Response to Coroner regarding Regulation 28: Report to Prevent Future Deaths

The practice has reviewed the report following the inquest into the death of patient GS by David Lewis the Assistant Coroner for Liverpool and Wirral .

The practice would like to acknowledge the sad circumstances of the patient's death and appreciate the ability to respond with changes that the practice has instituted following reflections on the case.

We understand the coroners concerns to be:

The **MATTERS OF CONCERN** are as follows:
(brief summary of matters of concern)
1. The GP to whom this case was allocated told the court that he did not know that Gloria Simon was in a care home setting (as opposed to a nursing home setting), which had no clinical staff of any kind, despite having previously visited the premises and despite the clerical assistant's note on a Consultation Report that this was a request from 'CH'. He indicated that it was as a result of this misunderstanding was that he did not visit the premises to make a face-to-face clinical assessment.
The court is concerned that a recurrence of this situation could leave vulnerable elderly patients with inadequate care. The court would like to know whether measures are being taken to ensure that those in the practice are properly informed about the nature and status of resident institutions with whom they have contact.
2. In its typed 'Request for Care' form, the care home noted that Gloria Simon's oxygen saturations were 84% and described them (correctly) as 'very low'. The time when the observations were taken was not stated. Despite a clerical assistant at the GP practice having noted down correctly that the reading was 84%, the GP misread the papers as saying 94% and described the oxygen saturations as 'low'.
The GP told the court that he would have been assisted by knowing the patient's previous medical history and would have acted differently had he known it. However, the records indicate that this information had been supplied by the care home, had been flagged by another GP who made a record on the practice's system, and was available to him.
There was no evidence before the court to suggest that the GP had: (a) requested sight of the previous medical history, or made any enquiry about it when (or before) he spoke to a member of staff at the care home; or (b) asked when the observations had been taken or recommended that any further observations should be taken; or (c) asked about whether those observing or caring for the Deceased had any clinical qualifications (having assumed, incorrectly, that she was in a nursing home setting).
The court considers that this elderly vulnerable patient should have had a face-to-face clinical assessment but did not because of insufficient attention to detail and/or clinical curiosity on the part of the GP. The court would like to understand how the practice can ensure that this is not something that will recur.

In response to the Coroners' Concerns we offer the following:

Note 1

With respect to the request for the care form submitted by the practice, this is the way that all care homes in our area communicate with the practice. The form is sent through

to the practice via email from the care home and is dealt with by a dedicated member of the administrative team.

The number of requests for care that the practice receives weekly is approximately 100. The number of care home patient bed registered at the practice is 335

It should be noted that the practice has not had any other Significant Events related to the care of patients in care homes in the recent past.

A timeline of the request for care in the case of GS is as follows:

Email was sent by care home at 14.52

This was added to Triage GP slot at 14.53

It was then reviewed by triage GP at 15.16 and flagged as urgent and an entry added to the clinical notes to highlight the urgency/priority of this case to the on call GP (JS)

The on call GP then made a telephone call to Riversdale Care Home at 16.04

The appointment that was made was an “oncall” 15 minute appointment.

Of note the request for care form does state “Riversdale Nursing Home”, which is incorrect and was completed by a Riversdale member of staff. As a result of our reflection, the form has been updated to include a question relating to whether a resident is in a residential bed or a nursing bed. The practice has a number of care homes some of which have dual care status patients. The clinical induction pack that is given to all new clinical practitioners has also been updated to give an overview to the general status of each home ie solely residential, dual status or predominantly nursing residents.

It is noted on the request for care form that several of the parameters were missing. We will reiterate the importance of a full set of observation from staff to care homes, but accept that this may lie outside of the competence of some care home staff. We expect all Marine Lake clinicians to ensure they are comfortable with the clinical information available but not at the detriment of delaying appropriate assessment of the patient.

Note 2

In response to the concerns raised as stated the care home rightly highlighted that the oxygen saturation levels were ‘very low’.

A full medical history was available at the time and elements of this were flagged up by the triage GP and a recommendation was made by him which is documented in the medical records.

The entry from the triage GP states:

“ for t/c (telephone consultation) soon sats low pulse up, pt fatigued ?for admission

PMH COPD

See GP summary and R4C (request for care)

T/C U(urgent) initially “

The triage GP then booked an appointment in an on call slot with JS with an added entry to highlight the urgency.

The practice agrees with the concerns raised in points a, b and c.

The transcript of the phone call between JS and the care home is attached.

We believe the care provided to this patient falls below the usual and acceptable level expected by Marine Lake Medical Practice. We plan to review and action this with the member of staff involved to ensure that further risk is not posed to our patients.

The practice agrees that the patient should have had either a face to face assessment, been admitted to hospital from a telephone call or a discussion should have been sought to establish the wishes of the patient’s family.

We are investigating the case formally as part of a Significant Event Analysis in line with practice policy. We are happy to share the outputs of this SEA with the coroner should he find that helpful.

We are a learning and reflective practice and have sought to support the GP involved. This has been with face to face discussions with senior members of the team and his nominated mentor on several occasions.