IN THE GLOUCESTER CORONER'S COURT

IN THE MATTER OF AN INQUEST TOUCHING THE DEATH OF

RONALD BREWER

Written response of [redacted], Director of Nursing,

Barchester Healthcare ltd to the Regulation 28 report

to prevent future deaths issued on 19th October 2017 by

HM Senior Coroner for Gloucestershire, Ms Katy Skerrett

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1. My name is [redacted], I am Director of Nursing at Barchester Healthcare, I have been in post for the last 3 years, but employed by Barchester since 2002. In my role I am responsible for the strategic development of a clinical framework for healthcare workers to practice within.

2. These submissions are made on behalf of Barchester Healthcare Limited ("Barchester") in relation to the Regulation 28 report to prevent future deaths issued on 19th October 2017 issued by the Learned Coroner pursuant to Sch 5 Para 7(1) of the Coroners and Justice Act 2009.

3. Upon receipt of the Coroner's report I undertook a review of policies, procedures and practise with a focus upon the concern identified by the Learned Coroner, specifically, "The administration of medications including in particular the documentation of and dispensation of palliative medications."

4. Following my review I can confirm that the following actions have been taken;

    a. A Deputy Manager has been appointed at Badgeworth Court with a background in palliative care and she has been given the responsibility to support training and practice in end of life care in the home. Also to continue

after training has been completed to supervise and embed new practices into every day work and continue and develop the relationships and involvement of the local palliative care team in the home.

b. The staff at Badgeworth Court have undertaken an assessment of their competencies and practices in relation to management of medicines and they have attended further training on this topic and in relation to record keeping.
c. Training has been made available through the Boots pharmacy e-learning modules in end of life care. Our registered nurse staff have been required to complete this training.
d. The General Manager at Badgeworth has arranged for ongoing training over the next 3 months, the training is to cover;
    i. End of Life Care Planning
    ii. Anticipatory care needs
    iii. Communication
    iv. Clinical decision making in medication
    v. Medication Management
e. The end of life and management of medication policies have been re-visited with staff and we have reiterated the importance of multi-professional working in end of life care.
f. Greater emphasis has been placed on anticipatory end of life care during weekly local GP visits. The home conducts a round of all residents where the GP and staff can address relevant issues. Although the decision to prescribe end of life medication is the responsibility of the medical practitioner, it is best practice to discuss such care using a multi-disciplinary team approach involving the local palliative team for advice and guidance.
g. In our review it was noted that during Mr Brewer's end of life care, a decision was made to administer Midazolam at a dose at the highest end of the prescribed dose range. Our finding was that the decision was appropriate and was made by an experienced nurse having considering the individual factors specific to Mr Brewer including his height, weight and level of agitation. Nevertheless, it was identified that more could be done to support

this type of decision making. The management of medicines and end of life policies have been reviewed and updated to provide guidance to the nursing staff on points to consider when administering medication where a range of dosage has been prescribed, in particular analgesia and controlled medication in end of life care considering the resident individually in relation to the initial dose of controlled medications and the tolerance levels which may lead to naïve residents becoming toxic very quickly.

h. We considered a recording error made when Mr Brewer's discharge notes were transcribed on admission. Two staff members failed to correctly transcribe Rivaroxaban from the hospital chart to the care home MAR chart. Following investigation the staff members conceded that, during transcription they had failed to consult the discharge summary and had solely referred to the hospital MAR. Clinical supervision was given to the two staff members on the relevant home policy regarding transcription. Both staff members no longer work in the home.

i. Whilst investigating the drug administration notes and checking remaining stocks of Zomorph it was noted that a recording error had taken place during the first administration of the drug at Badgeworth Court. The dose had been recorded on the hospital MAR chart instead of the newly created home MAR chart. The error created two distinct risks;

    i. Firstly, the record gave the erroneous impression that a tablet of Zomorph was missing. It was only when the hospital MAR chart and the controlled drug book was checked that it was discovered that the shortfall was a recording error,

    ii. Secondly, the error created the possibility that a staff member reading the Barchester MAR chart could have concluded that Mr Brewer had missed a dose of Zomorph. This could have conceivably resulted, in a second dose being administered.

The incident was raised at staff supervisions with staff and was focussed upon as a learning point during staff training and assessment.

j. Policies and procedures have been updated centrally to reflect good practice in medicine management and End of life care.

k. The facts of this case, anonymised, will now form the basis of a case study which forms part of a learning resource for staff during induction and workshops.

5. Barchester Health Limited is committed to a process of ongoing review to ensure the highest standards for its service users. Our review of this case has allowed us to reflect, remediate and improve our service.

[redacted]

Director of Nursing

Barchester Healthcare Ltd

12th December 2017