Broadland View Care Home – Response to Regulation 28

1. **A Night Working Policy was being prepared but this is still not completed some 3 years following Mrs Walsh's death.**
   I. The Night Working Policy is a recent part of our continuous improvement and not part of the improvements 3 years ago. In our experience, it is not usual that a Care Home has a specific Night Work Policy. We chose to write this policy recently because of all the improvements that we have made over the last 3 years, and we wanted to consolidate all the work, where it related to Night Work specifically, into one policy.
   II. Broadland View decided as a part of continuous Improvement to have some enhanced actions they could take, to bring together the learning and information that night staff specifically need, into this policy.
   III. The main focus of improvement 3 years ago, was to implement a process that reduced the risk of wilful neglect by care staff, which was the Daily Notes Audit.
   IV. When this audit was introduced, we investigated night observations across all residents and staff over a period of 12 months and it was only the one staff member that was prosecuted that falsified the records.
   V. We still run this audit daily to ensure that no staff member pre-records observations. This written process was, and still is very successful, and has now become part of the Night Working Policy.
   VI. The content of the Night Work policy is based on the Induction and training that Night staff have always had and information from policies on expected practice, so the information has always been in place.
   VII. This tailored policy was uploaded onto the QCS system and added to the reading list for staff on 01/08/2023, which was always its planned date for implementation.
   VIII. Broadland view have a comprehensive policy and documentation electronic system in place (QCS) which is a long-standing external policy provider for care establishments.
   IX. With the Daily Notes audits put in place immediately after the incident guidance was written for Care staff and Management on the recording expectations for night observations.
   X. To clarify, the night work policy is an enhanced action that we took as part of our continuous improvement plans.
   XI. **The following <u>existing</u> forms** were reviewed and included in the Night Working Policy and Procedure, as part of our consolidation exercise:
      - Guidance for Daily Notes Audit - Care Staff
      - Senior Task checklist
      - Handover Report
      - Spot Check Form
      - Medication Observation Competency
      - Observation forms x 6

   XII. The new alarm system has been installed, and the Night Working Policy has been updated to include this.
2. **Evidence was heard that a new electronic system to monitor checks on residents was being sourced. This is not in place some 3 years following Mrs Walsh's death.**
   I. The current Nurse call system was in place at the time of the incident and was regularly checked, however, the mat alarm in Mrs. Walsh's room was reported as not working when the incident took place. The former Registered Manager, at the time of the incident, who was a very experienced care manager, was responsible for the alarms and their consistency to work and did not report that the system needed changing.

   II. Immediate actions at the time of incident 3 years ago:

- Daily notes audit: to monitor and audit night observations
- Walkie Talkies: to enhance communication between staff and work in every area of the building

Further actions taken:

- additions made to ensure that staff limit the time in laundry/medication room
- Daily audit of handover, this includes call mats.
- 2nd line sampling of daily notes audit by the Care Manager
- If there is a discrepancy in the night checks, staff are required to explain why and complete an incident form around this.
- Interim monitor system put into Laundry and Meds room so that alarms can be heard.
- Alarms tested to ensure that they can be heard from all rooms.

III. Medication is administered from a mobile secure medication trolley, and the only time that the Senior carer is in the Medication Room is to collect and return the trolley. They are instructed to have the door open whilst they collect and remove the trolley then close and lock it afterwards. Audits on controlled drugs and homely remedies is only completed when both management are on site ensuring that a senior member of staff is able to hear the alarm. Interim monitor system was installed into the medication room until the new monitoring system was fitted.

IV. Time spent in the laundry room is only a problem at night, as this is when the bulk of washing is done. Before staff enter the laundry room, they communicate the intention to do so via Walkie Talkie, then laundry trays are brought into the communal area on a laundry trolley. The laundry is then folded and sorted where alarms can be heard. Staff must radio to say that they are going into the laundry which will consist of loading/unloading the washing machine and driers, and then clean laundry is brought into the communal area to sort. When a staff member is in the laundry room, no other staff member will be on their break. This is managed by the senior carer. Interim monitor system was installed into the laundry room until the new monitoring system was fitted.

V. New monitoring system: This is part of our continuous improvement plans. The Medicare system means that accurate recording of room checks, and response times will all be documented, and a detailed report can be obtained. There are sounders in all locations within the home ensuring that all staff can always hear the emergency alarms during their shift.

3. **Evidence was heard that carers are responsible for work alongside caring for residents, including cleaning and laundry, A Night Tasks List was referred to as being "currently under review" and under the heading "Actions" was included "Implement revised night staff task list" in an investigation carried out by Adult Safeguarding in an Adult Safeguarding Record from 2022. As at the date of the inquest this document was not complete. There was no evidence as to what this List would include.**

I. The Night Task checklist was reviewed, and the purpose was to determine whether the laundry would remain as part of Night work. It was decided that both laundry and kitchen tasks would remain on the task list, for night staff, as this is common practice in care homes to assist with the smooth running of the service, however doing these tasks must not have any impact on the care and support that the residents need during the night, as care and support takes precedence.

II. The handover report includes reporting on laundry and kitchen tasks and handing over any unfinished tasks to the day staff where care and support duties have been the expected priority.

III. The residents support and care through the night takes precedence and always has. It is the Senior Carers responsibility to carry out resident observations, calling on the carers if extra help is needed.

IV. The carers on duty prioritise personal care and supporting any residents nightly needs and preferences. They will only perform housekeeping duties if the shift allows.

V. The checklist underwent further review prior to the implementation of the night work policy and procedure.

4. **An investigation carried out by the Home found that records had been edited and some falsified by a member of staff. A statement made by the new Deputy Manager at the Home dated 14 July 2023 stated that only senior management could go into the system to edit existing records. Evidence was heard at the inquest from the Registered Manager who stated that care staff can access and edit the records. It is a concern that senior management are unaware the system can be edited as well as a concern that it is acceptable for staff to edit entries.**
    I. It was the former Registered Care Manager that gave evidence at the inquest.
    II. Care staff need to have edit rights on a resident's care notes in order to record the work that they carry out. They will record their notes via the handheld devices that they carry on shift.
    III. However, they can only edit the care notes by going to the office and doing this via the computer, which is under the supervision of the Senior carer or the Management team.
    IV. The reason that a member of staff could edit the notes at the time of the incident was because they were a Senior carer, and the member of staff whose login was used was also a trained Senior carer, so they had access to the computer at the time of the incident.
    V. The current Care Manager and Senior staff are fully aware of the edit functionality and access permission for care staff.
    VI. The system CareDocs. is used throughout the health and social care sector, in many care homes, and the edit rights would be the same for those services.
    VII. The former registered Care Manager and former Deputy also undertook daily audits of the system which were immediately put into place after the incident when they found that real time records could be found for the night observations. The Daily notes audits have been ongoing daily since the incident. We have found no edits made for night observations, except for the falsification of records by the member of staff that was prosecuted.
    VIII. CareDocs were contacted asking about the function of being able to edit, their response was that this cannot be amended, if the edit function is removed from staff, they are not able to complete any record keeping. This is monitored by Seniors on duty, the Care Manager and Deputy.
5. **Conflicting evidence was heard as to whether night staff are allowed to sleep during breaks whilst on night shift.**
    I. Staff working at night are referred to as Waking Night Carers which means that they are not allowed to sleep on shift.
    II. However, if a waking night staff takes a break, authorised by the senior carer, then this is their own downtime. They can choose to nap in that break as long as they are contactable in an emergency, and they are back on the floor at the expected time.
    III. Waking Night Carers are not allowed to sleep whilst on shift, however what they do in their downtime is their decision. If they are struggling and feeling tired, then they are to inform the senior ensuring they get the correct support.
    IV. This information is part of Night staff Induction but is also in the Night Working Policy.
    V. The Care Manager and Deputy continue to complete 2 to 3 spot checks a month.
    VI. Managers will work part or full night shifts periodically to observe working practices of night staff and give them support.
    VII. The Night Work Policy is available in the staff area. It is also uploaded to the QCS policy system where staff have access to all policies.
    VIII. Managers discuss the new Night Work policy at staff meetings.
    IX. Staff receive practical training in Safeguarding and whistleblowing to ensure they are confident in reporting any member of staff that is found sleeping when they should not be.

6. **The warning alarms requiring immediate response cannot be heard in all places at the Care Home. It is understood walkie-talkies have been introduced for use by all staff, but this adds in another step to be taken by staff before the alarm is responded to.**
    I. The areas identified where warning alarms may not be heard are the Medication Room and Laundry Room. At the Inquest there was mention of alarms not being heard from Rooms 1 & 2, by former employees working at the time of the incident.
    II. **Medication Room**: The new monitoring system is now in place and prior to this medication was, and still is administered from a mobile secure medication trolley. The only time that the Senior carer is in the Medication Room is to collect and return the trolley. They are instructed to have the door open whilst they collect and remove the trolley then close and lock it afterwards. Audits on controlled drugs and homely remedies in the medication room are only completed when both management are on site ensuring that a senior member of staff can hear the alarm. Also, an interim monitor system was installed into the medication room until the new monitoring system was fitted.
    III. **Laundry Room**: The new monitoring system is now in place and prior to this, the laundry room was only a problem at night, as this is when the bulk of washing is done. Before staff enter the laundry room, they communicate the intention to do so via Walkie Talkie, then laundry trays are brought into the communal area on a laundry trolley. The laundry is then be folded and sorted where alarms can be heard. Staff must radio to say that they are going into the laundry which will consist of loading/unloading the washing machine and driers. Clean laundry is then brought into the communal area to sort. When a staff member is in the laundry room, no other staff member will be on their break. This is managed by the senior carer. Also, an interim monitor system was installed into the laundry room until the new monitoring system was fitted.
    IV. **Rooms 1 & 2**: this was only raised at the Inquest, but the current Care Manager reported that the alarms can be heard in this area. She has since tested to ensure this and the alarm from could be heard from rooms 1&2, prior to the new monitoring system being fitted. However as additional precaution, sounders have been placed near these rooms ensuring that the emergency can be heard.
7. **The Director of Training and Operations referred to the Incident Investigation carried out internally and found that PIR sensors were not in use in Mrs Walsh's room at the time of her fall. PIR sensors were referred to in witness evidence and also in Mrs Walsh's Daily Care Notes. It was found at the inquest a PIR sensor was in Mrs Walsh's room at the time of her fall and the PIR sensor did not sound an alarm as required in the Care Plan, at the time of Mrs Walsh's fall. It is a concern this investigation did not read Mrs Walsh's Care Notes before reaching this conclusion when concerns that the PIR sensor did not sound could have been addressed.**
    I. The Director of Training and Operations (DTO) is not an employee of Broadland View Care Home (Medicare corporation) and is a remote worker, for another business.
    II. The DTO of Careskills Academy questioned the PIR Sensor in their statement for the inquest because the former Care Manager, employed at the time of the incident, was unsure whether there was a PIR sensor in Mrs Walsh's room, which became known during the inquest preparation. It would have been the Care Managers responsibility to ensure that the correct sensors and alarms are in place for each resident and have knowledge of which sensor alarms are used by each resident.
    III. The DTO from Careskills Academy was asked at the time of the incident to guide the Deputy Manager in an investigation of CareDocs to ascertain whether night staff had recorded their observations correctly as there were questions being asked about the length of time that Mrs Walsh was on the floor, at the time of the incident.
    IV. The Deputy Manager, employed after the incident, found that real time entries were also recorded with the night observation times in a report from the back end of the system and based their investigation on this, then sent their findings and evidence to the DTO of Careskills Academy who

looked at all the evidence submitted and wrote a summary report of their findings, based on the evidence given to them.

V. The investigation evidence that was presented at the time determined that there had been falsification of records in the CareDocs system for the night observations carried out.

VI. The DTO of Careskills Academy referred to only the alarm mat not working in their summary report as this was a finding from an incident report submitted with the Deputy's evidence. There was no evidence submitted to them that mentioned a PIR Sensor.

VII. The DTO of Careskills Academy did not have access to CareDocs and therefore would not have seen whether a PIR Sensor was mentioned in the care plan. They were only involved in looking at the evidence pulled from the system regarding night observations and balancing this against staff incident reports, which mentioned that the alarm mat did not sound.

8. **(8a) The Care Quality Commission carried out an inspection in February 2023, nearly 3 years following Mrs Walsh's death, and raised similar concerns as raised during this inquest, including:**

a) Safeguarding concerns had not always been appropriately identified and referred

I. The Safeguarding concerns referred to involved one member of staff. The Care Manager apologised on the day of inspection and notifications rectified.

II. The Care Manager questioned the Inspector because medication errors referred to were proven to be 'near misses' so no errors were made and therefore this was the reason that a safeguarding was not made. The inspector said that 'near misses' must also be raised as safeguarding, which is not something that is usually done. We would like to reiterate that the medication in question was successfully and safely taken by residents.

III. This member of staff had given poor personal care on one shift which was addressed and did not happen again. The manager apologised for not raising a safeguarding on this occasion and this was subsequently done.

IV. This member of staff was suspended after the medication near misses, investigated, then dismissed and reported to the Disclosure and Barring Service, before the CQC inspection took place.

(8b) Risks relating to falls were not dealt with, including a faulty sensor mat was still in place some days later.

I. On the day of inspection, a sensor mat was found to be faulty and changed immediately, as is normal practice. The Care Manager had not done their daily walk round of the service where they test the sensor mats, because of the arrival of the CQC Inspector.

II. It is common in care that senor mats can become faulty or stop working, and there is a process in place for testing and replacing them. For the mat in question there had been a fault recorded on 27.01.2023 where the mat and the box had been replaced on the 28.01.2023 by the maintenance team.

On the daily checks recorded by the seniors, the mat was then reported as working until 10.02.2023 when there was a fault mended by Maintenance. The mat was reported as working every day from 10.02.2023 up until the inspection on 20.02.2023. It was working on 19.02.2023 when tested which was the day before the inspector arrived.

iii. Sensor mats are checked 3 times a day, once by the day senior, once by the night senior, which is recorded on the Senior Task Checklist and then again by the Care Manager/Deputy on their daily walk round. The Maintenance team alarm checks have now been increased from Monthly to Weekly. If mats require changing, they have always been documented either on the senior task list, the managers walk round, or the maintenance checklist, dependent on who changes the mat. This information is also handed over on the handover report. If the call point is faulty then extra checks will be completed on the resident that night until maintenance are on site to repair, it.

iv. The Handover Report has regularly been reviewed and updated. Call mats are included on the handover report. Staff are required to change at the point of failure, and if the call point is damaged,

then additional checks will be required, and if it is a busy night the on-call manager will be asked to come in to support the home or put in an additional member of staff to help with the extra checks.

v. Night spot checks continue and have always been part of the Care Manager's practice. This is now recorded on the managers monthly reporting sheet, and on the night shift audit. Testing sensor mats is also part of the managers spot checks.

vi. There is always a stock of spare mats for replacement and the current Care Manager has sourced a more robust type of mat that does not require sticking down as they are naturally non-slip.

vii. Faulty mats are replaced immediately and if the call point is found faulty then observations are increased to every 30 mins until fixed. Staff are aware to notify the management team when the replacement mats are running low.

viii. A new monitoring system has been installed to further enhance the Nurse Call system already in place. This has added sensors for staff to actually login when they enter a resident's room, and the system also connects to the sensor mats already in place. The manager will be able to check call response times more accurately, and observations that take place in real time physically. This information can be pulled up on a daily report, at this moment in time it is also being cross referenced with the notes being input onto CareDocs, ensuring that timings are the same or in proximity.

ix. Staff have been and continue to be trained on how to use the new system, and feedback has been positive.

(**8c) Since a historic issue of staff neglect, further incidents of poor staff performance were identified, and effective action had not always been taken. It is stated this failure to learn lessons placed people at risk of harm.**

i. This incident relates to one member of staff on one night shift and is the same member of staff referred to in section 8(a) of this report.

ii. The member of staff in question came with two excellent references which did not give any reason to give cause for concern at the time. The member of staff upon starting at Broadland View presented as keen to learn, and enthusiastic in their role, was involved and person-centred with the residents, and up until the delivery of poor personal care and concerns with medication practice there had been no reason to be concerned about their performance.

iii. After this incident, the staff member was supervised and observed on all medication procedures until suspended and finally dismissed. Training, working, suspension and dismissal was over a period of 5 weeks. During this time, they did not work every day and had a period off sick, where they were hospitalised. When they returned to work after the period of sickness, they did not lone-work and were observed by management before being suspended and subsequently dismissed.

iv. Managers continue to complete 2 to 3 spot checks a month. Managers will work part or full shifts to observe working practices of staff. Managers discuss the Night Work policy at staff meetings and a copy is available in the staff area. Staff are confident to follow the whistleblowing policy and Safeguarding is discussed at all staff meetings. Staff receive practical safeguarding and whistleblowing training with scenario-based exercises.

v. As part of lessons learnt, the Staff Induction Record has undergone another review and additional observation reports for staff have been implemented.

vi. The Care Manager will refer staff that have been dismissed sooner to the Disclosure and Barring Service, if appropriate and did this in November 2022 when a longstanding member of staff block booked too many observations after they had taken place.

(**8d). Recent audits carried out by the Home had not identified concerns found by the CQC**

i. Daily notes audits are carried out <u>daily</u> and pick up in real time when observations are entered. On the day of inspection, the CQC Inspector asked to see the night spot checks, which were shown. This is a record of what happened at that moment in time when the Manager appears unannounced in

the service. However, it is the Daily Notes Audit that evidences what happens during every night shift, but when offered the CQC Inspector refused to look at these. In the Inspection Report there is confusion over the name of the report and their terminology used which we addressed with the CQC in our representations following the Inspection. The CQC refused to change the terminology.

ii. The medication audits picked up a meds error where action was taken.

iii. Every audit for mat testing is recorded, but the mat that did not work on the day of inspection had not had the fault recorded as the Care Manager had not carried out their walk through because of the CQC Inspectors arrival and therefore it was done later than usual.

iv. The Maintenance task list did pick up a faulty thermostatic valve, which had not yet been replaced when the inspection took place. The Registered Care Manager did apologise for this. It has been replaced and all water outlets have thermostatic valves. The Maintenance task list records water outlet testing, but it was reviewed again to include more detail about every water outlet.

9. **The Registered Manager did not accept many of the concerns raised by the CQC during their attendance and this is a missed opportunity to learn lessons, improve care and prevent future deaths.**

I. The Registered manager has accepted the concerns raised and did apologise on the day of inspection for any actions of concern missed.

II. There was a lesson learnt as the Care Manager was not aware that 'near misses' should be raised as Safeguarding. The Care Manager will report these going forward. It is not something they were aware that had to be done in all their years of care experience and training completed. This is the lesson learnt.

III. There were concerns over the staff member that was dismissed not signing some meeting notes. The Care Manager apologised and explained that the staff member was suspended and dismissed before there was opportunity to get the notes signed. The lesson learnt is that the Care Manager will ensure there are notes to sign on the day of any meeting if a signature is required.

IV. All concerns that were raised were addressed in the CQC Action Plan and all actions have been met. The Care Manager submitted representations to the CQC following inspection, about concerns raised, giving a full explanation with evidence for the concerns raised. The CQC ask for these to consider any changes for the inspection report, however they chose not to make any changes.

V. Broadland View has a long-standing relationship with an external compliance company that visit 4 times a year to inspect the service. We have recently engaged them to do a more thorough 3-day inspection and are arranging monthly visits from them going forward to assist the Care Manager in identifying areas of continuous improvement and putting in new systems and processes in place, as required, and are appropriate to the service. The DTO from Careskills Academy is a source of remote advice and support and uses their knowledge of the health and social care sector to build systems, processes and reporting tools should they be needed to improve the service further. They meet with the Care Manager on a weekly basis to determine what actions are needed and discuss the completion of compliance records. This is a source of support for the Care Manager in keeping all parts of the service on track.