compass wellbeing

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Private & Confidential

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

[redacted]

13 July 2017

Dear Madam Coroner,

Inquest into the death of Nasar Ahmed - Response to Regulation 28 Prevention of Future Deaths Report

This is a response on behalf of Compass Wellbeing ('CWB') to your Regulation 28 Prevention of Future Deaths Report issued following the inquest into the tragic death of Nasar Ahmed.

CWB have carefully considered each of the matters of concern raised by you and this response addresses each concern in turn setting out the action taken or proposed to be taken, along with a timetable for the actions. The purpose of this reply is to set out and demonstrate the actions taken by CWB to ensure that similar deaths do not occur in the future.

Following the death of Nasar Ahmed and prior to the inquest commencing in May 2017, CWB undertook an internal investigation into the actions of the staff member directly involved, established core facts and sought to learn lessons from our failures and those of the School Health Service to ensure as best we can that those are not repeated. You may recall that one of our senior members of staff gave evidence to you and the family in May about the steps that were being taken and we take this opportunity to answer your 4 questions and also update you on the further action the organisation has taken.

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1. **When the school nurse (employed by Compass Wellbeing) conducted a review of Nasar's medication in May 2016, he did not have the medication stored in school in front of him at the time, but relied on its description by a school receptionist**

It is established practice that at each child's review meeting, all of the child's medication must be physically present and visually checked by the school nurse. The review must then be recorded in the Child's Health Record and any action points followed up accordingly.

It is evident from an investigation carried out by CWB and the evidence given at the inquest into the death of Nasar Ahmed that, on this occasion, our (Nurse) staff member did not carry out a visual inspection of the medication at Nasar's review meeting in May 2016. That is a matter of very deep regret.

All of CWB's school nurses receive 'Health Care Plan' training as provided by CWB which specifically covers the requirements for reviewing medication and how and when this must be undertaken. The Nurse in this case attended that training in June 2015 and we have attempted to understand whether the failure was an individual one or is wider. We have established that the Nurse had previously undertaken two periods of study successfully completing a practice portfolio demonstrating a knowledge and understanding of reviewing medication during a Health Care Plan meeting. We therefore believe that the Nurse was fully aware of the requirement for medication to be physically present and visually inspected at a review meeting and he should have done so in May 2016 when Nasar Ahmed's medication was reviewed.

Steps Taken

We have reminded all of our staff that there are no circumstances when a school nurse would not be expected to have the medication in front of them when conducting a review. Our staff have been reminded that we would consider a similar breach to be an act of gross misconduct and would also result in a professional conduct referral.

To assist with ensuring that medication is visually inspected by school nurses across the service at review meetings, a checklist has also been introduced for use during Individual Health Care Plan ("IHCP") review meetings. This new measure is designed to ensure that all areas of the review process have been covered during the meeting. This new checklist will act as guidance and prompt to all school nurses and, once completed, will be scanned onto the Child's Health Record. A copy of the 'School annual review asthma/wheeze checklist' is enclosed. The completion of this checklist will form part of the bi-annual IHCP audit, further details of which are provided later in this response.

As part of their investigations, CWB have undertaken a wider review of the School Health Service, records kept and IHCPs, all of which are key areas in working to ensure that IHCP and medication reviews are conducted correctly and in a timely manner.

In December 2016, CWB carried out a sample audit of IHCPs to review a cross-section of IHCPs and identify any areas that required improvement across the service. The findings showed that the IHCPs were of a good standard overall. During this review, there were examples of high standards of documented care however, it was noted that there was a lack of consistency across practitioners in terms of recording and articulating details of care plan meetings. As a result of this sample audit, it was identified that there was a need for a more robust approach ensuring that all children requiring an IHCP have one that is in date and fully and consistently detailing the support required; including a particular focus on identifying what action is to be taken in the event of an emergency.

An IHCP improvement plan was subsequently implemented to identify, review and monitor all IHCPs across the service using a centralised database. This will support the identification of IHCPs requiring review which will be automatically flagged to the senior management team by an identified data manager. The database has been designed with a flagging system in it. The system counts down in days when an IHCP is due to be renewed and turns the date yellow 60 days prior to the expiry date and red once the date has arrived. The database will be managed by a data team on a daily basis and details of IHCP due (within 60 days) sent via email to the individual nurse responsible for the school and their line manager. This will be overseen by the clinical lead for the service and monitored as part of the performance data for the service.

A full Quality Standards Audit was commenced in June 2017 for IHCPs and is due to be completed in August 2017. This audit will review all IHCPs across the whole service. Once this audit has been completed, the annual audit schedule will be extended to include IHCP audits on a bi-annual basis. We will put in place a robust action plan to deal with any deficiencies identified.

CWB has also fully reviewed and identified the training received by school nurses and what they are required to receive in order to complete IHCPs in line with CWB's Competency Framework. The Competency Framework is a learning and development resource for nurses and this is completed upon their induction to the service. Re-training has been delivered in line with this Competency Framework. IHCP training has also been undertaken by all staff on 22 June 2017 in order to re-emphasise the role of a qualified nurse with reference to the guidance and the support of administering medication by non-

registered (NMC) individuals. As part of the re-training exercise staff were told of the tragic events of this case.

In addition to the above training, the bi-annual training received by the school nursing service was delivered in June 2017. During bi-annual training, the service is suspended and training takes place across all staff groups. The training has been tailored to support the key learning points from the tragic death of Nasar Ahmed and the requirements and expectations of a school nurse. It covered a range of key areas including how to improve record keeping and the importance of this, the increased function of school nurse administrators in communication and following up actions with key staff in school and the parents, the use of electronic diary systems and diary management. A copy of the training schedule undertaken in June 2017 is attached.

Specific IHCP training will continue to take place on a bi-annual basis. The next scheduled training is for September 2017.

We believe that there is now in place a rigorous and proactive approach to auditing, reviewing and monitoring of IHCPs and we are determined to re-enforce the correct medication review process is followed by all of our staff.

2. **Although Nasar's mother was present for the review, there was no school representative, such as the year learning manager (head of year), there for the meeting**

CWB recognises and understands the importance of the collaborative working arrangements involved in preparing IHCPs and the ongoing support, communication and processes for children in schools with medical conditions. The Supporting Medical Needs Policy clearly sets out that a number of organisations have roles and responsibilities and that school staff, school nurses and parents must work in partnership to ensure that the needs of pupils with medical conditions are met effectively.

Steps Taken

Following Nasar's sad death CWB have prepared a Partnership Agreement between CWB and schools across the Borough of Tower Hamlets. This agreement sets out arrangements for support and training for education staff, as well as detailing the expectations across the organisational boundaries. Page 7 of the Agreement (copy enclosed) outlines the roles and responsibilities of the School Health Service and the school. It specifically requires that a member of staff will be identified who will liaise with the School Health Service. The identified school staff member is the person responsible for that child and who has

the appropriate levels of authority to agree possible actions generated from an IHCP and who is able to disseminate information regarding the child's care across the school, including what to do in an emergency. The staff member will work to ensure support and consistency is provided by the school and School Health Service, particularly in relation to the creation of IHCPs and attendance at review meetings. CWB is currently working with the London Borough of Tower Hamlets Public Health and Education departments, as well as Tower Hamlets head teachers representatives, to finalise and roll out the agreements across all schools.

Alongside this, joint letters have been sent to all school head teachers within the Borough of Tower Hamlets detailing how schools can become "asthma friendly". This also outlines the expectations and requirements of the school and the School Health Service. This has been prepared and sent in partnership with the specialist teams led by [redacted] (from whom you heard evidence at the inquest).

Furthermore, as part of this partnership, CWB with the assistance of the respiratory clinical nurse specialist, has revised an asthma plan template for children and a process for sharing individual asthma plans with the school nursing service and schools has been commenced. A child's individual asthma plan created by the GP/practice nurse or the specialist team will now be sent directly through to the School Health Service via secure generic email accounts. These email accounts are monitored on a daily basis. The plan will be attached to the child's health record and an email alert sent to the relevant school nurse. Training has been given to our staff team.

In addition, school nurses are being supported to actively encourage appropriate members of education staff in the schools to be present during IHCP meetings. All school nurses are aware of the draft Partnership Agreement (see above) which states that there is a requirement for a school staff member to be present at these meetings. With the support of senior managers, school nurses will work to encourage the presence of school staff in IHCP meetings.

CWB has also initiated a Project Plan for an incident reporting system called the 'Radar Incident Reporting System'. This system is used to record incidents and risks within the organisation and also highlights where communication difficulties occur, including where IHCP meetings need to be postponed due to non-attendance of education staff. The Radar Healthcare risk register will enable CWB to fully record and manage the major risks to the organisation and the objectives that they compromise. Risks are prioritised and can be linked to existing incidents and complaints that have been recorded. The system allows regional and corporate risk registers to be managed, with actions, alerts and reviews being tracked to ensure effective risk management.

The automated workflow and alert system for each event type ensures that there is a consistent approach to reporting, recording and managing events through the use of electronic event recording forms. Once completed, the event forms generate workflows including identifying reporting lines and governance arrangements and incorporating configured templates to help in performing effective investigations, root cause analysis and trend reporting. The project is being implemented in a number of phases which are set out at page 3 of the attached document. Phase 2 and the training on the use of the Radar system is to be undertaken in August 2017 and it is expected that once Phases 3 and 4 are completed in early September 2017, the system will be fully rolled out to all staff for use.

These steps have been taken to ensure that all those involved in the effective care and support of children in schools with medical conditions work effectively and collaboratively and that there is an identified member of staff within each school to play a pro-active part in the preparation and updating of IHCPs and to attend review meetings.

3. **The school nurse then updated the care plan by using the allergy action plan (mild-moderate with asthma) instead of the correct one used the year before allergy action plan (severe with asthma). This meant that Nasar's medication box contained an EpiPen without any description of when or how to use it**

In evidence to you the Nurse accepted that he used the incorrect care plan. CWB's investigation has concluded that the Nurse had not reviewed the previous IHCP from October 2014 marked "Allergy Action Plan (Severe with Asthma)" or the updated April 2015 IHCP, again marked "Allergy Action Plan (Severe with Asthma)". Both of these previous plans were readily available to the Nurse as they had been uploaded to the EMIS (the electronic health record system) to which he had access. Paper records were also made available to him. When a school nurse is preparing to review an IHCP, it is established practice that they should go onto the EMIS and review the previous IHCP. This did not happen on this occasion.

It has further been accepted by the Nurse that even if he did not have access to or see the previous plans, he should have completed the "Allergy Action Plan (Severe with Asthma)" for Nasar Ahmed based on the information he had available to him at the time.

As part of CWB's investigation, each of the IHCPs prepared by this Nurse at Bow School were reviewed. CWB's investigation found that other IHCPs prepared by the Nurse had errors in them and were required to be re-written. That process has now been completed.

Steps Taken

The Coroner is referred to the steps set out in response to the first concern raised and the processes that have been implemented across the service to provide assurances in relation to the auditing, quality and consistency of IHCPs prepared and completed by school nurses.

4. **He identified the medication as being out of date, and asked that in-date medication be provided, but did not diary forward to the following week to ensure that current medication was now in the box. This meant that he also did not complete the action plan with the dose of the relevant medication**

The Supporting Medical Needs Policy indicates that the responsibility of checking that in-date medication is provided is a shared one between the school itself and the school nurse. It is fully expected that the school nurse and the school would have a conversation to discuss follow-up actions arising from a meeting and appropriately diarise to check that the correct medication has been received and, if not received, to chase this up in a timely manner. As a qualified health professional, the school nurse is able and expected to understand whether a prescription is appropriate and whether the correct medication has been received. Any outstanding actions must be followed up and completed as a matter of course and in accordance with their professional duties.

As referred to above, CWB has carried out an investigation into the actions of the Nurse, including his failure to diarise to ensure that the current medication was provided and in the box. As was evident from the Inquest, the investigation findings are that the Nurses' diary made no mention or record of any follow-up action relating to checking the medication. There is no evidence to show that he checked the medication had been received and was in Nasar Ahmed's box and that is a matter of very deep regret.

Steps Taken

CWB have implemented additional measures to ensure that the checking and updating of actions from IHCP meetings are routinely followed up by all school nurses and to prevent this event from happening again.

All clinical staff have received guidance on how to manage an electronic diary in order to assist staff in diarising appointment, reminders and sharing calendar appointments. All clinical staff have access to mobile working devices, for example laptops, and the service is moving to a fully electronic diarising system in order to support sharing of appointment calendars and the effective use of an electronic diary and reminder system. Specific training on electronic diarising and the use of this took place on 21 June

2017 and we believe that the system is fully understood by our staff team. The system will be fully rolled out in the new academic year (September 2017). Furthermore, the bi-annual training referred to earlier above will also cover the use of electronic diary systems and diary management and act as a reminder of our expectations. Having an electronic diary system in place operated by trained staff will enable appointments to be clearly made and set out within the calendar and reminders and electronic prompts to be set. This will assist in ensuring that actions are followed up on a prompt and routine basis. We have told our staff that they should not be afraid of letting us know if they are struggling to 'get to grips' with the electronic system of working.

CWB have re-enforced to all staff the requirement and expectation across the service to ensure that accurate and contemporaneous records are kept, including recording and documenting action points and dates for follow up, as well as documenting who is responsible for each action point. This has been re-enforced through medico-legal training which was arranged for all staff in order to address the implications of poor documentation keeping and the effect this has on the delivery of healthcare. This training took place on 19 June 2017.

The requirement and importance of record keeping is also set out within CWB's Competency Framework which states that there is a need to "ensure all records are written contemporaneously and in accordance with the NMC record keeping standard and local record keeping and documentation standards and guidelines including local electronic documentation, storage and deletion policies". As referred to previously within this response, this is a framework reviewed and completed by school nurses upon their induction to CWB. Whilst we wish to avoid repetition we confirm that training in relation to this framework and the relevant competencies has been re-run.

We hope that this response provides clear and substantive evidence of the actions taken by CWB to prevent future deaths. However, should you require any further information or clarification, please do not hesitate to contact us.

Yours sincerely,

[redacted]

[redacted]
CEO of Compass Wellbeing CIC