Parc Pendine Pendine Park
Gofal Goleuedig Inspiring Care

Wrexham Gwern Alyn • Hillbury • Highfield • Penybryn • Bodlondeb
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17 September 2021

Mr John A Gittins, H.M. Coroner
H.M. Coroner's Office
County Hall
Wynnstay Road
Ruthin
LL15 1YN

Dear Sir

Response to coroner due by 20 September

In response to Mr David Lewis, Assistant Coroner's report dated 26/07/21, I would like to provide the following response to each "Matters of concern" item raised.

1 Mr Rowlands was admitted into Gwern Alyn home on 08/05/2017, because he had been frequently falling in his own home and was at the time only receiving several visits a day from domiciliary care staff. As a result of this he was frequently left unattended with no source of support for long periods.

Having moved into Gwern Alyn, he was supported by staff being available 24 hours a day and was placed on a "North Wales Prevention and Management of Falls in Care homes falls pathway".

This included the support of a falls coordinator, a falls risk assessment and regular reviews of the risk assessment which over the time he was with us included frequent regular checks of his medication, muscle tone and strength, gait, mobility, visual and hearing impairment, continence, footwear and footcare, mental health and wellbeing, fracture and osteoporosis risk. Falls reviews were regular and included a request to the falls coordinator, and GP for additional physiotherapy and medication review on 13/11/2020.

While in the home he had regular reviews from his GP, none of which identified anything else we could do to offer additional mobility or falls management support to Mr Rowlands.

Taking all of these factors into account, we believe that nothing further could have been done to prevent him from becoming infirm as he was aging.

With capacity and freewill, he was able to freely move around the home. There were no recommendations from medical practitioners or health professionals to restrict his freedom of movement.

He had been assessed for, and provided, with a suitable Zimmer frame prior to joining the home, which was regularly checked for continued suitability, and which enabled him to maintain his independence and mobility.

When in bed, Mr Rowlands had a call bell to use, if required, and was able to access and use it.

A pressure mat was placed at the side of his bed to alert staff that he was getting out of bed. At the time of the incident, we believe that it could have been kicked under the bed when Mr Rowlands got out of the bed, rather than it being misplaced.

Mr Rowlands' bed and mattress had been suitably assessed to meet his needs including the fact he did not require bed rails.

It is important to note that Mr Rowlands was independent and did not always use his Zimmer frame, sometimes needing prompting from staff to use it, nor always use the call bell.

In relation to the comment made that the home had not "eliminated the falls risk", for Mr Rowlands, we respectfully submit that this is an is unrealistic and unachievable aim, in an elderly person, with capacity to make choices about movement and not subjected to DOLS, where 'The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.'

We have reviewed statistics from 1999 through to 2021, looking at falls in the community and falls within inpatient settings, to support this point, and quote them below.

Incidence of unintentional falls

In 1999, there were over 647 721 fall related A&E attendances in the UK for persons aged ⩾60 years (population =12.1 million); of these 66% occurred in those aged ⩾75 years (population =4.3 million).

These falls resulted in 204,424 admissions to hospital, 78% of which were in those aged ⩾75 years.

The rate of A&E attendances per 10 000 population for unintentional falls for those aged ⩾75 years was almost three times that of the other age groups (table 4). British Medical Journal (Journal of epidemiology and community health volume 57, Issue 9, [redacted])

In 2016 Welsh Government, Chief Nursing Officer (Welsh Health Circular WHC (2016) 022) stated that Falls are the most frequently reported adult in-patient clinical incident and are a significant patient safety challenge for the NHS in Wales.

There are more than 240,000 reported in acute hospitals and mental health trusts in England and Wales every year (that is over 600 a day), Royal College of Physicians. National audit of inpatient falls, Audit report 2015. London: RCP, 2015

This has increased so that there are 247,000 falls occurring in inpatient settings each year in England alone (National Audit of inpatient falls, Royal College of Physicians 2020).

Unfortunately, we therefore cannot agree that we can ever completely eliminate the risk of a fall, we can only minimise, with the use of an appropriate falls pathway, including exercise support and equipment provision for residents, but cannot ever prevent or eliminate the risk of all falls.

In fact, considering Health and Safety Executive guidance when conducting a risk assessment, we have to reduce the risk of harm to as low as is reasonably practicable.

Where a resident has freedom of will and capacity, we cannot ever guarantee they are free from risk of falls without depriving them of their liberty.

2 The member of staff feeling pressured perhaps needs clarifying, from our conversation with her, we believe that it was an internalised pressure, as she wanted to move onto some scheduled activities with other residents, it was not a matter of insufficient staffing levels.

In relation to staffing levels, the home has been assessed and received a report from CIW stating that "the service is well managed with good staffing levels". (19/04/18) See report on following link

https://gov.wales/docs/cssiw/report/inspection_reports/00007874_c_180424_e.pdf

At the time Mr Rowlands fell, the home had 5 care staff in work, including a registered nurse, supporting 23 residents. This had only reduced from 6 staff, 10 minutes before the fall, as most residents had gone to rest after their lunch. The care and nursing staff were in turn supported by a number of ancillary staff including housekeeping, catering and maintenance staff.

3 15 rooms at the home have an ensuite room, 4 have shared Jack/Jill bathrooms.

Mr Rowlands had been moved for his own safety from the first floor to the ground floor, to reduce the risk of a fall downstairs, shortly after he moved into the home.

While an ensuite room was being redecorated and prepared for him, he was temporarily placed in the room, where he later experienced his fall.

Mr Rowlands had been offered the refurbished and redecorated room with ensuite facilities, as soon as it was available, but he refused, on more than one occasion, preferring to stay in the room he was in, as it was closest to the lounge and the office.

He had capacity and freedom to make this choice and we did not want to place him against his free will into another room.

As a result of this however, he did have a short walk (of the same distance as if he had been in an ensuite room) to the toilet.

Mr Rowlands had to access the toilet through two sets of doors, but he was observed to manage them with ease.

Each door has been tested for the amount of force required to open it, and all are compliant with requirements of The Equality Act (EA) 2010, Part M building regulations and BS 8300, recording force required to open the door of less than 30 newtons or 6.71bs.

We believe that this confirms that the doors were not a barrier to Mr Rowlands' safe movement, access or egress to and from the toilet or bathroom, nor the office or lounge that he frequently visited each day.

We take the best care possible of all our residents and take any incidents seriously, wanting to learn from them and share the learning with all our staff.

In reviewing this incident and considering solutions, we have sought advice, through Care Forum Wales, and by holding an internal accident /incident investigation review, using an independent safety consultant who has been an active member of the All-Wales National Falls Prevention Taskforce for over 5 years. As a result of this we have put together the following action plan.

Action plan

1 We aim to continue to be suitably and fully staffed as we were at the time of Mr Rowlands Fall.

2 We will continue to work with GPs and other health professionals to support any resident that has a history of falls, or starts to fall, using the North Wales Prevention and Management of Falls in Care Homes Pathway.

3 We will continue to ensure that within the care plan that staff utilise and maintain the relevant falls management documents as follows:

- Care Plan Falls Management Core
- Evaluation Falls Management Core
- Falls and Accident Record
- Falls Risk Assessment
- Post Falls Report for GP
- Red Flag Assessment

4 We will communicate with staff the importance of them advising senior carer or nurse if they are feeling pressure at work, though in the case of the worker supporting Mr Rowlands, we believe from discussion with her, that it was not a pressure of work, but rather her own desire to move onto scheduled activities with other residents, that caused her to feel that way.

5 We will introduce a programme of testing door pressures where mobile residents encounter doors they need to go through and do this in line with fire door safety checks that are undertaken.

Yours sincerely

[redacted]
Registered Manager, Hillbury & Gwern Alyn