



## Adult Practice Review Report

**North Wales Safeguarding Adults Board**

**Extended Adult Practice Review**

**Re: NWSAB1/2024**

### **Brief outline of circumstances resulting in the Review**

*To include here: -*

- *Legal context from guidance in relation to which review is being undertaken.*
- *Circumstances resulting in the review.*
- *Time period reviewed and why.*
- *Summary timeline of significant events to be added as an annex.*

An Extended Adult Practice Review (APR) was commissioned by the North Wales Safeguarding Adults Board on 30/04/2024 on the recommendation of the Adult Practice Review Sub-Group in accordance with statutory legislation set out in section 139 of the Social Services and Well-being (Wales) Act 2014 and accompanying guidance Working Together to Safeguard People – Volume 3 – Adult Practice Reviews (Welsh Government, 2016).

The criterion for this review is met under Chapter 7, Extended Adult Practice Reviews:

The Board must undertake an extended adult practice review where an adult at risk who has, on any date during the six months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health.

The purpose of the review is to identify learning for future practice. It involves practitioners, managers, senior officers and direct engagement with individuals and families exploring the detail and context of agencies' work with an individual and family.

The review considers the work of statutory agencies and the statutory plan(s) which were in place for the individual. The output of a review is intended to generate professional and organisational learning and promote improvement in future inter-agency adult protection

practice (Working Together to Safeguard People – Volume 3 – Adult Practice Reviews (Welsh Government, 2016).

The review is undertaken by two reviewers working closely together, appointed on behalf of the Review Panel. They have responsibility for examining how the statutory duties of all relevant agencies were fulfilled, and reporting on this to the Review Panel and the Board.

### **Methodology**

- Review Panel convened with a Chair.
- Two Reviewers appointed.
- Terms of Reference agreed.
- Timelines were developed by each agency.
- Panel members produced a summary/analysis of each services' involvement.
- A letter sent to the family providing the opportunity to participate in the process.
- A Learning Event for practitioners.
- A Review Report produced with learning points and presented to the Review Panel.
- Review Panel meeting to finalise the report.
- Action plan developed from recommendations.
- Review Report presented by Reviewers and Chair of the Review Panel to the Adults Case Review Group and the North Wales Safeguarding Board.
- Submission to Welsh Government.
- Feedback to Family.
- Publication of Report on NWSB website.

### **Review Panel:**

The services represented on the Review Panel were as follows:

- Health Board
- GP Practice
- Local Authority Adults Services
- CIW
- Police

### **Terms of Reference**

Core issues to be addressed in the terms of reference of the review will include:

- What were the barriers to the essential preventative prescribed medication not being ordered and given for a substantial length of time with no escalation.
- Concerns around escalation to management at the time when it was identified that the medication was missing.
- Record keeping inconsistencies and no record of escalation.
- Whether previous relevant information or history about the adult at risk and/or family members was known and taken into account in professionals assessment,

planning and decision-making in respect of the adult at risk, the family, and their circumstances. How that knowledge contributed to the outcome for the adult at risk.

- Whether the actions identified to safeguard the adult at risk were robust, and appropriate for that adult and their circumstances.
- Whether the actions were implemented effectively, monitored, and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the adult at risk. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the adult at risk and family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

#### **Timeline:**

The timeline for this APR covers a 13-month period from 1st May 2023, which was five months prior to the significant incident, to 7th June 2024, the date of her discharge from hospital .

Agencies were also asked to consider their involvement prior to the timeline, if relevant.

Information was made available in regard to professional involvement with the adult. This provided a clearer picture of the functioning of the adult and an understanding of their daily lived experience.

#### **Circumstances resulting in the review.**

Adult A, whom we will hence refer to as 'Rose,' resided in a residential care home, where she had lived since October 2022 and self-funded this placement. Rose was prescribed anti-coagulants which are a preventative medication due to high risk of a stroke. The supply of medication ended on 27/10/23 due to the medication not being received with the monthly medications and not followed up in a timely manner. The lack of essential preventative medication was noted by senior care staff on 26/10/23 but was not escalated to the Home Manager, or GP. Medication was last administered on 27/10/23, the new supply of prescribed medication was received by the Care home on 17/11/23 and clerked in on 19/11/23. Unfortunately, Rose had already sustained a stroke and had been admitted to hospital.

This health episode had a long-standing impact on Rose's health and well-being and very sadly, she later passed away in a Nursing Home on the 2nd of January 2025. At the inquest into her death on the 20th of June 25, the Senior Coroner for North East Wales and Central, John Gittins concluded. "For a period of 20 days from 28 October 2023 due to a prescribing and dispensing error the deceased was not given her medication. Her

condition deteriorated from the time of her stroke onwards resulting in her being immobile until her death. Her stroke in 2023 has more than minimally contributed to her death and it is probable that this would not have been the case if medication had been delivered.”

### **The Adults History and Contextual Information**

The reviewers are grateful to Rose’s family for agreeing to meet with them and share their memories.

Rose was born in 1937 in Manchester. On leaving school she went to work for the Coal Board in the wages department, having taken extra examinations to secure the job. In those days wages were paid in cash, and it was Rose’s job to deliver the wages to the men at the pit, traveling there and back in a truck.

Rose was singing in a choir when she met her future husband, who worked for General Electric Company (GEC) in Old Trafford. They had three sons, and the family has remained close, with everyone staying in regular contact with Rose throughout her life.

Rose and her husband moved to Fleetwood in 1970 and bought a newsagent which they ran for four years. Although successful, Rose found it difficult combining the work hours and raising three young children and so they sold the newsagent with her husband returning to work for the GEC and Rose working for a local company. After the children left school, their old newsagent business came back on the market, and they bought it again and went back to running a Newsagents once more.

When they retired, they decided they would like to live nearer to their family and moved to North Wales in 2001 to a house just across the road from their middle son and daughter-in-law. It was a really successful move and Rose loved spending regular time with their son, daughter in law and grandchildren.

Rose and her husband loved travelling including visiting one of their sons and family in Australia. Rose always liked dogs and in particular had a great fondness for poodles. Her son describes Rose as a real home maker, and a fantastic cook who made her own wine.

Rose loved being with people, and she remained very sociable throughout her life.

In later years Rose started to have dementia and she used to go to the memory club one day per week and then a day centre twice a week. In both, Rose would wholeheartedly join in with everything that was going on.

Rose’s husband passed away in 2012, and in later years Rose experienced physical challenges eventually needing a walking aid following two hip replacements and a knee replacement. Her son describes her as being mentally very stoic and someone who loved having regular contact with both her grandchildren and great grandchildren. Rose moved to a Residential Care Home in October 2022 where her son and daughter in law would regularly visit. Staff often commented to the family how determined Rose was and how she wanted to do so much for herself.

In summary Rose was a positive and determined lady with many skills and interests.

**View of the family:**

Rose went into a care environment on a staged basis as her dementia progressed. She had previously lived in close proximity to family members but after suffering a number of falls when she was without her pendant, it was decided that Rose could no longer live alone. It was for this reason that the family then sought recommendations for a care home facility which could provide additional support to Rose.

The family started looking around for a suitable environment. She was still mobile and eating well. She needed help getting up, getting dressed, having meals and medications. The family found the care home, through recommendations and their own research.

On moving into the care home Rose settled in well with a good channel of communication established between staff and Rose's family. If something happened, the home always got in touch with family members e.g. she had a fall around Christmas 2022. Family members took her to Holywell for an X-Ray. The home was also trying to get a continence assessment done and as a family, they helped. The family always felt the care home knew Rose's family was supportive and were at end of the phone.

At the end of 2022, the care home underwent a period of instability which included the death of one of the owners and the long-term manager leaving the home. Although some of the original staff remained, the family noted those staff had some frustrations with the changes as a result of these events. When Rose had the stroke, only then did it become apparent to the family, that she had not had her medication.

**Learning Event:**

The purpose of practice reviews is to identify multi agency learning for future practice. Therefore, on the 15/7/25 the reviewers and the chair held a learning event with twenty-two key practitioners and managers from seven agencies involved in the care of Rose.

The following organisations attended:

- Health Board Hospital
- Health Board Pharmacy Services
- Community Pharmacy
- Adult Social Services
- Social Services Commissioning and Contracts
- General Practitioner Surgery
- Police
- CIW.

It is of concern that the care home involved did not respond to requests to participate in the learning event and did not send any representatives. It is felt that this would have

provided an important opportunity to gather learning and identify good practice from the providers perspective.

During the learning event, professionals highlighted key learning areas which are detailed within the body of this report.

### **Practice and organisational learning.**

*Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances.*

The following themes relating to practice and organisational learning have been identified:

#### **1. Administration of Medication:**

The key issues identified relate to the prescription for critical medication, not being issued or the omission rectified in a timely manner. There were three different agencies involved the GP, Pharmacy and Care Home. There were roles played by all three agencies which resulted in the omission of the required medication, with profound consequences for Rose.

Firstly, the prescription for Edoxaban was not issued with the other medication on three occasions by the GP in August, September, and October 2023.

August: The prescriptions for the monthly medicines for start date August were dated 8.8.23 but the Edoxaban was missing. An email was sent to the surgery by the pharmacy, on the 23/08/23 to chase the Edoxaban prescription and an email was received from the GP for a prescription (dated 23.8.23). This was dispensed on 23.8.23 and delivered with the rest of the monthly medicines during the afternoon of the 23.8.23.

September: The prescriptions for other medicines were received at the pharmacy dated 7.9.23. The Edoxaban prescription dated 13.9.23. All the prescriptions were dispensed on 14.9.23 and delivered to the home on the 20.9.23 for a start date of the 24.9.23.

October: Prepared medicines were checked on the 17.10.23 and delivered to the home on the 18.10.23 for a start date of 22.10.23. Edoxaban was not dispensed as no prescription was received, it was marked on new MAR as quantity zero supplied. On this occasion, the Edoxaban prescription was not re-ordered by the pharmacy.

On the 6th of November 8 days after the last Edoxaban had been administered to Rose, a telephone call was received by the GP surgery from the care home querying the absence of Edoxaban. This issue was responded to by the Practice Manager and the dose reviewed and reduced, (in response to the blood tests done in August) and Edoxaban was reinstated in the prescription.

The senior Pharmacy Technician from the GP Practice attempted to make telephone calls to the home to explain the change to reductions in Edoxaban dosage but was not

able to get an answer. Therefore, the decision was made to send the new prescription to the pharmacy for dispensing.

The omission of Edoxaban from the October prescription was explained as 'Human error' by a GP practice representative during the Adult Protection Conference on the 23/01/2024. On this occasion it was not chased by the Community Pharmacist. It was also not chased or questioned by the care home staff or management until the 6th November. The prescription for Edoxaban was then reviewed and reduced and a script was issued and received by the pharmacy on the 07/11/2023.

It should be explained, that in August 2023, District Nurses attended to obtain blood from Rose for routine tests. Good practice indicates that where Edoxaban is prescribed annual monitoring should take place or more frequent if clinical concerns. However, following on from these blood tests, the dosage of Edoxaban was not reviewed or reduced until 6<sup>th</sup> November. Though this was clearly clinically driven and appropriate, there is nothing to indicate that the review of the medication would have taken place at that time without the telephone call from the care home on 06/11/2023, querying the absence of Edoxaban. This does not however, materially change the seriousness of Rose not receiving the Edoxaban in the critical 20-day period from the 27/10/2023 until the 17/11/2023.

It is acknowledged that thousands of prescriptions are issued by the GP practice, nevertheless, there is learning for the GP Practice to ensure that Quality Assurance and oversight of the issuing of critical medications is as robust as it can be to enable any missed essential medications to be identified and rectified at an early stage.

In addition, the Pharmacist has a role to check the medication before passing onto the patient and Care Home. In this case, the Pharmacists in August and September did realise that Edoxaban was not included with the usual medication. The pharmacist ensured that it was reinstated. However, this did not happen in relation to the October prescription when it was omitted again, and the Edoxaban was not supplied. Although it is accepted that other agencies, the care home, and GP have a clear responsibility to check the medication, there is learning for the pharmacy regarding oversight of key medication.

Even though the corrected prescription with Edoxaban was received from the surgery on the 07/11/2023 by the pharmacist, there was a further period of delay of a full 10 days before it was received into the care home.

The care home clearly had a responsibility to check that the medication prescription and delivered medication was appropriate and consistent with the MAR chart, which is the official document which acts as a record of medication. The Care Home staff may have realised there was an issue, and the home have said that they telephoned the surgery on the 30/10/2023 of October. However, there is no record of this phone call in the recordings of the GP system.

There was a lack of urgency by partners in seeking to ensure the medication was available for Rose. The pharmacy could have been more diligent in contacting the home to inform them the medication was available. Certainly, the home staff should have prioritised picking up and giving the required medication without further delay. It would

have been appropriate to escalate this issue to the senior responsible person at the care home to ensure these critical issues were resolved. Having raised this issue with the GP on the 06/11/2023, it would seem reasonable to assume that care home staff would follow up the outcome of the issue with some urgency. This clearly did not happen.

## **2. Communication:**

Communication appeared to have been ineffective, inconsistent, and laboured between the Care Home, GP and Pharmacy, during the critical 20-day period when medication was not given. This allowed almost 3 weeks to elapse without Rose receiving critical anti-coagulant medication.

There were genuine issues with the communication between agencies to seek to rectify the mistake. The care home reported that they attempted to telephone the GP surgery on 30<sup>th</sup> October, although there is no record of this at the surgery. The Adult Protection conference notes of the meeting of the 23<sup>rd</sup> January report that the Responsible Individual of the care home accepted that this call had not been made, and a call was only made on the 6<sup>th</sup> November.

The Surgery reports that they tried on three occasions to telephone the care home and received no reply. In this context it is evident that agencies should have a process of escalation and different routes of communication in order to resolve urgent issues. The use of telephone communication appears to have been problematical in this situation. In this context other forms of reliable communication such as secure email or messaging should be considered which enable secure and reliable written communication in real time.

It is also apposite to ask with the potentially serious implications of essential medication not being administered for Rose, whether it would have been appropriate to fall back on traditional but important forms of communication such as the care home staff or manager visiting the surgery and or pharmacy to resolve the issue. It is acknowledged that care home rotas can be pressurised, but this may well have made a significant difference in this case.

On a broader point the Escalation of Concerns process had allowed sharing of information with certain agencies regarding the needs for improvement at the Care Home but some agencies, notably the Pharmacy, had no knowledge at all about these conversations. It may have helped to have this wider communication when there are medication concerns regarding a care provider.

## **3. Recording, Auditing, Medication Checking and Quality Assurance:**

The care home records were handwritten, unclear and incomplete. There is no sufficient evidence of clear checking and quality assurance by the managers of the home. The safeguarding meeting on 23/01/24 noted that there was no oversight of medication administration in the home.

Care Inspectorate Wales had identified the management of medication as an area requiring improvement on the 03/10/2023 and it appears to have been a relevant issue in the critical period of this review from August to November 2023.

It is appropriate to question whether the Quality Assurance approaches in the GP and Pharmacy practices to identify and correct prescribing errors were sufficiently rigorous and embedded, as the process cannot rely on the reporting of errors by patients or carers alone.

There needs to be a good understanding of medication management practices by all agencies including commissioning and contracting staff in Social Services and Care Inspectorate Wales. In the learning event it was not evident that the Standard Practice Operating Procedure for Medicines Management in Care Home Settings In North Wales' (MM89) developed and issued by the Health Board, was fully shared and understood by all agencies involved including Social Services and CIW.

There was a lack of written guidance regarding the oversight of medication in the care home and the clear role for the Responsible Individual which needs to be addressed.

The MAR chart process is described by the GP Practice as a relevant piece of guidance, but it is not clear where this process has been developed and formally agreed.

#### **4. Urgency:**

At the centre of this issue there appears to have been lack of urgency in actions taken to ensure that Rose received the medication that she needed. What started as an administrative error was allowed to develop into a profoundly serious and life changing risk for Rose. It may well have been the case that if urgent action were taken by key partners most notably the care home to sort out the medication issue at an early stage that there would not have been disruption in the administering of a critical medication.

As discussed above telephone communication was not very effective between agencies but we have to ask why there was no real urgency in ensuring that effective conversations were had, such as the care home physically visiting the pharmacy or General practitioner Practice to sort the issue promptly. It may be that this urgency should be reflected in future training for care home staff.

Additionally for Pharmacy and General Practice colleagues there may be a requirement for a red flag process needs to be introduced so that added scrutiny is given to Critical medication. This was a theme reflected in the learning event.

#### **5. Leadership and Delegation**

The management and leadership of the Care Home had been under a period of change, and this may well have undermined appropriate leadership in the home during this critical period of Summer/ Autumn of 23. The importance of robust leadership in social care organisations is known to be vital in promoting positive practice as reflected in inspection reports.

One further issue is the need for clear lines of accountability and mechanisms for escalating key issues such as absence of required medication to the manger in a timely manner. It is not evident that this was effectively achieved in this case.

The review found that leadership and the effective management of medication needs to improve in the care home. Similarly effective leadership is essential to all the partners involved, including GP, Pharmacy and Social Services as is the importance of appropriate escalation of issues.

## **6. Duty to Report**

Safeguarding reports were not made in a timely manner. A safeguarding report was made to the Local Authority by the care home on the 27/11/23 and on the 29/11/23 by the GP Practice.

More awareness of the 'Duty to Report' is required, as per the Wales Safeguarding Procedures (2019) and also referenced in 'The 'Good Practice Standard Operating Procedure for Medicines Management in Care Home Settings In North Wales' (MM89).

Appendix 9 lists high priority medications which includes Edoxoban and Appendix 10 sets out the escalation process regarding medication not received.

The SoP states in Appendix 10: 'If resident misses a dose(s) of their prescribed medication due to lack to of supply the:

- Care home must inform relevant local authority via safeguarding referral.
- Care home must inform resident and/or Next of Kin /Advocate

If a care home experiences ongoing issues with medication supply, consideration should be given to contacting the practice manager for meeting and/or the Medicines Management team for support.'

The Regulation and Inspection of Social Care (Wales) Act 2016, 58.(1) states that 'The service provider must have arrangements in place to:

- (1) Ensure that medicines are stored and administered safely.
- (2) These arrangements must include the arrangements for—
  - (a) maintaining a sufficient supply of medicines.
  - (b) the effective ordering, re-ordering, recording, handling, and disposal of medicines.
  - (c) regular auditing of the storage and administration of medicines.

A review of the frequency of inspection of medication audits undertaken by the care homes should be considered, particularly following a period of inspection or within the Escalation of Concerns process where medication errors are identified.

## **7. Staffing (Experience Training and Competencies):**

The number of relevant CIW referrals, and the Escalation of Concerns process indicate that a lack of consistency of staff at the care home was a problem and this may have contributed towards this incident.

Training regarding medication administration is critical. It is evident that some training was effectively taken forward including that being given by Medicine Management colleagues. This should be embedded and systematic. Changes in management and staff will mean that awareness and expertise may be lost over time. Training also needs to be regularly reviewed and monitored by the Registered Manager and overseen by the Responsible Individual to ensure that those administering medication are competent.

Training regarding the key elements of a medication within an overall care plan should be understood fully by all the partners involved in care and so consideration should also be given to how this is taken forward by other partners (e.g. Social Services, CIW) as well as direct care providers.

#### **8. Involvement of Family:**

It is critical to involve family members effectively and, in this case, it is worth reflecting that doing so may have aided the resolution of the issue of the medication:- Certainly, the sense of urgency of the case may have been increased.

A letter was sent to all families from the EoC (Escalation of Concerns) process advising generally that there were concerns. It may be that reference to the specific issues around medication in this case may have alerted families who may then have intervened. There were 3 separate EoC processes, but it appears that only one letter was sent to families. Accepting that there is a difficult balance to be struck between supporting the Care Home to achieve the required standards whilst keeping families informed

#### **9. Risk Assessment:**

The medication risk assessment completed in respect of Rose had no mention of specific medication, its purpose, nor risks associated with the non-administration of this critical medication. An effective medication risk assessment would be person centred, contain information about the persons medical diagnosis, capacity in relation to self management of medication, preferences, and information relating to critical medication

#### **10. Escalation of Concerns, Inspection and sharing of issues:**

The Responsible Individual expressed concern about the pressures that the increased number of professionals attending the home was putting on the staff. The care home had been subject to CIW inspections and the Escalation of Concerns process after experiencing significant issues over a prolonged period of time. Escalation of Concerns warrants proactive or reactive intervention from those commissioning services, possibly from one or more commissioning agencies, meaning an increased presence of professionals. The process is designed to improve the quality of services and, where possible, prevent what might be avoidable home closures.

Care Inspectorate Wales has a key role in ensuring quality and safety of services delivered under the regulation and inspection framework. CIW received a number of

safeguarding reports before and during the period of this review. The increasing number of concerns and safeguarding reports submitted following the changes in management, highlights the requirement for robust and consistent oversight. On review, it was felt that opportunities for CIW to consider an earlier inspection may have been overlooked.

Furthermore, at the learning event, the point was made that only a certain number of agencies are involved in the sharing of concerns regarding care homes with some partners e.g. pharmacy colleagues, intentionally excluded. Of course it is important to achieve the right balance, but consideration should be given to the effective sharing of information with additional relevant partners when an Escalation of Concerns process has been taken forward.

### **Improving Systems and Practice**

*In order to promote learning from this case the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes: -*

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In considering the evidence provided during the review and the reflections and learning presented during the learning event the following have been identified as the key learning points for system and practice improvement:

#### **Recommendations:**

1. The Standard Operating Procedure MM89 to be shared, fully understood, agreed, and embedded by all agencies. Furthermore, it should be reviewed to further strengthen the escalation process regarding high risk or red flag medications with more emphasis on the 'Duty to Report' following missed doses due to lack of supply and informing next of kin / family.

The escalation process also needs to be strengthened in relation to missed medication occurring during weekends and bank holidays.

#### **Responsible agencies All - Timescale April 26**

2. Review the current channels of communication in the event that telephone communication cannot be made.

#### **Responsible Agency BCUHB and Primary Care - Timescale April 26**

3. Medication audits in care homes and training records of staff in relation to medication management, to be rigorously checked by inspectors and commissioners where issues around medication are highlighted in inspections

and in Escalation of Concerns procedures. Where there are failings, priority actions should include further training for all staff including the RI and Manager.

**Responsible Agencies CIW, Local Authorities, Health Board. Timescale April 26**

4. Pharmacy colleagues to be involved in safeguarding discussions – when safeguarding concerns are highlighted in the context of missing or delayed medication.

**Responsible Agency: All safeguarding agencies - Timescale January 26**

5. An urgent review of systems in place to check re-ordering of critical medication to avoid errors in General Practice, Pharmacy and in Care homes, considering best practice in other areas e.g. red flag.

**Responsible Agency General Practitioner, Community Pharmacies, Care Homes. Timescale April 26**

6. Ensure that there are effective systems to escalate operational issues of urgency. Escalations processes must follow established pathways and be accessible to all agencies including third sector colleagues and family members.

**Responsible Agency. All. Timescale January 26.**

7. Ensure escalation of concerns meetings promote good oversight and a coordinated approach across all agencies to avoid any exacerbation.

**Responsible Agencies. CIW, LA and BCUHB. Timescale January 26**

8. Ensure that reviews of individuals (including those who are self-funded) when an organisation enters the Escalation of Concerns process considers the need to review the details of any critical medication prescribed and evidence of effective medication management.

**Responsible Agency. Local Authorities and BCUHB. Timescale April 26**

9. In the context of limited involvement by the care home in this review, ensure that all care homes are appropriately informed of the learning highlighted within this report.

**Responsible Agency ALL. Timescale January 26.**

**Good Practice:**

During this review, the following good practice was identified:

**Multi-Agency Engagement:**

Good communication between CIW, Commissioners, Safeguarding and Community Nursing teams.

Prompt multi-agency response due to the concerns raised and the escalation of the issue resulting in the effective calling of Part 5 meeting and referral to Police.

### **Social Services /Contracts & Commissioning:**

Effective use of a Review for a self-funder (which would not automatically have been the case), on this occasion triggered by the Escalation of Concerns Process. This ensured the appropriate and continued involvement of family in the Safeguarding process.

Training and auditing of staff at the care home post incident by medicine management staff and community pharmacy.

### **Health Board:**

Health Inpatient staff provided good acute and rehabilitative care following admission.

Proactive reporting and resolution by the pharmacy after identifying that the critical medication was missing from the August prescription. As a result of this incident there was a prompt review of the Practice Standard Operating Procedure for Medicines Management in Care Home Settings In North Wales' (MM89).

### **Conclusion :**

At the inquest into her death on the 20th of June 25, the Senior Coroner for North Wales and Central concluded. "For a period of 20 days from 28 October 2023 due to a prescribing and dispensing error the deceased was not given her medication. Her condition deteriorated from the time of her stroke onwards resulting in her being immobile until her death"

The stroke that Rose suffered in 2023 has more than minimally contributed to her death and it is probable that this would not have been the case if medication had been delivered ".



### **Reference List**


Welsh Government (2016) *Working Together to Safeguard People - Volume 3 - Adult Practice Reviews*

Welsh Government (2019) *Working Together to Safeguard People (Volume 6 Handling Individual Cases to Protect Adults at Risk)*

*Wales Safeguarding Procedures (2019)*

*MM89 – Good Practice Standard Operating Procedure (SOP) for Medicines Management in Care Home Settings in North Wales – V4.0*

Statement by Reviewer(s)			
<b>REVIEWER 1</b>		<b>REVIEWER 2</b> <i>(as appropriate)</i>	
<b>Statement of independence from the case</b> <i>Quality Assurance statement of qualification</i>		<b>Statement of independence from the case</b> <i>Quality Assurance statement of qualification</i>	
<p>I make the following statement that prior to my involvement with this learning review: -</p> <ul style="list-style-type: none"> <li>• I have not been directly concerned with the individual or family, nor have I given professional advice on the case.</li> <li>• I have had no immediate line management of the practitioner(s) involved.</li> <li>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.</li> <li>• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.</li> </ul>		<p>I make the following statement that prior to my involvement with this learning review: -</p> <ul style="list-style-type: none"> <li>• I have not been directly concerned with the individual or family, nor have I given professional advice on the case</li> <li>• I have had no immediate line management of the practitioner(s) involved.</li> <li>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.</li> <li>• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.</li> </ul>	
<b>Reviewer 1</b>		<b>Reviewer 2</b>	
<p>(Signature) </p> <p><b>Name</b> Neil Ayling</p> <p><b>Date</b> 11/11/2025</p>		<p>(Signature) </p> <p><b>Name:</b> Ramona Murray</p> <p><b>Date</b> 11/11/2025</p>	

<b>Chair of Review Panel (Signature)</b>	
<b>Name</b> Sophie Chance (Print)	
<b>Date</b>	11/11/2025

**Appendix 1:** Terms of reference **Appendix 2:** Summary timeline

<p><b>Adult Practice Review process</b></p> <p><i>To include here in brief:</i></p> <ul style="list-style-type: none"><li><i>The process followed by the Board and the services represented on the Review Panel.</i></li><li><i>A learning event was held and the services that attended.</i></li><li><i>Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.</i></li></ul>
<p><b>Methodology:</b></p> <p>The review was undertaken by two reviewers appointed on behalf of the Review Panel. They had responsibility for examining how the statutory duties of all relevant agencies were fulfilled, and reporting on this to the Review Panel and the Board.</p> <p><b>Review Panel:</b></p> <p>The services represented on the Review Panel were as follows:</p> <ul style="list-style-type: none"><li>Health Board</li><li>GP Practice</li><li>Local Authority Adults Services</li><li>CIW</li><li>Police</li></ul> <p>Timelines were requested from all agencies, together with any relevant historical information.</p>

*(It is to be noted that very limited information was received from the care home in response to communication from the Chair of the NWSB following repeated unanswered requests.)*

**Four** Panel meetings were held and learning event took place on 16/07/2025.

**Learning Event:**

A learning event was held on 16/07/2025 the following agencies were present:

- Health Board
- GP Practice
- Local Authority Adults Services
- Local Authority Commissioning & Contracts Services
- CIW
- Police
- Community Pharmacy

*\*\* It is to be noted that requests for representatives from the care home to attend were unanswered.*

**Family Involvement:**

The reviewers met with the family prior to the learning event and their views were conveyed to both panel members and attendees at the learning event. Family were updated regularly on the progress of the review. The reviewers met with family again prior to the publication of the report.

Family declined involvement

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Date information received .....

Date acknowledgment letter sent to Board Chair .....

Date circulated to relevant inspectorates/Policy Leads .....

<b>Agencies</b>	<b>Yes</b>	<b>No</b>	<b>Reason</b>
CSSIW	<input type="checkbox"/>	<input type="checkbox"/>	
Estyn	<input type="checkbox"/>	<input type="checkbox"/>	
HIW	<input type="checkbox"/>	<input type="checkbox"/>	
HMI Constabulary	<input type="checkbox"/>	<input type="checkbox"/>	
HMI Probation	<input type="checkbox"/>	<input type="checkbox"/>	