Monarch Healthcare

To: Mr. Steve Eccleston.

Office of HM Coroner
The Medico-Legal Centre
Watery Street
Sheffield S3 7ES

Regulation 28 Report To Prevent Future Deaths

Date of Response: 14th August 2024

1. Background

Following receipt of the Coroner's Inquest into the death of Mrs Mavis Dewey, we acknowledge and respect the medical cause of death, reported by Steve Eccleston H.M. Assistant Coroner for South Yorkshire (west) as follows:

- 1a Multi organ failure
- 1b Covid 19 and open fracture of right proximal tibia and fibula
- II Alzheimer's Disease, Heart Failure

As stated in evidence, Monarch Healthcare (HB) Ltd accept the fact a carer directly employed at Heeley Bank Care Home, and another carer regularly retained through the agency, neglected to follow direct instructions clearly stated in Mrs Mavis Dewey's care plan and culminating in her untimely death.

As also stated in evidence all staff, including regularly retained agency staff receive moving and handling training and undergo practical assessment to ensure they are competent to carry out moving and handling procedures. This training and assessment includes where to find the information relating to a resident's care needs.

It was confirmed the 2 carers cited had received their training and assessment as follows:

Carer 1 (employed by Heeley Bank Care Home) received Moving and Handling training with sign off of practical assessment on 24/01/2024. She was due for her 3 month competency assessment on 24/04/2024.

Carer 2 (retained by agency agreement) received Moving and Handling training with sign off for practical assessment on 25/10/2023 and further competency assessment signed for on 06/02/2024

The above detail was taken from the home's training matrix at the time of the investigation following Mrs Dewey's fall. Monarch Healthcare (HB) Ltd believes appropriate instruction and assessment was in place and the accident occurred because the carers failed to adhere to the care plan and failed to carry out correct

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moving and handling techniques. Mrs Dewey's care plan clearly stated a stand aid should be used to assist her to stand and further stated that a walking frame must not be used. The appropriate stand aid was available in Mrs Dewey's ensuite bathroom at the time it was required for use.

Following the accident, immediate action was taken to suspend both carers, removing them from the home. Appropriate HR procedures followed and neither carer returned to work at Heeley Bank Care Home , or for any other Monarch Healthcare Service.

A referral to the Disclosure and Barring Service (DBS) was submitted for carer 1 and a request to the agency for carer 2 to undergo similar proceedings and to also be referred to the DBS.

Evidence during the inquest raised concern to the Coroner in respect of agency workers not always reading residents' care plans.

An explanation for this is that care plans are often lengthy and detailed documents. An agency carer may be allocated to support a number of residents during the working shift. It would not be possible for them to read and remember the entire care plan for all residents they are expected to interact with and to provide support for. We recognise this is a risk to residents if staff are not fully aware of a person's specific needs.

2. Risk Mitigation

To mitigate this accepted risk the following processes were already in place for agency workers, (and regularly employed staff) prior to 23rd March 2024:

- Working with a preferred and limited number of agencies.
- Obtaining profiles for all agency workers and checking NMC PIN, references, DBS and training status, prior to accepting and commencing the shift.
- Requesting agency workers who have worked in the home previously and who are reported as knowledgeable and competent.
- Completing an Induction to ensure the agency worker is familiar with the building, fire safety and infection control procedures; also the correct use of the systems for safe medication administration and care plans.
- Allocation of agency staff to work with an experienced member of the team for guidance.
- Access to Monarch Healthcare's suite of training and competency assessments for regular agency workers retained and working to Heeley Banks staff rota.
- Summary Care Plans are available to all staff via hand-held mobile point of care devices.
- Summary Care Plans are available to all staff via electronic tablet devices located around the home (larger viewing platform).
- Full Care Files are available to all staff via the nurses' laptops.
- Handover Form – The document includes a photo of the resident, their room number and key identifiable information, including their diagnoses and care needs. The Handover Form also includes information about a resident's recent presentation to impart between shifts.
- Manager walkarounds to monitor and complete spot checks.
- Regional Manager visits and clinical oversight. (Visits were increased to minimum 3 days/week from January 2024 in conjunction with support from Sheffield Council and ICB.
- Adhoc viewing of CCTV following a fall in a communal area, to establish cause and assess likelihood of injury. Please note, this is in addition and does not replace the nurse examination or protocol for actions to be taken following a fall.

The above actions have been reviewed and are confirmed as embedded into practice as of the date of this report.

Despite the above procedures in place and both carers having received training and confirming they were familiar with Mrs Dewey's moving and handling care plan, they chose not to follow it, for reasons we were unable to fully establish during the pursuing investigation. For this reason the carer employed directly by Monarch Healthcare was referred to the DBS as unsafe to continue practicing. A request was also made to the agency for similar proceedings to take place.

3. Actions Implemented

Following Mrs Dewey's accident and subsequent investigation, we implemented additional processes between 23rd March and 1st June 2024, for all staff:

- Key Care Plan details transferred to individual posters for display in residents' bedrooms (on inside of wardrobe door to maintain GDPR regulations for sensitive information).
- Key Care Plan details transferred to 'key chains', issued to all staff on shift for easy reference and planning of residents' care.
- Reading out and reiterating each resident's diagnoses and referencing key care and clinical needs, including their moving and handling requirements, the equipment to be used (and not used), number of staff and reminder of risks.
- Implementation of the Daily Clinical Oversight Form and increased management spot checks, to report to Sheffield Council and ICB.
- Appointment of 2 Clinical Leads to provide guidance to the care and nursing teams and to complete clinical governance and the Daily Clinical Oversight form.

The above actions have been reviewed and are embedded into practice as of the date of this report.

4. Further Actions to Prevent Future Deaths

Following the Coroner's Inquest on 7th August 2024, we further reviewed risks and are in the process of implementing the following:

- A review and implementation of a new Clinical Oversight form to further breakdown observations of moving and handling practice, to ensure robust recording of the observation.
- Regular observation of the CCTV to monitor staff carrying out moving and handling procedures in communal areas, when they are not aware they are being watched. Trainers also have access to CCTV footage to support completion of training needs analysis.
- Implementation of routine audit for checking residents' bedrooms to ensure all required equipment is in place and no surplus equipment is in the room.
- All staff to sign attendance to the handover meeting, as indicated on the handover form.

The timeframe for implementation of the above actions is 31st August 2024.

The timeframe for review of the above actions is 30th September 2024

We deeply regret the accident and tragic consequences for Mavis and her family. Mavis was a much-loved resident of Heeley Bank Care Home. She was a larger-than-life character known to all the team, as well as to Senior Management and other visiting Monarch employees and external professionals. We miss her banter, her expressions and most of all her affection for everyone who cared for her. We again express our sincere apologies to Mavis' family for failing Mavis and for the loss of their trust.

We wish to reassure all reading this report that we have reviewed our policies and procedures in depth and also sought and acted upon advice and guidance from various professionals, and continue to do so.

The above response to the Regulation 28 Prevention of Future Death Report is an accurate and true account to the best of my knowledge.

Signed: [redacted] Date: 28th August 2024.

Managing Director Monarch Care Group, on behalf Heeley Bank Care Home