Tricuro

Official

To: Rachael Griffin

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[redacted]

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7th October 2022

Dear Rachael,

I write in response to your letter relating to a person who resided in one of our services, we have carefully reviewed this event to ensure that this does not happen again and that we have sufficient policy and procedures within Tricuro to inform all staff as to what they need to follow.

Background information:

Mr Gerald Tuck (known as Gerry)
Sidney Gale House, Flood Lane, Bridport, DT6 3QG

Gerry was admitted to Sidney Gale House Residential Home on 15th January 2017.
On admittance a care plan commenced and added to and changed over time due to differing needs and outcomes. All care plans are reviewed on a monthly basis with input from the resident, carers and family. Waterflow etc
Gerry required assistance with maintaining all aspects of personal care throughout the day and night. Gerry was able to mobilise independently with the use of a Zimmer frame, he chose to spend all his time in his room including mealtimes. At night a sensor mat was used to alert staff to Gerry getting out of bed as frequently throughout the night he would be sat on the edge of his bed. Gerry had the daily paper delivered. At times it was hard to converse with Gerry due to his loss of hearing and staff would write things down for him to read.
Gerry lived with the following health conditions
Type 2 Diabetes – Insulin administered daily
Glaucoma
Essential hypertension
Atrial Fibrillation
Mixed Dementia
Sensorineural hearing Loss
Allergy to Trimethroprim, erythromycin and mepore
A DNAR was in place

I have broken down our response and actions to each area:

The 25TH of December 2021 – Gerry fell in his room

The service did follow the falls policy and call for an ambulance as it was an unwitnessed fall, and he takes warfarin. Gerry also said he had hit his head.
Post fall observations were taken until the ambulance arrived and admitted Gerry into Hospital. When he returned to the service he returned with antibiotics for an infection, and the staff updated his medications, and monitored his health and wellbeing.
On review of his notes, I can see staff frequently checked on Gerry and updated his body map to reflect a skin tear from the fall that the District Nurse was tending to.

However, what should have happened is that his care plan and risk assessments were reviewed and updated following his arrival back into the service.

On the 26th of January 2022 Gerry was visited by the GP due to him being unsettled in behaviour and more confused, the GP prescribed some antibiotics and suggested a trial of Memantine.

I can see staff recorded checking on him frequently.

On the 27TH of January 2022 Gerry had an unwitnessed fall, they stated no injuries, and they did commence post falls monitoring to observe for any deterioration and did not note any.

However, given that he takes warfarin the protocol *should* have been to contact the ambulance service to assess, and his care plans and risk assessments should have been updated.

On the 28th of January 2022 Staff contacted the GP as they felt he was more confused than normal and were awaiting antibiotics to be delivered, they called the GP to chase the medications.

Sadly, he later fell and had clearly injured himself as staff observed some blood on the fall and they followed policy by calling for an ambulance.

Our Falls policy does state the need to use the post falls assessment tool and had this have been used and followed accordingly following his fall on the 27th of January 2022 the staff would have been guided that as he takes warfarin medical assistance should be sought.

To mitigate further risks we have uploaded the post falls assessment tool to the electronic recording system that is used to ensure staff do see, follow and record on this.

The falls policy has been reviewed and updated to reflect the need of anticoagulant recognition and escalation following an fall.

Our policy also reflects that staff are expected to update the falls risk assessments and mobility care plans after any fall to ensure that the care, support and risks are managed accordingly. We have ensured that all staff within the service and the wider company are very clear of the policy and that this must be followed.

Tricuro have also now introduced a live accident and Incident reporting system, this means that any falls or other accidents or incidents are directly available for our quality assurance teams to see, our locality team and the registered managers.

This means that we can instantly check that the service has carried out all of the necessary actions in response to events and that the persons support plan and risk have been actioned. We also have created a policy and procedure for any deaths in service which details the need to investigate any unexpected deaths, this will prevent us from being unaware at head office of anyone who sadly passes away.

Death reports are now reported internally to Head Office which means we can review all reports to ensure that deaths were handled appropriately but also to ensure that the care and support prior to this was as it should be.

Services are ensuring that falls are monitored within service level and any root cause analysis is completed and actioned as needed, managers share any lessons learnt or recommendations with other services.

Furthermore, we have falls focus group which means we are able to keep staff updated and reiterate the falls policy process and importantly how to reduce the risk of falls.

Tricuro also now have a monthly safeguarding and accidents/incident report that is presented at Senior leadership meetings for scrutiny and review.

I hope this provides you with the assurances you need relating to this event and to prevent and mitigate any future risks.

Please do let me know if you require any additional information.

Yours sincerely

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Executive Director of Operations