RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Deceased: **Derrick Lawrence BROCKLEHURST**
Date of death: **2 December 2016**
Your ref: **5967/HC**

BACKGROUND

1. On 6 June 2017, the Chief Executive of Tameside Metropolitan Borough Council received a report from Alison Mutch, OBE, Senior Coroner for the coroner area of South Manchester. The report was made under paragraph 7, Schedule 5 of Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

2. The report was made following the conclusion on 17 May 2017 of an investigation and inquest into the death of Derrick Brocklehurst (dob 23/07/1930, dod 02/12/2016).

3. A matter of concern identified by the Coroner and directed to the Chief Executive of Tameside Metropolitan Borough Council was as follows;

> *There was no documentation available of the carer visits. The care provided and any issues with the provision of care could not be established. They were not recovered by Social Services when care stopped. There was no system for recovery of care notes when care ceased.*

RESPONSE OF TAMESIDE METROPOLITAN BOROUGH COUNCIL

Care Record Book

4. In circumstances where Tameside MBC ("the Council") is required to meet the needs for care and support of an adult in its area, one of the ways it can do so is by providing domiciliary care at the home of the adult or "service user". To do this the Council contracts with independent providers who are registered with and regulated by the Care Quality Commission as a 'homecare agency'.

5. The service user's care needs are assessed by a social worker or an assessor and this assessment is recorded on the Council's electronic care management system, IAS.

6. The social worker or assessor, following consultation with the service user, any family members or carers for the service user and any other relevant persons such as Moving and Handling Officers would then prepare a support plan detailing the type and nature of the care to be provided.

7. Once this support plan is authorised it, together with any other relevant information, is sent to an independent care provider commissioned by the Council to provide the care to the service user. Having regard to this information the provider carries out and records assessments of the service user's mobility, risk of falls, nutrition, skin integrity, environmental risks and other such matters. This information enables the provider to formulate the actual care to be provided to the service user in their home.

8. Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires the provider to

> *maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided*

9. The "Helping People To Live At Home Service And Extra Care Support Service" contract between the Council and each care provider states at part 7.2.12

> *"The Provider will ensure a care record book is introduced within the individual Service Users' homes. The Provider will be responsible for ensuring the information within the care record book (including information provided by the Commissioner and/or CCG in relation to Complex Care) is kept safe, is up to date and appropriate records are maintained by its staff"*

10. A provider does this by completing the 'care record book' which includes relevant documentation such as the care plan, the above mentioned assessments with reviews and updates, Medication Administration Records (MAR), weekly meals records, food and fluid charts, weight charts, and any other relevant information. Daily 'running sheets' would record the day to day visits of carers, the tasks completed and any issues such as a refusal of the service user to take medication. The care record book will contain sufficient information to allow a carer to visit the service user and provide the necessary support that the service user has been assessed for. Records are required to be thorough and document any concerns or safeguarding issues that the carer may have. The care agency is required to notify the Council of any such concerns or issues.

Monitoring by the Council of the Care Provided to Service Users

11. The Council has a contractual right to request sight of all information within the care record book. Part 11.5.3 of the Helping People To Live At Home Service And Extra Care Support Service" contract states a provider must

> *"comply with all reasonable requests relating to the performance of any aspect of the Services, including those areas that demonstrate the Provider's ability to ensure this Agreement is complied with, such information to be returned to the Commissioner (or the CCG in relation to Complex Care) within 14 calendar days of the request"*

12. The social worker for the service user completes a reassessment of the need of the service user six weeks after the commencement date of care being provided. This is to ensure that the care and support is appropriate and meeting the assessed needs. Subsequent reassessments are carried out depending on the complexity of the case. An annual review is also undertaken by the social worker. In carrying out any reassessments or reviews the social worker will consider the care record book to establish that the required care is being provided and to identify whether there are any issues with this care.

13. In addition to this monitoring of the individual service user, the Commissioning Team undertakes monitoring of the provider by way of a minimum of two validation visits every year and two contract performance visits per year. The validation visits focus on the provider's recruitment and selection policies and procedures, and the training of employees. In addition a number of service user files are randomly sampled to ensure they have the appropriate information contained within.

14. The contract performance visits look at any issues raised from the validation visits, as well as focussing on other issues such as complaints, matters raised by the provider or social workers, safeguarding investigation outcomes and the steps that have been recommended following a safeguarding investigation. Additional unannounced visits can also be implemented should it be deemed necessary following a complaints or concern.

15. If the Council had concerns that records were not being completed or that a support plan was not being followed the Council's Adult Services would in the first instance investigate following which the care agency would be advised of the steps required and the time for compliance. A recommendation may also be made that care agency staff be provided

training. Adult Services would work closely with the Commissioning Team and performance would be closely monitored.

16. The purpose of monitoring following concerns regarding record keeping would be to encourage providers to improve performance to an acceptable level. The Council will support providers to do this. Should the Council continue to have concerns with a provider's ability to maintain accurate records it can take further action such as issuing a contract default notice and, ultimately, terminating the contract. A default notices could be issued in circumstances where there has been persistent breaches or for a more serious breach (normally identified via safeguarding) that has put a service user at serious risk.

System for Recovery of Care Records

17. When the care provided to a service user is to be stopped the Council will notify the provider of this. The reason for ceasing care and support are varied but typically would be because the service user has died, moved to residential or nursing care or been in hospital for a period of time exceeding 3 weeks. Users and their families can also decide to stop receiving care and make other arrangements themselves. Once the care is stopped the provider is notified by the Council's Home Care Commissioning Team and the provider is then required to recover and archive the care records that have been maintained in the user's home. The Care Quality Commission requires a provider to store this information for 7 years from the last date of entry on the records. Each provider has its own procedures for recovery and retention of records. In preparing this report inquiries were made of the provider which last provided care to Mr Derrick Brocklehurst. That provider advised that its procedure is for the last care worker to visit the service user to recover the care book and other records. These records will then be returned to the provider and placed in a numbered box which is then sent to a central archive depot. The local office of the provider maintains a register of archived boxes so that records can be retrieved if necessary.

18. There will be circumstances where the Council and the provider receive no prior notification of care ending (such as when a service user is admitted without notice to hospital and subsequently dies). In such circumstances the provider will be notified by the Home Care Commissioning Team that care has ended. The provider must take steps to try and recover the care record book. The provider will rely on the cooperation of whoever may still be residing at the service user's home, such as family members and others, to recover the care records. However if cooperation is not forthcoming the provider cannot enter the property to recover the records knowing that the service user isn't present and that the contract to provide care has ended.

19. In these situations the provider may not be able to recover the care record book. This will not mean that the provider has no records whatsoever. The provider is required to keep copies of the care plans and assessments which were carried out. In addition the provider is required at regular intervals to obtain copies of other documents such as the MAR, weekly meal records, daily running sheets and all other documents which are updated by carers on their visits to the service user. However it will mean that on occasions the provider will not be able to recover these updated records for the period from when copies were last taken to the period when care ended without prior notification.

Records relating to Derrick Brocklehurst

20. The Council accepts that the records detailing the care provided to Mr Brocklehurst for the period 31 October 2016 to 17 November 2016 when care ended had not been recovered by the provider and were unavailable for the Coroner conducting the inquest.

21. From 31 October 2016 the provider of care to Mr Brocklehurst had changed following the Council terminating its contract with the previous provider. The provider had not in that

relatively short time made copies of the documents recording the daily care given in that period.

22. On 10 November 2016 the new provider contacted the Council with concerns that Mr Brocklehurst wanted to terminate his care. A Council Officer together with a manager employed by the provider visited Mr Brocklehurst on 16 November 2016 when he and his wife indicated that they wished for care to end. It is clear from the Council's own reassessment document, updated by the Council Officer on 17 November 2016, the care record book was being updated. She records that she "*looked at the care record book and minimal tasks are being provided. Derrick does not like the carers supporting with his personal care and prefers his wife to undertake this*"

23. The provider last visited Mr Brocklehurst on 21 November 2016 following which his care was ended in accordance with his wishes. The provider was formally notified of this on the 22 November 2017.

24. It is accepted at this point the provider should have made arrangements to recover the care record book. This was not done. On 28 November Mr Brocklehurst was admitted to hospital where he remained until his death on 2nd December. Again it is accepted that the provider did not make any arrangements following Mr Brocklehurst's death to recover and consequently had no record of the care it had provided since taking over the contract on 31 October 2016.

25. Efforts were made by the Council in advance of the Inquest to recover the Care Book from [redacted] However it appeared that the care book had been discarded by [redacted] in February 2017 during a 'de-cluttering' of the property she had shared with her husband.

CONCLUSION

26. The Council regrets that no documents relating to the care visits were available to the Coroner. However the Council believes that this was an isolated incident rather than an example of a systemic failing and it is only very rarely that a care provider is unable to provide to the Council when requested the actual care record book from a service user's property.

27. Care Providers are under both a regulatory and contractual obligation to maintain accurate and up to date records of the care provided to a service user. Enquiries with the provider responsible for Mr Brocklehurst's care have established that the provider was aware of these responsibilities and also had a procedure for the recovery and archiving of care record books following the termination of care. However to minimise the risk of a provider failing to recover a care book following the termination of care the Council has taken or proposes to take the following steps:

    a. The agenda for a Provider Forum, due to take place on 25 July 2017, included an item relating to Care Record Books. Unfortunately this forum was postponed. The item will be included on the agenda for the next Provider Forum at which providers will be reminded of their obligations and in particular the obligation to;
        i. maintain accurate records;
        ii. regularly obtain copies of documentation contained in the Care Record Books which is updated on a daily/weekly basis such as, but not limited to, daily running sheets, MAR, weekly meals records, food and fluid charts, weight charts, and any other relevant information;
        iii. make adequate arrangements to recover Care Record Books when notified that care is to be or has been ended;
        iv. record the reason for failing to recover a Care Record Book;

v. archive the Care Record Book and any other records for a period of 7 years from the last date care was provided.

b. Following the Provider Forum the above points will be confirmed in writing to all providers;

c. With immediate effect on a weekly basis the Homecare Commissioning Team will run a report detailing which service users have ceased to receive care. The relevant provider will be sent a copy of this report with a request for confirmation that the care record book has been recovered from the service user. Where the provider states records cannot be recovered the provider must notify the Council, detail the attempts that have been made to recover the records and give reasons for not being able to do so;

d. Where a provider has been unable to recover a care record book the matter will be raised and discussed with the provider at a contracts performance meeting. If necessary and appropriate to do so the Council will require the provider to take steps and measures to address the failure to recover record book.

28. The Council trusts that these actions and proposals are sufficient to satisfy that Coroner that the Council does take this issue seriously, that there is a system in place for the recovery of care record books and that care providers will be advised of their record keeping obligations. This in turn will minimise the risk of care record books not being available at future Investigations and Inquests.

Yours sincerely,

Steven Pleasant MBE
Chief Executive of Tameside Metropolitan Borough Council &
Accountable Offcer for the Tameside & Glossop CCG

Dated 27 July 2017