Bupa Care Services
Bridge House
Outwood Lane
Horsforth
Leeds
LS18 4UP

T +44 (0)113 381 6100
F +44 (0)113 259 1229
bupa.co.uk/care-homes

HM Coroner Birmingham & Solihull
Mrs Louise Hunt
Coroners Court
50 Newton Street
Birmingham
B4 6NE

16th February 2015

Dear Mrs Hunt

Noreen Mary Cecilia Porter deceased – Regulation 28 report to prevent future deaths

I write on behalf of Ardenlea Grove Nursing Home to respond to the Regulation 28 report which you sent to [redacted] the home manager, on 22nd December 2014.

In your report, you stated the matters of concern to be as follows:

1. No CPR was undertaken by the staff when the deceased collapsed;
2. There appears to be no process or procedure in place to ensure resuscitation in undertaken when an emergency occurs.

During the inquest you heard evidence as to the circumstances of the deceased's collapse in that she appeared to stop breathing whilst being assisted with her meal. You also heard evidence of how the staff responded. Whilst the attending nurse did check for signs of choking and the presence of food obstructing the airway, it is the case that CPR was not commenced whilst the staff waited for the paramedics to attend.

It is Bupa's policy that unless there is a valid DNACPR document in place, then CPR should be commenced. Aside from the policy, all trained nurses are required to be aware of the circumstances in which CPR should be commenced as part of their nurse training competencies and continuous professional development requirements.

In the case of Mrs Porter, as you may have heard during the evidence, prior to her discharge from hospital into Ardenlea Grove, Mrs Porter had a DNACPR document in place. This was no longer valid upon discharge from hospital into a new care setting and with a new set of care plans in place. The day after admission to the nursing home, the GP met with Mrs Porter's family with a view to establishing a new DNACPR, but it was not signed off by the GP because not all family members were in agreement. The staff caring for Mrs Porter were aware that there was no valid DNACPR in place and therefore the default position in accordance with Bupa's policy is that CPR must be commenced in the case of respiratory collapse.

The reason for the failure by the nurse to commence CPR in Mrs Porter's case was investigated following the incident because it was apparent there had been a breach of Bupa policy in this case. The nurse told the investigation that he was aware there was no valid DNACPR for Mrs Porter and he was aware of Bupa's policy. He said that events had "happened quickly" and that he was unable to explain why he failed to attempt CPR on this occasion. His response had been to check for signs of choking and to look for food particles which might have been blocking the airway. Once he had completed that task he was unable to explain why he did not take further steps or commence CPR pending the paramedics attending.

Since this incident, the home manager at Ardenlea Grove has carried out the following steps to ensure all staff are aware of Bupa's policy and the steps that they must take in a similar situation and to learn the lessons from this tragic incident.:

- Focussed supervisions have been carried out with all nursing staff employed at the home to cover Bupa's policy on CPR and the circumstances in which CPR must be commenced;
- Bupa's policies on resuscitation and choking have been re-issued to all staff;
- Refresher CPR training is being scheduled for delivery across the home (a refresher training session had been scheduled prior to Mrs Porter's death, however this had to be cancelled due to an outbreak of Norovirus in the home and is now being re-arranged) .
- Two more suction machines have been ordered so that there is now a machine on each floor of the nursing home. We appreciate that this was raised by the deceased's family during the inquest and I understand that the conclusion was that suction was unlikely to have altered the outcome for Mrs Porter in these circumstances. Nevertheless this case has caused the management team of Ardenlea Grove to reappraise all the procedures and processes for life support in place in the home and it was concluded that having a suction machine available on each floor was appropriate based on the assessed risks and needs of the resident population. These are now in place.

Bupa's policies are of national application across all its care homes in the UK. Part of the policy framework is that in all homes, it is a mandatory requirement that on each shift, there is a trained nurse/ first aider who is competent in life support procedures on duty at all times and that was indeed the case when Mrs Porter collapsed. It is therefore regrettable that the appropriate procedures were not followed at the time.

In the circumstances, in relation to your two areas of concern:

1. We accept that in relation to this incident, CPR was not carried out on Mrs Porter when it should have been;
2. I hope we have been able to satisfy you that there are appropriate policies and procedures in place to direct staff to carry out CPR in appropriate cases, in response to an emergency. Sadly, on this occasion the procedures in place were not followed despite being known to the staff involved.

In order to help our staff to learn the lessons from this tragic incident, your report and this response has been shared with our operational management teams so that the key

messages and learnings are cascaded to our other homes across Bupa and used as part of the ongoing training and to reinforce the importance of Bupa's policies and procedures.

I would like to apologise on Bupa's behalf, to the family of Mrs Porter, that CPR was not carried out as required. I would also like to send my condolences to the family, although I recognise that this will be little comfort to them at this difficult time.

If I, or my colleagues can assist you further please do contact me. I can be reached on:

[redacted]

Telephone: [redacted]

Yours sincerely

[redacted]

Head of Legal – Provision