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10 December 2025

Dear Mr Place,

Thompson Elliott - Prevention of Future Deaths report

We write further to your Prevention of Future Deaths report (PFD) issued on 15 October 2025 following Mr Elliott's Inquest. [redacted] the Chief Executive Officer of Care UK, asked me to carry out a thorough investigation before formally responding.

I am a Solicitor having qualified in 1996. I joined Care UK in October 2007 to set-up the legal function and have run it since then. One of my responsibilities is the oversight of any Coroners' Inquests that Care UK is involved with.

At Care UK we take a Prevention of Future Deaths report very seriously. The investigation has involved [redacted] the Home Manager of Grangewood care home; [redacted], the Regional Director who manages [redacted], the Head of Nursing, Care and Dementia; [redacted], Head of Regulatory Governance and [redacted] the Director of Care, Quality and Governance who manages [redacted].

First, we respectfully remind the Court of the information provided at the inquest in terms of the steps undertaken following the incident and prior to the inquest. As set out by the Home Manager in her statement for the inquest and confirmed by her in evidence, following investigation of the case by the care home, extensive discussions were undertaken with all care home staff including reference to the Medication Administration Record and wider records, to ensure all clearly understood what went wrong in Mr Elliott's case and the steps that need to be taken to prevent repetition. These steps focused upon (a) Checks to be made when a resident returns to the care home following admission to hospital; (b) Documentation and communication requirements; and (c) Medication knowledge and confidence to challenge. Each of these are elaborated upon below, including further information (and enclosed relevant documentation to illustrate) of further steps taken since the inquest.

Steps taken since the incident/inquest

(i) <u>Checks when a resident returns to the care home from hospital</u>

The initial failing in this case was around not taking all reasonable steps to establish the position when Mr Elliott returned from the hospital with new medication but no discharge documentation.

Discussion and further refresher training with all relevant staff has emphasized the need to ensure home management is informed immediately of any concerns regarding residents returning from hospital and that checks are undertaken with the hospital. The training has reinforced that if the hospital cannot be reached for an answer, colleagues should check with the GP and failing that contact the 111 service.

The emphasis is upon obtaining same day advice to resolve any concern/query so as to ensure correct and timely administration of the required medication. These enquiries must continue before administration of medication, where there is any doubt or lack of clarity.

To remind staff, a visual flow chart has been introduced at the care home to provide clear, step-by-step guidance for staff involved in supporting residents returning from hospital where there is no accompanying discharge letter to support changes in medication. A copy of this flow chart, which has been shared and discussed with staff to embed awareness of it, accompanies this letter **(enclosure 1).** This flowchart is laminated and attached to the medication keys as an immediate prompt to staff. Additionally, there are copies of this flow chart in poster format on the wall of the care home's treatment room and there is a further copy contained within a dedicated discharge file held in the Deputy Manager's office. This dedicated file has been brought in following this case and contains the flow chart prompt and copies of Care UK's relevant up-to-date policies to which I refer below.

The care home leadership has reinforced Care UK's 'Admissions and Discharge Policy' **(enclosure 2)** and the 'How to Guide - Supporting a Resident Returning from Hospital' **(enclosure 3)** as well as the 'Medications Management Policy' **(enclosure 4).** These documents provide clear guidance to staff as to what to do in circumstances where a resident arrives and/or returns to the care home from hospital and there is insufficient/absent information regarding their discharge and attendant medications. All staff have completed a mandatory "read and sign" process to confirm that they have read and understood these documents, all of which have been discussed with staff as part of further refresher training sessions undertaken.

The Home Manager and/or Deputy will ensure that any imminent or new discharges to the care home are discussed at the daily 10@10 meetings and weekly clinical review meetings to ensure staff are aware of the discharges, the relevant information is obtained and any matters requiring follow-up are actioned. In addition, it is also important to note that there is always a member of the management team available (seven days a week) and so at any time the discharge process is taking place, there are senior staff available to help deal with/advise on any issues arising with the discharge.

Since the incident, the Home Manager has met with the care home's allocated Trusted Assessor at the local hospital Trust (the individual leading on Discharges/the Discharge Lounge) to review Care UK processes, and to explain why staff will be asking the questions they will be asking the hospital team. The Trusted Assessor has provided very positive feedback in relation to these and is in agreement with their use to facilitate the care home staff completing the necessary documentation and accepting a discharge.

As set out later below, these processes have already been effective in practice.

(ii) <u>Documentation and communication:</u>

Another factor identified in this case was poor recording of the issue (the medication query), action taken and handover/communication of the issue and action needed.

Refresher training has since focused upon the need to properly document the issue (in this case the absence of discharge notice/instructions and presence of new medication in replacement of a previous medication) in the records and at handover (10@10, Clinical Review meetings) to ensure all relevant staff at the care home are clear about what the issue is, the calls that have been made for clarification, the results of those, what further steps need to be taken (and their urgency) and, crucially, what should be done/any advice received with regard to the medication pending clarification. The care home has also sought to emphasize the need to ensure Team Leaders and home management are made aware of the issue to ensure answers are provided with sufficient urgency and that there is clarity around who will take the task forward.

Training and discussion around the above mentioned policies has emphasized the need to document in the resident's own daily care notes as well as the communications/handover book all interactions/calls made with other providers/services to ensure all those interacting with the resident are aware of any issue arising, the need for that to be resolved and what steps have been taken to date to do so.

There is now a monthly review of hospital discharges checking compliance with the relevant processes outlined above; medication is promptly updated and any required follow-up actions completed.

(iii) Medication Knowledge and confidence to challenge:

Whilst Grangewood is a residential care home, not a nursing home, it has, as the Home Manager explained in her statement and at the inquest, worked hard to improve medication knowledge.

The care home has run extra medication training sessions to raise knowledge of and test understanding of drugs in use at the care home including why they are prescribed, the effects/side effects, brand names and generic names. The refresher training also included how the online British National Formulary should be used. To begin with this additional training focused only on the pain relief medication in Mr Elliott's case but, due to its success, has since focused on other drugs commonly in use at the care home.

Staff have worked through a Medication Reflection and Training Workbook to further assist learning and best practice in line with the Medications Management policy. All staff have completed a mandatory "read and sign" process to confirm that they have read and understood the policy. The care home management team has also reset the learning cycle to ensure all staff recomplete their medication training and the care home has re-run EMAR training (exploring the use of the Electronic Medication Administration Record including further information and resources which can be used to understand medications and potential issues with the same).

The aim has been to encourage staff to think more deeply about the medication, prescribed by others, that they are administering and to have greater confidence to raise questions if something may not look right, and to ensure compliance with Care UK's expectations in relation to medicine management.

Continued partnership with discharging hospitals:

The care home has continued to work closely with the Trusted Assessor team at the hospital which discharged Mr Elliott to try to streamline communication/interaction in relation to discharges. The aim is to ensure all documents are securely and promptly shared including via NHS email if possible to support timely and safe transitions of care from hospital to the care home. This work is ongoing but the care home and its hospital partners share a commitment to best practice to achieve these aims. As noted above, the Home Manager has held meetings with the local hospital's Trusted Assessor to discuss the care home's discharge policies to ensure agreement and buy in to the process.

The care home management team has also re-emphasized (to Care UK colleagues and the hospital Trusted Assessor team) the importance of its hospital travel passport. This document goes with the resident whenever they attend hospital and is requested to be returned with them when they come back. The first page provides a profile of the resident and his/her needs, and full details of their next of kin along with their contact details. The second page is any DNAR/ECHP in place for that resident and the final page is a copy of the EMAR for that resident to ensure the hospital has clear information regarding the relevant medications taken by the resident. The care home has updated the document to ensure that it now contains, in addition to the main care home number, on-call numbers for all of the care home's team leaders to provide hospital staff with a number of potential points of contact. Again, in meetings with the Trusted Assessor from the local hospital, this has been discussed and emphasis placed upon the need for hospital staff to ensure its return with the resident on discharge.

Recent evidence of effectiveness:

As confirmed at the inquest, the care home had a resident return from a hospital in September 2025 without direct handover and without a discharge letter. The Team Leader on duty immediately escalated this to management and undertook relevant enquiries of the hospital, challenging the fact of the discharge without relevant information. The Team Leader ensured same day delivery to the care home of the required documentation and follow up contact ensured all information for safe return to the care home was obtained.

Since then, in October 2025, the care home was contacted by the hospital discharge lounge regarding a resident about to return that day to the care home. This was the first time there had been any indication that a discharge was taking place. Staff followed the correct processes with prompt calls to the hospital team in order to ensure they had the information required to accept the discharge and identified, by so doing, that the resident did not have his hospital passport with him at point of discharge, and hence further enquiries were made to the hospital to seek its recovery.

Conclusion

Grangewood care home and Care UK reiterates its regret with regard to the errors in Mr Elliott's case. Care UK and the home have worked hard to ensure training and reflection by all staff and to ensure all appropriate policies and processes are known and understood by staff, so as to do all they can to prevent repetition.

Yours sincerely,

[redacted]

General Counsel and Company Secretary

[redacted]

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