RSN: 9075

Sandra Main

RECEIVED
13 MAY 2019

HC-One The kind care company

Nadia Persaud
Walthamstow Coroners Court
Queens Road
Walthamstow
London
E17 8QP

File RSN: 9075

10 May 2019

Re: Mr Brooker – Bakers Court

Dear Miss Persaud,

I write to inform you of the actions taken at HC-One in response to your Regulation 28 report to prevent future deaths.

Please find enclosed an action plan, which has been implemented at Bakers Court to address the concerns you highlighted [Exhibit 1].

Since the date of Mr Brooker's death, HC-One has undertaken a lot of work internally on the topic of falls and increased its focus on falls awareness and prevention. In particular, efforts have been made to improve falls awareness across the organisation, minimise falls so far as possible and to ensure the appropriate management of falls across the organisation.

Regrettably, it is not uncommon for older people to experience a fall, for a variety of reasons. Such falls cannot always be prevented but as an organisation we are committed to supporting people to maintain their safety wherever possible and to ensure that our Colleagues respond appropriately in the event that a fall does occur.

HC-One is committed to enabling Residents to live a full and active life. We embrace the concept of keeping Residents as independent and as mobile as possible whilst minimising the risk to their health, safety and wellbeing.

a. Multi-factorial Risk Assessments

It is important to identify all Residents who may be at a risk of falling and as such, thorough assessments should be conducted. A Multi-factorial Falls Risk Assessment [Exhibit 2] will inform the development and implementation of a daily plan of care. The risk assessment that is used in HC-One has all of the factors indicated through the National Institute for Health and Care Excellence (NICE).

The falls guidance, risk assessment, policy and guidance has been developed using the Care Inspectorate guidance, "Managing Falls and Fractures" and this has been implemented widely across the UK.

All Residents must have a full and comprehensive Falls Risk Assessment completed prior to admission. Residents identified to be 'at risk' on the Pre-Admission Assessment, must then be re-assessed on admission in their new environment.

At HC-One we consider any risk within the Multi-factorial Risk Assessment as a potential reason for people to fall and as such requires to be managed. It is clearly recorded on the risk assessment that if any risks are identified then a Falls Care and Support Plan needs to be developed.

Residents identified as having any of the factors that are considered to be a risk must have a full review on a monthly basis, or more frequently as the Resident's condition dictates.

Our policies are clear that a new assessment must be completed following a fall and/or if the physical or psychological condition of the Resident changes.

A plan of care must be in place for mobilising, including the use of mobilisation aids. The use of walking aids and other equipment should be considered, after assessment by a physiotherapist or occupational therapist where a potential risk has been identified.

The use of assistive technology should be considered where appropriate. This can include call mats, seating and bed sensors, room sensor beams, low beds, anti-roll mattresses or non-standard equipment, which is recommended by external professionals.

All assessments and reviews must be fully documented and recorded in the Resident's care file.

Our Risk Assessments will identify predisposing factors, which may lead to falls, such as the use of a wheelchair which requires the use of lap straps.

b. Post Fall Protocol

Following a fall, immediate action must be taken to ensure the safety and comfort of the Resident. Staff must not leave the Resident unattended and immediate assistance should be summoned. It is important that the Resident is assessed and examined promptly to see if they are injured. This will help to inform decisions about safe handling and ensure any injuries are treated in a timely manner.

Our policies are clear that all falls must be properly recorded and investigated.

As soon as possible, after the fall, an incident report should be logged on our Datix incident reporting system. The incident report should be comprehensive and give a clear picture of what happened and what immediate action was taken.

The incident must be investigated in order to identify what happened, how it happened and why it happened. The intention is to learn from the incident and take action in order to reduce the likelihood of further falls and/or minimise the risk of harm in the future. Care plans and risk assessments will be reviewed and reformulated as necessary.

Particular attention should be given to Residents who have experienced more than one fall in a week or more than three in a month. The more falls a Resident has had the greater the falls risk.

Even if a fall is minor and causes no injury, it is our policy that the Home Manager must still investigate and try to prevent it happening again.

A Post Fall Protocol Flow Chart [Exhibit 3] is available and provides useful at-a-glance guidance for staff teams to remind them of the steps to follow after a fall. In order to ensure compliance with the process, a checklist has been developed to provide prompts to the care home team on documentation and process [Exhibit 4] and to ensure that our staff teams are actively thinking about each of the actions required after a fall.

c. Trend analysis

Datix can be utilised in order to carry out trend analysis. An analysis of falls will help Home Managers to identify any trends and any areas of concern to target, from which they can take suitable action. They can also monitor whether the preventative actions they have taken are having the desired effect in reducing the number of falls and the harm caused following a fall.

Home Managers are able to analyse the falls of a particular Resident or look at all falls in a home. Datix can show many things, including where falls are happening, their location, the time of falls and the level of harm caused. For example, a fall analysis may identify that many falls are taking place in a particular location around the same time of day. Home Managers are encouraged and supported to use these tools.

d. Review of care practices, specifically relating to falls

Following any incident that has affected Resident health or well-being, an incident record must be uploaded onto the Datix system. This system captures any untoward event that occurs, whether it causes harm or not – predominately this is falls, ill health, medicine errors, safeguarding and complaints.

Once the incident is entered on Datix, the appropriate area and specialist teams are notified and depending on the nature/severity of the incident, this will advise who will undertake the investigation.

Falls are reported at group level, area level, home level and finally to Resident level through our internal reporting systems where we can ultimately see how the individual Resident's care is supported.

At home level there is a three monthly full audit of falls, including falls team meeting and a monthly review through the Key Clinical Indicators report, which will identify key high risk Residents for the home to follow up on, and as part of the Resident of the Day monthly review process the care plan will be checked. We have implemented a monthly clinical review where falls are a key part of the review with the senior team at home level – the Area Quality Director supports with this and monitors outcomes.

At area level, the Area Director/Area Quality Director's review falls as part of their home visits and our internal inspection team of Quality Regulation Managers review this on their inspection visits. We believe that the governance around falls management broke down through poor reporting and have looked at re training and shared learning for the home team and manager's with oversight to drive this forward to improvement.

Falls and serious incident trends are discussed quarterly at the Quality Governance Group comprising members of senior management and lessons are shared across the organisation.

We continually review the NICE guidance in relation to falls and implement new technologies to support Residents.

e. Further support

All of the falls processes have been summarised onto one page documents called "Here's How To...". These are available to all care teams and will be reviewed twice a year [Exhibit 5].

The Clinical Quality Team supports with falls root cause analysis for any fracture or serious injury sustained following a fall. They support with the investigation and outcomes, and report back through the quality governance structure.

Where any shortfalls in individual practice or non-compliance with the process are identified, this will be followed up and appropriate actions taken.

Falls training is provided to all direct care teams in the form of an online module and face to face falls awareness training sessions.

Actions and oversight by the company is ongoing in respect of the above matters, to ensure ongoing compliance with company expectations.

I do hope this information is helpful and offers you the reassurance that we, at HC-One, have taken the issues raised very seriously and have taken appropriate action with the intention of improving the care and safety of our Residents.

Yours sincerely,

[redacted]
Head of Quality and Regulation