Regulation 28: Report to prevent future deaths following from conclusion of the Inquest Touching on the Death of Mrs Tripta Bhanote.

Response from Manor Court Healthcare Ltd on behalf of Anson Court Residential Home

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Background

On 18 October 2021 Black Country Coroner's Court issued a Regulation 28 Report to Prevent Future Deaths ("**Report**").

The Senior Coroner found there to be the following matters of concern arising from the Inquest:

1. Evidence emerged during the inquest that there was a lack of clarity and understanding by care staff in the requirements for escalation to emergency services when a patient/resident becomes acutely unwell.
2. There was lack of clarity and understanding by care staff of the role of the enhanced care and quality team and circumstances for referral to them.
3. There was evidence of poor procedures in place in identifying the DNAR status of residents.

With the above in mind the Senior Coroner believed that Manor Court Healthcare Limited (the "**Company**") has, on behalf of Anson Court Residential Home, the power to take such action to prevent future deaths arising in similar circumstances.

The following represents the Company's response to Mr Zafar Siddique, Senior Coroner, Black Country Area.

The Concern

The care home owners may wish to consider reviewing their training and guidance on DNAR and escalation to emergency services

Actions in response to Concern

Following the conclusion of the Inquest, the Anson Court Senior Management Team undertook a range of key actions to ensure care quality standards within the home including:

1. Review of Do Not Attempt Resuscitation (**DNAR**) and Escalation to Emergency Services procedures;
2. Provision of clear, immediate guidance regarding revised DNAR and Escalation to Emergency Services procedures, highlighting any and all changes to care provision in these areas;
3. Review of the Staff Training Program to ensure that updated procedures will be incorporated into future training and induction programs for all staff.
4. Initiating recruitment processes for a Care Quality & Compliance Officer (**CQCO**) to enhance training and ensure care standards compliance.

A - Review of Do Not Attempt Resuscitation (DNAR) Procedures

All resident file information and Care Plans are kept in the Main Office at Anson Court Residential Home. An electronic database containing the care plans of all residents (in addition to the hard copy care plans) is maintained, which also notes whether a resident has a DNAR in place. The database is accessible to all staff.

If a resident has a DNAR order in place this will be kept in the resident's care plan. The Main Office is accessible to all staff.

In response to concerns raised at the Inquest, a separate binder has been created, containing a full copy of all DNAR orders in place for residents in Anson Court Residential Home. This folder resides permanently in the Main Office next to the manager desk. It is available for immediate reference by all staff 24 hours per day. The file is clearly and prominently marked DNAR.

A visual reference for staff working with residents has also been adapted. The notice board in the Main Office has a list of all of the residents currently in residence at the home. The list has been annotated by a red asterisk immediately to the right of the resident's name if the resident has a DNAR order in place.

To further support staff in immediate identification of a DNAR order in place for a resident who may be acutely unwell the following additional steps have been taken:

- A sticker of the same symbol (large red asterisk) is placed above the en-suite door inside the resident's bedroom to indicate a DNAR order is in place. If the resident DNAR status changes/is to move bedrooms/leaves the home the red asterisk will be removed and/or displayed in the changed room as applicable.
- Checks and audits are undertaken on a regular basis to ensure that the relevant red asterisk sign is clearly displayed at all times.
- The manager has provided training and guidance to the staff to ensure staff are aware to double check the Main Office notice board or binder for an acutely unwell resident when circumstances allow.

B - Review of Escalation to Emergency Services Procedures

Anson Court Senior Management Team is mindful of concerns raised by the Coroner regarding clarity and understanding by care staff of the role of the Enhanced Care & Quality Team (**ECQT**) and understanding by care staff in the requirements for escalation to emergency services when a resident becomes acutely unwell.

The ECQT are no longer embedded within Anson Court Residential Home and would only return in event of another Covid-19 outbreak/similar scenario.

With this in mind, Anson Court Senior Management Team has reviewed and re-established its longstanding, widely-understood **Escalation to Emergency Services Procedure**. This procedure is purposefully straightforward:

- The Senior Carer in Charge will escalate to emergency services immediately upon realising that a resident may be acutely unwell.
- The Senior Carer in Charge of each shift is aware of this responsibility and that they are empowered to contact emergency services immediately as required in the best interests of

the resident, without needing to seek any further authorisation from the Anson Court Residential Home Manager.

Anson Court Senior Management Team are clear that if future circumstances arose whereby the ECQT were to be embedded within the home, the following actions would be undertaken:

- Anson Court Care Home Manager would immediately meet the ECQT lead professional to clarify roles in caring for residents at the home, including outlining Anson Court Residential Home's DNAR and Escalation to Emergency Services policies and procedures;
- Anson Court Senior Management Team would immediately alert all staff of the ECQT's presence, their role and how DNAR and escalation to emergency services procedures would function whilst the ECQT were on site.

C - Training, Guidance & Compliance

All staff have received up-to-date and clear and specific guidance from the Anson Court Management Team on how information is recorded and displayed for immediate reference for residents who have DNAR status. This will be reviewed by the Anson Court Residential Home Manager on a periodic basis and/or when circumstances change or a resident is admitted or discharged.

Staff have been made aware of the updated DNAR system. Guidance notes have been issued and have been read and signed by staff members indicating that they understand the updated policy and procedure. The guidance notes are also on notice boards in the office and staff room.

The updated DNAR procedure will be flagged and discussed in team meetings. Training on this will be provided during new staff induction.

Any changes to a resident's DNAR status are raised at shift changeovers, individually at handover and more widely in team meetings.

We consider the addition of the DNAR binder supplements the previous system as the binder will only contain information relating to residents who have a DNAR order in place. Hence all the information relating to residents with a DNAR is kept centrally in one place and is accessible by all staff. The binder also serves as a double check to the Main Notice board and/or the Asterix above the en-suite door inside the bedroom.

The Anson Court Staff Training Program has been reviewed in light of concerns outlined in the Report.

D – Timetable of changes to the general training program for staff at Anson Court as a result of the Inquest, specifically regarding DNAR & escalation to emergency services and the implementation of training and/or induction processes

1. The DNAR - Citations policy has been reviewed and updated to reflect changes.
2. All staff have been trained on the revised DNAR policy & escalation to emergency services. There will also be periodical monthly refresher of the DNAR training.
3. All senior staff have been trained to contact the emergency services when required and if they feel that other professionals are not taking the appropriate action.
4. Following on from the Inquest and the issuing of the Report, the Company is currently (at the time of this response) seeking to recruit into a new position – Care Quality & Compliance

Officer (**CQCO**) - to support the Anson Court Senior Management Team. A key element of the CQCO's role is to:

a. Implement staff training
b. Ensure compliance with key internal and external policies and quality assurance care standards within the organisation in line with legislative and CQC requirements
c. The CQCO will be apprised of the Report and the updated measures put in place by the Company in respect of the DNAR and Escalation to Emergency Services procedures as part of ensuring compliance in the best interests of all residents.

The Company wishes to again extend its condolences to the family of Mrs Bhanote. We are hopeful that the implementation of the above measures will prevent future deaths occurring in similar circumstances.

Manor Court Healthcare Ltd on behalf of Anson Court Residential Home

6 December 2021.