Pentree Lodge
CARE HOME LIMITED

Pentree Lodge Care Home
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12th November 2019

Dear Mr Cox

It is with sadness under the circumstances that we correspond. I would like to take this opportunity to evidence the actions taken by Pentree Lodge following Dylan's unfortunate death.

The actions are as follows:

1. Any resident that is known/diagnoised with seizures is to be encouraged to be assisted/escorted in the bathroom, in compliance with the relevant acts, dignity and consent from the resident. A shower is encouraged/advised over a bath and the relevant measures/ training to be put in place. Care Plans and Risk assessments to be done with the support and advice of the specialist Epilepsy Nurse. All relevent physical illnesses where an ambulance/out of hours doctor are called, accidents or hospital admissions are reported to the relevant bodies ie. Care co-ordinator. The GP has access to this information via R.I.O. A report is also sent to the GP from the relevant bodies.

2. Since the inquest management of the home have reviewed all residents physical health. Management have picked up that another resident who has a history of seizures, she hasn't had a seizure since being in the care home for over 5 years but has not been reviewed by any health professional for at least 10 years regarding her history of seizures. This is now being reviewed by [redacted] When confirmation of this is sort the home will review its Risk Assessments and Care Plans and put in place the relevant measures surrounding bathing and showering, training on this specialist area will be undertaken by all staff.

3. The actions taken regardng the hoarding incident are as follows;

The homes medication procedure was reviewed, all staff to attend rigorous face to face medication training on the 10th December 2019. All residents are to come to the office/medication room individually. Residents are given One to One time whilst medication is administered behind a closed door, allowing staff time to check medication is taken following the relevant standards and legislations. Room checks have been reviewed it was felt that there was little improvement to be made, other than if medication is found in a room then room checks are done immediately after medication times. This would be reviewed regularly, this has also been added to the homes Medication Policy. These changes are to be made within the home in the forth coming weeks following relevant guidelines and legislation.

4. The home also reviewed the wording used when undertaking care notes, such as hoarding. It could be argued in opinion whether two tablets found could be deemed hoarding, also if not taking three tablets is deemed medically as non compliant. Of

course this should be documented and the relevant bodies made aware but mindful of the wording used when undertaking care notes. In such incidents a request would be made by the home for the relevant health professionals to carry out relevant assessments such as Capacity etc where appropriate.

5. The home recognised that there were communication errors between MDT and can only apologise. Firstly we now liaise with the GP and mental health team regarding relevant issues we face. Notifiying all concerned via telephone or email and documenting where appropriate. All incidents of absconding are reported to the relevant bodies ranging from the Care Team to the Police. Measures are then taken to prevent further incidents occuring, such as observations following the relevant laws and legislations such as DOL's , Capacity Assesssment, Mental Health Assessment that need to take place before the home has the power to prevent someone leaving the building as the home is an open facility. Lawfully this documentation needs to be put in place and legislation followed.

6. Dependent on the level and frequency of abscontion the intention and the risk. The appropriate placement of the home would be assessed. The MDT would immediately be informed in the event of any abscontion, if there are relevent teams in place, if not a referral is made. Reviews and monitoring visits take place 6 weekly or more frequent if needed by the care home. The placement of the home is reviewed in these visits if needed and where appropriate.

We as a home would like to offer our sincere condolences to the family and endevour to prevent where possible similar incidents occuring in the future.

Yours sincerely

Director