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FAO Ms Tanyka Rawden
HM Senior Coroner for South Yorkshire (West)

South Yorkshire (West) Coroner's Service,
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Sent by Email:
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Our ref: [redacted]

Your ref: TBC

13 August 2024

Death of Maureen Alison Woollen (D.O.B. 24 September 1931, D.O.D. 31 October 2023)
Response to Regulation 28 Report to Prevent Future Deaths

Dear Sirs

We have been asked to assist Sheffcare in relation to the matters of concern raised in the Coroner's Report to Prevent Future Deaths (PFD) dated 19 June 2024 raised under Paragraph 7 of Schedule 5 Coroners and Justice Act 2009. The PFD was addressed to Deerlands Residential Home, 48 Margetson Road, Parson Cross, Sheffield S5 9LS ("Deerlands") which is the address at which Mrs Maureen Woollen was residing when she had an unwitnessed fall on 3rd October 2023. We attach a small bundle of documents which is referred to in this response. For the avoidance of doubt Sheffcare is the company that own Deerlands.

Although we did not represent Sheffcare at the Inquest it is our understanding that the Learned Coroner considered several areas of concern which were: a failure to escalate matters and seek medical advice on 3rd October 2023 and subsequently a care worker noted on 6th October that Mrs Woollen had bruising to her face but did not seek medical advice about this either. There were also concerns about the lack of detailed risk assessment from the outset and that care notes were not completed adequately. Before dealing with the specific concerns, we thought it would be helpful to set out an overview of the current status regarding changes that have been made since the sad death of Mrs Woollen as well as the generic systems that Sheffcare have in place that are relevant.

[redacted] is the new Director of Quality and Care for SheffCare. [redacted] was not in post at the time of Mrs Woollen's fall, but since she took on the role of Director of Quality and Care, has been implementing changes and improvements at the service. She is a senior and very experienced member of the management team at Sheffcare having over 30 years' experience in the private care sector. The service through [redacted] has taken the opportunity to consider wider matters arising from the inquest and although strictly not part of the PFD request, Sheffcare wish to document reassurance that it has

reviewed its relevant policies and guidance including Falls and Risk Assessment and Admission Policy **[see documents 1 and 2]**. There is also stringent auditing at "root" level within the service and detailed reporting to the Board to track incidents and ensure compliance with various relevant regulations **[see documents 3-6]**.

The Learned Coroner is aware that Mrs Woollen was admitted to Deerlands when her previous placement had stated that it could not address all of Maureen's needs. This was after a fall for which she had been treated at hospital. On discharge she was subject to the S2A Pathway. This means that she needed to leave hospital as she was medically fit for discharge but that her initial placement with Sheffcare was for a period of assessment. Assessment of risk is dynamic, and it can take some time for an individual (especially with dementia) to settle in sufficiently for a baseline to be established so that person centred care can be fully implemented.

The relationship between the service provider and the local authority, under the S2A Pathway is important. The Local Authority gleans information from the discharging Trust, and this is what the needs for admission into the private care provider's service is based on. There is therefore significant reliance upon the Local Authority to provide the most up to date information although it is an essential part of the admission that the service conducts its own risk assessment on admission too.

There must be liaison between the service and the local authority to ensure that the service can meet the individual's needs – a decision which needs to be made prior to discharge. It is therefore paramount that all the relevant information is given by the discharge team. A further full assessment must be undertaken by the receiving service to ensure that the risks within that environment are noted and ameliorated.

At a recent meeting between senior members of the management team of Sheffcare and the Local Authority a frank discussion on Risk Management and Incidents was undertaken. The service drew the Local Authority's attention to the following:

- *Forms are often unreadable and filled with high-risk fall indications without detailed explanations.*
- *There's a discrepancy between hospital and care home assessments,*
- *Lack of information about patients' routines and history from the community is problematic.*

A senior member of the team at the Local Authority (RA) confirmed that over the next six months (July to December 2024) *"efforts will focus on improving the S2A pathway, addressing identified issues, and preparing for a new model to be implemented post-April*."

RA also confirmed that comprehensive information from the discharging hospital would be sought to enable better decision making around admission and to inform the risk assessment process.

Finally, RA confirmed that he would be immediately responsible through the "Referral Workstream" for the implementation of a process for completing and transferring fall risk assessments from hospitals to care homes seamlessly.

Whilst these matters are not a direct response to the concerns raised, Sheffcare is concerned to ensure that the Learned Coroner has other pertinent background information to evidence the proactivity and collaboration between the service and the Local Authority with the intention of reducing risk before admission to the service.

It is anticipated that due to this enhanced reporting and more proactive relationship – service users' risk will be assessed more accurately prior to joining the service. This will provide the service with a better understanding of the individual's needs and enable staff to make appropriate provision for admission.

The Registered Manager of the service is then responsible for carrying out a full risk assessment on admission. Staff are subject to training to recognise changes in risk and have clear information of how and when to escalate matters.

Directly after the incident with Mrs Woollen, the service met with staff at Deerland and what is known as "huddles" were carried out **[see document 7].** A huddle is an informal meeting at which matters to celebrate as well as concerns are raised directly with staff. The incident with Mrs Woollen was discussed and staff were reminded of the policies in relation to falls risk, documentation, and escalation it has also been part of their mandatory training and discussed in supervisions. **[see document 8]**.

The importance of maintaining care notes was discussed at the Deputy Managers' meeting on 2 July 2024 **[see document 9]**. Sheffcare already have sophisticated Person-Centred Software, but this does not appear to have been used effectively at the time of Mrs Woollen's care. Sheffcare has now improved the training sessions which already focus on the importance of keeping timely and accurate care notes by incorporating within the existing training real and anonymised scenarios to reinforce to staff understanding. The software includes training around ensuring a falls risk assessment is completed on admission. Falls (witnessed or otherwise) must be documented in the Person-Centred Care system and there is a monitoring and tracking section in the notes. This is audited.

Refresher training has been rolled out at all Sheffcare homes to include the completion of assessments prior to admission to the home and the importance of making detailed Person-Centred Software entries and maintaining daily care notes. The roll out of this refresher training was completed on 31

July 2024. It is now a continuing feature of regular updating training. The training programme is reviewed and reported upon every month. The training matrix is attached **[see document 8]**.

Subsequent to Mrs Woollen's fall, there has also been a complete review spearheaded by Louise of the Quality Assurance Systems for the Person-Centred Care systems which links care plans and risk assessments automatically this is audited **[see document 3]**. There is a three-tier approach to quality auditing headed by the Team Leader, Deputy Manager and Registered Manager who undertake quality audits which then inform the monthly quality dashboard report. **[see document 4]**. There has been further focus on the process at Team Leader level to capture whether falls and requirement for medical attention is being escalated appropriately. The auditing also includes analysis of whether care notes are properly updated. This review was completed on 8 July 2024. In addition, the Registered Manager and Deputy Manager QA now incorporate management checks on the Person-Centred care system and daily care notes are sampled to promote good record-keeping principles. This gives further quality assurance and the end of the roll out of this new part of the services oversight will be completed by 31 August 2024.

The governance of Quality Assurance processes is kept under review by the Executive team and Quality Committee. Reporting at Director level to the Board is in place and includes all areas of risk management. Director home Quality Assurance visits were introduced in May 2024.

A Lessons learned briefing was issued on 21 June 2024 to all homes to ensure that this matter was discussed across all the teams **[see document 10]**.

[redacted]held a Deputy Managers' meeting on 2 July 2024 and issued notes for all the homes to ensure a generic approach and focus on, the process for completing body maps and taking photographs of any injuries or marks. Updated guidance on ensuring correct and robust use of body maps. This was completed on 12 July 2024 **[see document 9]**.

[redacted] met with Care Plan Coordinators on 16 July 2024. The Care Plan Coordinator role and remit is to upload the PCS notes from assessment and ensure that all assessments are undertaken. They support the operational management team in building care plans on PCS and ensure care plans are kept under close review. The meeting focussed on ensuring that falls risk assessments are in place prior to admission or on admission day, along with care plan review processes. [redacted] is undertaking an analysis of PCS falls assessment data, which will provide additional reassurances that all residents have falls risk assessments in place and any additional information around the management of falls is appropriately reviewed. The Initial findings will be presented at the 22 August 2024 Quality Committee meeting, and this will be completed by 31 August 2024.

The admissions policy was reviewed and updated on 1 July 2024 to further outline that falls risk assessment are to be completed prior to or on admission to Sheffcare homes. This will include a

person's falls history and associated risks which could increase the risk of falls along with any falls which occur during the residency within a Sheffcare home.

The falls prevention policy was reviewed and updated 1 July 2024 to reiterate the procedure for completing first aid checks on a fallen resident and referring to medical attention, also to ensure that any injury/injuries are monitored and reviewed within the care notes **[see document 1]**.

The updated admissions policy and falls prevention policy were sent to Registered Managers and Deputy Managers on 1 and 3 July 2024 for them to read and to familiarise themselves with the changes, and to update their staff teams **[see document 9]**.

Unannounced visits have been undertaken by the Head of Quality and Improvement and the Director of Quality and Care provide additional assurances and visibility to the team. Following these visits, a review is being undertaken to include any observations and learning arising.

Increased due diligence of referrals was discussed with managers on 24 July 2024 at the managers' meeting and a frank discussion regarding referrals which arise, with limited information, or areas of assessment which identify possible areas of risk a new due diligence process has been implemented (see comments regarding the Local Authority involvement above).

There is now oversight by the Executive team of any inquests providing further opportunity to undertake thematic reviews that may require additional oversight or action, including any relating to HR, health and safety or financial investment.

Mrs Woollen's case (and the improvements and learning from it) will be discussed on 22 August 24 at the Quality Committee meeting. This will include the outcome of inquest, the PFD, actions put in place and a review of progress. The service has been in direct contact with CQC and updated on all improvements made.

In short there has been a significant overview by Sheffcare in relation to the quality of services, risk assessment and training.

Specific matters of concern from PFD

- **No process in place to ensure medical attention is promptly sought for residents who require it,**

Please see the above regarding the Person-Centred care system. Further, all staff at the service receive basic training in relation to life support and falls management. All staff are aware of how to contact the local GP, when to escalate and when to call 111. Staff are aware that if in doubt then 111 should be called for further advice **[see document 11]**.

That care notes are not fully utilised – especially for recording of injury and incidents.

The Person-Centred Care system as stated above has a section for specific recording of injury and incidents. Staff have received refresher training and there is ongoing audit being undertaken. Please see response above

- **Falls risk assessments are not being conducted on admission.**

A complete risk assessment including falls risk assessment is undertaken by the Registered Manager on admission in accordance with the new policy **[see documents 1 and 2]**. As stated previously, the care notes are subject to spot checks to ensure compliance. In addition to the huddles and cascading of information through managers, this is discussed at staff supervisions.

We do hope that this response will go some way to reassure the Learned Coroner that Sheffcare has taken its responsibilities very seriously. It has been gravely concerned at the issues that were identified by the Learned Coroner and has used this opportunity to undertake a complete review under the supervision of the Director of Quality and Care.

If the Learned Coroner seeks clarification of any of the issues raised, then please contact Sarah Knight ([redacted]).

Yours faithfully

[redacted]

Legal Director
Weightmans LLP