Phoenix Care Centre
Ancaster Avenue
Chapel St Leonard
Lincolnshire
PE24 5SN

Response to the Regulation 28: Report to prevent further deaths

Re: Sheila Johnson (SJ)

13th September 2023

The response is to address the Coroner's Concerns, detailed as Point 5 in the report.

1. An inadequate generic falls prevention policy appeared to be in place
   Our Policies are supplied by a professional company that takes into account latest legislations in terms of Legal, Health & Safety, CQC, Safeguarding, etc. They are specifically written for care homes. We use them as it ensures we are compliant with these different areas.

   Normally a Policy, when an update is sent to me, is forwarded to the Home. The Manager goes through it and personalises it for the Home. Depending on the policy, it generally requires the care home name added and small changes made where necessary.

   In the case of the Falls Prevention and Management, the Policy is very comprehensive in the actions that the staff/Home have to follow. The staff do read this and policies can be accessed either electronically (through the Care Planning Software) or a paper copy that is maintained in the senior's office.

   We note that Policies should be personalised more and the Manager has taken this on board. Where existing policies are generic, they will be personalised.

2. Doors to unoccupied rooms were unlocked when they should have been locked
   Bedroom doors in a care home cannot be kept locked at all times. Phoenix Care Centre is a Residential Home and most of the residents there go in and out of their rooms whenever they wish to. They have the choice and freedom to do so. We even 'personalise' doors with their names, photographs of either themselves or items they recognise/associate with.

   In certain circumstances, after discussions with other professional parties, we did lock some bedroom doors when unoccupied. This situation was happening at Phoenix at the time as we had 1 resident who would go into some rooms and take food items (usually chocolates) from the residents' rooms. He would normally go to only specific rooms where he knew he may find something. Discussions were done with staff and management and it was agreed to lock those rooms when not occupied. This was to break the behaviour pattern of this resident. Staff are familiar with the residents' behaviours e.g., residents that would go to their rooms during the day, those that would remain in the lounge, etc. The unoccupied rooms that were locked during the day were 2-3 on either side of the said resident.

   I have not seen a standard policy of locking bedroom doors in a residential home unless it is a local decision for the safety of other residents or their possessions.

3. Night light in common places not on
   No idea as to how this has been brought up. All common areas, particularly corridors, have lights on 24/7. Bedroom lights are not always kept on – the decision for that is usually up to the resident as most of them do have the capacity to make that choice.

   In the case of SJ, she went into the bedroom where the light was not on, as there was no one in the room at the time.

The resident or family or our trained staff, where there is diminished capacity, would tell us if a night light is required for their room. It would be documented in the care plan.

All common areas such as corridors have lights on at all times and even lounges, at night have some lights on as the night staff are working.

4. <u>No signage to bell ring in place</u>
I have asked several care home owners that I know and also posted the question in a Forum of care home operators. No one has call bell signs in bedrooms especially in residential homes. I will continue to ask and look out for any suitable signage that can be used.

5. <u>Inadequate periodic nightly observations recorded at inquest</u>
Our night checks are done every 2 hours and have always been done. We do not recall being asked about these records at the inquest. Care plans were submitted, but records of night checks are kept separate.

   At the time of this incident, we had a manual care planning system. Night checks were recorded by the night senior in a separate folder which they would have with them as they are doing the checks. At CQC inspection and LCC inspections (done regularly), these would have been looked at and it has never been brought up as not suitable. We now have an electronic care planning system and the checks are recorded electronically – which directly links with the resident's care plan.

   Regular night checks is one of the main roles of the staff on duty at nights. It is standard practice for these to be done.

It is very unfortunate for this incident to have happened to SJ. She was well settled in the Home and her daughter, who worked as an independent hairdresser at the Home, witnessed this on the days she was there. She regularly commented that her mum was well and liked being in the Home. SJ had been assessed several times for her risk of falls and the assessment came to Medium Risk each time. The electronic care planning does an objective assessment which is discussed with her Social Worker and Medical Professionals. SJ had Demetia and what she really liked was to walk around the Home. She was in a secure environment and every day (and for most part of the day) she would walk up and down the corridors and around the lounges.

On this day, she went into another room and must have tried to get into the bed that she was not familiar with. From the observation of her condition when she was found, we can deduce that the bed covers had slipped and SJ must have hit her front on the wooden bar of the profiling bed as she fell. She had just had tea and was in the lounge area for a short time (where she was seen by the carers during handover) before setting off on her walk. Post handover and around 20 mins later the carer who was going down the corridor heard her cry for help.

The staff followed all the procedures they are trained for when a fall is discovered.

The Home followed all the procedures after an unwitnessed fall, including reporting to CQC, LCC and Safeguarding. The Manager spoke with the CQC inspector and the Safeguarding Lead. Both agreed correct procedures were followed.

SJ was not on a 24hr watch care plan. What she really enjoyed was walking around the Home and did so every day. Staff would speak with her throughout the day as they went about their work. Her Medical professionals advised that was the best thing for her and that she should have this freedom. SJ was 91 years old, and although not really frail in physique, did have brittle bones (for which she was on medication). She came to the Home with a fractured hip because of a fall she'd had at her own home.