Regulation 28 – Report to Prevent Future Deaths

Ref: Mr John Francis Howlett – deceased 31st January 2024

Response from The Lakes Care Centre

Narrative:

The Lakes Care Centre, at the time of the incident and when Mr Howlett was admitted and resided, was under the control and management of The Lakes Care Centre Limited. We were registered with CQC for Nursing, Residential and Residential with Dementia.

Mr Howlett was supported on our Nursing Unit – Derwent. As reported previously in our Report to Coroners Court 15th Jul 2024 which outlined the challenges, we encountered operating and managing a Nursing Service at The Lakes Care Centre.

We have since de-registered with CQC for Nursing Services. In addition, since September 2024 we have now managed to secure a full operational management team with both experience and qualifications to enable The Lakes to create reasonable, time focused and effective Action Plans for Improvement.

We have achieved this by welcoming in the Local Authority Quality Improvement Team. They have undertaken a Quality Audit (Sep 24). This was in line with CQC style inspection and covered every aspect of the services we provide.

The outcome of which is closer working relationships with the Local Authority Contract Compliance Teams, Quality Improvement Team and local NHS ICB.

The new Manager and myself have been busy implementing changes to our in-house recording systems and care monitoring systems to ensure we identify and action any changes in residents' welfare and health at the earliest opportunity.

We had also identified the dual GP services we used were not working well or indeed in partnership with The Lakes. This resulted in little or poor support on matters such as nutrition management and identification of any appropriate health care planning to support our residents.

In November 2024 a new single GP service has been commissioned and we hope this will improve communication and clinical observation of our residents including weekly 'ward rounds' to identify early sign of improvement or deterioration in their health.

In addition to our internal improvement plans we have been working with the MAC Process (Multi Agency Concern) panel made up of professionals form a broad spectrum of disciplines. We meet monthly to review and assess progress to our improvement goals.

This is now showing major improvement in managing and providing good outcomes for our residents whilst looking at a process of continue improvement through regular care reviews, incident reviews and referral on to appropriate services for support in providing a timely and safer and more effective service to our residents.

We monitor and respond to Service User Feedback, Relatives/Visitor feedback and professional feedback both positive and negative.

All of the above has seen a reduction in the levels of concern raised about our services, improvement in outcomes for our residents and a more robust and systematic approach to reviewing, learning and improving.

To expand on what we have undertaken so far:

a) Started all training from 'scratch' to ensure all employees get the same level and undertraining of what is required in all care and health matters. This is via Team meetings, individual 1:1 sessions, E Learning and Face to Face training.
b) We are introducing (Sep 24) a new E Learning platform which enables employees to access mandatory and developmental learning with associated policy and procedures attached as part of that learning. It also provides much better visibility of employee learning progress and prompts employees and managers of the expectations in a timely manner to maximise attendance and outcomes.
c) The New Management Structure is working closely with senior carers about the ability of the Digital Care Record to assist in ensuring Residents Well Being and the Hydration Chart is a good example of this.
d) All Senior carers are now using our Digital Care Record daily to monitor and use the Hydration Tracker to identify any shortfalls or concerns about resident's intake of fluids. This is then escalated and remedial actions identified and delivered.

e) We have begun to nurture again our relationship with the local Infection Prevention Teams and Contract Monitoring Teams to 'move' forward on our performance on a day-to-day basis and improve the quality of care and support and outcomes for our residents.
f) Reduce our reliance on 'agency staff' to a level that is lower than at the time of this residents stay. This helps us be confident in our employees/workers skills and performance. In addition, we have more day-to-day confidence that our employees are following our Core Values in everyday practice.
g) Improve employee morale with clearer direction and support to get things right first time. Feedback from employees has been excellent since we took over and they are saying they feel more supported and valued as a team. This is an ongoing management focus.
h) Improve resident and family feedback. From some initial surveys and face to face meetings, the feedback we are getting is that our service is more welcoming, and more caring. The facilities are described as outstanding and very homely.

Therefore, given all of the above, we hope this helps you understand the progressive steps we have made since the sad death of Mr Howlett and how we understand the need for clear and effective care/support to ensure the safety and well-being of all our residents in their time of need.

[redacted]

Response written by: [redacted]
Operations Director and Nominated individual (CQC)

On behalf of The lakes Care Centre Limited.