Salutem LD TopCo Limited &
Salutem LD TopCo II Limited
Minton Place
Victoria Street
Windsor
SL4 1EG

HM Senior Coroner
Manchester South Coroner's Court

01/12/2020

Dear Sirs,

Inquest touching the death of Christine Rosemary Neild

Regulation 28 Report Response of Meade Close Care Home

Thank you for your letter dated 2 October 2020 enclosing the Regulation 28 Report to prevent future deaths signed and dated 2 October 2020 by HM Senior Coroner for South Manchester, Ms Alison Mutch OBE. The Report was also sent to The Care Quality Commission, Trafford Metropolitan Borough Council and NHS Trafford Clinical Commissioning Group.

The Senior Coroner has set out her concerns at paragraph 5 of her report. She requires a response from Meade Close Care Home in respect of matter of concern (2):

> *"2. There had been an earlier incident when Christine Neild had put a non-food item in her mouth. The carer did not escalate this and there was no further risk assessment".*

The Coroner does not require a response from Meade Close Care Home in respect of the other matters of concern set out at Paragraph 5 of the Regulation 28 Report.

Background

Meade Close Care Home is a residential care home for adults with complex care needs. We aim to provide high levels of support to enable our residents to meet their personal goals and future aspirations. The Care Home consists of two bungalows, each bungalow can accommodate four residents. Each resident has an appropriate bespoke Care Plan to address their particular needs. We work in conjunction with healthcare professionals and the Council to make sure we are providing the highest levels of care possible.

Christine Neild resided at Meade Close Care some between April 2016 and 31 January 2019 when she sadly passed away. Christine had complex care needs which were carefully managed by Managers and Support Workers at Meade Close. She was diagnosed with a number of complex conditions including Dysphagia which meant that she struggled to swallow.
Her meals had to be blended to a specific consistency and one meal per day was bought into the service for her.

On a date in October/November 2019, Christine was spending time with her Sister, [redacted], at Meade Close Care Home. Her sister was removing gel nails and to do so she had wrapped Christine's fingers in cotton wool and foil. During the Inquest, [redacted] told the court that she had been measuring up Christine's bedroom for furniture and so she had left Christine alone whilst she went into her bedroom. She was alerted to the fact that Christine had the cotton wool and foil in her mouth by a Support Worker and she immediately removed the item from her mouth. She referred to the incident as a "one off".

The Support Worker who witnessed Christine with the cotton wool and foil in her mouth did not report the matter to her senior colleagues or record it in Christine's daily log. As a result of this the matter was not escalated and a risk assessment was not carried out. This was not in compliance with our policies and procedures.

Actions taken and agreed

As a result of the concerns raised by the Coronial investigation, we have undertaken the following:

1. Enhanced one to one supervision has been undertaken with the Support Worker involved in the incident when Christine placed a non-food item in her mouth. It is accepted that the Support Worker did not report or record the incident. During the supervision session, the details of the incident were discussed and the importance of reporting incidents of this nature. The Support Worker said that she was aware of the importance of reporting and the reasons why she should. She accepted that in no reporting the incident meant that the incident was not escalated and a risk assessment was not carried out. She is aware of the consequences of not reporting such matters. She was disappointed in herself that she had not done so. The Support Worker was advised of the appropriate ways to report incidents, by recording them in the residents Daily Log, speaking to a Senior Support Worker and/or the Manager.

2. A staff meeting has taken place to discuss the issues raised by this case and specifically the risks of not reporting and recording incidents. It was agreed that all staff would have a recording and reporting training reset.

3. A review is being carried out of all staff inductions to make sure all staff members have received the same level of training. It has been agreed that all staff will undergo a full Salutem induction.

4. All staff members have undertaken a Reporting and Recording e-learning module however as a result of the issues raised by this case all staff are required to retake the Reporting and Recording e-learning module to refresh their memories and make sure that their learning is up to date.

5. When residents are spending time with their families Support Workers are now required to ask the family member for a briefing of the time they have spent with the resident and to specifically ask whether anything arose during their visit that they think the Care Home staff need to be aware of. Support Workers must record the briefing in the resident's daily log and escalate any matters that have been identified as a risk. We are preparing a checklist of issues for Support Workers to go through with family members to make sure all relevant risks can be identified.

6. A meeting was held on 23 October 2020 between the Manager of Meade Close, [redacted] and the Salutem Group Head of Talent and Development. During the meeting

discussions took place in respect of staff training and induction. It was agreed that all staff are to undertake refresher training in respect of Key working, Mental Capacity Act, Support planning/risk assessment, choking, recording and reporting, first aid and inductions. We **attach** a table detailing the actions agreed during the meeting.

7. We spoke to CQC over the telephone on 6 November 2020. During the call we discussed actions taken and action to be taken in respect to the concern raised by the Coroner.

8. We have carried out risk assessments for each resident, specifically in relation to the location of gloves, their access to them and any associate risk. For each resident we have considered the location of the gloves, both in communal areas and their personal bedroom and any risks that present for the individual resident. We assessed the precautions that are already in place and any further steps that need to be taken. A copy of the risk assessment has been placed in the individual residents Care Plan and the outcomes of the assessments have been communicated to all staff members. We will review the risk assessment every six months as a minimum if an issue arises that prompts an earlier review this will be carried out immediately.

9. We have carried out night time risk assessments for each resident. For each resident we have considered their sleeping pattern and for mobile residents we have considered the risk associated with them getting out of bed. We have assessed the precautions that are already in place and any further steps that need to be taken. A copy of the risk assessment has been placed in the individual residents Care Plan and the outcomes of the assessments have been communicated to all staff members. We will review the risk assessment every six months as a minimum if an issue arises that prompts an earlier review this will be carried out immediately.

10. We have completed a lessons learned log a copy of which we have shared with Trafford Metropolitan Borough Council for the comment.

Conclusion

We are sorry that it was necessary for the Senior Coroner to issue a regulation 28 report into the issue of reporting and recording at Meade Close and hope that our above mentioned actions satisfy the Coroner that we have taken her concerns seriously. We seek to reassure the Coroner that this was a one off incident. Having discussed Christine's care with all staff members we can confirm that Christine had not been known to put non-food items in her mouth before or after this incident. Support Workers were knowledgeable with regards to reporting and recording incidents which would not be considered usual on a daily basis. However, as a result of the issues raised by the Coroner in this case, and as a reminder of the reporting and recording requirements, all staff members have received additional training with regards to identifying risks and then reporting and escalating the concerns in the appropriate way. All staff members have received training in respect of safeguarding adults and children, basic life support, first aid and reporting and recording of incidents.

We hope that the Coroner will be satisfied that Meade Close is providing the appropriate level of care to all residents whilst trying maintain a home away from home environment. We highlight the comments made by Christine's sister during the Inquest who commented that the staff at Meade Close Care Home were "amazing".

Please do not hesitate to contact us via our legal representatives, RadcliffesLeBrasseurLLP should any further information be required.

Yours faithfully

Meade Close Care Home