Title **Tower Bridge Care Centre Southern Cross Independent Investigation Summary Report**	To **Briefing for Health and Adult Social Care Scrutiny Committee Chair**
From **Lily Lawson Independent Investigator Diane Brown Ltd**	**Date: 26 October 2011**

1. BACKGROUND

Following anonymous emails received in July and August 2011, the London Borough of Southwark commissioned an independent investigation by Diane Brown Ltd, to thoroughly investigate an allegation of medication mismanagement at Tower Bridge Care Centre, a Residential Care Home with Nursing, owned and operated by Southern Cross Healthcare.

Diane Brown Ltd is an independent social care consultancy with extensive experience in the field of Adult Social Care and Health.
The anonymous emails were received by the London Borough of Southwark, the Care Quality Commission and Southern Cross (Court Cavendish) and were processed according to the Whistleblowing policies in each respective organisation.

The issues involved in the allegation of medication mismanagement were:

Allegation 1 –missed medication

The 21:00 dose of medication had not been given to Residents on the 3rd Floor on Friday 15 July 2011

Allegation 2 –cover up activities regarding medication missed

Subsequent actions were taken on Tuesday 19th July to amend records and destroy medication to cover the missed medication incident on Friday 15 July 2011.

The date of amendment of records in the whistleblowing emails was linked to a Care Quality Commission compliance visit which was in fact, Thursday 21 July 2011. It was later confirmed that the subsequent actions occurred on Thursday 21 July.

Tower Bridge Care Centre is registered to provide accommodation for up to 128 residents who require personal and nursing care.

Residents are currently accommodated on 3 floors and occupancy at 13/09/11 was 72 residents. There are currently 53 residents funded by Southwark Council.

25 residents were present on the 3rd Floor at the time of the alleged incident of medication mismanagement on Friday 15 July.

2. INDEPENDENT INVESTIGATION PROCESS

Following the guidance provided by the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, the independent investigation was conducted using the following process:

a) the collation of information from internal investigation, CQC and from Council monitoring officers.

b) the research and verification of information available to the current investigation

c) the undertaking of selected staff interviews to capture relevant information

3. PREVIOUS ACTIVITY

The Care Quality Commission conducted a routine compliance visit during the period of the whistleblowing email communications on 21st July.

The Care Quality Commission compliance visit was undertaken within the regulatory framework and verbal discussions around initial findings found no major concerns. However, following receipt of the Whistleblowing emails and in discussion with London Borough of Southwark, the Care Quality Commission made an unannounced visit on 29th July. Some evidence to support the allegation of medication mismanagement was found, which led to agreement that Southern Cross would conduct a robust internal investigation, reporting by 15 August 2011.

Southern Cross conducted an internal investigation led by the Area Manager and Quality Assurance Adviser. The Quality Assurance Adviser was included to ensure impartiality, however, further whistleblowing emails implicated the Area Manager in medication mismanagement and other issues. The Southern Cross internal investigation found no inconsistencies in the medication records examined.

However, the Quality Assurance Adviser who was leading on the investigation into medication mismanagement, confirmed that the internal investigation focused on medication administered on the 3rd Floor on 20th and 21st July and not on 15th July as communicated by whistleblowing emails to London Borough of Southwark.

London Borough of Southwark Contract Monitoring Officers conducted 2 monitoring visits on 01 August and 04 August. An Alert was also raised with the Safeguarding Team and strategy meetings were held on 28 July and 04 August, where actions supporting an independent investigation were agreed.

Given the lack of confidence in the outcome from the internal investigation, London Borough of Southwark commissioned a fully independent investigation focusing on the specific allegation of medication mismanagement and alleged subsequent actions to cover the error. This investigation was completed 21st October by Diane Brown Ltd.

4. INFORMATION PROVIDED FROM PREVIOUS ACTIVITY

London Borough of Southwark:

At a meeting with Contract Monitoring Officers and the Head of Service at London Borough of Southwark on 05/09/11, the following relevant documents were shared:

- Southern Cross internal investigation report
- Photocopied Signing In record – supplied Whistleblower
- Photocopied Rota
- Whistleblowing emails
- Medicine Administration Records (MAR sheets)
- Medication Disposal Record
- Stock Balance Record Chart

Care Quality Commission:

At a meeting with the Care Quality Commission Inspector and Pharmacy Inspector on 12/09/11, an outline of involvement and initial findings from the CQC draft compliance visit report were discussed.

Southern Cross:

At a meeting with Southern Cross Head of Governance on 02/09/11, there was general discussion on the process of the internal investigation and an outline provided on the framework for the independent investigation.

5. INFORMATION PROVIDED TO THE INDEPENDENT INVESTIGATION

Document Review

The document review was undertaken at Tower Bridge Care Centre on Tuesday 13 September 2011 and the following documents were examined:

- Signing In Book
- 4 Weekly Timesheets
- July Payroll
- Current List of Staff for Administering Medicines
- List of Residents present on 3rd Floor 15/07/11
- Staff Rota
- Draft and Final Compliance Visit Report CQC
- Training Matrix
- Policies viewed
- Incident Book viewed
- MAR Sheets
- Stock Balance Record Charts
- Residents Daily Records
- Action format for revised medication procedures
- Medication policy
- Serious incident policy

Staff Interviews

Staff interviews were undertaken in 5 sessions over a period of 4 weeks. The period for staff interviews was extended due to availability of staff and to provide every opportunity for staff contribution.

Staff from all Floors were selected for interview, consistent with their presence on duty on Friday 15 July (night) and Tuesday 19 July (day) as confirmed by the Rota and Signing In/Out Book which staff complete routinely.

These dates were provided by the Whistleblowing emails as the dates on which the medication mismanagement incidents took place.

In addition, the Home Manager, 2 Deputy Managers and the Administrator were also interviewed and 2 Southern Cross Senior management staff, the Area Manager and Quality Assurance Adviser.

In total, 35 staff were selected for interview inclusive of management and senior management.
Interviews were conducted at Tower Bridge Care Centre and Camberwell Green Care Home.

Of 35 staff selected:

- 27 staff attended
- 2 were on annual leave
- 2 were currently suspended

- 2 no longer work with the company
- 2 were unavailable and made no response to telephone contact

6. FINDINGS

Documentary Evidence confirmed:

- 8 residents on the 3rd Floor were recorded and signed off as having received the 21:00 medication dose from the Team Leader. The remaining residents were recorded as having refused medication.
- The working rota showed the Team Leader as working for 2 hours (20:00-22:00) on Friday 15 July
- The Team Leader did not "sign in" as working for 2 hours on Friday 15 July and was not scheduled on the Master rota for duty
- The Team Leader was not paid overtime for those 2 hours and they were not included in her overtime total either for the week or the month
- There was no evidence that these 2 hours were taken as time off in lieu and no system was presented for time off in lieu
- There was a consistent absence of scheduling of a Senior member of staff responsible for the administration of medicine, on the 3rd Floor on each night shift

Reported information from staff interviews confirmed:

Friday 15 July

- There was a customary practice, understood by all staff, of passing responsibility for the night administration of medicine on the 3rd Floor, to the Senior person on the 2nd Floor.
- On Friday 15 July this handover process was confused and medication was not given to 8 Residents on the 3rd Floor
- No one was recorded as "calling in" the Team Leader to administer medication on Friday 15 July.

Saturday 16 July

- On Saturday 16 July, the Team Leader reported to the Deputy Manager that the scheduled 21:00 medication had not been given to Residents on the 3rd Floor on Friday 15 July. The Team Leader understood that the Deputy Manager was dealing with the matter.
- This incident was not reported according to the regulatory protocols.

Thursday 21 July

- On Thursday 21 July while the Care Quality Commission were conducting a routine compliance visit, the Team Leader was approached by the Manager and asked to amend the records in respect of the medication which should have been given to Residents on Friday 15 July.
- Although initially refusing, the Team Leader was later led by the Deputy Manager to the medication room where she confirms she amended the records (MAR Sheets) to show medication as given to residents at 21:00 on Friday 15 July. While she was doing this, the Deputy Manager destroyed the medication not given, to retain a consistent stock balance. In addition an Administrator was posted outside the room to keep watch.

- The Team Leader readily admitted these actions when given the opportunity for interview and confirmed that she felt under pressure from management to comply. She also stated that she thought the Area Manager had been informed of the medication incident and complicit in the actions taken.
- Other staff confirmed these details as they had been reported to them, at the time, by the Team Leader. One HealthCare Assistant witnessed the meeting between the Manager and the Team Leader where the request to amend records had been made and also witnessed the unusual circumstances at the 3rd Floor medication room while the incident was underway.

6. INDEPENDENT INVESTIGATION CONCLUSIONS

Allegation 1 – that the 21:00 dose of medication was not given to 8 Residents on the 3rd Floor on Friday 15 July 2011 was **UPHELD**

Allegation 2 – that actions were taken (on Thursday 21 July) to amend records and destroy medication on the instruction of the Manager and with the involvement of Management staff was also **UPHELD**

7. INDEPENDENT INVESTIGATION RECOMMENDATIONS

The London Borough of Southwark, as Commissioners, to consider:

1. An immediate embargo on all new placements at Tower Bridge Care Centre and given the operational mismanagement identified, how this may be relevant to other Care Homes within the Group.
2. Using the Safeguarding Adults process to agree a strategic plan to investigate Tower Bridge Care Centre, identify residual risk to Residents and require the Provider to develop action plans to comprehensively address operational issues and ensure the safety of Residents.
3. Sharing information with the Care Quality Commission and establishing a monitoring and evaluation framework for a specified period (working closely with the Care Quality Commission) to develop a culture of best practice and a clear focus on the well-being of Residents.

These measures should restore confidence in the quality of the service in the longer term.

Southern Cross, as the Provider, was asked to consider:

1. Appropriate and proportionate disciplinary action (with due regard for continuity of care for Residents) in respect of:
    a. The staff member who signed off the 21:00 medication dose as given on Friday 15 July 2011
    b. The Deputy Manager who signed in the Team Leader as present on Friday 15 July 2011 and apparently took the lead in ensuring the amendment of records and destruction of medication on Thursday 21July 2011
    c. The Deputy Manager who had clear knowledge of the medication missed on Friday 15 July and failed to take appropriate action to report this in line with

regulations and further, provided a confused statement about the incident, citing a sequence of events later denied by other staff.
    d. The Administrator who denied knowledge of the incident but took steps to frustrate access to a key staff member in the interview process.
    e. The Home Manager who has overall responsibility for service delivery
    f. The Area Manager who has overall quality and monitoring responsibilities in the operation of service delivery.
2. Establishing a comprehensive operational guidance document on medication administration available to staff on each Floor.
3. Training in the use of this guidance as soon as possible with refresher training plans in place
4. Senior staff with responsibility for medication administration to be rostered to the 3rd Floor on each night shift
5. Further monitoring and evaluation, to address wider service concerns indicated by these occurrences and the fact their internal investigation failed to discover the facts.

8. INVESTIGATION OUTCOMES

The findings were shared with Southern Cross and the Care Quality Commission at a formal meeting at London Borough of Southwark offices, on Friday 21 October 2011.

The following actions were taken and agreed:

The London Borough of Southwark established an immediate embargo on all new placements to Southern Cross homes in Southwark (Tower Bridge Care Centre and Camberwell Green Care Home).

The Council is working closely with the NHS Care Home Support Team to ensure the safety of existing residents and to develop a sustainable quality improvement plan.

Southern Cross agreed to 1) consider immediate and proportionate disciplinary actions that would ensure safety of our residents and 2) to urgently set up an immediate further internal investigation process, led by staff external to the operational management of Tower Bridge Care Centre into why their initial investigation failed.

The Council was subsequently informed that 3 staff, including the home manager have been suspended and a further 2 staff are subject to disciplinary process. At a very senior level, Pam Finnis, Regional Director at Southern Cross Healthcare and Managing Director designate for HC-1 (successor organisation) has agreed to oversee follow through on these matters. A senior HR specialist within the organisation has been appointed to conduct the disciplinary investigations in accordance with their policies and procedures.

The Care Quality Commission confirmed they will consider appropriate action under the regulatory framework.