Serencroft

MISS N PERSAUD
HIS MAJESTY'S CORONER
East London Walthamstow Coroner's Court,
Queens Road
Walthamstow, E17 8QP

30th July 2024.

Dear Ms Persaud,

RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

This is Gable Court's response to your report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 10 July 2024, following the tragic death of Richard Fitzgerald on 26th June 2023.

Thank you for your conduct of the inquest and for your identification of a number of matters of concern, which are set out in the Report.

Richards tragic death has had a profound effect on the whole team and our deepest condolences go out to Richard's family.

Richard had resided at Gable Court for eight months and during his initial placement, when he was able to communicate his needs, he expressed that he was very happy with his placement at Gable Court. He had formed many positive relations with his fellow residents, also many staff had a very positive relationship with Richard, and they were extremely fond of Richard. Sadly, his condition deteriorated, and it became more difficult for Richard to express his needs effectively and it became more and more challenging for him. Richard remains very much deep in our thoughts.

As an organisation we will strive in every way to prevent this from happening again.

Action Gable Court took immediately following the incident.

1. Further First aid including Basic life support training has been delivered in house to all staff.

2. Further Dysphasia, Dysphagia and IDDIS training has been delivered in house to all staff. (Since the incident, Gable court staff have had several training sessions on Dysphasia and IDDIS to ensure all staff understand signs and symptoms and know when to escalate any concerns promptly, and to ensure all staff are equipped with the full knowledge and are competent as well a confident in an emergency situation.

3. The Swallowing policy has been reviewed and updated. This has been disseminated to all staff and has been discussed at team meetings and at the daily flash meeting regularly.

4. Staff are briefed daily at handovers on the importance of any high-risk residents.

5. Grab files have been re-issued to all the units.

6. Choking risk assessments have been completed on admission and reviewed monthly for all residents living at Gable Court, as well as when instructed to do so by external professionals or after incidents.

7. A new Clinical support manager has been appointed that is highly experienced to support the home manager.

8. The protocol for the safety of the food trolley has been reviewed. The trolley is not left unattended at any time unless it is in a locked room.

Further improvements we made prior to the hearing on 1st July '24 to mitigate future incidents:

1. A SALT register has been developed and shared with kitchen, including all IDDIS Levels.
2. An Escalation to signpost the management team and leadership team at Gable Court, in particular if they are experiencing challenges with any resident in providing safe care. This includes which professionals should be contacted and involved in the resident's care review. This also includes a risk management plan to support the home in minimising the risk of deterioration in the resident's physical and mental wellbeing.
3. An extra member of staff has been allocated to the ground floor; they will be present during mealtimes to oversee the safety of high-risk residents.
4. Ensure that all care plans are being followed and monitoring this, ensuring that difficulties in following care plans due to Residents' behaviours are fed back to external professionals so that these can be adapted to ensure the Residents are safe and their needs are being met.
5. A Clinical Lead/Unit Manager was appointed to oversee any clinical concerns in all units, care plans, risk assessments and to support staff with all clinical work aspects.
6. Care plans and risk assessments are now more robust and improved to meet individuals care needs.
7. Care plan training both online and face to face has taken place.
8. Gable court to keep the local authorities informed of any changes in resident's care needs.
9. The Pre-admission assessment has been reviewed in ways that Gable court assess new residents to ensure that we can fully meet their care needs before admission, especially around challenging behaviour and appropriateness of the environment.

Matter of concern 1

The Care Home staff were aware that the SALT care plan could not be consistently followed in terms of close supervision, but dld not discuss this with the SALT team to ensure that a contingency care plan could be put into place.

<u>Further action that has been taken since the Inquest</u>

- The Senior management team, alongside a specialist Independent Consultancy team have reviewed every resident care needs, with swallowing difficulties. They have ensured

that a robust risk assessment is in place, that specifically captures any barriers in providing the care that SALT have prescribed. This piece of work has been completed.

- Meetings are taking place with the whole staff team, to share the findings from the Inquest. These have been transparent and used as a learning opportunity for staff to understand, the importance of escalating concerns back to the practitioners that prescribed the resident's care. These meetings will continue over the next couple of weeks, until all staff have been shared lessons learnt. We anticipate that we should have met with all the staff by the end of July '24.
- Clinical review meetings that take place are specifically capturing any difficulties staff are experiencing in delivering safe, effective care and these will be triggered for a re-referral to the relevant professionals. This is an on-going piece of work.

<u>On-going learning</u>

- Clinical review meetings will take place every 2 weeks that will identify all high-risk residents and pick up on any barriers in delivering safe/ effective care. If any concerns are noted these will be escalated to the relevant professional team as well as the funding authority.
- The home has a clinical support manager, and alongside the manager they will oversee all high- risk residents on-going care needs.
- The Clinical lead / or home manager will ensure they are in attendance of any SALT assessments / reviews. If they are not available then it will always be a qualified nurse of senior carer that attends the review, to ensure any changes are flagged immediately to the SALT team.

Matter of concern 2

The risk of Mr Fitzgerald picking up food was known to staff but was not incorporated into the choking risk assessment and risk management plan.

- As mentioned above the SMT alongside an Independent Consultancy team have reviewed all the choking risk assessments, specifically capturing any associated risks.
- The Clinical support manager has met with the senior teams, including nurses, seniors' carers and clinical lead clarifying the importance of capturing all the associated risks.
- We will meet with the whole team and share the findings from this report and go through the risk assessment process, highlighting the importance of staff raising, and documenting all incidents and any concerns with residents. We will complete this by the end of July' 24.

<u>On-going learning</u>

- Clinical review meetings will take place every 2 weeks that will identify all high-risk residents and if any risks are identified. The manager will then ensure, that they allocate the relevant staff member to update any risk assessments and that will be reviewed by the home manager.

- The home manager will update her daily report to the RI and the Quality and Compliance Manager, the Quality & Compliance Manager will then audit that care plan and risk assessment.

Matter of concern 3

The emergency protocol for choking was not followed by staff in attendance on 24 July 2023 (including qualified nursing staff)

- Emergency response training , including First aid and Basic life support training has been delivered to all staff, specifically focusing on choking incidents. This training also included –Basic life support this was delivered on 10th July '24.
- We have made referrals to the NMC for both the qualified staff. One of those staff resigned from her position due to personal reasons. The other member of staff is on bank following their return from maternity leave and we are not currently using her on our bank. A further investigation is taking place and should be completed and concluded by mid - August.
- We have received a decision from NMC in regard to the two referrals that were submitted.
- Nurse EO they have concluded that there are Regulatory concerns that they will be investigating further under RC1: "Failure to respond appropriately to a deteriorating patient – in that you neglected to provide the necessary care to Resident A when you knew he was deteriorating"
- Nurse SA they have considered the fitness to practise concern raised and they have decided we won't be investigating it further at this time.

<u>On going learning</u>

- Regular workshops will take place to further embed all the learning from the training that has been delivered; this will include how to deal with practical situations. This will further empower staff and give them more confidence in dealing with emergency situations.
- Visible posters are available for staff throughout the building.
- Grab files that include how to deal / respond in certain situations will be regularly discussed / shared at team meetings.
- We have liaised with our colleagues from SALT to seek their advice on the use of anti-choking devices. If they feel that it would benefit our service, then we will source appropriate devices and arrange training on the use of these.

Matter of concern 4

The Care Homes investigation lacked thoroughness and professional curiosity.

- It was very clear from receiving the updated bundle, that the situation on the day was chaotic.
- *The senior manager that led on the investigation, is no longer in post she left in late October '23.*
- The Home Manager is also no longer with the organisation
- We have appointed a Consultancy Care Company to support the team at Gable Court, whilst we appoint a suitable new Home Manger.

<u>On-going learning</u>

- Following any significant events, the investigation will be allocated to at least two independent investigators, not from the Care Home involved in the incident. This has been implemented immediately.
- If there are not two Senior Managers available from the group, consideration will be given to outsource the investigation to an independent person not from our group. This has been implemented immediately.
- Once a thorough investigation has been completed, this will be presented and further scrutinised by at least two members of the Board of Directors, to satisfy themselves that a thorough and robust investigation has taken place. This has been implemented immediately.
- Training is being sourced for the Senior Management team on preparing for Coroners inquests, this will further support them in being more thorough in their Investigation skills. This will be completed throughout September.

Once again, we would like to take the opportunity to thank you for highlighting these matters of concern, and for giving us the opportunity to respond. We will continue to work with SALT and the Local Authority to make sure we have robust risk assessments and care plans in delivering safe effective care to vulnerable people with swallowing difficulties who are at risk of choking.

Yours sincerely

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[redacted]