28th February 2023

Johanna Thompson
Assistant Coroner for
Sefton, St. Helens and Knowsley

Dear Madam Coroner,

Inquest touching the death of Beryl Ellison
Response to the Regulation 28 Report to Prevent Future Deaths

Thank you for your Regulation 28 Report dated 3 January 2023, following the conclusion of the inquest into the very sad death of Mrs Beryl Ellison. This letter sets out the response to your Report.

I know that you will share a copy of this response with the family of Mrs Ellison and I would like to express my condolences for their loss. Please be assured that the safety of those in our care is my absolute priority.

In your report, you raised the following matters of concern:

Mrs Ellison was resident at Alexandra Care Home and was found deceased on 28th June 2022 by staff. Her family expressed concern that she had been left with syringe medication unsupervised by staff and raised concerns about this with the care home both historically and four days prior to her death. A post mortem examination revealed Mrs Ellison to have an excessive concentration of oxycodone in her system, which was likely to exceed any acquired tolerance level. The evidence heard at inquest revealed no explanation as to why Mrs Ellison was found to have taken the excessive quantity of oxycodone, which contributed to her death. Furthermore, the systems at the care home were stated categorically to be the same as those that were in place prior to Mrs Ellison's death

The Four Seasons Health Care Group (the Group) comprises a number of Registered Social Care Providers, and we recognise the importance of looking after the health needs of our residents, ensuring that our staff have the requisite skills, confidence and ability to provide high quality care.

We are also aware that it is extremely important for us to operate an effective medication management system and that lessons are learned when incidents occur. This is supported by ensuring that our investigations into incidents are progressed in a timely manner and by way of an open, frank and transparent process involving all relevant stakeholders from an early stage.

During the course of the inquest touching the death of Mrs Ellison, Wendy Martindale provided evidence to you about the immediate actions taken at a local level at the Alexandra Care Home. These actions were taken in response to concerns raised initially by Mrs Ellison's family, which identified that the policies, due process and appropriate escalation of actions as mandated by the Group had not been followed. By way of reminder, a summary of action taken at Alexandra Care Home is as follows:

- Team Members responsible for the administration of medicines completed medication competencies, irrespective of when these were last conducted.
- A Warning Notice is displayed within treatment rooms, advising staff of the correct process to follow when administering Controlled Drugs.
- Weekly observations of drug rounds are now completed.
- Medication issues and areas of learning or development are discussed within daily flash meetings.

Following the inquest, we have carefully reviewed the Regulation 28 Report issued by you. We now write to give you assurance that further steps have been taken and actions implemented to address the matters of concern. These have been incorporated into the ongoing provision of care services at the Alexandra Care Home and more widely across our business as part of our approach to learning and continuous quality improvement.

Lessons learned and action taken to address the concerns raised by you are as follows:

Policies; training of staff, and communication

The Group works to *The Managing Medicines in Care Homes Social Care Guideline [SC1]* published by the *National Institute for Health and Care Excellence (NICE)*

The Group's medication competency assessment, which applies to all members of our care team was reviewed and refreshed in November 2022 and reissued to every care home. Prior to commencing this assessment, staff must complete the following:

- Read the Four Seasons Health Care Group's Medicines Management Policy (Document reference number: CQpol-009) and associated How to Guides which identify the key requirements under the Medicines Act 1968 and the Misuse of Drugs Act 1971

- Complete all Medication Administration and Management eLearning modules

- Read the Managing Medicines in Care Homes Social Care Guideline [SC1] published by the National Institute for Health and Care Excellence (NICE) https://www.nice.org.uk/Guidance/SC1

The Group have further reviewed and improved the competency assessment for Care Assistants who witness Controlled Drugs (CD) administration, stock counts and signing the CD register. This assessment now validates staff knowledge on Controlled Drugs and the Misuse of Drugs Act 1971 alongside practical assessment on the process of witnessing the correct administration of Controlled Drugs.

The How to Guide for Administration of Controlled Drugs has been reissued across the Group. Home Managers were instructed to discuss this with all team members who are responsible for medication management during regular meetings held at the home.

More generally, as part of our efforts on continuous quality improvement for the benefit of our residents, the Group has invested in a new dependency tool called DepenSys, a proven, effective and researched methodology for assessing the holistic care needs of residents, from the point of pre-assessment, while supporting the professional judgement of the Home Manager. DepenSys assists Home Managers to successfully calculate the care and clinical team requirements, their deployment and required skill mix, to meet the needs of all residents in the home. DepenSys, in conjunction with our comprehensive pre-admission assessment process covering all activities of daily living, ensures a clear record of any area of risk that may be associated with medication management or the behaviour of a resident, for the attention of the Home Manager and so such risk can be supported by the team working at the home. Alongside the rollout of DepenSys, the Group has recently introduced a new behavioural management care plan template, which allows team members to create personalised plans for any resident that may experience a behaviour that could result in risk and the necessary management of that risk; specifically this would include any known issues with hoarding of medication, addiction to medication or suicidal ideation.

Additional learning and development - Learning and development that is based on a team/team member's specific needs, identified either as knowledge gaps (information that employees need to know or understand but currently don't), or skills gaps (actions that employees need to be able to carry out or perform but currently can't). This is usually identified as part of the processes of supervision, annual appraisal

or compliance (i.e. to meet the requirements of a particular service or local authority contract). It often leads to the development of personal improvement plans, which are regularly updated, reviewed and monitored.

Monitoring of compliance with training takes place regularly across all operational portfolios, reviewed by Managing Directors and Operational Managers to identify any corrective action where required. Compliance may be further assessed during internal and/or external audit. Group learning platforms continually monitor compliance data and alerts are issued to Managing Directors and Operational Managers on a monthly basis to ensure line of sight of all care team compliance.

Further to the improvements made to medication competency assessments detailed above, the Group's Heads of Care Quality and Care Support Managers have introduced medication management learning surgeries on the last two Thursdays of each month, where support, direction and discussion takes place under lessons learned following any incident of concern or more generally to ensure best practice in compliance with the Group's policies is followed at all times. These surgeries are available for all staff who administer medications and allows for open discussion and lessons learned on a national scale across the Group.

The Care Quality Team have further expanded upon the learning focus for medication management across the Group, with the introduction of medication management bulletins which are distributed to every home within the Group on a monthly basis. Edition 3: November 2022 Medicines Management Bulletin specifically discussed Controlled Drugs.

Medication issues and areas of learning or development are discussed within daily flash meetings held by the Home Manager or Deputy Manager, allowing for improved communication and increased staff awareness. This is a change introduced on 23 December 2022.

Incident Management

Through reflection and review, it has been recognised that the Group Incident Reporting System, RADAR was not utilised at the Alexandra Care Home in the way for which it was intended.

The RADAR system was deployed across the Group in 2021 as a fundamental change to the previous system DATIX, an incident management system commonly used in the sector. Whereas the DATIX system was controlled by the external program developers, which restricted our ability to invoke change when this was required to meet the needs of our business, the RADAR system allows for full participation and control to enable positive change by the Group.

Every incident reported has a designated workflow to guide and prompt team members as to the information required and notifications that may be required; these workflow steps are regularly reviewed to support improved reporting and investigation. A Root Cause Analysis function aligned to incident reporting has been simplified and improved with additional guidance and prompts to support team members. Furthermore, the Group has developed a bespoke training module to guide team members on how to conduct an investigation; this is directly aligned to the Incident Management System, workflow steps and effective completion of a Root Cause Analysis and is delivered nationally across the Group. The training has been developed using a 'lessons learned' approach and guides managers through the process of completing a timely, thorough and effective investigation. Areas covered include: reasons why we have to investigate an incident; the four steps of effective investigation and the correct method; and terminology for completing an investigation. The training also encompasses interactive participation, where attendees review a case study and then discuss methods of investigation, identification of risk, causation, corrective action needed, how to write the investigation report and finally how to cascade lessons learned to the wider team.

The completion of the incident management process is reliant upon human elements, namely the importance of understanding the process, an honest and accurate approach to completion and the ability to execute this through comprehensive and open reporting. At Alexandra Care Home, group supervisions have

been held concerning the importance and requirement to report any concern, incident or near miss in a timely manner and ensure effective use of the Group RADAR system, to allow management to be notified immediately of any incident, allowing for timely action. Across the Group, regular clinical meetings attended by Home Managers and team members are reminded of the importance of escalating any concern reported or issue identified to management within a timely manner. Monthly Nurse and Care Home Assistant Practitioner (CHAP) meetings are held at all homes with the purpose to review the previous month's incident management system and medication audit, which provides further assurance that incidents are escalated accordingly and appropriate action is taken.

The DepenSys system provides a continuous process of review and assessment which identifies changes in care needs and acts as an early warning indicator for emerging risk, supporting the review and updating of care documentation and risk assessments in a timely manner.

Where a risk to medication administration or management is identified for any resident, a specific medication risk assessment will be written and shared with the nursing and care team to ensure awareness of the specific risk and control measures in place. For ease of reference and to ensure that this potential risk is highlighted at each drug round to the member of staff administering medication, a copy of this risk assessment will be held alongside the medication administration records for the individual resident.

Thank you for bringing your concerns to my attention. I hope that the detailed information provided in this response, offers you assurance about both our systems and processes and the significant and continuing improvements we have made and will continue to make in order to mitigate risk to our residents.

We are sincerely sorry for the shortcomings in the care of Mrs Ellison and are committed to ensuring that the improvements we have made are sustained both at the Alexandra Care Home and across our wider business.

Yours sincerely

Chief Operating Officer
Four Seasons Health Care Group