NORFOLK CARE HOMES
Celebrating Life Together

Prevention of Future Deaths Report (Regulation 28): The Limes Residential Care Home's Response

JUNE 2024

Coroner's concerns in relation to The Limes Residential Care Home

CORONER'S CONCERNS

During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows:

1. Care Plans and Risk Assessments were not consistent and clear as to what steps were required to mitigate the risks of Mrs Alden falling.
2. Staff were unclear in evidence as to what was required in respect of Mrs Alden to mitigate the risks of her falling.
3. Residents deemed as at very high risk of falls were, and still are, allowed in communal areas with no carer present.
4. Staffing levels may be insufficient for the number of residents. Evidence was heard that "staff can't be everywhere at once".
5. The Inspection Report dated 6 October 2022, carried out following Mrs Alden's death, found "There were enough staff on duty to meet people's needs and people told us they never had to wait long for assistance. The registered manager had reviewed how staff were working and deployed staff in a way that meant that the right staff were in the right places when needed. This meant people in communal areas were never left alone ...". This sentence is not supported by the evidence heard at inquest.
6. Residents deemed as at very high risk of falls were, and still are, in their bedrooms with a call bell and no other means to alert staff if they get out of bed and mobilise, this includes leaving their room and entering corridor areas. I am concerned this will lead to carers responding to a fallen resident, rather than preventing the fall.

The above concerns were shared via email following the conclusion of the inquest with NCC and CQC Dated-11/04/2024

Summary

Keeping our resident's safe is of high importance to us as a social care service. We strive to mitigate and prevent risks wherever possible.

The following are key areas of improvement already implemented or scheduled for implementation.

Training

We have reviewed the training we have in place to support staff. We have introduced a 'Falls Champion' role to provide continuous drive and improvements to our working practices. This is an active member of the staff team providing support, guidance and coaching around falls prevention. Knowledge and understanding checks through competency assessment and sign off following completion of this for each staff member. Our in house trainer has completed a falls, train the trainer programme, date 21st May 2024 this will also support ongoing improvements for both the training package being provided and the Falls Champion role. We will continue to develop and adapt our training with further awareness sessions being offered to friends, families and advocates etc.

'Falls Prevention is Everyone's Business'

'Falls Prevention is Everyone's Business' is an awareness raising publicity campaign we introduced in May 2024. To build and develop all staff awareness and understanding. This initiative is further going to be rolled out across the home to involve all stakeholders and will include residents, their families and friends. We are also hoping to include health and social care professionals further with its continued development. This will then become a whole home approach. We envisage this will just be the start of a new way of working where we promote and talk about risk management and falls prevention on a daily basis. 'Falls Prevention is Everyone's Business' is displayed on the staff knowledge board within the home and has also been used as topic of the week for a six week rolling period. Making it a discussion point of reference as part of the daily handover process, so all staff are supported and aware of the importance of falls prevention and management. Promotional posters, leaflets and other resources are actively being used and made available.

'Getting Active'

An initiative we will be introducing during June 2024 to build and develop resident's physical abilities, to improve muscle strength, bone density and to support health and wellbeing.

Policies and procedure reviews

Policies and procedures are continuously reviewed as part of our development as a company. Special emphasis has been given to any of our policies linked to falls, including environmental factors, individual risks, actions to be taken to improve staff guidance around understanding and interventions required to mitigate risks where possible.

Coroner's concern number one

Care Plans and Risk Assessments were not consistent and clear as to what steps were required to mitigate the risks of Mrs Alden falling

Actions taken prior to the inquest:

Care plans and risk assessments were fully reviewed and revised. Working with an external consultancy for guidance and advice we changed the structure and wording of our care plans to better reflect a person focused approach with a higher emphasise of risk management embedded within these documents.

Training was completed for senior staff to support with completion of care plans. Bite size care plan training was cascaded to regional deputy and team leader and then introduced across the senior staff team to develop their knowledge, understanding and reasoning for the changes. Training completed in relation to falls linked to Safeguarding. Face to Face training was brought in to support staff knowledge and confidence with regards to falls linked to Safeguarding to continue to promote an open and transparent workplace.

Management changes were implemented. Manager in situ at the time of the incident left the role, initially regional manager stepped into this role whilst a new manager was recruited. New manager in post from May 2022. Further management changes in March 2024, where we introduced an interim manager, she is currently in post to continue to drive improvements.

Review of equipment in place to support the individual and what additional measures we can put in place to further support making sure details are within care plans and risk assessments.

Auditing processes reviewed and updated to actively identify inconsistencies within care plans and risk assessments.

Garden access risk assessments completed for each individual and periodically reviewed.

Actions taken immediately following the inquest:

Meeting with the management teams across the company to discuss actions to take place with immediate effect.

These included:
Falls Champion role see above 'Training' for details.

Risk management risk overview sheets within the home shared at Handover meetings to highlight the risks associated with residents to all staff, to build on knowledge and understanding. Risks to be aware of on Person Centred Software (electronic care plan system used) checked and updated if required, again to support staff knowledge and understanding. Pre-admission assessments of falls risk has been introduced to identify and mitigate risks prior to admission. Falls risk analysis completed with the management team for the whole home, to drive further improvements and identify and mitigate risks where possible. Falls analysis is completed monthly for the whole home, this is managed as and when falls occur with weekly clinical meetings and weekly accident/incident sign offs by management.

Falls assessments fully reviewed and corroboration of information checked against mobility and function assessments and care plan need to make sure information staff are accessing is current and accurate. Time line and actions taken listed for each individual.

Assistive technology review of all equipment currently in use, additional equipment considered and introduced where appropriate. Equipment is reviewed following any changes to an individual's physical, mental or emotional health. This is evidenced within assessments linked to the relevant change and within weekly clinical meetings. Management, senior staff are responsible for making these changes.

Auditing care plans and risk assessments continue to be reviewed on a monthly basis as a minimum or when there is a significant change. Care plan audits have been completed with regional management support, and is now set as 10% of the home each month, being completed by the management team. This includes all aspects of the care plan including risk assessments, Mental Capacity assessments, front page, planned care, photo etc.

Continuation of referrals to the relevant health professionals, to support with individuals plans and needs.

Continuation of reporting to Safeguarding and CQC volume of falls (in accordance with statutory and NCC guidance). This links to referrals back to Social Services for reviews where required for additional funding or notice being issued as we are unable to meet an individuals specific needs.

Further actions we plan to take:

Multifactorial Falls Risk Screening Tool introduced May 2024 to support and pull together the work for each individual, this includes an action log that shows how we measure the outcomes and changes for each person.

Our approach developing the whole home approach to be proactive with managing and mitigating falls wherever possible.

Progress continue to review, develop and improve auditing processes and policies to support continued improvements.

Coroner's concern number two

Staff were unclear in evidence as to what was required in respect of Mrs Alden to mitigate the risks of her falling

In addition to the remarks under 1 above the follow actions relate to Concern 2

Actions taken prior to inquest:

Health professional referrals completed so involvement and guidance is accessed to mitigate falls for individuals who have experienced falls.

Actions taken immediately following the inquest:

Falls prevention to be an agenda item for meetings to promote the further awareness.

Further actions we plan to take:

Falls awareness training is being developed further, our trainer has completed a falls train the trainer session on 21st May 2024. Following this a full review of our current training linked to falls will be completed and additional details added to both the Moving and Handling training and Safeguarding training.

Staff knowledge and understanding checks – this will be completed through the format of a questionnaire linked to the 'React to Falls' guidance used as part of the Champion role being introduced.

Manager's meeting standard agenda item for each meeting, discussing falls at every possible opportunity. Making sure it isn't dropped from any priority list and making sure it continues to be developed further within the staff teams and whole homes approach.

Activity and Wellbeing provision reviews – 'Getting Active' being introduced for our residents. Adding more physical activities into the weekly planners – consideration of timings/involvement/resources and impact.

Coroner's concern number three

> Residents deemed as at very high risk of falls were, and still are, allowed in communal areas with no carer present

In addition to the remarks in 1 and 2 above, the following actions relate to Concern 3.

Actions taken prior to inquest:

Dependency tool in place and used to calculate staffing hours – occupancy has fluctuated over time, staffing hours has mainly been maintained at our highest dependency score to support continuity across the staff team.

Actions taken immediately following the inquest:

Care staff are allocated to communal areas of the home to provide relevant help and support for any residents within these areas.

Assistive technology in place within communal areas of the home for those residents identified as needing to alert staff if they are attempting to mobilise independently.

Dependency tool completed to review staffing April 2024 (overstaffed by 18hrs a day).

Garden use with staff allocated to this area now in place. Staff within the garden areas are equipped with a radio (walkie talkie) to alert colleagues within the home. i.e in an emergency or if someone requires support with something. Staff knowledge and understanding was confirmed through staff memo and handover process.

Further actions we plan to take:

Level of needs continue to review for each resident and refer back to NCC if additional funding needs are required to be met.

Involving other stakeholders as much as possible, including health professionals, Norfolk County Council, friends, families and advocates.

Coroner’s concern number four

> Staffing levels may be insufficient for the number of residents. Evidence was heard that “staff can’t be everywhere at once”

In addition to the remarks under 1, 2 and 3 above the following actions relate to Concern 4.

Actions taken prior to inquest:

Key coded access was fitted to the door to the garden, access with staff support is required.

Actions taken immediately following the inquest:

Dependency tool completed to review staffing April 2024 (overstaffed by 18hrs a day).

Further actions we plan to take:

Continue to use the dependency tool to calculate staffing hours, as and when changes occur in the service. Working with above the level of staffing required where possible.

Coroner's concern number five

> The Inspection Report dated 6 October 2022, carried out following Mrs Alden's death, found "There were enough staff on duty to meet people's needs and people told us they never had to wait long for assistance. The registered manager had reviewed how staff were working and deployed staff in a way that meant that the right staff were in the right places when needed. This meant people in communal areas were never left alone ...". This sentence is not supported by the evidence heard at inquest

Actions taken prior to, follow and plan to take, are all listed above under Concern 1, 2, 3 and 4.

I'd respectfully draw Coroner's attention to the fact that this is a report of the regulator and as such only the regulator can defend their report. We do happen to agree with CQC's independent assessment dated 5th October 2022. The inspection is a 'snapshot' of our service. Our internal auditing processes provide evidence of our staff being allocated to areas throughout the service to effectively meet individual's needs, which gives us the assurance that the remarks in the CQC report were accurate.

Coroner's concern number six

> Residents deemed as at very high risk of falls were, and still are, in their bedrooms with a call bell and no other means to alert staff if they get out of bed and mobilise, this includes leaving their room and entering corridor areas. I am concerned this will lead to carers responding to a fallen resident, rather than preventing the fall

In addition to the remarks listed under 1, 2, 3 and 4 above, the following actions relate top Concern 6.

Actions taken prior to inquest:

Assistive technology was also used in bedroom areas of the service, this included sensor mats, door alarms etc.

Staffing allocations within the home are split into different corridors to support residents remaining in their bedrooms.

Actions taken immediately following the inquest:

Further actions we plan to take:

Developing additional resources for friends and families, guidance to support, introducing a whole service approach.