Stockport NHS
NHS Foundation Trust

Our ref. 1922/John Anthony Davies
Your ref. 5652/HC

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16th June 2017

Dear Ms Mutch,

Re: John Anthony Davies (Deceased)

Thank you for your letter, of 26th April 2017, concerning the inquest of the above named patient. As always, I am grateful to you for highlighting your concerns on the Regulation 28 'Report to prevent future deaths' and for providing me with an opportunity to respond.

Your concerns are as follows:

There was no process in place for risk assessment plans to be completed when a resident's needs changed from care to nursing needs and a bed was awaited.

A multi-agency risk assessment has been developed this will support residential home managers to provide safe and effective care for patients have been assessed as needing twenty four hour nursing care and are waiting to be transferred to a nursing home. This risk assessment is to be launched at the Stockport Care Home Managers' meeting in June 2017 and due to be implemented in July 2017.

The District Nursing Team were unaware of the change in status and there was no system in place to involve them in discussions.

The Stockport District Nursing (DN) service, like many other District Nursing services, recognises the challenges associated with delivering care to patients in a residential home when the patient's care needs change from residential care status to Continuing Health Care (CHC) or Funded Nursing Care status.

The DN team who visited this patient within the residential home were unaware that the patient's status had changed; the CHC / Funded Nursing Care team had not informed the DN staff, nor had the staff within the residential home. The DN Pathway Lead met with a representative of the Stockport Clinical Commissioning Group CHC team to discuss how communication could be improved between the CHC team and DN teams. As a result of the discussion it has been agreed that the CHC staff will, as a matter of course, use the Contact Access and Triage service (CATs) to invite DN staff to patient CHC/Funded Nursing Care meetings.

Patient records complete by the District Nursing Team lacked detail and were not completed in the required timescale.

The Trusts accepts that the patient's District Nursing notes did lack detail especially around the deterioration of the patient's physical and mental health and were not completed in the required timescale. This has been addressed with the team and a reflective session has been facilitated regarding the patient's nursing care. An audit of the team's patients' notes has been carried out by the DN Clinical Lead and improvements have been noted. The Patient Records audit is being repeated to ensure that the improvements have been sustained.

There was no continuity of care provided by the District Nursing Team

The Named Nurse for the each care home will undertake all visits to the residents within their allocated home; however, when not on duty, the Named Nurse will hand over any relevant information to whichever nurse is assigned to visit.

The information in the handover will include details regarding risks, non-compliance, patient issues and care planning. The visiting nurse will then hand over to the Named Nurse when he/she is back on duty. This process will be overseen by the Caseload holder.

There was little evidence of communication and information sharing between the care home and the District Nursing Team

A new Named Nurse has been appointed to the residential home involved in this case. This nurse will ensure communication and documentation is improved and this will be overseen by the DN Caseload Holder (Band 6 Nurse). The Named Nurse now attends monthly meetings at the residential home with the manager and the staff to ensure all aspects of patients' care are discussed and communicated to the DN team. The home manager will also invite Adult Social Care staff, District Nursing staff, GP and home care staff to the meeting for ongoing discussion of the patients' care.

The key information from these meetings will be recorded and shared at the DN 'Time Team' meeting. Implementing the above will improve continuity of care to the residents of the home and also improve working relationships with the staff within the home.

The Care Home notes were lacking in detail

The Care Home notes are not the responsibility of the Trust, and we respectfully request that this concern is forwarded to the Care Home.

A suitable nursing home placement could not be identified once it had been agreed that the Care Home was no longer the best place to meet the needs of Mr Davies

Locating and assessing Nursing Home placements is not the responsibility of the District Nursing Team, and we respectfully request that this concern is forwarded to the Stockport Clinical Commissioning Group's Funded Nursing Care team to be addressed.

Advice was not sought by the District Nurses when they had difficulties examining Mr Davies

District Nursing staff are experiencing increasing challenges when nursing patients with mental health problems or conditions associated with mental health or behavioural issues. The DN team accept that advice should have been sought from other professionals when the patient's behaviour affected the ability to provide DN care.

Good practice would have been to speak to mental health practitioners for advice or to have undertaken a joint visit in order to ensure best care was given to the patient.

Stockport Together, a major transformation programme across the health and social care partners in Stockport, has been instrumental in enhancing multi-professional and multi-agency working, bringing together health professionals from a variety of backgrounds, social care and the third sector to benefit patient care.

A Community Psychiatric Nurse now attends Neighbourhood Triage meetings on a monthly basis alongside the Psychiatric Consultant and these meetings provide an open forum for discussion about individual patients with challenging situations, such as in Mr Davies' case.

[redacted] (Consultant Psychiatric Doctor for Older People) is also planning educational events with the District Nursing staff from July 2017 in order to help and support the DN staff in the management of patients with Dementia.

District Nursing staff have also been advised through discussion at Caseload Holders meetings, Locality meetings and Local Leadership and Triage meetings that if they are involved in the care of any residential

care home patients who display signs of declining physical or mental health they must obtain the contact numbers for the patients next of kin so that they can make contact and discuss possible strategies to improve compliance with care.

The correct procedure was not followed on previous occasions when a trigger point was reached in relation to pressure relieving strategies

The Trust has a Prevention and Management of Pressure Ulceration Guideline (2015). All members of staff in the District Nursing team have been reminded of the requirement to adhere to this guidance and new staff have been booked on to the mandatory pressure ulcer training which includes how to identify trigger points and provide pressure relieving strategies.

Yours sincerely,

Ann Barnes
Chief Executive