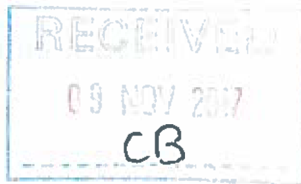

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Tameside General Hospital
Fountain Street
Ashton-under-Lyne
OL6 9RW
Tel: 0161 922 6000

Her Majesty's Senior Coroner for Manchester South
HM Coroner's Office
The Coroner's Court
1 Mount Tabor
Stockport
SK1 3AG

26 October 2017

Dear Ms Mutch

Inquest: Margaret Postill

I write further to the inquest touching upon the death of Margaret Postill, at the conclusion of which I was sorry to learn that you indicated that you would be issuing a Regulation 28 Report to the Trust as a result of your concerns regarding the standard of clinical documentation within the Emergency Department (ED).

As I understand it, during the course of the inquest, evidence was provided by Locum ED Consultant [redacted] with respect to Ms Postill's care and management within the ED, specifically in relation to the management plan surrounding a potential CT head scan. During the course of his evidence [redacted] was asked to refer directly to the notes made by the Advanced Nurse Practitioner outlining the rationale for the non completion of a CT head scan and the subsequent management plan [redacted] found it difficult to decipher the documented notes and when asked whether this was acceptable, advised that the ED department can be exceptionally busy, sometimes to the detriment of clear and legible documentation.

After concluding the evidence, you asked that enquiries be made by the Trust's Legal Services Manager, who was present to support the witnesses, as to the implementation of electronic documentation with the ED. You were advised that this was to be rolled out in November this year. Despite this further information having been provided, you stated that you had residual concerns that there appeared to be a culture at the Trust whereby senior doctors were accepting of poor documentation and as a result you confirmed that you still felt it necessary to utilise your powers and issue a Regulation 28 Report to the Trust. We presume this cultural concern stems from a number of inquests you have heard, as opposed to this specific hearing.

Being equally concerned by your views on this, I have sought to obtain some clarification in respect to your concerns, specifically with regards the potential culture of poor documentation within the ED Department.

Within the ED, a Board Round is held three times a day every day, to discuss issues and concerns with all clinicians on duty. The Board Round is overseen by a Senior ED Consultant. It is reiterated during Board Round that it is the expectation of the Trust and the Senior Consultants in charge of the ED that documentation must be completed in full and to a legible standard. This message is regularly reinforced so that clinicians are fully aware of their expectations.

Where it is identified that clinicians are not complying with the expected standards in terms of documentation, a formal discussion with a Senior ED Consultant or the Clinical Lead for the ED will take place, at which time the expectations are again reiterated in respect to full and clear documentation. Reflective development of this nature is included within that clinician's Personal Development Plan in order to ensure that they have appropriately reflected upon their mistakes in order to demonstrate learning has been undertaken to avoid future reoccurrence. ED documentation is also randomly audited to ensure compliance with the Trust expectations. Where issues are identified these will be picked up and dealt with as per the above mentioned process.

All new clinicians who join the Trust receive detailed information regarding Trust Policy and Protocol, including information regarding the expectations in respect of documentation. Documentation is an issue that is also often picked up at both the Grand Round for clinicians and at Trust training sessions/clinical meetings to ensure that the message is reinforced not only in the ED Department but on a Trust wide basis.

As advised at the inquest by the Trust's Legal Services Manager, the Trust is to implement a fully electronic documentation system within the ED at the end of November. This system will replace handwritten documentation, which will ensure that issues regarding illegibility of handwriting are eliminated, as all clinicians within the ED will be required to type their clinical notes in to the system, thereby making it easier for subsequent clinicians involved with the care to review the notes and manage the patient accordingly.

At the inquest hearing, I understand that submissions were sought from the Trust Legal Services Manager as to the electronic system that was to be introduced within the ED Department, but information regarding the 'culture' of poor documentation was not considered. At the time submissions were requested, it was not possible for the Trust's Legal Services Manager to proficiently address you on matters with respect to 'culture' without first obtaining some further information and clarification to assist. We would assert that the Trust is aware of the importance of good record keeping and to aid and assist this it is implementing the electronic data capture system in recognition of this.

We would hope that once you have had a chance to consider this further information with respect to documentation within the ED Department you will be reassured that there is clear evidence that there is not a cultural acceptance of poor documentation with the ED Department and that the department, particularly the Senior Consultants, work hard to ensure that all clinicians fully understand their obligations with respect to documentation and where these expectations are not met, that action is taken to ensure reflective learning is undertaken to prevent future reoccurrence. I can assure you that this is a message which is constantly being reinforced. Furthermore, electronic documentation is also to be introduced to ensure that illegible documentation does not impact upon the care and management of patient's within the ED Department.

I am disappointed to hear that the evidence heard gave cause for concern and I would wish to reassure you that the Trust take issues of this nature exceptionally seriously and it is for this reason that we have taken immediate action to ensure that you are provided with the reassurance needed. I hope in light of this that you will feel it is not necessary to issue a Regulation 28 Report after all.

Please do not hesitate to contact me should you require any further information to assist.

Yours sincerely

John Fletcher
Director of Quality & Governance

HM Senior Coroner Ms A Mutch OBE
The Coroner's Court Manchester South
1 Mount Tabor
Stockport
SK1 3AG

Your ref: 7480/CLE

8 February 2018

Dear Madam

Re Mrs. MEP, Sunnyside Care Home

Following receipt of the Regulation 28 report and covering letter of 21 December 2017, I write on behalf of HC-One to outline the content of our policy and procedure relating to falls prevention and care and also the specific actions we have taken to improve outcomes for Residents and address the specific concerns you raised in the report, both at home level and also across the group of homes.

We, at HC-One, recognise that falls and their subsequent outcomes are serious risks to people who live in our care homes.

We know that slips, trips and falls are a major cause of injury in the older population and that in care homes, falls account for around 90% of reportable injuries to Residents and those Residents aged 65 and over are at the highest risk of falling.

We recognise that a fall, or fear of falling, can dramatically reduce the quality of life for a Resident, as there is a risk they could suffer any of the following:

- Increased social isolation, particularly if they become bed bound
- Increased problems with maintaining their independence due to any injury
- Increasing tendency towards depression and possible mental health problems
- Increased physical and emotional dependence, possible due to a lack of confidence

HC-One is committed to enabling Residents to live a full and active life. We embrace the concept of keeping Residents as independent and as mobile as possible whilst minimising risk to their health, safety and wellbeing.

All of the above facts are included in the preamble to our Falls prevention and management policy.

We continually review the NICE guidance in relation to falls and implement new technologies to support Residents and ensure that our policy and procedures reflect this guidance, which we have completed again specifically following receipt of the Regulation 28 report.

Within the policy there is a specific section entitled **Assessment and Prevention.** This section details the following:

It is important to identify all Residents who may be at a risk of falling and as such, thorough assessments should be conducted. A Multi factorial Falls Risk Assessment will inform the development and implementation of a daily plan of care.

- *All Residents must have a comprehensive Falls Risk Assessment completed prior to admission. Residents identified to be 'at risk' on the Pre-Admission Assessment, must then be re-assessed on admission in their new environment.*

- *Residents identified as 'at risk' must have a full review on a monthly basis, or more frequently as the Resident's condition dictates.*

- *A new assessment must be completed following a fall and/or if the physical or psychological condition of the Resident changes.*

- *A plan of care must be in place for mobilising, including the use of mobilisation aids. The use of walking aids and other equipment should be considered, after assessment by a physiotherapist or occupational therapist where a potential risk has been identified.*

- *The use of assistive technology should be considered, where appropriate.*

All assessments and reviews must be fully documented and recorded in the Resident's care file.

Assessments will identify predisposing factors which may lead to falls such as:

- Undiagnosed Infection
- History of falls
- History of chronic illness
- Reduced mobility/unsteady gait and muscle weakness
- Diagnosis of osteoporosis
- The individuals perceived functional ability and fears relating to falls
- Unfamiliar surroundings/disorientation
- Environmental and clothing/footwear hazards
- Alcohol use
- Medicines
- Postural hypotension or episodes of dizziness
- Constipation
- Impaired cognition/depression
- Reduced eyesight

- Altered bowel or bladder habits including incontinence or urgency
- Disturbed sleep pattern
- Use of antipsychotic medicines
- Foot care
- Use of a wheel chair which requires the use of lap straps

The policy then goes on to define the following:

<u>Person specific risk factors and preventative measures</u>

The risk factors associated with Resident falls rarely exist in isolation, therefore effective falls management requires a preventative, holistic and person centred approach that considers all of the contributory and person specific risk factors.

Residents are at a greater risk of falling during the first three months following admission, or where a cognitive disability is present and this should be reflected in their individual care plans.

The person specific risk factors are mainly related to:

- *Drugs and alcohol use, including prescribed medicines*
- *Age related physiological changes (e.g. vision)*
- *Medical conditions (e.g. stroke, Parkinson's disease)*
- *Instability, balance and physical inactivity*
- *Footwear or foot care issues*
- *Lack of or incorrect use and servicing of mobility aids and postural care*
- *Pain*
- *Cognition, memory and mental health problems*

The policy also includes the following:

<u>Post Fall Protocol</u>

Following a fall, immediate action must be taken to ensure the safety and comfort of the Resident. Staff must not leave the Resident unattended and immediate assistance should be summoned. It is important that they are assessed and examined promptly to see if they are injured. This will help to inform decisions about safe handling and ensure that any injuries are treated in a timely manner.

<u>All falls must be properly recorded and investigated</u>

As soon as possible, after the fall, an incident report must be completed and the incident should be logged on Datix. The incident report should be comprehensive and give a clear picture of what happened and what immediate action was taken.

The incident must be investigated in order to identify what happened, how it happened and why it happened. You must learn from the incident and take action in order to reduce the

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likelihood of further falls and/or minimise the risk of harm in the future. Care plans and risk assessments will be reviewed and reformulated as necessary.

Particular attention should be given to Residents who have experienced more than one fall in a week or more than three in a month. The more falls a Resident has had the greater the falls risk.

Even if a fall is minor and causes no injury, you must still investigate and try to prevent it happening again. An increasing number of minor falls is likely to result in a more serious fall in the future.

Trend Analysis

Datix can be utilised in order to carry out trend analysis. An analysis of your falls will help you identify any trends and any areas of concern to target, from which you can take suitable action. You can also monitor whether the preventative actions you have taken are having the desired effect in reducing the number of falls and the harm caused following a fall.

You could analyse the falls of a particular Resident or look at all your falls. Datix can show you many things, including where your falls are happening, their location, the time of falls and the level of harm caused. For example, a falls analysis may identify that many falls are taking place in a particular location around the same time of day.

Reports are available on a dashboard within Datix, which is the electronic risk management system used by the company.

Review of care practices, specifically relating to falls

Following any accident or incident, that has affected Resident health or well-being an incident record is completed by the home team and uploaded onto the electronic Risk Management system mentioned above.

This system captures any untoward event that occurs, whether it causes harm or not so we can review any near misses- predominately this is falls, ill health, medicines errors, safeguarding referrals and complaints.

Once the incident is entered on Datix, the appropriate area and specialist teams are notified and depending on the nature/severity of the incident, this will advise who will undertake the investigation.

Falls are reported at group level, area level, home level and also at individual Resident level through our internal reporting systems, where we can ultimately see the how the individual Residents care is supported.

At Home level there is a three monthly falls audit, which includes details of the falls team meeting discussions and a monthly review through the Key Clinical Indicators (KCI) report, which helps identify key high risk Residents for staff at the home to follow up on and as part of the Resident of the day programme, the care plan will be checked.

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Scrutiny at area level by the Area Directors (AD) has been increased in terms of the quality of the completion of assessment and evaluation through the review of falls as part of their monthly home visit and the Quality Regulation Managers (QRM) on their internal inspection visits.

The Clinical Quality team undertake a monthly review and follow up with the ADs and the Managing Directors on the 'quality calls', which have been initiated since the incident and have now become routine across the group of homes.

Falls and serious incident trends are discussed at the quarterly Quality Governance Group (QGG) and learning is shared across the group. This is the company's bed to Board governance structure. The frequency of follow up actions from the QGG has increased to a monthly basis, following this incident, to provide clear accountability and mapping of improvements in working to reduce falls and ensure appropriate assessment and evaluation following each fall at individual home and group level.

As mentioned previously, we continually review the NICE guidance in relation to falls and implement new technologies to support Residents.

All of these actions assist to ensure that our policy is being followed at home level and that risk assessments are being appropriately completed and that post-fall evaluations are being carried out and documented.

Initial local actions

The AD attended the home on the 24 October 2017 to share the findings from the case with the team at the home and the following actions were agreed:

- Sample falls risk assessments were shared with the staff team to ensure full understanding of expectations in relation to the completion of the falls risk assessments, in particular in relation to evaluation and assessment of a resident following a fall.

- A clinical risk register has been implemented and shared with the operational team, which identifies any Residents with falls and the date of the last care plan audit. This is reviewed monthly and key actions agreed to reduce further risk by the Home Manager and also Area Quality Directors via monthly clinical review meetings.

- The falls flow chart has been implemented at the home giving clear guidance on what actions to take following a fall within Sunnyside.

- The review of falls is part of our daily quality assurance and the Home Manager's daily diary prompts a review daily of any accidents or incidents and this includes a review of the records completed by the care team which includes the falls risk assessment.

- The daily flash meeting is undertaken 7 days per week and any accidents or incidents are discussed with the team. The Home Manager/ Deputy Home Manager records this and checks any additional actions are completed, including referral to the GP and to

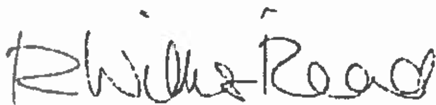
update the falls risk assessment, which is completed by the senior care staff. The falls risk assessments are reviewed and updated by the home's internal falls team, which comprises all the Heads of Department in the home and are subject to audit every three months. This team was set up in the home after the incident and has been effective in pulling staff together to improve knowledge, accountability and ultimately outcomes for Residents through increased awareness, diligence and good record keeping.

- Each accident/incident record has a 24 hour observation record and an additional clinical walk round, which is undertaken by the Deputy / Home Manager to review Residents who are unwell, have fallen, have a peg or catheter etc. to make sure their care needs are effectively met on a daily basis. This is then fed back to the team at the flash meeting where any concerns are identified. This has now been implemented to ensure that the person is checked by a senior person following a fall and this process is audited by the operational team and the internal inspection team.

- The area team support the monthly review of all of these actions and I can confirm that since the incident in October, the audits have identified that these actions have been effective and risk assessments are being appropriately completed and residents are being appropriately assessed following a fall or other incident.

I do hope this information is helpful and offers you the assurance that we, at HC-One, have taken the issues raised very seriously and are committed to learning and working to prevent recurrence of such incidents.

Yours sincerely



Head of Standards and Compliance