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SENIOR LIVING

THE JOY OF EVERY DAY

3rd February 2015

Mr Pollard
Coroners Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Sir

Please find below the response to your request for information relating to the Regulation 26 Report for Dr Rhys Williams.

There appeared to be a lack of training (in a number of areas) of the carers having immediate care of Dr. Williams. I was told that they should all undertake eLearning but it was far from clear as to how or whether this was monitored and checked.

All staff working in Sunrise Senior Living are required to complete training appropriate to their job role upon induction and at specific refresher dates if not identified before.

In relation to training on bed placement and safe use of profiling beds (including using brakes on such beds), we now have incorporated this into our manual handling training which is mandatory for all care and nursing staff. Compliance is monitored via manual handling training compliance reports, which are reported weekly to the business. Any concerns on compliance are acted upon by the Director of Operations.

The company's training programme consists of a combination of eLearning modules by an accredited provider, bespoke in-house classroom learning delivered by qualified trainers, and practical assessments to check competency together with completion of workbooks to confirm the that staff understand their role and responsibilities in caring for residents.

Training of all our team members is monitored and reported with full access provided to our managers to ensure compliance of their teams' training.

In any complex cases where reasons are identified for placing a bed against a wall despite the resident being at risk of falls, a Regional Training Officer now attends homes to provide face to face training to support the home and ensure the safety of the resident.

Despite the assurances of the Managing Director, who was very frank and helpful in her evidence, I remained far from satisfied that all the team members were aware of the rules relating to the positioning of the 'profile beds' which are on caster wheels. Because of this lack of certainty amongst the staff members, Dr. Williams' bed was placed, allegedly, against the wall when apparently this should not have been the case. Are all the staff members now clear as to the Rules relating to the positioning of the profile beds? Is there a rule about the need for crash mats and sensor mats on both sides of the bed?

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If a person is at risk of falling from the bed and does not have bed rails, there is a clear general rule that beds will no longer be placed against walls and will have crash mats and sensors on both sides of the bed. This has been clearly communicated to staff across the group. Exceptions will be rare but may include cases where the resident has capacity and insists on the bed being placed against the wall. Any such cases will be fully risk-assessed and, as explained above, will involve the input of a regional training officer.

A blanket ban against placing beds against walls for those who are not at risk of falls is not proportionate. However, all staff are trained regarding the safety issues of placing beds against walls. This is now included in our moving and handling training and as such every carer and nurse team member is trained on an annual basis. Similarly there is not a rule of a need for sensor or crash mats on the side of each bed as this would be unnecessary for many residents who may be at low risk of falls. Risk of falling is assessed on admission and monthly at a minimum thereafter. As explained above, however, crash mats and sensor pads are now placed on both sides of the bed when a resident is at risk of falling unless exceptional circumstances apply.

We also now monitor the number of beds placed against the wall on a monthly basis. This data is monitored by the Care and Quality team which liaises directly with homes where concerns may be identified. Such concerns included particularly high or low numbers, upward trends or statistics that do not match visual checks. Any concerns or queries are addressed as an immediate and urgent matter by the Care and Training Support Nurses. The care team then addresses any inappropriate locations of beds and supports homes to ensure beds are located in the safest possible position. The data will also be shared at the company Health and Safety Meeting every quarter.

I was told about the way in which Care Establishments must now assess their clientele and based on that assessment, they should determine how many staff members are required at any time. I remain unconvinced that a proper assessment had taken place but in any event I was told that the night staff members had to perform additional tasks of cleaning and laundry. Has this assessment of the number of staff and the additional duties to be taken by them, been addressed?

Staffing levels are based on an evidence-based model, determined by how much care and support residents need. The care team at Bramhall and throughout Sunrise Senior Living are not required to provide laundry and housekeeping duties in their entirety, but rather a small proportion. The laundry and housekeeping hours for each Sunrise Senior Living home are calculated per resident and are added to the hours of care needed by residents. Staff are required to respond to the residents' needs first, and at no time have they been instructed to ignore these in place of delivering domiciliary duties. It is however considered reasonable to use any quiet time throughout the 24 hour period to support the residents with their laundry or by cleaning or tidying their personal spaces. This is standard practice across the care sector. Housekeeping and laundry teams are hired in every Sunrise home to manage the bulk of the domestic cleaning and commercial laundry.

During the course of the evidence it became apparent that public money was being sent to Sunrise Senior Living for the provision of nursing care for Dr. Williams. Whilst I accept that a nurse was present on site albeit in the other part of the Home, this was accepted by the Managing Director as not amounting to the provision of nursing care. The payment was apparently 'credited' against the account of Dr. Williams, but I am concerned that as a result of this apparently flawed system, he was not in fact allocated to the correct type of care. Has this system now been reviewed and any change brought about?

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The accounts team now provides information about who is receiving FNC each month to the Operations Director for those homes. Each Operations Director manages approximately nine homes. As part of their monthly reviews, they check with the managers of each home that those listed as receiving FNC do in fact receive nursing care.

We now also run a monthly companywide report to compare the number of nursing hours in each home against the number of residents receiving FNC. Where there is a noted disparity, enquiries will be made by the operations team.

It should be emphasised that in the vast majority of cases, the manager of the home will be involved in any assessments or reassessments of residents and will know which residents are eligible for nursing care. However, these new systems have been put in place to manage those few cases where for whatever reason, the NHS has not communicated directly with the home.

The requirement for bed brakes to be properly applied when the staff members are not in the room should be an absolute requirement and this should be reinforced in writing to all staff.

This is now a key part of the bed safety training which is included in manual handling training for all care & nursing staff. Further details about monitoring compliance with and effectiveness of, training is addressed above.

There was an apparent failure by the staff (notably the managers who changed on a number of occasions) to pass relevant information to their successors, and the daughter of Dr. Williams had to reiterate the same information several times. This led to a lack of confidence by the family of the deceased that his care needs were properly being made known to those having care of him.

Following on from 6 above, the system for providing relevant information to the relatives was flawed as the necessary files were archived and inaccessible. Has this been changed or is it intended that is should so be? This is relevant to the future deaths, because it may hamper the ability to ensure that the patient is receiving optimum care in the most appropriate establishment

We have undertaken a full review of our Care documentation. The revision proposes that when care plans are updated, all information will carry forward to the new plan. That includes all information obtained from all sources since the last update. This will remove the need for repeated communication of contact and background information when the new assessment is released. We had already commenced the process of contracting with an external archiving organisation which will enable a far more robust process of storing and retrieving residents' historical documentation.

Care notes were completed for the full period of the night shift of the 3rd to the 4th March 2014, at the beginning of that shift, i.e. before the visits had actually taken place. This was clearly unacceptable. Has anything been put in place to prevent this happening in the future?

Repositioning charts used in the company are clear in that they require the team to complete once an episode of care has been given. The Director of Operations disclosed immediately and without request, prior to external scrutiny, that there appeared to be breach of process regarding this particular care note discrepancy. The individuals responsible were suspended, interviewed formally and the responsible person dismissed once this breach of process was confirmed. A communication has been sent to all staff outlining clearly the expectations of Sunrise when completing these forms.

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Some members of staff were clearly under the impression that they should not call an ambulance but should contact the nurse on site who would then do so. This could lead to unacceptable delays in the attendance of potentially life-saving emergency services. Has this misapprehension been addressed?

A communication has been sent to staff (with instruction to be discussed and signed for at handover) that the emergency services must be called by the person discovering the incident if the situation warrants it, and to clarify that there is no need to delay this process by finding the nurse. To ensure that this communication is embedded into the organisation it has been added to the General Managers' training which is in turn delivered to all team members as they join Sunrise.

Yours sincerely

[redacted]

[redacted]

Managing Director
Sunrise Senior Living UK