HC one The kind care company

Mr. Derek Winter
HM Senior Coroner
Civic Centre
Burdon Road
Sunderland
SR2 7DN

8 June 2018

Dear Mr. Winter,

Inquest into the death of Patricia Heslop
Regulation 28 Report to Prevent Future Deaths Response

We write in response to your Regulation 28 Report following your investigation into the death of Mrs. Heslop. This response has been prepared by HC-One and addresses the concerns listed 1 to 9 in section 5 of your Regulation 28 Report.

As you are aware from the evidence provided during the inquest, HC-One has taken this incident extremely seriously. Two investigations were undertaken by the organisation immediately following the incident and work has been ongoing to establish how services can be improved and lessons learnt from this incident.

We address the concerns identified as numbered in the Regulation 28 report and provide details of action taken together with actions that will be implemented in the future.

1. Falls Reporting.

1.1 You have identified that the fall was unwitnessed and was unreported. Evidence was heard from a number of HC-One employee witnesses, none of whom were able to identify the circumstances of any fall or confirm that staff were aware of Mrs. Heslop requiring assistance. It is therefore acknowledged that any fall was unwitnessed and / or unrecorded.

1.2 Evidence was provided in the statement of [redacted] Head of Standards and Compliance with HC-One, as to the existing procedures in place at HC-One for incident reporting. HC-One recognises the importance of

incidents and falls risk assessment management and positively encourages openness and transparency from all staff regarding any issues involving the care and welfare of residents, specifically including any incidents of falls. This culture of openness and transparency is a golden thread throughout all company policies and procedures all of which are underpinned by our vision and values of accountability, involvement and partnership to achieve the best health and care experience for our Residents.

1.3 The company has an Incidents; Reporting, Investigating and Learning guidance document for Home Managers, which indicates there to be three components, which must always be followed to ensure effective incident management,

1. Accurate and detailed incident reporting
2. Incident investigation
3. Learning lessons as a result of the incident

This guidance requires that any accident, incident or untoward event, involving a resident, whether it causes harm or not be recorded on an incident form by the Home team and uploaded on to the Datix (Risk Management) System, as outlined by [redacted] in her statement and at the inquest. The Datix system predominantly records falls, ill health, medicine errors, safeguarding and complaints and has been designed with integral prompt questions to elicit maximum information from the individual providing the information. All incidents are then required to be determined in terms of risk, grade levels of harm and severity of issues. Once the incident is entered onto Datix, an automatic alert notifies the appropriate area and specialist teams and senior management within the company, depending on the severity of the incident. This will determine who will undertake any necessary investigations. Falls are automatically reported at group level (Managing Director) area level, (Area Director/ Area Quality Director), home level (Home Manager) through these internal reporting systems.

1.4 All incidents must be investigated and the HC-One policy stipulates that those undertaking an investigation should aim to complete this within 14 days of the date of the incident. The investigating officer is asked to consider many aspects around compliance with policies and procedures, known risks and controls, levels of training, colleague practice and conduct, care plans and risk assessments etc. and opportunities missed.

1.5 The investigating officer is guided though the process through use of an investigation template, which leads them through the fact findings to conclusion and actions to prevent future incidents.

HC one The kind care company

1.6 Following this incident, action has been taken at Hebburn Court to ensure that all staff have the knowledge, skills and tools to identify, record and manage falls to reduce risk and prevent harm. All staff have been reminded of the importance of alerting nursing colleagues and managers to any fall and documenting within the individuals' records. Learning on this has been facilitated by reassignment of the falls prevention module from our award winning online learning platform, Touchstone. In addition staff have received further coaching and assessment of competencies in this area through staff meetings and individual supervision sessions. Training statistics in this area are currently 93.5% of the staff team and plans remain to press for this to increase to 100% by the end of June 2018.

1.7 Additional Duty of candour training has been undertaken with all staff. Our Standards and Compliance team leader has delivered training on Duty of Candour to the Hebburn Court staff team and the CQC guidance on Duty of Candour has been printed and placed in the nurse's offices. As mentioned above supervisions for all nurses and nursing assistants, which have included discussion on the contents of the Duty of Candour guidance, have been completed and will continue to be refreshed annually. Our Standards and Compliance team support colleagues in Home teams to determine whether an issue meets the criteria for duty of candour through revision of incidents that are input on the Datix system and offer same day advice, if the person inputting the information has not recognised the incident appropriately.

1.8 Since the inquest the internal inspection team have visited and assessed the home and found staff to be competent and confident in falls management and Duty of Candour, which will continue to be assessed at every inspection (which occur a minimum of twice each year) to ensure sustainability of this learning and practical application.

2. Care Records documentation.

2.1 You identified that there appeared to have been a change in Mrs. Heslop's presentation and a number of factors preceding her hospital admission were not collated and recorded in her care records. This includes the use of wheelchair, a rocking manoeuvre which involved two members of staff and the fact that two members of staff are required to support Mrs. Heslop when walking. It was acknowledged by HC-One during the inquest that these matters were not recorded as they ought to have been nor were the family informed as they should have been, both in accordance with policies and therefore company expectations.

2.2 Oral evidence was provided during the inquest hearing by [redacted] [redacted] in respect of a pilot electronic care planning system to be implemented

across HC-One. HC-One is now able to provide further information in respect of this system which, we suggest will address a number of the additional concerns identified during the inquest hearing.

2.3 Significant work has been undertaken by HC-One to introduce an electronic care planning system, e.care. The pilot has continued to be implemented, evaluated and refined in a number of homes and the measurable successes achieved to date have resulted in a date for roll out across the organisation in October 2018. The electronic system will remove the requirement for paper care plans to be kept in multiple files and enable all information and care plans to be stored in one place.

2.4 Evidence was heard during the inquest that there were numerous forms to be completed by staff and there was a lack of clarity as to who was required to complete forms and at what time intervals. The electronic records system will provide a single record system and clear instructions.

2.5 As part of the implementation of the e.care system, all staff will receive training to ensure they can navigate and optimise its use to the benefit of residents and their care and support needs. Care, nursing staff and management will all have access to the system, which places the resident at the heart of the system and captures all the support needs and actions required to guide and support staff in meeting their needs. There are categories of care to help prompt appropriate assessment of need but also infinite options for adding bespoke information to inform the care planning.

2.6 Areas that were found wanting within your report at Hebburn Court are included in the e.care system, for example body mapping, the importance, what it tells us and what we do if and when we find a bruise. This process was reported on by [redacted] and we have revisited at Hebburn Court for all staff and can confirm that all residents have had refreshed body maps completed. These are regularly reviewed as part of the Resident of the Day process as a minimum each month or sooner and this means management have clear oversight of bruising, unexplained or not and can support staff with learning or other actions to minimise repetition.

2.7 The recording of use of wheelchair and techniques for manoeuvring will also be recorded in the e.care system, ensuring staff complete appropriate assessments of needs and making overtly transparent, which is a bonus compared to the paper system currently in use.

2.8 It is acknowledged that family members were not informed of specific aspects including use of wheelchair and manoeuvring techniques. This can be attributed to staff not identifying and recording individual variations to the care plan and therefore not appreciating the significance of any individual

assistance provided. The e.care system will ensure that any changes to care provided are recorded and therefore create a single record of information, which can then be communicated to relevant professionals and, importantly, family members. This is possible because of the integral flag and prompt aspect within the system, which reminds staff of the need to review care plans through scheduling these and then not allowing progression through the system, without addressing the action.

2.9 HC-One has also undertaken additional work to ensure that shift and Household leaders have been instructed to obtain as many details of family contacts as possible and ensure that family contacts are reviewed regularly. This is being managed through individual coaching sessions by the Area Team on leading and managing and effective completion of the Resident of the Day process, which prompts the person completing to review and seek confirmation from family members or carers that details held are correct and that any specific parameters are accurate.

2.10 Similarly, the Area Team have coached and role modelled good practice staff handovers at the home to ensure that handovers will include all information.

2.11 It is anticipated that a single electronic record system will enable earlier recognition of signs of deterioration in a patient and more comprehensive, accurate and consistent recording of individual details.

3. Terminology and identification of a deteriorating resident.

3.1 You identified that a number of terms were used regarding Mrs. Heslop's developing condition. [redacted] provided evidence during the inquest that whilst it is not possible to remove all differences in clinical description (including the use of colloquialisms and staff language) to describe a resident's individual presentation nor is it necessarily appropriate to do so, it is however important to provide consistent language and indicators which can provide an early warning system based on observations.

3.2 Evidence was heard during the inquest of the increased use of NEWS early warning system to enable observations to be obtained. NEWS is a well validated 'track and trigger' early warning score system used in the majority of UK hospitals. It is based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present or are being monitored in healthcare settings. Use of NEWS score assist in the identification of a sick patient. Evidence was provided that staff at Hebburn Court have now been trained in the NEWS system. All nurses and senior care staff have received training in the system and this will also then be delivered to care staff over the coming few months.

3.3 The observations obtained from the NEWS system will be entered into the e.care system as detailed at Paragraph 2 above. This will ensure that an overview and "joined up thinking" can be obtained in respect of an individual's presentation. Whilst these observations may not provide a clear explanation of a change in presentation, they will enable carers to identify patterns of presentation and any deterioration and therefore ask questions to begin understanding the need to involve increased support or external professionals etc.

4. Care records.

4.1 A concern was identified in respect of incomplete or inaccurate care records and lack of review of care records. As detailed in Paragraph 2 above, the implementation of an electronic care record system will provide a clear and comprehensive record of each individual. Access to care records will be enabled for all nursing and care staff, and training in the use of electronic records system will be provided to ensure that documentation remains up to date.

5. Incident investigation and witness information.

5.1 It is stated in the Regulation 28 Report that no attempts were made to take statements from individual witnesses immediately after the fall in November 2016. Immediately following the incident in November 2016, an investigation was undertaken by the then Home Manager, BJ and completed on 26 November 2016. As part of this investigation, witness information was obtained from 8 witnesses. A further investigation was undertaken by HC-One by LL, Area Director dated 7 February 2017. For the purposes of this second internal investigation 12 witnesses were re-interviewed and additional information obtained. Further witness statements were obtained for the purposes of the inquest investigation to re-examine the information and provide more comprehensive statements. It is acknowledged that none of these witness statements identified any evidence of when or how Mrs. Heslop suffered a fall or may have been assisted after a fall.

5.2 HC-One has a clear incident investigation process in place as detailed in [redacted] statement and above. Since this incident action has been undertaken to ensure the quality of incident investigation reporting is monitored, which has lead in turn to refreshed Investigation management training. This has been provided at both Home Manager level and also as part of an 8 day intensive and practice focussed induction for Area Team Managers. This was conducted by the Head of Standards and Compliance and Leadership Development Manager for the company during March and April 2018.

HC One The kind care company

6. Delay in obtaining treatment.

6.1 Evidence was heard during the inquest that the delay in obtaining treatment, whilst did not directly contribute to the death, did result in Mrs. Heslop being in pain for a longer period than necessary. This can be attributed to by carers and nursing staff not appropriately recognising and acting upon indicators of deterioration. The Resident of the Day reviews identify any changes or deterioration now that the quality assurance system has been reset and embedded at the home. This will be further enhanced by the e.care system, as mentioned previously in terms of robust monitoring and reviews of care and support needs.

7. Use of multiple forms.

7.1 There were concerns raised as to numerous forms required for staff to complete and read rather than an integrated IT system. The evidence provided at paragraph 2 above provides details of the action taken by HC-One to implement an improved IT system, which consolidates and simplifies management and oversight of care delivery and monitoring for individual residents.

8. Induction and Dementia Training.

8.1 HM Coroner notes that comprehensive induction and ongoing dementia training may be beneficial. We can confirm that induction training includes all aspects of the Care Certificate requirements, which is the recognised and statutory requirement for care staff. In order to achieve the Care Certificate, staff must complete a workbook, which is validated on a regular basis throughout their induction. The induction sets out all expectations of learning and practical assessment to establish competency of each individual, along with the timescales to achieve. This induction and the training at HC-One has been awarded 'centre of excellence' status by Skills for Care.

8.2 The Manager, with Human Resources support review training statistics for Hebburn Court and action would be taken to ensure that any individual employee who does not complete their training will receive follow up correspondence from HC-One to advise that training is required. This process is now linked to HC One Human Resource procedures. Therefore action has been taken by HC-One to ensure staff are aware that non-completion of comprehensive induction training may result in disciplinary action of staff. Training statistics for Hebburn Court indicate that this has not been experienced since the incident, with staff embracing all learning opportunities and resultantly the statistics for the home have stabilised at a level above the minimum company expectations of 85%.

8.3 Dementia Training is provided for all HC-One staff. Evidence was provided during the inquest that Dementia training formed part of the fundamental training for all carers. This includes four separate modules called, "Open Heart and Minds". Content starts with understanding dementia and the brain, the biology of dementia and the experience for the person, through to engagement and involvement of the person and their loved ones, importance of the physical environment, use of resources to delivery of person centred, informed and educated dignified care, and effective support for residents to promote their personal sense of well-being. This training is completed in 5 stages. Since this incident, HC-One has ensured that staff at Hebburn Court have all undertaken dementia training. At the time of writing, staff at Hebburn Court had

- Open hearts and minds 1 – 76.7% with a further 11.6% assigned to new staff.
- Open hearts and minds 2 – 78.6% with a further 9.5% assigned to new staff.
- Open hearts and minds 3 – 75.9% with a further 13.8% assigned to new staff.
- Open hearts and minds 4 – 79.3% with a further 10.3% assigned to new staff.
- Open hearts and minds 5 – Classroom training has also been scheduled.

A programme of review and full compliance is to be completed by 30 June 2018.

8.4 HC-One is also currently carrying out a further pilot of additional training entitled "Memory Care". There are three homes undertaking phase 1 of the pilot scheme, which involves refurbishment to a research based dementia friendly environment, with physical resources such as life stations and bespoke training for the whole staff team. At the same time, there is a phase 2 approach, where 20 homes have training for the team and a starter resource trunk to build their own life stations based on learning from the resident group about their interests. Life stations include office environments, football, potting sheds, kitchen and laundry areas. The aim of this training is to ensure the appropriate ethos is maintained and there is a focus on the individual resident and how we support optimising their personal well-being. It is anticipated that training will be rolled out across homes by September 2018.

8.5 Evidence was heard during the inquest that all staff at Hebburn Court had undertaken additional refresher training in basic first aid, which is currently sitting at 75% with 10% assigned and Safer people Handling, which now stands at 93.8% and Safeguarding at 90.7%.

9. Recognition of appropriate treatment.

9.1 The Regulation 28 report identifies a concern that there ought to have been a realisation that an x-ray was required to obtain appropriate treatment.

9.2 Evidence was provided during the inquest from nursing staff of their reflection

and review of this matter both personally and during ongoing staff supervision. HC-One has taken action to ensure that all those staff involved in this matter have been informed of the clinical concerns identified during a staff meeting on 29 November 2016 and during individual supervision sessions with staff.

Further Action taken by HC-One.

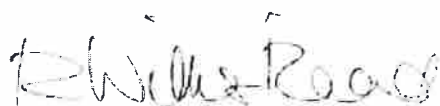
Since the inquest hearing in March 2018, HC-One has also undertaken additional internal scrutiny of Hebburn Court. This requires in depth assessment against company and regulatory requirements and which results in an overall rating. The ratings range from Red 1, where issues have been identified that might impact resident safety and welfare and require immediate attention through to a Blue 5, where the outcomes for residents sustainably outstanding. The most recent internal inspection completed in May 2018 awarded a rating of Amber 3/Green 4, indicating good outcomes for residents.

The most recent CQC inspection report, completed just after the inquest shows an improved picture with three key questions judged as Good and two as requires improvement, which can be seen to have improved further in the internal inspection findings two months later in May 2018.

HC-One has used the recent CQC report, our internal inspection report and Regulation 28 report to form the basis of ongoing work at Hebburn Court and throughout HC-One.

I trust that the information provides you with the necessary assurances that HC-One has invested significant time, effort and resource into investigating this matter including the specific issues that you have identified with the intention of improving the care and safety of care home residents, in addition to reducing the risk of any adverse incidents or outcome in the future.

Yours sincerely



Head of Standards and Compliance