Improving lives together

Cygnet Health Care

Dr Elizabeth Didcock
Assistant Coroner

[redacted]

2 July 2024
Sent via email

Dear Madam

Thank you for your letter regarding the issuing of a Regulation 28 Report to Prevent Future Deaths at Cygnet Health Care. I will address each of the four areas identified within the report and update you on the actions that we have taken and any future actions that we will be taking to ensure the risk of any future death has been minimised. I am responding for Dr Romero as I am the Chief Executive Officer of the Social Care Division that was responsible for Mr Dickens' care.

A lot of work was undertaken at Beeches and more widely across Cygnet following Mr Dickens' death. I apologise to you and Mr Dickens' family that Cygnet staff were unable to give you sufficient reassurance at his inquest.

Your first three matters of concern were as follows:

a) ***The persistent lack of compliance by staff with Eating and Drinking guidelines- there remains a lack of understanding by Beeches management of the reasons for the lack of compliance- if not understood, it is difficult to rectify in the future***
b) ***The lack of recording of the specific strategies used at mealtimes when there is an Eating and Drinking guideline in place***
c) ***The Failure of management and the Multidisciplinary team to effectively monitor compliance with Eating and Drinking Guidance- I have no evidence before me that demonstrates improvement with this important issue***

Cygnet responds as follows:

Beeches

In January 2023 a new registered manager came into post at Beeches. Of the staff members who gave witness statements to the police, as included in the inquest bundle, only 1 support worker still works at Beeches (in addition to the pre-existing deputy manager). There was no one consistent reason given in those statements as to why plans weren't followed. It is therefore not possible for the registered manager to establish the reasons why the staff at the time did not follow Peter's care plan and eating, drinking and swallowing (EDS) guidelines.
The new manager has implemented a raft of measures since coming into post. He describes himself as having an extremely rigorous approach to eating, drinking and swallowing practices and prides himself on having built a safe space for staff to be open, honest and committed to self-development and improvement for the sake of residents at Beeches.

New staff induction

When a new staff member starts they receive a one week induction during office hours (Monday to Friday, 9am to 5pm) so that they have the benefit of the management team being on site. They meet all of the residents, go through all of the care plans and policies, undertake online training and book on to face to face training. If they are unable to complete their reading and show understanding of care plans, their induction is extended. Once induction is completed they then undertake two weeks on the rota with the team they are joining, shadowing shifts with, ideally, a residents' key worker but otherwise, an experienced member of staff. Following this they have a formal meeting with a Team Leader who checks their confidence and competency. They then have a monthly supervision session during a 6 month probation period.

Agency staff must be pre-approved by the manager and they undergo an induction process. They are then allocated to work with less challenging residents. They must read and understand the care plans of the residents they will be working with during the shift and whilst they are undertaking this, the activities coordinator will check the staffing numbers so that staff numbers are not reduced. The Team Leader then conducts regular checks throughout the day to ensure that the agency staff member of staff is competent and to provide support and answer any questions. The agency staff used do on the whole, know Beeches and the residents.

A copy of the choking/dysphagia competency assessment and supervision questionnaire is attached to this letter as Appendix 1.

Spot questions

When the manager is walking around the corridors, he regularly stops staff members and asks on the spot questions to test understanding of the resident they are with and/or of policies. This can be on any topic but during meals, it will be eating, drinking or swallowing related. The manager also undertakes a formal fortnightly walk around the entire unit and undertakes checks in all areas. This includes choking awareness monitoring. A copy of the walk around record is attached to this letter as Appendix 2.

Spot checks

In July 2023 the manager implemented Team Leader spot checks. Twice during the day shift and once during the night shift, Team Leaders undertake spot checks. On the day shift, at least one Team Leader has to be around for the eating and drinking at meal times and the second tends to focus on how staff are interacting with residents. The night check is always at dinner or breakfast. The Team Leader focuses on a member of staff, observes them and records aspects of the check. For example, a meal time check would include what food was eaten, how it was cut, whether it was prepared correctly and that a staff members was present. Any issues are reported back to the manager. The spot checks are discussed every Monday in the morning meeting. A copy of the spot check template is attached to this letter as Appendix 3.

Weekly guidance checklist

Following Peter's inquest, in March 2024 the manager implemented a weekly guidance checklist. This involves a minimum of two weekly guidance checks, one of which is always on EDS. The manager, or in his absence the deputy manager, observes a mealtime and makes sure that the EDS guideline is followed, that the staff understand it and ask questions of the staff to ensure they know what they are doing and the reasons whys. If there are any concerns or the manager wants to check anything, for example that the guidelines are still current and accurate, he raises this with the Speech and Language Therapist (SLT) Team. A copy of the checklist is attached to this letter as Appendix 4.

Multi-Disciplinary Team (MDT) visibility

The manager has also implemented a "meet the MDT" initiative. Each member of the MDT has provided an information sheet which includes "my name is", "my job is", when they were at the Beeches, which includes how to contact them and other information about them and their role. These sheets are displayed on a notice board in the link corridor between the main block and the residential block. It also includes information for staff on what to do if guidelines are not being followed and provides details so that staff can contact members of the MDT directly. This has improved visibility, strengthened staff relationship with the MDT and fostered an approachable and collaborative environment. A photograph of this board is attached to this letter as Appendix 5.

The manager also gave a presentation to the Corporate Safety Response Group on learning from Peter's inquest and detailed the initiatives which are set out in this letter. A copy of that presentation is attached as Appendix 6.

Choking board in main corridor

There is a large board in the main corridor displaying choking risk and awareness posters. Copies of those posters are attached as Appendix 7.

Monthly theme boards

In March 2023 the manager implemented an initiative to raise competency and refresh knowledge. A large notice board is displayed in the main corridor in the residential unit. A topic is chosen each month and the board has a range of resources on it pulled from the Cygnet intranet, CQC and the Local Authority.

The April 2024 topic was eating and drinking following Peter's inquest (photograph attached as Appendix 8) and the June topic was lessons learned, how to mitigate the risks and why (photograph attached as Appendix 9).

At end of each month there is a knowledge test on that month's topic. The results are scored and put into graphs and a team percentage reached. If a staff member's score is low, an action plan is developed. This could be a team meeting agenda item, retraining, or something else (for example flashcards with QR codes for reporting were developed following the safeguarding topic and questionnaire scores). There is then

a write up of that month's topic. The write ups for April and June 2024 are attached as Appendices 10 and 11.

EDS guidelines and auditing

EDS guidelines are located in each resident's care file in the duty office, in the main kitchen with the chefs and in the therapy kitchens. There are currently two residents in each of the two Beeches units who have EDS guidelines. Compliance with EDS guidelines is audited by the SLT Team.

Datix incident reporting

The manager has improved and increased incident reporting protocols so that he and the wider staffing group has an improved awareness of these matters.

Management handover

Each shift leader completes and sends a handover to the manager, deputy manager and team leaders. This covers things such as resident health, PRN required, any issues and meal times (its content could vary from shift to shift). As well as documenting ever resident, it also captures staffing. A copy of the management handover form is attached as Appendix 12.

Fortnightly triangulation analysis

The manager undertakes a fortnightly triangulation analysis whereby he reviews Datix (the incident reporting system), Pink Notes and handovers. He will pick a resident at random and go through the Pink Notes to check that entries are sufficiently detailed, correct and activities recorded. He will then look to see if any incidents are recorded on Datix and that these are cross-referenced between the two systems and on handovers. A copy of the triangulation analysis form is attached as Appendix 13.

Cygnet

Training

Dysphagia and Choking Awareness training is part of the annual mandatory training and additional training can and is sourced from the SLTs as and when required.

Audits

The SLT team are conducting audits of Cygnet's EDS guidelines at set time intervals. The outcomes of these audits are discussed with managers and presented at our Clinical Audit Committee for wider discussion and learning.

Choking vests

Research suggests that most people don't deliver back slaps effectively. The Director of Nursing has therefore ordered two further choking vests which will be trialled on two sites for a period of 1 month and if successful will be rolled out across every site within Cygnet. At the Lessons Learned meeting in June 2024 a commitment was made to ensure that sites which already have vests utilise them as part of life support training.

Awareness

Each year there is a nutrition and hydration week across Cygnet and we take the opportunity to raise the profile of choking and its prevention and treatment. The week also includes a national swallowing awareness day. We ran this campaign in March 2022, 2023 and 2024. During these weeks, we shared a series of blogs, posters and resources. Services were also supported to refresh their knowledge of critical documentation such as our Choking Risk Screening Assessment Tool. We are also running a corporate choking awareness campaign in September 2024. This will see a range of educational and promotional materials relating to choking risk being delivered across the coming months.

In March 2022, we also hosted a learning lessons conference, and Choking Risks and Dysphagia were an agenda item.

Serious incidents

The Director of Nursing chairs a complex case panel which reviews all incidents graded as moderate harm and above. Incidents of choking recorded on our incident reporting system (Datix) that reach this threshold are discussed. This is a very important panel to review incidents and identify any learning opportunities that can be explored. Under the new incident reporting framework (PSIRF), if incidents of choking are identified, there will be system-based thematic reviews which will look to see if there are any common themes and wider learning.

There is also a monthly lessons learnt meeting where we identify any themes from incidents and any associated learning. Following this a learning bulletin is shared across all sites within the organisation.

The Director of Nursing also reports choking incidents and any areas requiring improvement at Executive Board meetings.

Your fourth concern was as follows:

> ***d) Apparent failure to provide the level of support that was funded for Peter the costings and support level were set out in his current care and support plan- the Beeches management team appeared unaware that he was funded for a total of 18 hours per day, which is broken down into 12 hours one to one support per day and 6 hours two to one support per day***

At the time Mr Dickens choked, he was receiving the support that he was funded to receive. For residents with complex needs and levels of support and staffing that changes throughout the day, funding is not straight forward and would require a deep dive into the contracting, commissioning and actual staff provision. A witness giving evidence over 2 years after the death of a resident would not be able to accurately recall the arrangements that were contracted and what was delivered when.

I do hope that this letter has provided you with a level of assurance following the tragic death of Mr Dickens. As an organisation we have taken a number of actions locally and across the Cygnet Group and continue to keep these under review. Any new operating guidance emerging from NICE or the Royal Colleges, will also remain under review and will be at the heart of best practice in relation to this area.

Yours sincerely

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Chief Executive Officer
Cygnet Social Care