The Lakes
Care Centre

Chris Morris
HM Area Coroner
Coroners Court
1 Mount Tabor Street
Stockport, SK1 3AG

28th November 2017

Dear Mr. Morris,

This is my response to the Section 28 report raised by you following the inquest of the late Mr. Geoffrey Spencer.

You raised concern during the course of the inquest that no formal investigation had been undertaken in relation to this incident, by The Lakes. I responded at the time by informing you that we had recently redeveloped our falls policy, post falls assessment and carried out a monthly analysis of all falls at The Lakes. The concerns you raised led me to reflect on our current practice and review what we could do better. This started with a complete investigation into what had actually happened on the day of the incident;

- Timeline of events
- Staff and designation on duty?
- Who was doing what and where?

Once I had done this, it was evident that all of the above were relevant factors in the incident. I will do my best to try and explain this to you;

It was lunch time period, the unit is a 25 bedded Dementia Care unit, at that time the occupancy level was 23 residents (2 empty bedrooms), of those 23 residents, 2 residents stayed in their own rooms, which left 21 residents in the communal lounge area.

All staff were on duty, our staffing levels are 4 care staff plus 1 activities coordinator throughout the day and 3 staff at night, as this is not a Nursing unit, there are no Nurses employed.

The residents of this unit suffer varying degrees of Dementia, not challenging behaviour to the extent of requiring a nursing unit, but certainly disorientation which can lead to agitation and confusion.....

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.....at lunch time, 2 members of staff support residents into the dining room, whilst 1 member of staff remains in the lounge area, and 1 staff member stays in the dining room to monitor incoming residents. Because of the very nature of the condition, this process can in itself become quite hectic as mobile residents will start to walk towards the dining room then turn around and go in the opposite direction, with staff trying to manage the safety and maintain a calm atmosphere at all times. In these conditions it is quite feesable that a resident could slip onto the floor from a chair, without being seen by care staff present, as they may be looking and dealing with other residents in the room.

By standing back and looking at this, it was clear to me that changes need to be made to optimise and make best use of the resources we have by changing work patterns. In this current climate it is not viable to increase staffing levels whilst the true cost of care is not being acknowledged, therefore I need to look at better ways of working to reduce risk and increase safety. This is what we have done;

See attached; Corrective Action Plan

Yours Sincerely

[redacted]

[redacted]

Registered Manager