National Care Group

Issue 1

#LEARNING TOGETHER

Lessons Learnt Update

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Passion I Empowerment I Respect I Collaboration

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Purpose of Briefing

This briefing summarises a number of internal and external incidents which services should take note of, reflect the likelihood of this occurring in their service, and share learning with colleagues.

National Care Group prides itself on having a learning culture rather than one of blame, you must also be able to evidence a culture which shows reflective practice being embedded.

This briefing should be shared widely with all colleagues and evidenced that it has been discussed within team meetings.

People We Support

The following represents the key learning issues arising from reported incidents that have occurred across National Care Group from October 2020 to March 2022.

1) **Missed medication** is a reoccurring theme locally and nationally, mainly in supported living services but also in some residential services. This could have a significant health impact on the person being supported, may have a regulatory implication and is poor support. Relevant colleagues should review the medication errors for their services to establish if there are any lessons to be learnt. IF further data is required to enable a review to take place, please contact Adetola.amusan@nationalcaregroup.com.
2) There are additional concerns with **people who self-medicate**, missing their medication. To evidence learning from this it is expected that relevant Managers should arrange for Keyworkers to review this with the people they support on a 1:1 basis to see what support systems they need to put in place to remind them to take their medication on time. This should be documented to provide evidence that a review has been completed.
3) **Missed signatures** is an escalating problem on MAR Charts. Please note this is still a medication error and is a breach of policy. Relevant Managers should assure themselves that the systems in place at handover are robust enough to check for missed signatures on MAR sheets.
4) There have been issues where colleagues have not followed a persons **eating and drinking guidelines** correctly. This has included either being supervised whilst eating or cutting food up to the right size.
5) **Choking risk** has previously been identified as a risk and is extremely dangerous and should be regarded as an extremely serious incident. All residential services, Day Services and Colleges should have LifeVac (anti-choking) devices provided. ***All colleagues should be clear as to their location and how to use them in cases of emergency***, Supported Living services are supplied based on risk as this is the person's own home. Registered Managers should discuss in team meetings with all colleagues and ensure all agency staff are briefed before commencing shift. An example a CQC prosecution in relation to choking is attached below: https://www.cqc.org.uk/news/releases/hampshire-care-home-ordered-pay-%C2%A396475-after-failing-provide-safe-care
6) Incidents of **financial abuse** in the form of theft of monies from people we support, generally in supported living services have occurred. The Personal Monies of Individuals We Support Policy has been reviewed following reported incidents. Colleagues should be reminded that they are required to count monies at the start and end of their shift, they are then accountable for the money until they handover to the next colleague. Where possible, Registered Managers should vary who is carrying out the finance audits or the relevant Manager should do a quarterly check for any irregularities. Keyworkers are encouraged to raise the risk of online fraud and other types of financial abuse with people they support.
7) Please review your **missing person protocols** to ensure they accurately reflect the up to date needs of the person. Is the picture up to date, has the person's behaviour changed? If someone is at risk of going missing, are you

delivering all of their support hours, if not, who are you escalating the risk to?

8) A person we support was arrested on suspicion of grooming due to his internet activity. Has everyone got a copy of the **internet safety** guide Mike Cleasby produced?
9) Please ensure you capture as much **historic risk information** as possible when doing initial assessments on new referrals. If you are getting limited information from the care provider, can you contact any previous social workers or clinicians?
10) Possible **placement breakdown** due to the location being too remote for the person we support. This led to property damage, aggression, and incidents of challenging behaviour for colleagues. It was felt they should have picked this up during the initial assessment.
11) A person with mobility issues **scalded** himself when making a drink. He wont wait for it to cool and it is causing behavioural issues. Services is working with the OT to see aids can be purchased, colleagues to support during mealtimes.
12) Person we support felt vulnerable going to meet someone in the community (possible risk of sexual assault). Person given advice by colleagues and installed Hollie Guard app on her mobile phone. The service did additional work in relation to sexuality and relationships.
13) Incidents during the quarter where colleagues were unaware of a person's trigger signs which resulted in **increased anxiety and behaviours.** Do colleagues recognise warnings signs and know the right time to administer PRN medication? Relevant Managers should ensure that their colleagues are fully aware of all issues that may result in increased behaviour and ensure that they are aware of what peoples coping strategies are.
14) When supporting a person who talks about suicide ensure appropriate risk assessments are in place and all colleagues are aware of risk and response expected.
15) **Mental Health** – Ensuring People have robust engagement and recovery plans is a key factor in maintaining wellbeing. It is important Managers feel comfortable escalating concerns about people if they feel Local Authorities or other stakeholders are not listening.
16) A person we support died of **Sepsis** during 2020. As a result, the Quality Team sent out awareness raising information to colleagues several times throughout the year to recognise the signs and also what action to take. Quality Director recirculated the information on 30th March 2022, please discuss in team meetings and handovers, you could save a life.

Colleagues

1) Colleagues not wearing appropriate PPE during the Covid pandemic. This puts the people we support, colleagues and visitors at risk of infection. In addition, this would be a breach of NCG policy and CQC/ CIW regulation. NCG keeps up to date with the latest Government guidance and aims to use the least restrictive option to keep the people support and colleagues safe. Registered/ Service Managers have a key role to play in ensuring colleagues are following current infection control/ covid guidance.

Premises

1) Colleagues noticed a burning smell coming from a void room but were unable to gain access as the room was locked and the keyholder was away from the service. This resulted in the Fire Service breaking the down to seek the source of the burning smell. Please ensure that the shift lead has access to any void rooms if they need to be locked.
2) Water outlet not checked in void room leading to build up of legionella. Service must ensure that all water outlets (sinks, toilets, showers) are tested in all rooms including any voids and staff sleep in areas. Please report any areas of concern to Mark Mason.
3) Risk of person's falling from upstairs windows. All properties should have window restrictors in place, and this is covered in Access Compliance audits. Managers to review audits to check no services are none-compliant.
4) Please also check that keycode for medication doors are different from other door keycodes within services.
5) First Impressions Check – Recently, several members of the Executive visited properties and found them environmentally below what we would expect from our services. Issues include rubbish in gardens, untidy/ dirty

bedrooms, broken furniture, poor office equipment, unsafe internet cable, boxes of archiving in a communal areas and an unsatisfactory colleague sleep in area. We have talked at the NCG conference about the Ellie test (mum test), would you be happy as a new colleague to do a sleepover in the room as it is? Please review who has done the last several environmental audits, have these become a tick box exercise? If you have the resources to get a fresh pair of eyes to do a walkaround please do so.

CQC/ CIW/ Ofsted Prosecutions (Not NCG related but useful learning)

1) Care home provider fined £81k for failing to protect resident from avoidable harm. This was after a resident with a known mental health condition assaulted another resident who later died. The provider was found not to have adequately assessed or mitigated the risk: https://www.cqc.org.uk/news/releases/oldbury-grange-nursing-home-ltd-ordered-pay-%C2%A381308-after-failing-provide-safe-care
2) Care provider fined £52k for failing to protect a resident from avoidable harm. Building works were going on in the service but the area of works was not made safe, and the door fell on the resident, this resulted in a hip fracture which led to her death: https://www.cqc.org.uk/news/releases/reading-care-home-provider-ordered-pay-%C2%A35104960-after-failing-provide-safe-care
3) A provider was fined over £40k and a Register Manager was personally fined £1697 after a person with a learning disability with a diagnosis of dysphasia choked to death. The service had not followed the recommendations of a Speech and Language Therapist and the person had choked on a doughnut: https://www.cqc.org.uk/news/releases/east-sussex-care-home-fined-after-failing-provide-safe-care
4) A specialist Education Autism provider had its Ofsted registration withdrawn following allegations of abuse within the school and Children's homes: https://www.bbc.co.uk/news/uk-england-south-yorkshire-59655231

Learning points

- Take some time with your leadership team to reflect on the lessons learnt in this document. How will you share any learning with colleagues?

- Do you have robust governance arrangements in place to review incidents, safeguarding's, and notifications at least monthly? Can you demonstrate a lessons learnt culture to reduce the likelihood of a reoccurrence?

- Can you create a culture of zero medication errors in your service for the next 3 months? How do you change the culture?

- What can you do in your service to stop audits becoming a tick box exercise? Do you have a mechanism in place for checking the quality?

- What did the last inspection report about the service within I work say? Could anything be improved?

#Learning MATTERS