[redacted]

THE CROFT SHIFA HEALTH CENTRE
BELFIELD ROAD, ROCHDALE, LANCS. OL16 2UP
[redacted]

Regulation 28 Report - Response

12th December 2023

Re: Death of Zulfiqar Hussain [redacted]

Dear Coroner Mitchell

I would like to extend my sincere condolences to the family of the deceased. I also offer my apologies to yourself for the delay in responding to the initial informal request for information.

With reference to the above and your concern regarding document workflow and adverse medication markers placed in medical records.

1. As previously raised in report to prevent future death dated 23 December 2021, incoming correspondence to the GP practice continues to be dealt with by administrative staff who decide whether or not it is placed before a GP. The concern is that there is no robust system in place to ensure that communication to the surgery which may require action to be taken by medical staff is brought to their attention.

Our document management was reviewed in November 2021 in response to a Regulation 28 Report issued by the coroner. We had a practice meeting and discussed the process of filing Did Not Attend notifications that were in place for secondary care services as well as screening services and '2 week wait' suspected cancer referrals. We agreed that we would amend the procedure for document management to expand the list to include the below mentioned specialities that would be sent to GP's, as a result of this incident. Please see attached Significant Event Analysis report.

We have two designated members of staff who are responsible for document management within the practice. The GP's discussed and informed staff that the below noted patients are 'high risk'. The Document Management Policy was updated to reflect the changes.

2 Week Wait (Suspected Cancer) referrals.
Learning Disabilities
Mental Health/Depression (all patients)
Safeguarding notifications
Addiction
Patients on Gold Standard Framework - patients who are on 'end of life pathway'.

Any correspondence for patients above is to work flowed to the GP the letter is addressed to. If the matter is urgent, a medication change or a notification of patient's personal circumstance (safeguarding/abuse) this is forwarded to the GP on call.

In this case the last letter received from Turning Point, Rochdale & Oldham Active Recovery service, was dated 22/3/2023. The service had a face-to-face meeting with Mr Hussain on 2/2/23 with his Recovery support worker present at the consultation. Unfortunately, I can only send screen shots of the audit trail of this letter as the document management system shows the history of the document workflow but does not allow this to be printed together with the document in view, I have therefore, attached screen shots to highlight that the letter was sent to the GP for perusal. I apologise for the fact that, at the inquest, I could not recall that the letter had been forwarded to me, as per protocol; I had not anticipated questions regarding this.

2. Adverse medication markers are not being placed on computerised medical records and this creates the risk that contraindicated medications may be inadvertently prescribed.

We conducted an audit on Mr Hussain's medical records which showed that an alert was added to the records on 10/11/2020 alerting any clinician adding medication that may have potential misuse (including not to add benzodiazepines, opiates and gabapentin/pregabalin) and listing medication that could have an interaction with methadone. I attach an audit trail of this.

This alert message appears as the patient record is accessed. However, to see further information within the record, this messaged must be closed to proceed further into the record. On the day of the inquest, I must have closed the alert, in order to proceed, therefore the message does not reappear unless a medication is to be added which would again trigger the alert to appear. This is the reason that, when questioned, it was not showing when you specifically asked about medication alert. I offer my apologies for this confusion on my part.

I hope that the above provides reassurances that the previous Regulation 28 was actioned, and the changes made have been effective.

Please accept my apologies again that this evidence was not provided at the inquest. I will be happy to provide further information, if asked to do so.

Yours sincerely

[redacted]

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On behalf of my Partners who have reviewed and agreed on the wording of this response.

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