MC

Persona
We're all about you

28 September 2018

**PRIVATE & CONFIDENTIAL**
FAO: Mrs L Hashmi, Area Coroner
HM Coroners Court
The Phoenix Centre
L/Cpl Stephen Shaw MC Way
Heywood
OL10 1LR

01 OCT 2018

Dear Mrs Hashmi,

**Regulation 28 Notice - Dr Donald Stuart Clegg (Deceased) - Ref: 64436**

I write further to your letter and the Regulation 28 notice in relation to the inquest following the death of Dr Clegg.

Firstly may I personally express my sadness at the loss of Dr Clegg and I send my sincere condolences to his family. Secondly I am disappointed that there are areas of our support which fell short of the high quality of care that we always aim to provide. I would like to reassure you that the comments you have raised have been fully considered and it is my priority that we learn from these and continue to improve our practice. We have a culture internally of continual improvement and we are not afraid to challenge the way we work. I have set out some further details below in response to your letter:

**Persona and Bury MBC**

1. *Communication and transfer of care between social services, the first placement and the final placement*

The comments raised relate to the inadequate communication between the care teams at Killelea (Bury Council) and Elmhurst (Persona), particularly given the complexities of Dr Clegg's circumstances.

A meeting has now taken place between the Persona Operations Director and the Business Manager responsible for Intermediate Managed Care at Bury Council. It has been agreed that going forward and with immediate effect where a customer is being discharged from Killelea to Persona services, or vice versa, a representative from Persona will be included in a multi-disciplinary team meeting with the appropriate health professionals. I will ensure that this is monitored to see how it works in practice and whether we need to review additional methods to ensure we have the right level of communications between the respective teams.

**Persona**

2. *The process of assessment of care needs prior to admission was inadequate*

The established assessment process within Persona is for a Customer Relations Assistant to take the initial referral, capturing information via an Initial Assessment proforma. The Registered Manager would then make a decision on whether they could meet the individual's needs and accept the referral, based on the information contained within the Initial Assessment. I must stress that the Registered Manager or their Deputy are the only individuals who would make a decision about whether to accept a referral and this would never be the decision of a junior member of the care or administration team.

In light of the findings from this inquest we have reviewed the assessment process and we will be enhancing our approach to admissions. . This involves the establishment of an additional post within our short stay services which will focus on admissions, ensuring that we obtain detailed information for the Registered Manager to allow them to make an informed judgement. This will also provide capacity for a face to face assessment or involvement in multi-disciplinary team meetings (as described at point 1) as required.

3. *The Medicine Policy and/or staff training were inadequate and unsafe. The audit process was perfunctory*

As an organisation we are striving for 100% accuracy on our medication management. We are fully committed to improving our processes and have opened a dialogue with staff to obtain their views and to review medication management. Throughout the year we have undertaken a number of different forms of analysis to better understand how and why errors occur. We have also reviewed the policies, protocols and training that we have in place. We have found due to the complexity of the services we deliver there is not a "one-size-fits-all solution" and each service needs a tailored approach. An action plan is currently in place which we are actively progressing in order to improve performance. By way of summary the actions taken so far include:

3a. Investment in an Electronic Medication Administration System (EMAR) which is designed to improve accuracy and safety in respect of medication administration whilst also improving audit trails. This is being implemented at Elmhurst this week (w/c 24/9/18) and will be rolled out to our other short stay unit Spurr House in October 2018.

3b. On-going exceptional Board reporting on medication errors and progress against the medication action plan.

3c. Review and amendment of the medication policy to make it clearer for staff and to develop visual one page guides on certain key aspects of the policy.

3d. Review of our current medication training which we felt could be improved. We have therefore sourced an additional detailed and assessed training package which will be rolled out to staff imminently.

3e. Review and amendment of the self-administration assessments and protocols. These now include a requirement to count medication weekly for people who are self-administering, and a mapping tool to allow the amount actually taken to be tracked against that which should have been consumed.

3f. Development of a comprehensive quality assurance framework (QA Framework). This has been completed in partnership with an external consultant. The work on the QA Framework has drawn current audit tools together to ensure that they are fit for purpose and all audits are meaningful, signed off by a more senior manager, and any actions are captured at a scheme and organisational level in an Improvement Plan. This work has taken place across the summer months and is currently being rolled out in

short stay during September and early October. We will work hard as a team to ensure it is embedded throughout the organisation.

3g. As medication in short stay services is particularly complex and busy we have reviewed the structure and are currently piloting having a Medication Co-ordinator role to provide more specialist knowledge and support in this area, as well as additional skilled capacity to undertake pharmacy and GP liaison and auditing.

3h. Review of the skills required by staff who administer medication has identified that there are skills around numeracy and attention to detail which had been underestimated in the previous job description and core attributes. These have now been added to job descriptions and will form part of the recruitment assessment in the future.

3i. Focus groups with staff are due to take place in early October 2018 to understand the challenges that they see in administering medication and any solutions which they feel would improve their ability to perform consistently well in this area. We are also talking to other service providers to look at sharing best practice tips and tools.

3j. In addition we have recruited a Compliance Manager (this is a senior appointment) who will be responsible for auditing medication. This post reports directly to me as the Managing Director. The post-holder commences on 1 October 2018.

4. *Staff were unable to recognise the signs of deterioration and did not seek medical attention in a timely manner*

This finding is one which we have reflected on at some length. As you will be aware, Elmhurst does not hold a Nursing registration and the staff we employ are social care staff and not medically qualified. Therefore the monitoring that we undertake when someone is unwell needs to be appropriate to the specifics of our registration. Having reflected and reviewed our approach I believe that this service would benefit from additional training and we also need to empower staff to ask more and better questions of medical professionals in order to understand what to expect, and what triggers to look for in an individual's specific case in order to know when to seek further advice or involve medical professionals. This is an area that we need to further review and we have added it to our Improvement Plan and we will be taking it forward during October 2018.

5. *Record keeping was inadequate and in parts incomplete*

Record keeping in social care has become an increasingly significant part of the role in recent years and as a result during 2017 we investigated a number of electronic care planning systems and in autumn 2017 purchased and began implementation of our chosen system Access Mobizio. Roll-out to Elmhurst took place in February 2018. It is now the case that all care planning is in the majority digital within short stay. The system allows real time recording, voice recording and more structured prompts which all contribute to improved record keeping. The QA Framework includes audits and spot checks of care records to assess the quality and accuracy of these. We have identified that there is still further work to do with staff to continue to embed the approach and to drive a culture of improved record keeping. Part of this process included a series of staff workshops on the system and on person centred recording in general which took place during August 2018. Continuing to improve record keeping remains a high priority on our Improvement Plan for this service. We will look at ways to fully embed this throughout the organisation as we strongly believe it will significantly help with accuracy of record keeping.

6. *There is no policy/protocol for observation/monitoring of service users when directed to do so by a medical practitioner*

Having reviewed this area, we do not have an adequate system and protocol. This links closely to Point 4 (above). We will be developing a simple protocol for staff and an appropriate recording system for observations to sit alongside the training mentioned earlier. The new Compliance Manager will be tasked with this as an urgent action.

Beyond the findings of your report I also wanted to take the opportunity to personally respond to the comment made about Persona representatives leaving court before the conclusion of evidence. I apologise on their behalf if this appeared in any way disrespectful or disinterested. This certainly was not the case and can be explained by the lack of experience in Coroner's of Court of these individuals. They believed they had been dismissed from Court and that it was appropriate for them to leave. We have recently developed a set of guidance around responding to Inquests, including what to expect when appearing as a witness. We are also exploring opportunities for Managers to observe cases at Coroners Court to increase their awareness of Court etiquette and confidence in this arena.

I hope the contents of this letter provides you with satisfactory assurances that as an organisation, we are actively and continually learning and improving our practices to safeguard our customers from risk, harm or injury.

In the event, that you require further information or have any follow up questions please do not hesitate to contact me on [redacted] or via email at [redacted]

Yours sincerely

**Kat Sowden**
**Managing Director**