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Oxleas NHS
NHS Foundation Trust
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Pinewood House
Pinewood Place
Dartford
Kent
DA2 7WG

Tel: 01322 625034
Fax: 01322 625727
Website: www.oxleas.nhs.uk

Ms Sonia Hayes
Assistant Coroner
c/o Ms Tracey Bishop
Clerk to The Coroner's Court
Coroner for South London Area
Floor 2, Davis House
Robert Street
Croydon, CR0 1QQ

Dear Ms Hayes

RE: Preventing Future Death Report touch the death of Julia Jane MacPherson, age 54

Thank you for your letter of 14th of February 2018, which we received on the 16th of February 2018, requiring a response by the 6th of April. The Assistant Coroner, S Hayes identified concerns and requested details of actions that were being taken to address these.

Each matter of concern is addressed in turn:

(1) *Ms MacPherson's mother requested a medical review for her daughter as she had concerns about her presentation following the introduction of Clozapine which had been prescribed off license. A note was left with nursing staff for her Responsible Clinician. The review did not take place as her Responsible clinician did not see the note. Ms MacPherson was not reviewed on the 16th of May. A review of her capacity to consent to treatment did not take place either even though her mother had expressed concerns on the 15th of May and staff found her to be confused on the 17th of May.*

The Trust has developed a Multidisciplinary Team (MDT) meeting template following a quality improvement project to enable every member of the MDT to contribute to the review. There is a section for families, carers and significant people in a service user's life in which any concerns raised are documented to ensure these are discussed in the meeting and agreed actions to address issues outlined.

Capacity assessments for treatment and other decisions are also reviewed at the MDT meeting and documented to ensure that patients continue to retain or otherwise capacity to consent to treatment.

A recent audit of the use of the MDT template and capacity assessments have shown that it is being used and that the views and concerns of families are being addressed. These audits will be carried out on a regular basis to give assurance to the trust.

MINDFUL EMPLOYER

POSITIVE ABOUT DISABLED PEOPLE

(2) Evidence at the Inquest was that hospital staff did not regularly read clinical and nursing entries in patient records.

The MDT template that has been developed ensures each Multidisciplinary team member /profession provides information that should be taken account of in the meeting. This is reviewed in the meeting and plans are formulated based on the information and discussion.

In addition, our Medical Director, Dr Okocha will write to all consultants in the Trust reiterating the expectations that they check and read notes which are written by their trainees and other staff.

(3) Medical records concerning discussions about her capacity to consent to the prescription of off license medication for her mental health were missing or incomplete despite the concerns being raised about confusion and sedation. NICE guidelines for the prescription of off licence medicines were not followed.

Although NICE does not issue specific guidance for the use of off licence medications, the General Medical Council and various Royal Colleges including the Royal College of Psychiatrists have issued advice for doctors when prescribing outside of license. A letter with the respective guidance will be sent to all doctors reminding them that they <u>must</u> follow these in practice. In addition, an educational meeting will take place before the end of summer to reminder doctors of the guidance and ensure that it is being followed in practice. Trust doctors (consultant and non-consultant grade) are expected to include this in their appraisals and reflect on how this has changed their practice.

(4) Patients detained under the Mental Health Act have statutory forms that lists all psychiatric medication that can be administered either on T2 (patient consents) or on T3(patient does not consent), this requires the approval of a Second Opinion Appointed Doctor(SOAD). There is no statutory process for recording consent to medication for informal patients.

The Trust will make clear its expectations of all doctors to regularly assess and document capacity and consent to treatment for informal patients. This should be done as part of the weekly MDT review process and where there are concerns about a patient's capacity to understand treatment then the patient's informal status must be reviewed and detention sought. This will ensure that such patients come under the statutory process described above. For patients prescribed off-license medication, the ward pharmacist will review the medications and ensure that all processes: discussion with patient and relatives, on-going capacity assessments and efficacy of treatment and risk/ benefits have been checked and are documented. If there are any concerns these will be shared with the consultant prescribing the medication and their Clinical Director.

I hope that my response has addressed your concerns.

Yours sincerely

Helen Smith
Acting Chief Executive