Avery
Optimum Care Providers
Advocates of Person Centred Care

1st December 2016

Louise Hunt
Senior Coroner Birmingham and Solihull
Coroner's Court,
50 Newton Street,
Birmingham,
B4 6NE

Dear Ms Hunt,

Following your Coroner's investigation and inquest into the death of Robert Arthur Davidson, the jury concluded that Robert's death was not an accident and was contributed to by neglect. During the course of the inquest the evidence revealed a number of matters of concern. I have listed these numerically below to correspond to each point you have raised, for clarity.

1. Health care staff had not been trained on basic process; the Health Care Assistant (HCA) that was instructed to make the 999 call failed to demonstrate an awareness that to obtain an outside line the caller must first dial '9'. Subsequently her attempt to call emergency services was unsuccessful resulting in the nurse having to leave the patient, whom was choking, to make the 999 call.
2. The RGN and HCA staff involved in the incident had not received training on the CPR and the Choking Policy. They were unclear when to start CPR.
3. The two HCA's involved had no experience or basic training before starting work as HCA's. They had limited understanding of conditions and processes and therefore consideration needs to be given as to whether there should be a mandatory training or minimum standards, which are objectively assessed, to ensure HCA's have the necessary skills and knowledge to undertake their role.
4. The deceased PICA behaviour was not highlighted or identified on his transfer between care homes, therefore some direction from the governing body needs to be provided to care homes to ensure essential information is provided and highlighted when a patient transfers.

As a provider Avery Healthcare does have appropriate systems and documentation in situ to address each of the above points.

For example, with reference to point 1. Avery's orientation checklist would sufficiently provide evidence of staff awareness regarding how to use the phone systems, how to utilise the nurse call system, inclusive of emergency call bells and actions to take in an emergency.

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With reference to point 2, Emergency first aid at work and basic life support training would provide an appropriate level of training for staff.

With reference to point 3, Avery have a robust recruitment and induction process, inclusive of the care certificate. This is to ensure that staff have the correct qualities and aptitude to fulfil the role of an HCA within Avery Healthcare.

With reference to point 4, Avery's documentation pertaining to pre-admission assessment and transfer of care is comprehensive and if completed correctly would indicate relevant clinical risk.

Unfortunately, whilst under the Restful Homes Group tenure, Aran Court had very few of these processes in place and where systems or processes were in situ they were often substandard. It remains an ongoing process to fully embed all of Avery's policies and procedures and in light of the inquests findings an additional action plan and timetable for action has been implemented.

Kind Regards

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Regional Manager