Regulation 28 Report To Prevent Future Deaths

Response to Coroners Concerns into the death of Mr Peter Mark Good who passed away on 9th January 2024 at Stepping Hill Hospital, Stockport.

Background

Harbour Healthcare is a family run care provider established in 2012.
Hilltop Hall is owned and operated by Harbour Healthcare, it is a nursing home offering nursing care for up to 56 residents with a current occupancy of 26. Our philosophy is quite simple, we strive to provide an excellent standard of care to our residents, treating them with complete dignity and respect. We like to call it, simply good care.

Circumstances Of The Death

Mr Good was a resident at Hilltop Hall Nursing Home. He was nursed in bed as a result of complex care needs arising particularly from a previous cerebral infraction.

On 26th December 2023, Mr Good was admitted to Stepping Hill Hospital, Stockport with a blocked gastronomy tube.

Despite treatment with antibiotics, Mr Good deteriorated further whilst in hospital and died on 9th January 2024.

A postmortem examination determined Mr Good died as a consequence of:

a) Pneumonia;
b) Cerebral Infarction, Parkinson's disease and skin ulceration

Coroners Conclusion

At the conclusion of the inquest, the coroner recorded a narrative conclusion *"to the effect that Mr Good died as a consequence of complications arising from a previous cerebral infarction, Parkinson's disease and skin ulceration which had significantly deteriorated whilst at the nursing home from which he was admitted to hospital for the final time."*

Coroner's Concerns

1. "The court heard evidence that a safeguarding alert was raised by nursing staff at Stepping Hill Hospital shortly after admission on the basis that Mr Good appeared to them very dirty and unkempt with some of his wounds looking and smelling infected."

2. "It was further suggested that on admission, Mr Good was noted to exhibit poor oral hygiene, with calculus-covered teeth which the hospital safeguarding nurse regarded as indicative of prolonged neglect."
3. "Whilst the Nursing Home's Deputy Manager gave evidence to the effect that she did not recognise this description of Mr Good, she accepted that she had last provided care to him several weeks prior to the admission to hospital."
4. "I am concerned in light of this description that Harbour Healthcare as the owner and operator of Hilltop Hall has not instigated its own investigation into the way which Mr Good was cared for, with a view to considering any ongoing risk of harm to other residents and whether any learning can be derived for staff and managers"

Response to Concern 1

"The court heard evidence that a safeguarding alert was raised by nursing staff at Stepping Hill Hospital shortly after admission on the basis that Mr Good appeared to them very dirty and unkempt with some of his wounds looking and smelling infected."

A full investigation has been carried out into the Coroner's concerns. This included taking statements from those present who denied that he left the home appearing dirty and unkempt.

Mr Good was admitted to the home on the 19 October 2023. He was classed as requiring end of life care on admission. He resided at Hilltop Hall for nine weeks and five days.

The PCS system records indicate that all care was delivered. He received a bed bath on 23 December 2023 and a shave. On 24 December 2023 he received a wash. On 25 December 2023 he received a wash and a shave. His skin integrity was checked and creams were applied in accordance with his care plan. The records also indicate that regular repositioning was in place and Mr Good had regular checks by the appointed GP who attended the ward on a weekly basis.

A specialist tissue viability nurse was also involved in his care and the ungradeable pressure ulcers to both of his heels were checked regularly. He had his feet elevated and wore repose pressure boots and used an air flow mattress with four hourly pressure relief. Feet dressings were changed every day as required. Appropriate notifications were made to CQC and the local authority about the ungradeable pressure ulcers. Harbour Healthcare is assured that the procedures regarding assessing, treating and monitoring wounds at the home were in place and were being followed.

The records confirmed that there were up to date wound charts identifying all areas affected and the types of wounds affecting Mr Good who came into the service with these wounds. There was full body mapping in place for each wound. There was a specific care plan in place for new developing blisters and oedema and Mr Good's treatment of these wounds was monitored by the GP.

At the time of the transfer to hospital, Mr Good did have an infected wound and had been visited by the GP in order to provide appropriate treatment. He also had a UTI at the time of admission which was being treated. He was prescribed antibiotics from 20 December 2023. It is likely that this is what the hospital staff are referring to.

The paramedics attending and transferring Mr Good to hospital on 26 December 2023 did not raise concerns about him being dirty and unkempt or about any odour from infected wounds.

Actions Taken

a The records have limited free flow of narrative by care staff – personalised entries would be more beneficial to provide further description and observations. **Introduced** This information has been shared across the company to promote best practice and mitigate risk. Introduced via a Harbour Healthcare Bulletin circulated to all Care Home Managers and Regional teams on the 19/2/25 **requesting immediate compliance.** This will be monitored by the Regional Operations and Care Quality Compliance teams going forward.

b The records confirm that the range of care needs required by Mr Good were in place. There were already systems in place to monitor pressure care and the general presentation of service users. The management teal m held weekly ward rounds with the GP and carried out clinical risk meetings. There was evidence of appropriate referrals to other professionals when required. What is not clear from the records is the general condition of Mr Good and his appearance/ presentation, this must be introduced to ensure a more personalised view of the resident is in place. **Introduced**. This information has been shared across the company to promote best practice and mitigate risk. Introduced via a Harbour Healthcare Bulletin circulated to all Care Home Managers and Regional teams on the 19/2/25 requesting immediate compliance This will be monitored by the Regional Operations and Care Quality Compliance teams going forward.

c The Hospital transfer documentation must be completed on the hospital transfer document on PCS and copied to the resident file on every resident's admission to hospital with all areas of the hospital transfer sheet completed, including a full body map. A verbal handover to paramedics is insufficient. This information has been shared across the company to promote best practice and mitigate risk. **Introduced** via a Harbour Healthcare Bulletin circulated to all Care Home Managers and Regional teams on the 19/2/25 requesting immediate compliance. This will be monitored by the Regional Operations and Care Quality teams going forward.

Response to Concern 2

"It was further suggested that on admission, Mr Good was noted to exhibit poor oral hygiene, with calculus-covered teeth which the hospital safeguarding nurse regarded as indicative of prolonged neglect."

A full investigation has now been conducted.

The investigation found that the records confirm that oral hygiene needs were carried out every day. It is noted that mouth care was being carried out during the early hours of the morning and the staff explained this as being due to Mr Good's salivation and the need to protect his facial skin and his neck in order to make him comfortable.

It is unclear whether the calculus to Mr Good's teeth was present before admission to Hilltop Hall on 19 October 2023. If it was, oral hygiene and brushing would not have removed the calculus. Mr Good was receiving end of life care from admission and given his presenting physical condition there were no arrangements in place for dental appointments.

We apologise that there was no oral hygiene care plan in place. An assessment was completed and the information was recorded on the End of Life care plan instead.

Actions Taken

a) There was no oral hygiene care plan - the oral hygiene care assessment was completed but this was not linked to a full care plan. This is recorded on the End-of-life care plan; however, a full oral hygiene care plan should have been in place. This information has been shared across the company to promote best practice and mitigate risk. Introduced via a Harbour Healthcare Bulletin circulated to all Care Home Managers and Regional teams on the 19/2/25 **requesting immediate compliance**. This will be monitored by the Regional Operations and Care Quality Compliance teams going forward

Response to Concern 3

"Whilst the Nursing Home's Deputy Manager gave evidence to the effect that she did not recognise this description of Mr Good, she accepted that she had last provided care to him several weeks prior to the admission to hospital."

We apologise that a member of the senior management team was not present at this inquest to support the deputy manager's evidence.

We also apologise that a full root cause investigation had not been carried out prior to the inquest to enable us to respond from an informed position.

Actions Taken

a) A member of the Senior management must and will attend and support our team members at all Coroner court hearings – This information has been shared across the company to raise awareness, promote best practice and mitigate risk. This information has been shared via a Bulletin to all home management teams, regional support teams and the Senior leaders for information
b) Harbour Healthcare will in future always consider legal representation at Coroners court moving forward to ensure our team member are appropriately supported and represented.
c) In all deaths that are referred to the coroner, Harbour Healthcare will complete a root course analysis, a full investigation and complete a candid lessons learnt. This information has been shared across the company to promote best practice and mitigate risk. This information has been shared via a Bulletin to all home management teams, regional support teams and the Senior leadership team on the 19/2/25. This will be monitored by the Director of Strategic Risk, Safeguarding & Regulation.

Response to Concern 4

"I am concerned in light of this description that Harbour Healthcare as the owner and operator of Hilltop Hall has not instigated its own investigation into the way which Mr Good was cared for, with a

view to considering any ongoing risk of harm to other residents and whether any learning can be derived for staff and managers"

We apologise sincerely for not conducting a full investigation prior to the inquest.

As Mr Good died in hospital, it would not be our usual practice to conduct an internal investigation unless there was reason to. We were not notified of the safeguarding referral until the Inquest. Furthermore, he was receiving End of Life care and his death was expected.

This has now been conducted and we have taken steps to ensure that it will not happen again.

Actions

a) In all deaths that are referred to the coroner, Harbour Healthcare will complete a root course analysis, a full investigation and complete a candid lessons learnt. This information has been shared across the company to promote best practice and mitigate risk. This information has been shared via a Bulletin to all home management teams, regional support teams and the Senior leadership team on the 19/2/25. This will be monitored by the Director of Strategic Risk, Safeguarding & Regulation.
b) To ensure lessons are being learned more widely the Reg 28 Notice and responses have been shared across Harbour Healthcare Care Homes with a view to ensuring each of our homes benchmark themselves against the actions identified and that Regional Operations and Care Quality compliance teams monitor these to ensure compliance and evidence of lessons learned. This information has been shared across the company to promote best practice and mitigate risk. Introduced via a Harbour Healthcare Bulletin circulated to all Care Home Managers and Regional teams on the 19/2/25 requesting immediate compliance. This will be monitored by the Director of Strategic Risk, Safeguarding and Regulation.

Conclusion

We would like to take this opportunity to offer our sincere condolences to the family of Mr Good on his passing.

We apologise sincerely for our failure to conduct a robust investigation prior to the Inquest. Had this happened we would have been in a position to respond appropriately during the Inquest and provide the necessary records and information to the Coroner. Action has been taken to ensure that this does not happen again.

We believe the above response addresses all the points highlighted by the Coroner through the Regulation 28 report. Our investigations have led to relevant improvements being made to our processes to ensure our service users are protected from the potential risk of harm and that we are more actively involved in Coronial proceedings moving forwards to aid the investigation process.

Should the Coroner require any further information about the investigation that has taken place, including supporting evidence, please do not hesitate to contact us.