Compton Lodge
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RECEIVED
15 OCT 2018

Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Response to Regulation 28 Prevention of Future Deaths Report dated 13th August 2018.

RE: Flora Marion Baber (deceased 22/02/2018)

We are required to respond to the Coroner's concerns as regards the recording and sharing of information between the Royal Free Hospital, Compton Lodge (owned by Central & Cecil Housing Trust (**C&C**), and Adelaide Medical Centre in relation to Dr Baber's sensitivity to opioids.

Diagnosis and recording of allergies to medication

It is important to clarify that if a resident develops an allergy to medication during their stay with us, we would expect confirmation from their GP or hospital before making any amendment to their care plan. Any information about a resident's allergy to medication would be advised in hospital discharge notes, or by the doctors in the form of an official letter. When a resident returns from hospital, a discharge letter should always be sent and a copy provided to the resident's GP to ensure that their records and those of the pharmacist are updated. Any advice concerning medication prescribed or any changes to such medication or dosage should also be recorded on their MAR chart.

Any changes in the condition of the resident, including allergies, would also be noted on their care plan by the Team Leader, being informed by the hospital discharge letter and / or advice from the GP. Our residential Care Homes are not staffed by clinicians who are qualified to make diagnoses of medication allergies or sensitivities. We rely wholly on the GP, treating doctors and hospitals to communicate any medical changes and medication updates relevant to our residents.

We understand the concerns raised by the family of Dr Baber in relation to her sensitivity to opioids and in particular that they informed staff of their concerns in this regard, which were not noted on Dr. Baber's care plan. We recognise that staff could have advised the family to discuss their concerns with the GP, and in turn the Home could have requested further guidance from

the GP on how best to meet Dr Baber's needs and what changes should be made, if any, to her care and medication. Care staff could not rely upon advice from family members concerning medication allergies and record this in Dr Baber's care plan however, without a supporting clinical diagnosis and advice from a medical professional to do so. The doctors would need to advise the Home through official communication (a letter) to ensure the MAR charts are updated and the pharmacist is notified.

Upon receiving such information, the Home has a responsibility to ensure its own paperwork is updated accurately. This would include both the MAR charts (updated by two senior members of staff who have completed appropriate training), front covers to care plans and (if the resident's medication includes controlled drugs), the Controlled Drugs (**CD**) book.

In order to improve the effective and accurate sharing of information concerning any changes to residents' medication (which would reveal any allergies or sensitivities), we recognise the importance of ensuring the consistent recording and sharing of information between the Care Home and the clinicians treating our residents. Following the death of Dr Baber and the inquest, C&C has reviewed its practices associated with medication records and the sharing of information with clinicians, across all of our Care Homes.

In order to drive forward improvements in this area, C&C has introduced a number of key changes in the areas of management and accountability, record-keeping and the management and disposal of medication. I have set out below a (non-exhaustive) summary of the relevant procedures we have in place and an explanation of how the lessons learned following the death of Dr Baber and the inquest, have led to substantive and lasting change not only at Compton Lodge, but across all of C&C's Homes.

1. Medication administration and allergies: record-keeping

a) Policies and procedures:

i) All the documentation and information concerning the resident's needs and medication is collated in the first instance from the resident's pre-assessment, which is completed in conjunction with the resident and relatives prior to joining us. Any known medication allergies at that time, would be noted on this form. This would then be confirmed by the resident's GP and/or any treating doctors following hospital discharge, once the resident has joined us.

ii) Any medication prescribed to a resident is listed on a Medication Administration Record ("MAR") chart when they join us. Again, any allergies would be noted and recorded on the front cover sheet within the MAR charts if advised and confirmed by a medical practitioner.

iii) Any changes to medication or discontinuation of a medication by a GP during their clinical rounds at the Home must be documented on the MAR charts within the Home. It should also be noted in the CD book. It is normal practice for the GP to be involved in this process; however we recognise the importance of ensuring that the practice of checking both the MAR and CD book concurrently, is imbedded in staff practice across all of our Homes. C&C is committed to working on a close and practical level with our residents' GP's to this end.

iv) The current process in place throughout our Homes for the disposal of discontinued medication is for the pharmacist to collect it on at least a monthly basis. Where medication is discontinued however, pending collection for disposal, we take immediate steps to ensure that this is reflected on the resident's MAR chart (and the CD book if relevant) and care plan. Discontinued medication is removed from the trolley in the medication room, and placed in the clearly marked return box for collection by the pharmacy. Any controlled drugs are kept in the controlled drugs secure cabinet, sealed in a pocket envelope and clearly marked as discontinued.

v) Residents have Hospital Passports and Transfer/Discharge documentation in the event that they need to attend hospital or are transferred to another Care Home. The Hospital Passport allows for the recording of medical information, personal details, allergies, previous medical history and the current care needs of the individual.

   The Transfer/Discharge document also includes a body map, to be completed by the Care Home staff on Discharge/Transfer and to include any skin issues such as rashes, bruising, pressure sores, and medicinal patches. It also includes a current list of medication, any infections present, allergies to medication, resuscitation status and the resident's GP contact details.

vi) In our residential Care Homes, it is the responsibility of the Team Leaders to complete the Discharge/Transfer forms, to ensure accuracy of the information provided, although Home Managers have overall responsibility for all documentation completed and maintained by the Home. Care plan documentation is reviewed on an ongoing (and at least a monthly basis) and is amended if the relevant information for the individual resident has changed.

vii) Staff best practice as regards reviewing and updating care plans is incorporated into care staff job descriptions as a key requirement to fulfil their roles. Best practice is monitored through regular one to one supervision meetings, and a comprehensive programme of staff training is provided.

viii)To the extent that it is appropriate and in accordance with the resident's wishes, relatives (next of kin) and / or Powers Of Attorney of each resident are given access to their care plan, and they can request to read and provide input into all the care plan documentation. A formal review of the care plans takes on an annual basis. Residents' relatives are able to participate in this review and sign off on any revisions if they wish.

ix) We also have a Resident of the Day (ROD) system in place. During this monthly process the care plans are reviewed by Team Leaders/Deputy Managers/Home Managers to ensure they reflect the individual resident's current situation and needs.

b) Changes and improvements

i) To ensure that the correct documentation is sent with a resident on transfer, a check list has been introduced for C&C Care Homes since the death of Dr Baber. This is to ensure the person in charge has considered and included all the required documentation and information about the resident's medical history and needs.

ii) Following Dr Baber's death, we have reviewed and tightened up medication recording practices to ensure that when the MAR charts are updated, the CD book is also checked and updated at the same time. We do this by ensuring that both the MAR charts and CD book are both taken on the weekly GP rounds, and that both are then handed over to the Manager, together with any notes made during the GP round, to be signed off. Staff are also trained to ensure that they consult both the MAR charts and CD book concurrently. The pharmacist is advised of any changes to a resident's MAR chart through the normal monthly ordering cycle of medication through the resident's prescriptions.

iii) Following issues with the consistency of collection of unused medication by Boots, we have requested that all our home Managers across C&C look to engaging with a local pharmacist to provide our medication. We have been consulting local GP's for their recommendations in this regard, and a new pharmacist has already been appointed for Compton Lodge. We believe that using local, recommended pharmacies will ensure that we have a more complete service going forward, to include the more timely disposal of medication and to initially include weekly audits, to support the Homes and provide further staff training as required. As confidence grows within this new relationship, we will move to external pharmacy audits on a monthly basis.

iv) C&C appointed a new Head of Care in September 2018. The Head of Care has completed a review of all the documentation, policies and procedures used by C&C and the induction process for care staff.

v) It is C&C's intention to introduce an electronic care plan system, which will prompt staff to complete and update all relevant information in order to ensure that all questions are considered. C&C are in talks with potential suppliers for this new system, and we intend to introduce this, together with updating training for all staff tasked with reviewing and updating care plans, in the first quarter of next year.

vi) In addition to daily, weekly and annual audits of care plan documentation, more focused audits by the Quality and Compliance Manager have now been introduced to ensure that the prescription of medications is recorded and any amendments updated as necessary. This process is next due for review in December 2018.

vii) C&C have appointed a Clinical Services Manager who is nurse qualified and supports the Homes with medication audits and provides support and training for staff in this area.

viii)C&C have also appointed a new Director of Workplace and Culture who joined us in May 2018. She has been reviewing all the company policies and procedures and has been working with the care team, including our Quality & Compliance Manager to review staff our induction programme, including how care plans are reviewed and updated.

2. Staff training and supervision

a) Policies and procedures

i) C&C is continuing to implement the good practice required by and set out in the policies and documentation currently in place, in addition to the further training being rolled out.

C&C has daily, weekly and monthly audits that need to be completed both by staff within the Homes and the Quality and Compliance Manager. All actions are then updated on a Service Improvement Plan (**SIP**).

ii) In order to keep best practice under review, all our staff throughout C&C have one to one meetings with their line Managers, which are conducted every four to six weeks, to ensure at least six take place per year. Within the Care Homes, the Manager will conduct the one to ones with their administrator and the deputy Manager. The deputy Manager conducts the Team Leaders' one to ones. The Team Leaders then conduct the carers' one to ones. However in smaller Homes, the Home Manager will conduct any of the one to ones throughout the Home especially if any concerns have been raised with any of her team.

b) Changes and improvements

i) Since the incident at Compton Lodge, C&C have reviewed and increased the training given to staff across all of its Homes, around care plan documentation and medication administration, to ensure our residents' safety. Further training focuses upon good practice around recording and evidencing information about the residents' conditions and needs, which is discussed and demonstrated in full. This has been developed as part of staff refresher training, which is currently being rolled out throughout our Care Homes, by our Quality and Compliance Manager. This should be completed by the end of this year.

ii) In addition to regular audits carried out by our Managers, C&C's care planning and medication administration system is now also monitored through additional, regular audits carried out by our Quality and Compliance Manager.

iii) Staff completion of the full induction programme is now checked and monitored more robustly, to ensure that induction is completed within a strict timeframe and staff are not able to commence working with residents until the full induction is complete. Induction includes demonstrations for new staff on how care plan documentation is to be completed and updated.

ii) Since the new Home Manager at Compton Lodge was appointed in June 2018, more rigorous checks have been put in place to ensure that the procedures for care plans and medication records to be updated and maintained are followed consistently. The storage of old care plan forms on local computers have been deleted to ensure that new and relevant information only is added to the correct, up to date version of care plan documentation for each resident. These improvements and checks have also been rolled out across our other care Homes. Moving forward, this discipline will be closely monitored by the Quality and Compliance Manager and continued improvements made across all of C&C's Homes.

iii) The development of further medication training is currently under review with our Quality and Compliance Manager, the Clinical Services Manager and the Director of Workplace Culture. The review is due to be completed within the next 3 months. Training already includes a formal face to face training session with a comprehensive test at the end which requires a 100% pass rate. This is in addition to the online training programme

provided by Boots, our pharmacists. If this training is not completed in full, then the Team Leader or RGN are not able to administer medication within our Care Homes.

iv) This year we have introduced a monthly review of the SIP, which includes a meeting with the Home Manager, Quality & Compliance Manager and the Operations Manager dedicated to reviewing the progress of those service improvements detailed in the SIP and to ensure that Managers are held accountable for their implementation. Actions can only be closed down once the Quality & Compliance Manager has confirmed the action is completed. This new process is already showing improvements in service quality throughout the Care Homes in C&C. The identification and monitoring of these actions has for example, resulted in the more efficient and timely rectification of issues, such as cleaning requirements and has prompted staff to address any risks identified by residents' waterlow charts, on the same day.

v) We feel that previously the staff did not always have open and honest discussions around new practices and the implementation of these policies. This is now regularly discussed via group staff meetings and one to one supervision meetings within our Homes.

vi) On 20 August 2018, the Home Manager at Compton Lodge held a meeting with care staff to feed back the Coroner's key concerns and lessons learned. The importance of maintaining good communication with residents' families and GP's was emphasised, and staff were advised to value and record any key information or concerns raised by family members concerning a resident's needs or care.

Valuable lessons have been learned in relation to the ways in which we communicate with GP's and medical practitioners and update our own records concerning medication and allergies. These have led to real changes in policy and staff training throughout C&C, and we recognise the importance of continuing momentum in order to ensure that such changes become established practice, embedded across our organisation and implemented effectively in all of our Homes.

Yours sincerely