin damage.



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Delivering evidence-based care and treatment

Care was delivered in line with best practice, including pressure care and nutrition. Monitoring supported timely responses to changes in health including weight loss.

Monitoring and improving outcomes

Outcomes were monitored to identify risks and drive improvement. Staff responded positively to professional guidance.

Shared direction and culture

Leaders promoted a clear vision and expectations. Staff understood their roles and responsibilities.

I trust that this report demonstrates the Company and its staff have undertaken a detailed and robust review of systems and process to ensure that the issues the Coroner raised have been addressed and effective measures have been implemented to ensure that improved ways of working are sustained.

In the meantime, should you require any further information, assistance or require discussing this matter further, then please don't hesitate to contact me on [REDACTED]

Yours sincerely?

[REDACTED]

Director