Action Plan: Regulation 28 Report to prevent Future Deaths MH

Point 1 Matter of Concern

During the course of the Inquest it was clear that overall the record keeping in respect of Mildred was poor. There was insufficient information taken about Mildred by the home before her admission to Pelham House, the information that was taken was at times inaccurate and this lead to an inadequate fall risk assessment being insufficient.

Response

Prior to admission the family had a meeting with the manager of the home and the deputy manager, they themselves provided all the information to us everything they believed relevant, my deputy questioned them about falls history and they said mum is NOT a high risk of falling having only one fall whilst in her own home, all information was provided by themselves, the risk assessment was sufficient at the time it was extremely difficult to explain the workings of the system in a court room with individuals that have never used a care plan system before I believe this is why the coroner made the comment about record keeping, (the paramedic in the court room understood perfectly well as he was familiar with the system) the system we used took the information provided by the family and generated a falls score, MH had not fallen in Pelham prior to her death and this meant that a falls referral would not be necessary, this is done after two falls or more and the information the family provided by the family did not warrant a referral, we are a Residential home not a nursing home and GPs do referrals or care homes.

Point 2 Matter of Concern

Whilst the drugs chart showed that Mildred was taking her medication regularly the amount of medication that was found after her death showed that this could not be the case. We were told that monthly drugs audits were apparently carried out but they did not pick up the discrepancies in the recording on the drugs charts and the amount of medication held.

Response

At the time of this incident visual medication spot checks were carried out by the Deputy Manager along with daily audits and monthly summaries. Assessing the competency of Senior staff administering medication is ongoing with a Senior member of staff that is a trained medical assessor and promotes in house training. Policies and procedures covering medication in the Home are well documented and accessible by all staff. Questionnaires on medication relating to the policies and procedures are used in the home as refresher tools for all care staff and all staff have training twice a year and an online course.

Pelham house response of actions taken.

POINT 1 Pelham house restructured the whole pre-assessment process the paper work was updated and now reflects all aspects of an individual's ADL as well as the existing questions (this was already in place just with some more information areas

to highlight and family members are now signing the pre-assessment forms to agree to what has been documented) family members continue to sit with management and go through the individuals life and health history the family still continue to assist with the care planning with the individual present so we can get a good understanding of need, we also now have recorded calls something that would have been very beneficial at the time of MH arrival and passing, we also have a new care plan system that is recognised by CQC and this is working very well and has all information risk assessments and an audit trail, it allows a gateway should relatives with to log in and see what's happening on a daily basis, Pelham house also employs an external auditor who comes to audit monthly and sooner where needed and is always available for advice all care plans and risk assessments are reviewed monthly and where needed if a change has occurred, and relatives have care plan reviews that are now signed, All staff have a log in to all policy & procedure on our external site there is a clear and concise falls procedure and all staff and new staff are required to read and act accordingly should a fall happen, (this was also in place at the time of the fall) we already work closely with the falls teams and occupational health.

POINT 2 medication

Medication is audited monthly

CCG / Kamsons pharmacy myself and the GP have worked together to ensure safe practices are ongoing,

Home manager Audits internally alongside the deputy manager and there is a visible summery at the end of the audit to highlight any potential concerns.

External auditor also audits medication and administration when he visits.

There is ongoing support from the CCG and Kamsons pharmacy

After a request from myself GPs now provide patient summaries for all residents that are currently in Pelham house and coming in to Pelham house.