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346/2015 DJC

Mr J S Pollard
Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

17th September 2015

Dear Mr Pollard

Re: E Clarke Deceased – Hurst Hall

I write to formally respond to your letter of the 19th August 2015, in which you have set out matters of concern which the staff at Hurst Hall needed to take action against following the death of Mrs E Clarke at the Care Home. I have detailed below each of the matters of concern and the action taken in relation to them in the order they appear in your letter:

1. There was an apparent lack of training for the staff at Hurst Hall in the appropriate use of calling either 999 or 111.

   Action taken
   The senior staff at Hurst Hall had previously attended first aid training which did cover appropriate use of 999 but they have also attended further refresher training on 21/7/15 which clearly explained the actions that need to be taken and the circumstances when these are required.

2. The staff did not know how to arrange for the attendance of a GP for a resident who was not fully registered with a local GP. In particular they appeared completely ignorant of the existence of a 'temporary GP registration form'.

   Action taken
   Staff had sent a new patient registration document to the Surgery. They were not aware of the existence of a temporary registration form. We did receive these forms from the Surgery after the client's inquest. All senior staff have now attended training in relation to the action they need to take when a Residents' GP is out of the area, and protocols are now in place to ensure that this does not happen again.

3. The level and quality of observation of the Residents were very poor and did not include even some of the most basic issues such as whether the Resident was warm, thirsty etc.

Action taken
The Care Home has undertaken supervision with all of the staff explaining the importance of clearly recording detailed information about the welfare of the Residents. These records are monitored weekly by the Home Manager and checked daily by the senior team to ensure compliance from staff in their effective completion.

4. There seems to be a complete lack of understanding about the legal requirements for prompt reporting of such matters as occurred in this case to the Care Quality Commission.

   Action Taken
   The Home Manager did not submit the required notification until the 17/2/15. This was a clerical oversight and systems are now in place centrally to ensure that when a death is recorded there is a check made to ensure that the required notifications are sent to the Care Quality Commission immediately.

5. When a local GP was visiting another Resident at the Care Home, the staff seemed unaware that they could and should have asked that Doctor to look at this Resident.

   Action taken
   Senior staff have undertaken additional training to ensure they are aware that they can ask another Doctor or the District Nurse to check a Resident they have concerns about if they are on the premises. They have been further advised that if they are in any doubt that they should request an ambulance. This continues to be monitored by the Home Manager, the Operations Team and Quality Assurance Team to ensure ongoing compliance.

6. There was a complete failure to maintain food and hydration records.

   Action taken
   Protocols are in place ensuring that all staff are aware that they need to clearly record what the Resident has had to eat and drink, particularly when they are on thickened fluids or if they are underweight or having any nutritional difficulties. Assessments have been completed to identify Residents who are at higher risk such as Mrs Clarke, particularly those who require specialist diets and food and fluid charts are now in place as required. These are reviewed daily by the Senior Team to ensure ongoing compliance and are further monitored during regular visits from the Operations Team and the Quality Assurance Team.

7. There was a failure to keep proper and sufficient notes of the care provided to each Resident.

   Action taken
   Care plan training has been undertaken with all staff ensuring they clearly document the care each Resident has received. This is checked following the admission of any new Resident to the Care Home and where changes

have been identified in a Resident's care and treatment needs. As a minimum all care plans are fully reviewed every month to ensure their ongoing relevance and effectiveness.

8. There was a failure to give full and effective 'handover' at each shift.

Action taken
A new handover process has been introduced which enables staff to share key information at the changeover of every shift. In addition, the Home Manager holds daily flash meetings with all members of the team to update them on any significant changes and identify any specific events or activities required that day. The flash meeting also updates the team on any Residents who require close monitoring. These meetings are documented and the records are held in the Care Home for review.

I trust you find that we have taken all appropriate action in relation to the matters of concern arising from the inquest into the death of Mrs E Clarke. Should you require any further information please do not hesitate to contact me.

Yours sincerely

[redacted]
Operations Director