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Rotherham Metropolitan Borough Council

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SM/LH	(01709) 822773	22773	Commissioner Manzie

11th September 2015

Ms N J Mundy
H M Coroner, South Yorkshire (East District)
Coroner's Court and Office
Crown Court
College Road
Doncaster
DN1 3HS

Dear Ms Mundy

RE: Phyllis Broomhead, (Deceased)
DOB: 05.03.1923 – DOD: 09.06.2013

On the 6 July 2015 you concluded the inquest into the death of Phyllis Broomhead. You recorded a narrative conclusion and submitted a report under Regulation 28 to express concerns about certain aspects of Mrs Broomhead's care. Your report was received in to the department on 26 July 2015.

You requested that the Local Authority respond to your report within 56 days outlining details of action taken or proposed to be taken, setting out the timetable for action. The original response time was extended to the 14th September 2015 by your office in a letter to Jill Wetherall, Service Manager, Safeguarding Adults dated 1st September 2015.

Please find enclosed a detailed action plan of recommendations made under regulation 28, actions taken by Rotherham Metropolitan Borough Council, if these actions have been achieved and a timescale to conclude any uncompleted actions. I hope these meet with your approval.

Yours sincerely

Stella C. Manzie

[redacted]
Commissioner and Managing Director

Rotherham Borough Metropolitan Borough Council

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Action Plan in regards to Coroner Mundy's Narrative Conclusion touching the death of Mrs Phyllis Broomhead

Source	Coroners' Recommendation	Work Completed	Work Outstanding	Timescale for Meeting Recommendation
Coroner's concerns, section 5	(1) Staff employed at Lord Hardy Court EMI residential Home require further training with regards to:- i) The head injury protocol, how this should be followed and the importance of doing so.	Head injury policy is in place, developed by health care professionals that support all care homes with the necessary interventions and protocol following a fall. New documentation to record and evidence observations following a fall has also been put in place (developed by registered health professionals). This has been rolled out across all RMBC residential services. Shift supervisors check and sign off the checklist at the end of each shift to ensure that all actions following a fall have been implemented. In-house training has been given. The new protocols have also been embedded in team meetings, individual supervisions and Personal Development Reviews (PDR's).	Achieved.	This action is complete but training is ongoing to ensure best practice. Officer Accountable: [redacted], Service Manager, In-House Provision.
	ii) Record Keeping.	Record keeping and the importance of accurate documentation have always been paramount to RMBC, however this has been further embedded in training programmes, team meetings, supervisions and PDR's. Regulatory site visits are carried out by Service Managers where random samples of care records are reviewed. From this the Registered Manager is informed of any remedial actions that are required.	Rolling out of the new Quality Assurance (QA) system which incorporates the formal monitoring of the care records.	This action is completed but training is ongoing to ensure best practice. Roll out (and testing) of the new QA system should be fully operational by December 2015. Officer Accountable: [redacted] Service Manager, In-House Provision.

Source	Coroners' Recommendation	Work Completed	Work Outstanding	Timescale for Meeting Recommendation
	iii) Indicators and triggers to seek social worker input.	Care assistants now report all changes to a resident's needs directly to the senior carer. It is for the senior carers to document whether an unplanned review of a resident is required and to contact the appropriate team to arrange this.	Registered Managers to be formally involved with "reviewing" complex residents. Best Interest meetings to take place to consider the ongoing risks for "high risk fallers".	Best Interest meetings process has commenced. Registered Manager reviews will begin to take place from October 2015. Officer Accountable: [redacted] Service Manager, In-House Provision.
Coroner's concerns, section 5	(2) With regards to the Safeguarding team, subject to the impact of any subsequent legislation, the importance of ensuring that any initial screening process following a referral is sufficiently detailed and objective to facilitate the making of safe, sound and informed decisions with regard to any future action which might be indicated or indeed before exiting the process.	Safeguarding Adults is a statutory duty in the Care Act 2014. Section 42 of The Care Act has addressed safeguarding processes and decision making within safeguarding. It also identifies that outcomes need to be clearly recorded and identified before a section 42 enquiry can be exited. The Care Act was implemented on 1 April 2015 and is still in the process of being embedded in practice. All relevant staff have undertaken mandatory Safeguarding Awareness training throughout April -June 2015. All Safeguarding training has been reviewed and updated to be Care Act compliant. South Yorkshire Safeguarding Adults procedures have been revised and re-written to be Care Act compliant these are currently active and ready for live launch	To roll out new safeguarding training beyond basic awareness. This includes training at all levels from basic awareness for all staff through to platinum level training for specialist workers in this field.	Training is timetabled for delivery from October 2015. Launch South Yorkshire Safeguarding Adults Procedures in October 2015. Officer Accountable: [redacted] Service Manager, Safeguarding Adults.

Source	Coroners' Recommendation	Work Completed	Work Outstanding	Timescale for Meeting Recommendation
		across South Yorkshire in October 2015 Safeguarding documentation has been re-engineered to be Care Act compliant and to ensure the customer journey is captured and recorded. More detailed recording is now standard practice to confirm what documents have been scrutinised, dates and people spoken to during the screening stage to enable the decision maker to make informed decisions before exiting.		
	Furthermore I heard evidence about three types of homes available; care homes, EMI care homes and nursing homes. For residents who are clearly continuing to be a high risk of serious injury, as was the case here, consideration should be given to ensure closer scrutiny and monitoring of such residents' progress. It seemed that although Mrs Broomhead was identified as being of high risk of falls, as it was felt that her needs didn't amount to nursing needs there was no	EMI care homes were developed for individuals with higher care and monitoring needs than those requiring residential care only, but with no assessed nursing needs. This was the level of care Mrs Broomhead had been assessed as requiring. Deprivation of Liberty Safeguards and the best interest decision are now considered when residents who lack capacity have a high risk of falls. This is to address the risks associated with the environment and whether needs are being met appropriately. This change in practice should now identify the need for a higher level of care when	There are nationally 4 types of registered 24 hour care provision: Residential Residential EMI Nursing Nursing EMI. Care providers can only register within these categories.	This action is complete.

Source	Coroners' Recommendation	Work Completed	Work Outstanding	Timescale for Meeting Recommendation
	alternative but for her to remain in a care home.	required. All care plans of people in care are reviewed by the provider every month and by the Local Authority at least annually.		

Senior Officer Responsible: [redacted] (Head of Adult Services)