Head Office

C/O Charing House, Canterbury Street, Gillingham. Kent. ME7 5AY
Telephone 01634 584600 Fax 01634 584650

Central & South East Kent Coroners
Cantium House
2nd Floor
Maidstone
Kent
ME14 1XD

28 January 2020

By Email and Special Delivery:
kentandmedwaycoroners@kent.gov.uk

Dear Sirs

Regulation 29 Response, following inquest touching on the death of Mr Terrance Ewart James

I am the Director for Care and Operations for Charing Healthcare, a group of Care Homes within Kent and Medway. I have worked with the group for the past 11 years, previously having worked with KCC for 20 years within the social care sector.

I attended the inquest into the death of Mr James and have also investigated the coroner's Regulation 28 report. I write to provide you with my response in this respect.

I have sought to address each issue raised below:

1. *The GP was due to attend Mr James on 17 April and was not informed of his fall prior to his attendance. He had bruising and abrasion to his head and was on anticoagulation medication. The GP examined him and found no apparent neurological symptoms or fracture. He advised that if there was any deterioration to seek further urgent advice. The GP evidence was that he would have advised that Mr James be taken to hospital*

We have a clear process in place in relation to escalating matters to the GP. Essentially, the senior on-duty in the morning calls the surgery every morning with a list of residents that need to be seen. The GP then attends the home after his/her morning surgery usually after 1pm . This is normal practice, and the process used by most care homes in conjunction with

their associated GP surgery. Furthermore, we are not able to unilaterally change this process, as it is driven by national GP arrangements

On this particular occasion, Mr James was already on the list to be seen by the GP, for another concern. Therefore, there was no reason to put him on the list following the fall, as he was already on the list and there was no immediate concern at that time because he had got himself up from the floor and back into bed. The GP would not come out earlier in these circumstances, as the GP has to attend to the patients in the surgery before coming out to the home. The only other option would have been to escalate the incident to an emergency and call 999. This fall was not deemed to be an emergency, and the GP also confirmed that Mr James did not require urgent intervention when he attended. As an organisation, we are under a duty not to escalate the matter unnecessarily, as this inevitably places further pressure on emergency services.

Number (1) quoted above refers to the GP advising that any deterioration required further urgent advice. Our understanding of the advice is that this referred to a deterioration in Mr James' condition, however, there did not appear to be a deterioration in his condition, rather Mr James had a further fall, which has been addressed below.

2. *The history of the fall on 17 April was not handed over to care staff who had returned from leave on 20 April.*

In accordance with the court's request, we did set out in detail our practices in relation to handover, in our letter to the Coroner dated 12 December 2019, and this is summarised below:

Prior to adopting an electronic system for care planning, monitoring and handovers, Charing Dale Limited used paper based 'handover sheets'. The paper based system used to be standard practice in all of the Group's Homes. This pro forma enables all staff to quickly see any issues that have arisen, and which residents need extra monitoring.

We moved to an electronic system in April 2019. We adopted the electronic system for a number of reasons, including the Care Quality Commission's guidance in relation to moving forward with regards to technology. The benefit of the electronic system is that it is completed at the time care is delivered and can incorporate a lot of information. It is difficult to demonstrate this in court due to the fact that the system is designed to enable access to the information electronically.

However, due to the concerns raised by the Coroner, we are conducting a full review of our handover system. For the time being, we have reverted back to the paper based system for handovers, across all of our homes as it is a visual tool that can be read straight away rather than having to find the appropriate tab on a system to read back in the notes. The system was put in place at Chippendayle Lodge immediately after the inquest on 11 December 2019. It was communicated to staff in internal meetings, and we are ensuring that all staff understand the importance of ensuring the handover forms are completed in full. This is being done through team meetings, which have taken place, for example, on 11 December 2019 and 13 December 2019.

With regards to the senior carers communicating between shifts, there is a book in place for this purpose. In addition, we now have a full and comprehensive handover sheet that will remain in the folder for two weeks for all staff to read to avoid any future miscommunications. All seniors sign the handover sheet over to the next shift senior as evidence they have read it. We are ensuring that all staff appreciates the importance of completing the paperwork fully and in a timely manner. This will be monitored closely and any concerns addressed with the relevant staff on an on-going basis. As indicated above, this was implemented straight after the inquest, on 11 December 2019.

A further staff meeting was held on Friday, 13 December 2019, and the manager shared the details of the inquest to ensure that all staff understood the importance of following the systems and protocols in place and to enforce expectations in this respect.

Furthermore, due to the concerns raised by the Coroner, we are implementing this paper based system in all of our Homes. All managers were notified of the change on 13th December by email. It was difficult to demonstrate how the electronic system worked in court but it does have some helpful and positive additions. However, whilst we conduct a comprehensive review of the handover system, we will ensure that all our Homes use the traditional paper based approach. At present, we are using both methods for handover, and it is likely this will remain a long term arrangement. We have a managers meeting on 29th January and I will be asking managers for feedback on the current arrangements.

The outcome of the inquest has been shared with the managers at all of our Homes as a learning opportunity. This took place on 13th December and we will also discuss it on 29th January at the manager's meeting.

3. *A chiropodist raised concerns on 18 April that Mr James was in pain and this was not escalated for further medical advice.*

We do have processes in place in relation to professional visits. We have an electronic care plan system where visits are logged. We have also retained some communication sheets so that professionals are able to write the notes up for each person they visit.

We understand there is a factual dispute regarding whether the chiropodist did raise concerns and who these concerns were raised with. Our records document the chiropodist's visit, but do not indicate concerns were raised and the chiropodist was not called to give evidence at the inquest to ask further detail in this respect.

4. *Mr James sustained a further unwitnessed fall at approximately 10:25 on 20 April. This fall was not escalated for further medical advice until after a change of shift at 19:00 when his deterioration was immediately noted and escalated.*

We have policies in place in relation to escalation. All staffs know that any concerns should be escalated to either the relevant member of staff on-call or to the Care Home Manager, who can be contacted at any time of day or night. This issue related to an individual member of staff making an incorrect judgment call. The staff member on duty did seek to address the matter, but relied too heavily on discussing the matter with the family, who had a POA health and welfare, rather than using her professional judgment. The staff member has received further training and the issues raised at the inquest have been discussed in depth with her. She very much understands the importance of ensuring escalation is immediate. In addition, as outlined above, the outcome of the inquest and concerns in this respect have already been shared throughout the organisation.

Furthermore, all these processes and procedures have been recommunicated to staff in team meetings and supervision sessions. These have taken place across the board, and many had taken place before receipt of the Regulation 28 report, within hours of the inquest taking place.

As an organisation, we also conduct regular audits. We have a schedule in place in this respect. We are also in the process of introducing a specific audit relating to the handover process, and this will be in place from 29 January 2020, after the managers' meeting, where it will be discussed. We have endeavoured to put robust systems in place to ensure that errors do not occur again. The above being said, we had in fact put a great deal of thought

Head Office
C/O Charing House, Canterbury Street, Gillingham. Kent. ME7 5AY
Telephone 01634 584600 Fax 01634 584650

into the processes in place before the inquest, and we do believe that where errors occurred, they were individual judgment calls, rather than systemic errors.

We take these matters extremely seriously. For this reason, both the care home manager and I (Director of Care and Operations) were present throughout the inquest in case there were any systemic issues that needed to be addressed. However, despite our attendance, no-one was asked to give evidence on behalf of the organisation, and we had no opportunity to set out our processes in place in respect of these issues.

In any event, we are always keen to review and revise our policies and procedures where appropriate and we do conduct systematic and rolling reviews as an organisation. Therefore, we have ensured robust systems are in place and that these have been fully reviewed, and updated accordingly.

Yours faithfully

[redacted]
Director of Care and Operations
On behalf of Charing Dale Limited