DARNALL GRANGE NURSING HOME

84 Poole Road, Sheffield, S9 4JQ

Tel [REDACTED] Email: [REDACTED]

24th October 2024

Tanyka Rawden
Senior Coroner - South Yorkshire West
Office of H.M Coroner
The Medico-Legal Centre
Watery Street
Sheffield
S3 7ES

REF: Darnall Grange Care Home – The Late Christina Betty Dawson

Dear Mrs Rawden,

I write to provide a copy of the report produced by our company in response to your letter dated 16th October 2024.

We have reviewed your findings and provide a response and actions. We have also provided this to CQC and our Local Authority.

We believe this addresses all the points highlighted by yourself as well as trying to clarify inaccuracies by third parties. We have included documentation including the original MAR Charts received every month, agency nurse induction which has been updated to include istumble and post fall protocol. If you would like a copy of the nurse/team leader attendance sheet this can be provided if required. There are only 2 members of the senior staff team that have not had the revised training session as they were both off sick and will have the training prior to them commencing back at work.

If you have any further questions about the response, please do not hesitate to contact me.

Yours Sincerely

[REDACTED]

[REDACTED]
Registered Manager
Darnall Grange Care Home

Summary and Approach of our actions

The coroner commented that the care plan provided did not pre date the homes electronic system. This was available as we do store our paper documents for 6 years. For the analysis we have carried out we have used the time period that the coroner reviewed.

Our analysis included looking at the following key areas such as fall prevention measures, equipment used, risk assessments completed and actions taken, review of the fall in terms of timings, locations, environment, whether it was witnessed, the outcome of each fall. We looked at medication management and communication between the GP practice and the home and the pharmacy. We reviewed the orientation of agency staff and their knowledge of our procedures and how they were trained and what information we hold on each member of staff.

ROOT CAUSE ANALYSIS

FALL PREVENTION MEASURES

1. *Why weren't further measures taken to reduce the person's risk of further falls?*

The falls that occurred from 30/03/2022 to the last fall 16/03/2024:

We have reviewed the post falls information, the accident forms filled in at the time of the incident, the analysis carried out by the home manager and the revisited falls risk assessment.

It can be seen that prior to the first fall on the 30/3/2022 that the equipment in place was the ultra low electric hospital bed, a pressure sensor alert mat, a de cluttered bedroom as Christina mobilised with a zimmer frame which was always kept in close proximity.

The corridors and lounges also are free of clutter and equipment wherever possible as we are aware of our client group being wondersome.

The issue raised by the coroner was that the post falls review carried out by the manager did not clarify if any further steps or equipment could be put in place. Looking at the equipment in place and the review that was carried out we feel no enhancements could be utilised to prevent the risk of falls, but we acknowledge that the review should have clearly stated that fact. This is a review point and action going forward.

The equipment that was in place and also the zimmer frame were reviewed by the OT and deemed to be appropriate at the time.

On reviewing the falls analysis, it can be seen that 7 out of 10 incidents did occur in Christina bedroom and the equipment in place was functioning and helped to mitigate the risk of serious injury. The only real method of prevention of the falls would have been to have 1-1 carers present which was not available due to her being a residentially funded client.

The second part of the review post falls looked at the action of the staff at the time which showed they did follow the Company falls protocol, seeking external medical intervention and carried out neuro observations as per the policy.

On 10/01/2024, due to the volume of falls over the previous 12 months, the OT visited upon the request of management team, to carry out an assessment. The OT assessed both Christina's mobility using her walking aid/zimmer frame as well as the environment and the equipment put in place in her room. The outcome of the review was to carry on care as planned with no recommendations to changes in the equipment of which if there was the home would have acted immediately.

The GP has visited on numerous times, all the reviews had no highlighted changes in strategy.

The final fall, which was the second fall of the day on 16/03/2024, was an unwitnessed fall in front of Christina's bedroom, on the corridor, at 21:30hrs. She was walking at the time with her walking aid. At 21:24hrs, she was in the lounge with members of staff who tried to encourage her to allow them to get her ready for bed, which she refused and then left the lounge area and started to walk down the main corridor which was normal for Christina. She fell prior to getting into her room and the staff responded immediately and took the correct course of action by alerting the nurse. The nurse has stated that Christina was trying to mobilise herself and trying to crawl. The Company's policy which we have enclosed and "I STUMBLE", a falls assessment tool clearly states that in all 999 cases residents should be kept calm, still and comfortable and also on the post falls decision making tool within our policy it clearly states under major injury highlighted in RED that patients should not be lifted but kept comfortable and maintain their position wherever possible.

These supporting documents along with our own falls management procedures make it clear that the nurse did not follow our procedures. The nurse involved no longer works for the agency as she has emigrated to Australia, but the agency has been informed in writing and provided with a copy of our very clear procedures and the need for these to be passed onto all future nurses that may work at Darnall Grange. As part of the agency induction sheet a post falls decision making tool and "I STUMBLE" a falls assessment tool are given to and signed for by ALL agency workers.

The management of Darnall Grange are having face to face meetings with Team Leaders and Nurses highlighting the Company's procedures and policies on falls to

mitigate the risk of causing further injury after sustaining a serious injury.

Conclusion:-

It was acknowledged by the Coroner that the falls risk assessment had been reviewed after every fall, however the Coroner made a comment that these reviews did not result in any change being made. The post falls monitoring had been carried out by the staff. The company's policy and procedures on seeking guidance from external health professionals including GP, OT and ECP had all being followed. The equipment provided and the environment as assessed by the OT were deemed correct, but we acknowledge with the coroner the post falls analysis and risk assessments should have been made more robust making it clearer if other equipment could have been provided and if not to state to that affect.

The second point of action in relation to our falls/procedures/policies, the agency nurse induction clearly has copies of our documentation prior to their commencing their first shift. This is signed for by the agency member of staff and the inductee.

Our own staff including both nurses/team leaders and senior carers are having face to face meetings and will conclude by the 30th of October 2024. They have been already made aware of the policy, but the meetings are to reinforce the policy and also to get a signed confirmation that they understand the strategy.

NEEDS ASSESSMENT REVIEWS

2. *Why was the person re-admitted to the home if you could not meet their needs?*

Darnall Grange is a dual registered residential and nursing home. There are trained staff present on both floors 24 hours a day.

The issue raised by the Coroner regarding applying for nursing care and our ability of meeting Christina's needs: Christina had her bedroom on the first floor and had her care led by a team leader. The management team felt that Christina would be best placed, due to her care needs not just for falls, downstairs in the nursing unit. This does not retract from the fact that a qualified nurse does work upstairs and has oversight of the residents, but the care is led by the team leader for residential service users.

The manager requested a DST to be completed while Christina was in hospital, so she could return to the ground floor, so the home could provide nursing care.

The manager carried out a face-to-face review prior to the re-admission. This confirmed we could meet her needs in the residential unit but would be better suited on the ground floor.

The manager upon the request of the family directly, did accept her back with the

residential status, as he had done face to face review with Christina in hospital and felt he could meet the care needs.

The manager at the time when he was questioned by the Coroner, was emphasising Christina's deterioration and her increased care needs, which he felt met the criteria for nursing. The assessment carried out by the hospital by 3 independent assessors did not agree hence Christina's' needs were still classified as residential when she left hospital.

Sheffield, like many other local authorities, uses the trusted assessor model, but despite this, the manager still carried out a face-to-face review prior to Christina coming back, as a best practice. This review is documented within her care plan.

Following Christina's return to Darnall Grange care home as with all residents, the care needs are reviewed on a monthly basis and only on January 2024 did these needs deteriorate to a level where a DST was requested again.

In summary, yes, the home manager did feel at the time she was in hospital, Christina had nursing needs, but after the assessments by three health professionals, this was not supported by them and they felt she had residential needs.

If Christina had been assessed as nursing and returned to the ground floor, would have this prevented the falls? The answer is no, as the same equipment, environment and staffing levels will be present.

The staffing level at Darnall Grange are two qualified nurse 24 hours a day and a further qualified nurse within daytime. There are 11-day carers within the home during the day and 5 at night time.

The Manager does understand his obligation to meet resident needs, and it clearly can be evidenced that he has refused residents to be re-admitted when he has felt he couldn't meet the needs. He did feel he could meet the needs for Christina's but felt that some of those needs met the nursing criteria which is very common on the grey area with assessment.

Conclusion:-

The conclusion is the home could meet Christina's needs and the impact of being returned to the residential unit on the first floor had no impact on the likelihood of her falls continuing.

MEDICATION MANAGEMENT & SYSTEMS

3. *Why the person's anti-coagulation medicine continued after it had been*

stopped by the GP?

On 03/01/2024, the GP did carry out out a falls review for Christina which was requested by the Home because of the high level of falls. The GP that visited was a locum GP, he stated at the time that he did not have a laptop, and he would return to the practice and review the medical notes and make any medical changes he saw fit and would directly inform the home with these changes.

At no point did the GP nor the Surgery or Pharmacy contact us with any medication changes.
Therefore we were not able to make any changes, and the medication regime continued.

The repeat medication was delivered by the Pharmacy at the end of January 2024 as per normal with all the medication present, no changes at all.

On the attendance of paramedics on 13/02/2024 following a fall, the paramedics informed us that the GP had discontinued the anti-coagulant medication- Edoxaban 30mg on 03/01/2024.

We, ourselves checked SystemOne and could verify that SystemOne did state the change of medication. The issues raised are that there was no GP contact to the home and the MAR sheets remained unchanged for the months up until March 2024. This is evidenced by a copy of the original MARS sent to us on January, February and March 2024(please see attached).

The SystemOne does show that medication has been stopped, but we have limited access to SystemOne except for requesting medication, not adding or omitting medication as this can only be done by the GP or hospital staff.

The medication was stopped by us on the 13/02/2024 following the fall, when the paramedics informed us.

Up until 13/02/2024 we had no direction to stop the medication. The new MARS were issued with all medication on them even up to an including March 2024.

This was all reported to the Safeguarding at the time with the evidence as why we did not cease the medication, and the matter was closed.

On the 24/01/2024, there was a number of medications reviewed that resulted in a number being stopped as listed: CalciD3, Cetirizine 1mg/1ml, Lansoprazole 30mg, Memantine 20mg, Mirtazapine 45mg. These were stopped immediately as per the GPs request.

The letter provided by the GP practice to the Coroner, was identified by the Coroner as not being accurate, as it wrongly states that the Home was told by DR. Rehan on

the 03/01/2024 to stop the anti-coagulant, but in reality, this was not done.

The second inaccuracy is that it states that on 24/02/2024 DR. Abdula re-confirmed that the anti-coagulant medication should be stopped. This is inaccurate, as on 24/01/2024, Dr. Abdula only gave the instruction to stop the medicines mentioned above, which we carried out and it's evidenced by SystemOne.

Conclusion:-
In conclusion, the medication was not stopped on the prescribing portal on SystemOne, and the GP did not instruct the home to stop the medication, as it continued to be prescribed and dispensed. The inaccuracy by the Surgery on the information given to the coroner regarding Dr Abdullah visit on the 24/1/2024 was not factual as the review did not include the Edoxaban.

Going forward, SystemOne is now utilised as the ordering and checking system so that we check the dispensed medication on a monthly basis as we receive it with SystemOne notes of discontinued medication.

Historically, the Home had a large numbers of locums covering our home. This has been highlighted in many meetings with the CCG and GP practice, but we are now allocated our own GP, and we can see improvements.

In relation to the permanent GP being in post, we also have direct access with the community OT who visits the Home weekly, and we are carrying out two residents reviews per week.

AGENCY STAFF SKILLS AND KNOWLEDGE

4. *What actions have we taken to ensure agency staff have the right skills and knowledge?*

The utilisation of agency staff is kept to a minimum as we now have our full-time nurses in post.
In relation to our care assistants, there has been staff that had meetings with management. We have enforced the policy that if a resident had a fall, they are not to be moved until they have had a clinical assessment.

With regards of our own nurses, meetings are being held commencing 21/10/2024-30/10/2024 to reinforce our policy and procedures on falls and obtain written confirmation they have had this training.

The nurse involved in Christina's incident, who wrongly allowed her to be moved to her bed, no longer works for the Agency as she emigrated to Australia, therefore we had no opportunity to give her feedback.

We have had a meeting with our Agency provider, giving them our policy, procedures

and protocols. The Agency provides full training, and they are invited to our training sessions and meetings. The Agency provides a full staff profile with the training and induction completed.

A comprehensive induction(see attached) and orientation is provided to every new agency nurse which includes a copy of “I STUMBLE” and post fall decision making tool(see attached).

SUMMARY OF ACTIONS TAKEN QQ01

Action Area:			
Details of Action Required	**Who is responsible for action**	**When to be completed by**	**Update on Progress & Date Completed**
Use System One to check there are no changes in medication and that the MAR charts provided match SystemOne	MANAGER	ONGOING	This has been done and completed and access to SystemOne is available for Darnall Grange and the system is being used to check the delivered medication on the monthly dispensing.
The falls risk assessment carried out post falls should clearly identify equipment in place pre fall and any additional equipment that could be supplied to mitigate risk further. If the equipment pre fall cannot be improved this must be clearly identified and highlighted in the review.	MANAGER	21/10/2024-30/10/2024	
Staff Meeting scheduled for Darnall Grange Nurses from 21/10/2024-30/10/2024 to re-enforce the policy of not moving a service user post fall until clinical assessments have been done.	MANAGER	ONGOING	This forms part of our training and induction process.
Inform the agency of the outcomes and make them aware of the breach of our company policy with regards to moving a service user after a fall.	MANAGER	30/10/2024	Completed and Manager Ali Akbar informed the Agency Concerned.
The induction checklist for agency workers has been updated to include the protocol on falls and we have included the "I STUMBLE" protocol and post falls decision making tool. We also hold staff profiles for each agency member staff provided where we are able to see their skills.	HERMES COMPLIANCE TEAM	ONGOING	This is ongoing as all new agency members of staff will be supported pre shift. All existing agency staff are attending our staff sessions by 30/10/2024

Yours faithfully,

Nadim Admani

Director
Darnall Grange Care Home
S&S Healthcare Ltd part of Hermes Care Ltd