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Coroner M E Hassell
HM Senior Coroner for Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

06 May 2020

Dear Ms Hassell

John Francis Gregory deceased – Prevention of Future Deaths report

We write further to your letter of 20 March, 2020, and in particular the Prevention of Future Deaths report issued following Mr Gregory's Inquest. As you know, Care UK had already put in place a number of changes following Mr Gregory's death but welcomes the opportunity to consider further improvements.

Please note that your PFD report was addressed to Jim Easton. The Chief Executive Officer of Care UK Community Partnerships Limited is Andrew Knight rather than Jim Easton. The Prevention of Future Deaths Report should have been addressed to Mr Andrew Knight rather than Jim Easton.

We note that you raised a number of concerns regarding Mr Gregory's care at Muriel Street Care Home and the actions we have taken are as follows.

1. **Being found slumped and not properly secured in a wheelchair on arrival at Muriel Street**

   For completeness, our understanding of the evidence, supported by the documentation from the family, is that the incident when Mr Gregory was found unsecured in a wheelchair was on arrival at Muriel Street, and not on the day he was readmitted to hospital. Further, our understanding of the evidence is that Mr Gregory was not in a public place, nor was he unresponsive at this time. That said, he should have been transferred into an armchair in his room.

   Care UK has robust moving and handling systems and procedures in place, supported by policies, "How to guides", "user manuals" and continuing training programs.

   The mandatory Moving and Handling training that is provided both on induction and then the annual refreshers cover the use of a wheelchair and the steps/checks that must take place. A copy of the Moving and Handling Training Plan is attached, along with the current training compliance report.

Care UK also has "How to Guides", supported by the wheelchair user manual, specifically in relation to wheelchair safety guidance and transporting a person in a wheelchair. Copies of these guides are attached. These guides are accessible to all staff within Muriel Street, and outline the safety checks that must be undertaken to ensure the safety of residents, including the use of footplates and safety belts.

Notwithstanding this, since Mr Gregory's sad death, Muriel Street has reviewed the manual handling training provided. Following this, it was identified that the training surrounding the use of wheelchairs could be strengthened. Consequently, the training has been improved, and the manual handling training now includes a specific section on wheelchair safety guidance. This includes highlighting and working through the "How to Guide – Wheelchair safety Guidance" (copy attached) during the training session. Due to the current pandemic, and the consequent restrictions placed upon the ability to provide group training, Muriel Street has undertaken 1:1 supervision / training sessions with all staff members in order to go through the how to guide, and ensure staff are familiar with the expectations set out therein. Further, there is now a laminated copy of this guide at every nurse's station to ensure that the guide is easily accessible. Additionally, where a resident's care plan requires the use of a wheelchair, a hard copy of the guide is placed into that resident's care plan folder in their room.

Muriel Street has also increased staffing levels since this incident, and there is now an increased senior presence on each floor with a senior manager (Deputy Manager, Clinical Lead or Care lead) based in each nursing office and the addition of a team leader who supports to carry out regular walk arounds of their floor / unit. The result of this is greater oversight of staff activities and monitoring of residents to ensure that residents' needs and safety are maintained.

Muriel Street also undertakes specific welfare checks upon residents at regular intervals throughout the day. Previously, whilst such checks would have been undertaken during the day as part of other care provision (e.g. during meal provision, or regular repositioning), there would be no separate documentation during daytimes. Having reviewed matters, since April 2020, in accordance with Care UK policy Muriel Street has now ensured that the welfare check sheets are completed during the day alongside the other documentation ie food and fluid charts, activities log books, turning charts and daily notes in addition to at night where they were previously completed. The documentation is kept in the resident's care plan folder in their room, (together with a sample completed form to assist and guide staff on how to complete this documentation) and is now regularly audited by the Home Manager who now as part of the daily checklist undertakes a random audit of documentation every day in order to ensure that these checks are being undertaken, residents are being properly monitored and the documentation is being completed to the expected standard across the home (details of documentation training are outlined below)

2. **Being found inadequately dressed shortly before his transfer to hospital**.

Care UK and Muriel Street take the safety, welfare and dignity of residents seriously. To this end, there are a number of systems, policies and guides which govern and guide staff in this respect We attach a number of policy documents, together with "How to Guides" and "Ways of Working" documents in support.

In relation to a resident's clothing, an inventory of a resident’s clothes is taken when they are admitted into the care home and then all of the clothes are individually labelled. The laundry room has named trays for each resident so that the clothes are returned to the correct resident’s room. In addition to the above, there is also the

“Resident of the Day” process whereby every month a resident's care is reviewed as a whole. This includes the checking of wardrobes and clothing labels to ensure that a resident's clothing is in order.

In order to ensure that a resident's dignity is preserved, there are a number of policies and guides in place, all of which re-inforce the need to ensure that a resident's dignity is respected and observed at all times. Part of this is to ensure a resident is appropriately dressed and personal care training extends to checking that the clothing belongs to the correct resident and is appropriate for the conditions. Whilst every effort is made to encourage a resident and to engage with them in this aspect of personal care, there are times when a resident may be non-compliant. In such instances, the expectation as set out within the policies is that this is clearly documented and depending upon the nature of the refusal, escalated to senior colleagues or external healthcare providers (e.g. the GP) as appropriate.

Staff are provided with training on this matter during the two week induction training course, the content of which is attached, which includes person centred care, privacy and dignity and the training compliance report previously referred to. The competency sign off sheet for personal care is also attached.

Since this incident, the requirement to ensure that resident's are appropriately dressed was specifically discussed during the daily "Take 10" meetings for senior staff, and during handovers when all other staff would attend. During these meetings, posters, which are now placed in each resident's wardrobe, outlining examples ways in which a resident may wish to be dressed depending upon the weather, drawing upon the circumstances of Mr Gregory as an example of an unacceptable standard of care. Further, staff were reminded of the requirement to document any issues with clothing (e.g. non-compliance) within a resident's care plan file.

It is the firm intention of Muriel Street that all staff will undergo a personal care training refresher course once the current pandemic and consequent lifting on restrictions allow.

Finally, as outlined previously, Muriel Street now has increased staffing levels and an increased senior presence on each floor / unit with regular walk arounds by senior team members to ensure that the high standards expected by Care UK are being met.

3. Being found in an unconscious state without any apparent staff support or monitoring.

The welfare and safety of residents in the foremost priority of Care UK and Muriel Street. As outlined above, the documentation of separate and regular welfare checks during the day are now in place at Muriel Street. In order to support staff in this regard, the need for separate welfare checks was discussed and explored at both the "Take 10" and handover meetings to ensure that all staff are aware of this new requirement, what is expected and how to complete the documentation fully and accurately. It is the expectation that the welfare check documentation would be checked daily by a nurse in order to ensure that any matters of concern are noted and actioned as required. Additionally, as outlined above, this documentation is also regularly audited as part of the Home Managers daily checklist to ensure such checks are undertaken, and documented appropriately.

Also, as outlined above, Muriel Street has increased the staffing ratio, resulting in greater senior staff presence on each floor / unit, prompting greater and more effective oversight of staff and the monitoring of the welfare of residents.

Additionally, since Mr Gregory's death, all nursing staff have undertaken a clinical skills workshop, part of which deals with the identification of the deteriorating patient and monitoring of the same, details of which are attached. Part of this course deals with the Restore2 deterioration tool which has now been rolled out at Muriel Street – details of which are below.

Further, Muriel Street has also undertaken a significant amount of focussed learning and training of both clinical and care staff in relation to the identification and escalation of a potentially deteriorating resident. This has been done via the Significant 7 training package, which is a training tool developed and administered by NELFT NHS Foundation Trust. The course is designed to enable non-clinical staff to identify and act upon "soft" signs of deterioration. Broad details of the course can be found at https://www.nelft.nhs.uk/significant-7. Since September 2019, the Home Manager at Muriel Street has become a registered trainer for the Significant 7 course, and all staff at Muriel Street have undergone the Significant 7 course. It also now forms part of the induction training for new members of staff.

To supplement this, since April 2020, Muriel Street has also rolled out the Restore2 deterioration tool (which is based upon the NEWS2 system commonly used across actual hospitals). A copy of the Restore2 documentation is attached and is contained within each resident's care plan file, and updated monthly by a nurse. The Restore tool assists staff members to be able to recognise the early signs that a resident may be deteriorating (as per the Significant 7 course), and then guides nursing staff on appropriate escalation and frequency of monitoring if required to ensure a resident is provided with timely and appropriate medical intervention. It should also be noted that the tool recognises that not all residents are the same, and therefore there is the ability to record additional signs of possible deterioration specific to a resident.

The Restore 2 system is a paper based system. In order to seek improvement, the nursing unit at Muriel Street is part of a trial, involving a number of other organisations in the local authority area, of an electronic monitoring system called Whazam. This system allow staff to electronically record a resident's vital observations and then calculates a NEWS2 score, prompting actions as necessary. The electronic system also shares a resident's vital observations with local GP surgeries and if necessary the London Ambulance Service, to ensure speedy and effective transfer of vital information should the need arise.

4. **Monitoring a resident's oral fluid intake**

Care UK and Muriel Street recognises the importance of ensuring that a resident's hydration is carefully monitored. There are a number of policies and guides in place to assist staff and highlight the importance of this aspect of care.

In this case there are 2 specific areas of concern raised by the Coroner:

Efforts to encourage residents to take oral fluids and escalation of concerns

Care UK has policies, "ways of working" and "how to guides" to assist staff in supporting residents to take oral fluids and maintain hydration. Copies of the same are attached. You will see from these that there is a clear expectation that residents' oral intake is monitored and concerns over the same escalated and reviewed (for instance

at weekly clinical review meetings). Further, in the event of more acute concerns in relation to oral fluid intake, the matter should be raised with the visiting GP to consider and advise, as occurred in Mr Gregory's case.

The "ways of working" and "how to guides", which are easily accessible by staff, provide information and guidance on the importance of hydration and the need for some resident's to have repeated encouragement to take oral fluids, together with suggested methods to encourage increased oral fluid intake. The guides also highlight the consequence of insufficient hydration and checklists for action in the event that there are signs of dehydration.

Since the death, Muriel Street has started and continues to educate staff of the need to encourage residents with oral intake of fluids. This has been done during "Take 10" and handover meetings. During these meetings all staff have been advised of the reasons why encouragement of oral fluids is so important, followed by an explanation and discussion of the ways of working and how to guides. Further, hard copies of these guides are now included in the resident's care plan file in their room. This provides easier staff access to the guides and serves as a constant reminder to staff of the importance to encourage oral fluid intake.

Additionally, once the current restrictions in place due to the pandemic are lifted, Muriel Street will be undertaking mandatory dining room training for staff, part of which provides training to staff on the need to encourage residents to increase oral intake generally, as well as refreshing techniques / methods to encourage residents to do the same.

<u>Recording of fluid balance and the accuracy of the same</u>
Clearly, part of ensuring a resident is taking sufficient oral fluid is to monitor oral intake via the fluid chart. Every staff member attends document training in addition to the induction training when they join the care home. This training outlines the documentation that staff are expected to complete and how to complete the same.

Muriel Street has reviewed the fluid charts used and has introduced new fluid balance monitoring documentation – copies attached. The new charts are clearer and enable details of a resident's input / output to be recorded in more detail. Further, staff are now instructed to document when the re-attempt to provide oral fluids to ensure that there is evidence of active encouragement.

In addition to the balance chart, there is also a fluid target record chart which is to be completed. This is completed daily and prompts active consideration by a nurse of a resident's fluid balance, and what consequential actions are required, ensuring a proactive approach to a resident's oral fluid intake. Any concerns are discussed at handover meetings with the clinical lead. Further, if there are lower level concerns, these are raised and discussed at the weekly clinical review meeting, in order to review the situation and decide upon future management.

All staff members have been trained in the use and completion of these new documents via discussions during the Take 10 and handover meetings, during which the forms are gone through in detail, the expectations of staff made clear, and the relevant how guides provided. The how to guides for the completion of the chart is also now included with the fluid charts contained in a resident's care plan file.

In order to ensure that these new charts are being completed correctly, all staff have been the fluid balance documentation is included in the regular random audit of documentation outlined above. Recent audits have demonstrated that not only are the

documents being completed in full, but there is also now documentation of repeated encouragement to take oral fluid.

As is clear from the above, there has been a number of changes made since the death. Ordinarily group training would be provided in order to re-inforce the improvements made. However, given the current pandemic, this has not been possible, and training has instead taken place in smaller groups. Notwithstanding this, once the current restrictions have been lifted, it is the intention of Muriel Street to have full group training on the following relevant areas:

- Manual handling – with the additional focus of wheelchair safety
- Personal care – with an additional emphasis upon dress
- Dining – with an additional emphasis upon encouraging oral fluid intake
- Documentation – with specific reference to the updated welfare checks regime, and the new documentation that has been introduced across a number of areas.

Additionally, Muriel Street would usually hold regular staff meetings / lessons learned sessions. Again, due to the number of staff, this has not been possible due to the current restrictions. However, once such restrictions have been lifted, Muriel Street intend to have a series of group staff meetings and lessons learned session during which the issues and concerns raised as a result of this case, and the changes made will be discussed in full.

As outlined at the beginning of this response, Care UK and Muriel Street takes the safety and wellbeing of resident's extremely seriously, and has in place a robust system to ensure that the high standard we expect are met. Nevertheless we also seek to learn and continue to improve. We are therefore confident that we have implemented a robust series of improvements, which will result in greater staff understanding and, timely and appropriate response to the matters of concern highlighted.

Yours sincerely,

[redacted]
Muriel Street Registered Manager