for quality care

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Miss S Haskey
Office and Main Court
The Council House
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29th January 2016

RE: Formal Response to Regulation 28 Report to Prevent Future Death

Dear Miss S Haskey

We would like to thank you for the time and attention you have given to the Inquest into the death of Mrs Elsie Brown, who resided at Langwith Lodge Residential Home, Mansfield NG20 9ES.

We make the following response to the Regulation 28

1. *There was no falls risk assessment nor bed rails assessment in place for Mrs Brown, nor was her mental capacity assessed.*

   The Company did have corporate documentation in relation to falls risk assessment at the time of the incident. The 'Multi-factorial falls risk assessment' (attached) was introduced in 2014. This documentation allows Senior and Managerial staff to assess the likelihood of a resident suffering a fall and includes a section about the risks at night time.

   The Company appointed an independent consultant in December 2015 to carry out an investigation into matters that had come to light during the course of the inquest. Part of this investigation looked into why this, and other corporate documentation was not used as part of Mrs Brown's care plan. The Company has now taken appropriate disciplinary action and a large amount of work has been undertaken with remaining key personnel to ensure they understand the procedures and are conversant with appropriate documentation that should be used throughout a resident's stay at one of our homes. There are also systems in place to ensure these are monitored, audited and reviewed for their effectiveness (see 2 below)

   The Company also, since 2010, have had corporate documentation and procedures in place to assess the mental capacity of residents. These are regularly updated, eg when there are changes in legislation. Mrs Brown's capacity was not formally assessed as it was not deemed that she lacked capacity, and the Mental Capacity Act states that capacity must always be assumed unless it is proved otherwise.

2. *Mrs Brown's care plan was incomplete, unsigned, undated and never reviewed, despite Mrs Brown falling from her bed on 8th March 2015.*

The Company has always had clear guidance for all staff on the compiling of care plan documentation in a timely manner. As part of our ongoing quality improvement plan we introduced a care plan matrix in October 2015 (attached), which outlines which staff are responsible for reviewing which individual care plans and this is monitored by the management team to ensure all staff are fulfilling their individual duties.

A falls management folder was introduced at Langwith in April 2015, which contains a number of different assessment tools to assist staff in reviewing the safety of a resident who is at risk of falls. This includes a specific bed rail risk assessment and algorithm (attached).

We recruited a Quality Manager in September 2015 who undertakes quality audits at all of our homes to ensure procedures are being followed and care plans are being compiled in a timely manner. All quality audits are supported by an action plan to ensure we continue to make improvements where necessary.

3. *No referral was made to the falls team nor (by Langwith Lodge) to Derbyshire Community Health as regards to the question of bed rails.*

Following our own investigation into the earlier incident on 8th March, we have found an entry in the staff handover book from 9th March 2015 (attached) which details that a referral had been requested through Claire Byrne. We apologise that we were unable to present this at the time of the Coroner's inquest.

Bed rail referrals have always been made via the nurse practitioner, Claire Byrnes to Derbyshire Community Health. It is the responsibility of the local health service to provide bed rails and we were awaiting an OT visit to the home to make a decision on them being used.

We would have expected a referral to have been responded to within 5-7 days, and at the time of the second incident on 23rd March 2015, no visit had been made. Since the inquest we have improved the system for recording when bed rail referrals have been made and how they are followed up. The new system should ensure that outstanding referrals are flagged up.

4. *There was a lack of clarity as to where the responsibility for an initial bed rails assessment lay*

The Company introduced a falls management folder in April 2015, which includes an algorithm and risk assessment for bed rails (See 2 above). Following on from this, if necessary, the care home would make a recommendation for bed rails to the local health service through a referral. An Occupational Therapist or District Nurse then visits the home and makes a decision on whether bed rails can be used to reduce the risk of the resident falling out of bed. Other alternatives are also considered.

The responsibility for the initial bed rail assessment lies ultimately with the person reviewing the persons care plan, which may be on a general basis or following an incident. The home Manager checks that this had been completed through regular audits of the care plan

documentation. All staff now have a clear understanding as to who has responsibility for the initial bed rail assessment.

5. *There was an insufficiently robust auditing process, in that omissions were not identified by Langwith Lodge nor by Your Health Ltd*

   We have a range of audits which Home Managers undertake monthly, quarterly, six monthly and annually to monitor the different areas of the service provision. The latest set of quality audits have been in circulation throughout the company since June 2013. Unfortunately, it transpired that the audit documentation at Langwith had not been kept up to date. The Company was unaware of this and has since put measures in place to monitor the audit process more thoroughly.

   In September 2015 we recruited a Quality Manager to work on a full time basis auditing the care homes within our group working with the managers to drive the quality assurance in the home. This ensures that Home Managers are more closely monitored and any omissions in their auditing records are found and addressed.

6. *Mrs Brown's fall on 23rd March 2013 was not handed over, nor recorded nor reported and there was a lack of clarity amongst staff as to where responsibilities for these matters rested.*

   The fall from her bed that Mrs Brown suffered on 23rd March 2015 was not handed over, recorded or reported due to the three staff on duty choosing not to do so. The company has established during the disciplinary process that all three staff knew the correct procedures to follow but that for different reasons they admitted not adhering to them. We have a robust induction and training programme in place to support knowledge and skills. All staff had a duty of care to ensure Mrs Brown received appropriate medical assessment and treatment.

   The Company has noted that there was some confusion as to who had overall responsibility when 2 senior staff were on duty and we introduced a staff handover document in September 2015 (attached) to document the daily responsibilities of individual staff on duty, as well as clearly outlining who the senior staff on duty were, and who was ultimately in charge of running the home.

7. *A member of staff who had responsibility for record making could not effectively and independently do so due to poor literacy skills.*

   Our records show that the staff member concerned had passed a basic literacy test, as part of the entry requirement for being enrolled on a course in Health and Social Care (NVQ level 2) with an Accredited training provider, which they passed. We were therefore satisfied that their literacy was of an adequate standard.

   However, as good practise we are introducing an internal basic literacy and numeracy test for all staff from 1st April 2016 across the company. This will ensure that all staff have adequate skills to facilitate excellent record keeping. Those who struggle with this process will not be discriminated against, but will receive extra support and guidance.

8. *That the night time provision of two staff members to cover the main Lodge and two to cover the Horton Suite (two separate but joined buildings) was not seen as a minimum requirement to ensure that health and safety of residents when at least one resident in each building*

needed the assistance of two carers, but that only three were regularly rostered for the night shift.

Langwith Lodge Residential Home has two named areas but is one building and everything in the main 'Lodge' is linked with the 'Horton Suite'. All the systems that make the home safe, such as fire alarms and the 'carer assist system', (colloquially called 'nurse call'), work equally in all areas of the home and are linked together, so staff across the building know when someone requires assistance. The Horton suite is accessible both at the front and rear of the main lodge through internal doors. We have the two identified areas to distinguish between the 'traditional care home' and the Horton suite which is marketed to more independent residents. Dependency checks are completed for all residents to support safe staffing numbers.

We take note of the Coroner's recommendations and have clarified the criteria for admissions to the Horton suite to ensure that safety levels are maintained. The Horton suite only caters for residents that are reasonably independent (require the support of one carer, if any) and are at low risk of falls. We do not intend having residents that require the support of 2 staff on the Horton suite but, in the rare circumstances that this could occur, we will ensure that we have a minimum of 4 staff on duty throughout the building to ensure that both areas of the home have adequate support.

9. *Handovers were not regarded as integral to the staffs paid shift and were informal and unpaid*

The Company has always recognised the importance of handovers as part of the daily routine for operating a service that runs 24 hours a day, 365 days a year. We are keen to ensure that the handover is a protected part of the day and is not interrupted in any way. We have consulted with staff and altered their shift patterns with effect from 21St January 2015, to ensure that we have an overlap of shifts which allows for a paid handover to take place to relay information about the people we are provided care and support to. We feel this will formalise the current system and make our handover process more robust.

I trust that these responses are satisfactory, but if you have any queries I will be happy to assist further.

Yours sincerely

[redacted]

Managing Director
Your Health Limited