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Your ref: 12108/CH Our ref: STOCCG/SM

29 January 2020

Private & Confidential Alison Mutch HM Senior Coroner 1 Mount Talbot Street Stockport SK1 3AG

Dear Ms. Mutch,

# Regulation 28 Report re: Arnold Fletcher Ward

I refer to your letter dated 16 December 2019 and acknowledge receipt of the Regulation 28 report in relation to this case.

Stockport Clinical Commissioning Group (CCG) commissions nursing care from nursing homes in Stockport through a standard NHS contract. The contract sets out the required operational standards; Schedule 6c of the contract refers specifically to pressure ulcers under incident reporting procedures in addition to the local quality requirements.

The CCG, through these contractual arrangements, and through its quality and safeguarding functions, has quality monitoring processes in place, which include serious incident reporting systems and improvement monitoring. All investigations into serious incidents are quality assured by the CCG to ensure that necessary actions are identified and implemented.

In considering this case you highlighted the following areas of concern:-

- Documentation in relation to the pressure ulcer failed to reflect the deterioration
- Delay in escalation to the specialist Tissue Viability Nursing Team despite clear signs of deterioration
- Photographs were not used to track and document the progress of the pressure ulcer
- No evidence of a robust system to track the status of a referral to the Tissue Viability Nursing Team

#### **Actions Taken**

 Record Keeping Review in response to the issue that documentation in relation to the pressure ulcer failed to reflect the deterioration, and that photographs were not used to track the progress.

From a review of this case it is clear that record keeping was not of the standard I would expect. I can confirm that staff at Fernlea Nursing Home now use photographs to track and monitor pressure ulcer development. Initial photographs are taken once a pressure ulcer is identified and the photographs are stored electronically on the nursing home system. Further photographs are then taken on a regular basis to allow comparison and highlight deterioration at an early stage. As a general rule photographs are taken every 2-4 weeks in line with individual Risk Assessments and Care Plans. In circumstances where a significant change is noted photographs are taken more frequently and referrals managed appropriately.

I am pleased to note that the nursing home has now adopted the Stockport NHS Foundation Trust pressure ulcer monitoring form to ensure consistent and regular monitoring of pressure ulcers.

Whilst this investigation has focused on an individual nursing home case, as the commissioner of services for the Stockport population we re-issued the pressure ulcer case review template to all Stockport Nursing Home Managers. The proforma asks the reporter to consider safeguarding concerns and develop an Action Plan. The form is reviewed by the CCG's Designated Nurse Safeguarding Adults and Quality Improvement Nurses. Cases can then be escalated as a safeguarding concern (if not already raised) or discussed with the quality team to determine if more targeted support such as 'React to Red' (pressure ulcer prevention initiative) training is required.

• Registration Requirements in response to the issue that documentation in relation to the pressure ulcer failed to reflect the deterioration

Registered nurses, midwives and nursing associates must comply with the Nursing and Midwifery Council's professional standards that apply within their professional scope of practice, which includes communicating effectively, keeping clear and accurate records relevant to their practice. The CCG's Designated Nurse Safeguarding Adults has developed a two page guide to effective record keeping. This document was emailed to all Stockport Nursing Home Managers on 24 January 2020.

The CCG/SMBC Quality Improvement Nurse is also going to share the guide and present it at the Care Homes Forum in May 2020.

 Refresh of the requirements of the referral to Tissue Viability service process in response to the issues of the delay in escalation to the specialist Tissue Viability Nursing Team despite clear signs of deterioration, and No evidence of a robust system to track the status of a referral to the Tissue Viability Nursing Team

The process of referral to the Tissue Viability Nursing has been reviewed and has now been changed; Referrals to the tissue viability service are no longer submitted via fax. The referral form now includes a prompt for nursing home staff to follow up any referral which is not actioned within 2 working days.

It is now standard practice for Fernlea nursing home to ensure a read receipt is requested so that the referring home can check to ensure that the e mail has been accessed / read by the Tissue Viability Team. In addition a follow up telephone call is made to the service the following day, irrespective of the pressure ulcer urgency status; during this call the date for a visit from the team is confirmed and added to the nursing home diary.

The Quality Improvement Nurse is monitoring that this change remains embedded as part of routine practice.

In addition, please note the additional actions to underpin the above changes

### React to Red Training

A training programme has been developed and rolled out across the Stockport Care Home community. The training includes the nationally NHS recognised React to Red training for pressure ulcer prevention within a care home environment. The training commenced in 2018 and I can confirm that since that time a total of 184 individuals from Stockport care homes and domiciliary care agency have undergone this training.

In relation to Fernlea Nursing Home I can confirm that the home currently employs 4 registered nurses, all of whom have attended either React to Red or an alternative advanced wound care training courses.

## Development of Nursing /Care Home Pathways

The Quality Improvement Nurse is also working with the Tissue Viability Nursing Service at Stockport NHS Foundation Trust to develop a number of pathways for care homes.

### Escalation Processes

Any serious or thematic quality concerns relating to pressure ulcers are now escalated and discussed at the Multi agency Quality Issues and Concerns meeting attended by members of the CCG, SMBC, Public Health and CQC.

After reviewing the completed actions, I am satisfied that appropriate steps have been taken in response to your findings.

If you require any further information please do not hesitate to contact me.

Yours sincerely

Accountable Officer