Ambassador House Home-Internal investigation

Service user; Etheline De -Gale

Date of allegation made; 7th/8th March 2016

Summary of our internal investigation

Introduction Background

The reason for this report is a request from the coroner for an action plan to prevent future deaths.

Our Investigation into coroner's concerns:

Concern was raised when the deceased fell out of bed following the response by LR to EDG call bell being rung for the EDG to go to the toilet during the night. LR entered the room, lowered the bedside rails and then proceeded to leave the room to get some gloves, leaving EDG unattended. There appears to be no recall as to why a carer would think that lowering bedside rails and the leaving the resident was acceptable. LR was a senior care assistant and has worked at Ambassador house for two years. She has completed all the relevant training and in this instance common sense and experience should have prevailed in that if a resident has bedside rails there is clearly a risk of falling out of bed. LR had read and signed the care plan to state that she fully understood the care required by Mrs EDG.

Concern 1:

The care plan had a mobility assessment stating clearly that two people were required to support EDG to transfer. There is also a bedrail assessment document. The carer was a senior who has been employed for the last two years and irrespective of the care plan, should have known that this was not limited to walking across the floor. The resident clearly needed assistance for all movements and was at risk of falling, otherwise the bedside rails would not have been on the bed. LR chose to lower the rails and then leave the room, thereby exposing EDG to a higher level of risk of falling.

LR had completed Falls Safety Awareness training on 12th October 2015, Safeguarding Vulnerable Adults training 18th May 2015, Theory of moving and handling people on 9th October 2015 and General Principles of Health and Safety training on October 2014 (which is valid for three years.) All of these less than 6 months prior to the incident.

Concern 2:

The Deputy Manager indicated that LR should have undertaken a risk assessment. As a senior carer her initial reaction should have been to assess the likelihood of the resident being a risk of falling out of bed if she lowered the bedside rails and left the room, leaving the resident unattended. This resident was at risk of falling, that two carers were required to support her to mobilise and this was clearly documented in the care plan, which LR had signed to say she had read. The risk assessment that the Deputy referred to was a common-sense assessment of the situation at the time, which would be taken by any carer assisting a resident.

Concern 3:

The numbers of staff on duty at the time of the incident were in line with regulation and are allocated based on need of our residents. At night time the residents are in bed and mostly sleep. There is a requirement of staff to regularly check those residents who require care and to attend residents when they call for assistance. It would be rare for two residents to call at the same time, however, should this be the case, a staff member would attend each resident independently, assess the need for the call, ensure the resident was safe and then prioritise the tasks with their colleague in order to assist the residents. The duty of the care staff attending a resident is to acknowledge the individual risk. In this case LR willingly left EDG on the side of the bed, without thought of her falling. She should have used the call bed to call for the assistance of the other care staff who was also on duty, thereby avoiding the risk of EDG falling.

Concern 4:

There is an unwritten policy with in the home known to staff, that should a resident be required to go to hospital, the staff will call either the Manager or Deputy Manager for assistance. This is clearly known as LR did call the Deputy and asked her to attend the home in case EDG needed to be transported to hospital.

The resident was assessed by the paramedics and along with a request by the granddaughter, who spoke to the paramedics, decided not to admit EDG to hospital. The advice as per the paramedic report was to give paracetamol and contact EDG own GP in the morning.

On arriving at work the following morning the Deputy went to see EDG and discovered that her knee was swollen and EDG told the Deputy that she was in pain. The Deputy decided that EDG did not need a GP but needed an ambulance to take her to hospital as a matter of urgency. The paramedics eventually arrived at 17.30 having called throughout the day stating that as EDG was comfortable they had other emergencies to attend to first.

At no point in the scenario was it deemed inappropriate to admit EDG to hospital because there were two care staff on night duty.

Concern 5:

The advice of the paramedics to call her GP was ignored on the basis that EDG's right knee was swollen and painful and therefore the need for a GP to come to the home and instruct us to call an ambulance was negated. It was clear to the Deputy that more specialist treatment was required.

Action to be taken:

As far as Ambassador House is concerned whilst we acknowledge that details of bedside rails and their use could have been more clearly documented, in this case there was a senor care assistant, LR, who blatantly ignored the instructions for two care assistants to attend EDG, she without thought lowered the bedside rail, compromising the safety of EDG and then left the room, leaving EDG unattended.

If the actions of LR had been in accordance with the care plan, her training and common sense, this could have prevented the need for EDG from falling out of bed and consequently requiring an operation. Had this been the case EDG would still be residing at Ambassador House.

Our Response:

Based on the information from statements, staff interview, care plans, risk assessments and LR's personnel file, we have concluded that in this case we have acted in accordance with our policies and procedures. The incident occurred, we believe, because of the negligence of a senior staff member (LR).

We have taken some learnings from this incident and these are as follows:

The care plan should stipulate that when bedrails are used for any resident and they are lowered for assistance to the resident, the resident must not be left unattended. This will be in place by 3rd March 2017.

Staff will be instructed to carry gloves in their pockets at all times, negating the need to leave a resident whilst they are requiring care. This has happened with immediate effect.

Paramedics who spoke to the Granddaughter, did not ask whether she held a lasting power of attorney for Health and Welfare, in order to make the decision of whether EDG went to hospital during the night or not. We are unsure of whether the paramedic made the decision not to take to EDG to hospital on the back of the granddaughters wish or the medical need of EDG. Our learning is to ensure that all residents relatives understand their ability to make decisions on behalf of their relatives, if they do not hold a LPA for health and welfare. We going to invite our relatives to a presentation from a local solicitor to explain the importance of LPA's. This will happen by the end of May 2017.