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Your ref

21 July 2014

Dear Sir

Albert Flynn deceased

Thank you for your letter of 3 July 2014 enclosing a report to prevent future deaths sent pursuant to Regulation 28 of the Coroner's (Investigations) Regulations 2013 ("the Regulations"). This letter is my response on behalf of HC-One Limited to that report and is sent to you pursuant to Regulation 29 of the Regulations.

Matters of Concern:

1. ***Whilst the care staff members were apparently concerned as to the condition of Mr Flynn, none of them were sufficiently well trained or qualified to make an informed decision as to how he should be treated.***

   Response:

   On this particular occasion the care staff members were experienced care assistants some of whom had undergone NVQ training and had also undertaken mandatory training courses in relation to certain aspects of the delivery of care. As a matter of routine all care staff receive training in essential elements of care and these include Safer people handling; Safeguarding; Emergency procedures; Falls awareness; Promoting healthy skin. It is accepted that in this particular case Mr Flynn was left undisturbed for too long before qualified assistance was sought and during individual supervision for the staff concerned and during induction training for new staff, the need to call for qualified assistance will be re-emphasised.

2. ***As a result of the above he was left sitting in a chair partially dressed, without food, fluid or medication for a period of approximately ten hours.***

   Response:

   It is accepted that this situation is unacceptable and the steps referred to in paragraph 1 above will address these issues so far as care staff are concerned.

3. ***None of the staff gave any indication of any, or any proper, training in the assessment of this type of event, nor did they attribute any, or any sufficient, weight to the fact that he had been administered blood thinning drugs the previous day.***

Response:

As part of HC-One's standard instructions to staff, all managers are required to carry out a Manager's Daily Audit. This is a written document which has been in existence now since December 2011 and this document is required to be completed by the Manager if he/she is on duty, or in his/her absence the Deputy Manager or person in charge. On the day in question the Deputy Manager was [redacted] RGN, but she failed to undertake the Manager's Daily Audit as required. Had she undertaken the Daily Audit she would have been advised about Mr Flynn having been sleeping in his chair since the early hours of that morning, so could have taken the action that she recommended later in the morning much earlier. As will be seen from the Daily Audit (copy attached) the second item to check is the lounge area and to ensure residents are well presented. Mr Flynn's condition should have been addressed at that stage. The nurse on duty would then have been able to attribute proper weight to the fact that Mr Flynn had received blood thinning drugs the previous day and his state of consciousness was cause for concern. The hospital did not provide any cautionary advice for the care team upon discharge back to the home on the evening of 14th March 2014 following the administration of anti-coagulation therapy, nor did the hospital initiate district nursing input across the weekend. Mr Flynn was accommodated as a residential client and so his day to day care would not have been provided by qualified nurses but by care assistants. The nursing input would normally be provided by the district nursing service.

4. ***The staff did not seem to appreciate the importance of administering prescribed medication.***

Response:

All staff who administer medication are trained both as to how it should be administered and about the importance of receiving medication. There will be occasions when a service user will either refuse to take medication or be unable to take it because they are sleeping deeply. In those circumstances the senior carer administering medication or the nurse administering medication, should refer to the residents care plan or in appropriate circumstances seek advice from the General Practitioner as to whether or not this medication omission presents a risk to the service user and therefore they should be roused from their slumber despite the fact that they may not wish to be roused. The importance of medication being provided at the appropriate time is something that is contained in the routine training and competency assessments undertaken by staff and repeated at annual intervals but conducted more frequently should individual concerns be raised. Senior care staff involved in this incident will undergo additional training and competency assessment to support her awareness.

Conclusion:

The circumstances surrounding the care staff's failure to alert the qualified nurse on duty of Mr Flynn's condition is regrettable and with the balance of hindsight is accepted by them as having been regrettable. The need to seek earlier help and intervention has been re-emphasised to all the care staff involved in this case during the course of supervision and this case will also serve as a reminder to all care staff working within the company to alert more senior staff should they have any cause for concern about the condition of a resident which is unexpected or extraordinary.

Yours truly

LESTER ALDRIDGE LLP