Northumberland Safeguarding Adults Board

Safeguarding Adults Review in Respect of Adult W

Independent Overview Report

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Contents

Executive Summary

This report provides the outcome of the examination into Adult W's death in accordance with Section 44 of the 2014 Care Act. Adult W, a 90 year old gentleman, died on 8th April 2017 at a Nursing Home in Northumberland where he had been admitted for a period of respite care, with the possibility of longer term care being considered. Prior to this admission for respite care on 31st March 2017, Adult W, with support, had maintained his independence in his own home. Adult W had a diagnosis of Type 1 diabetes alongside a number of other medical conditions. The cause of death for Adult W was identified as Diabetic Ketoacidosis (hyperglycaemia) and Broncho-Pneumonia.

A salient descriptive chronology of Adult W's care pathway between January 2017 to April 2018 is provided in the main body of the report to assist an understanding of the context for this review. There then follows an analysis with identification of key findings based on the agreed Terms of Reference which then allow conclusions to be determined with the overall aim of identifying learning opportunities. It is these learning opportunities that have informed the recommendations of this report.

The benefit of hindsight has been most useful as it has enabled the author of this report to consider issues that could have been improved in the care pathway relating to Adult W, being cognisant of hindsight bias. In learning from the death of Adult W, it has been possible to identify a number of key themes and it is these themes on which the conclusions of this report are based:

Management of Adult W's deteriorating condition in April 2017:
Adult W's physical health deteriorated in Nursing Home 1. It is important to identify that Adult W's condition had medically deteriorated to the extent that this was outside of normal clinical management, as corrective action had been ineffective for some time. There should have been a clear documented care plan of what 'sick day rules' were to be followed at the point that Adult W became unwell and blood glucose became significantly elevated. Nursing staff failed to recognise the severity of the presentation and failed to escalate the situation to emergency status when the situation warranted such a response.

Review of Adult W's diabetes plan:
It is clear that there was a bespoke diabetes care plan developed in 2014 by the Specialist Diabetes Service. This is not standard practice for every patient with Diabetes and was developed as a result of concerns raised by the family of Adult W at that time. This was good practice in responding to concerns and involving Adult W and his family in decision making around Adult W's Diabetes Management plan. The formal written diabetes plan was a comprehensive document and was clearly identified by the family, General Practice and a number of support agencies as the framework for the management of Adult W's diabetes.

Subsequently, when Adult W was admitted to Hospital in 2017, a decision was made in consultation with the specialised diabetes team, to change the medication regime (one element of the overall plan). There should have been but there was not a common understanding of accountability across all agencies of the bespoke diabetes care plan which was seen as being central to the care of Adult W by a number of agencies and his family. The formal review of the bespoke plan had not taken place in accordance with national best practice standards. Whilst it is acknowledged by the author that the bespoke plan was not standard practice for all patients, it was the standard set in relation to Adult W, and a standard the family, General Practice and other support services had worked within for a 3 year period, albeit without a formal review.

The priority identified through discussion by the clinical teams in hospital, indicates that the avoidance of hypoglycaemia was the clinical priority within Adult W's diabetes management and therefore this was the reason for the changes to the medication. This is considered a reasonable and appropriate decision given Adult W's history of falls. The family consider the risks associated with the impact of the change of Novorapid in relation to hyperglycaemia were not fully considered. They feel strongly that the condition is not understood by professionals and have indicated the importance of recognising the risks associated with, and specialist training required, for the successful treatment of this condition. However, as stated earlier,in a situation where Adult W's medical condition was outwith normal clinical management (emergency status) the action required was outside his prescribed level of Novorapid medication which had been ineffective.

Whilst it is acknowledged that the bespoke diabetes care plan was not updated, this did not impact within the District Nursing service on their implementation of the revised insulin regime. However, the changes made to Adult W's medication regime were not effectively communicated across all agencies with responsibility for Adult W's care in a timely manner which in 2015 had been clearly identified as the responsibility of the District Nursing Service. There was some evidence that non statutory agencies, on occasions, felt poorly informed.

Communication & Integration of the care pathway:
Effective communication can be modelled differently depending on local agreement. What would be expected to be seen in any practice however, would be:

- clear legible notes with clarification of individual needs and requests;
- Past history such as blood glucose management;
- involvement of relatives (as appropriate);
- any particular relevant information to meet the needs of the individual in current or new care settings;
- anticipation of any new support required given a change in environment and health and social care needs;
- undertaking discussions with and by the most appropriate/senior member of staff.

These expectations would need to be carried out at the most appropriate time as near to transition as possible and relay accurate details that support the transition of

care for the individuals and their families. This communication is not evident in respect of Adult W's admission to Nursing Home 1.

The transfer of care responsibilities from the District Nursing service to Nursing Home 1, as stated above, was not comprehensive. These communication deficits contributed to a poor level of understanding in relation to Adult W's diabetic and holistic care needs in the week leading up to his death. The limited development of a person centred care plan to meet Adult W's medical needs was below the standard expected.

Communication at the point of contact with the 111 service was influenced by the call being initiated by a Healthcare Professional and as such, standard algorithms were not followed. (Algorithms are in place that would be receptive to hyperglycaemia should the call be from a non-healthcare professional). The verbal interaction that took place between the 111 service and the out of hours GP was influenced primarily by the clinical judgment of the Registered Nurse who, whilst recognising Adult W was deteriorating, failed to recognise the urgency of the situation.

Discharge for Adult W following his period of inpatient care did not recognise the relevance to other agencies of Adult W's bespoke diabetes plan.

The weekly General Practice clinical meetings and monthly multi-disciplinary meeting where patients are discussed and concerns raised, demonstrated effective communication within the GP practice regarding higher risk individuals such as Adult W, who had been discussed in such meetings. This is good practice.

The standard of record keeping varied in relation to Adult W and there was no formal update of the bespoke diabetes plan. Adequate care planning, risk assessment and risk management are fundamental and the lack of a specific diabetes care plan and other associated risk assessments did not provide clarity on the specific interventions that were being carried out, particularly in emergency situations. As a result, the care record was not conducive to supporting the provision of a coordinated care and treatment programme for Adult W's diabetes.

There was a strong person centred value base evident in each organisation and there was an intention to provide services for Adult W in maximising his independence in relation to health and social care needs. What was not evident however, was that there was a seamless service and robust co-ordination across the full pathway.

Within the provision of care to Adult W, services did demonstrate a commitment to work in collaboration with him through his active involvement in decision making and listening and responding to his wishes. Adult Social Care were responsive to the needs of Adult W's daughter aiming to provide support to her quickly and reduce the risk of a re-admission to hospital by arranging alternative respite care, which can be identified as good practice. There is however, no evidence that Adult W's daughter was offered a Carers assessment in providing proactive support.

Policy and Procedure:

A number of organisations had in place policies and procedures in relation to diabetes with a governance framework operational to regularly review these and update them in supporting evidence based practice. A number of other organisations had identified either policy deficits or areas for improvement and as a result of their Individual Management Review, had initiated action to address these matters.

The GP practice has a strong governance policy/process in place in relation to chronic health conditions/surveillance checks and annual reviews. The General Practice provided routine and acute health assessments, annual reviews for chronic conditions and advice and support to Adult W, which included his annual elderly care health check and dementia annual review. All of these are good practice. This did not however, include a formal review of the bespoke written diabetes care plan.
Contemporary Safeguarding information and policy is available on the statutory agencies websites for the general public. This is good practice.

The time delay in initiating the Section 44 review process has added to the distress faced by the family, in addition to not being supportive to them in being able to seek assurance and closure to their unanswered questions and ongoing concerns.

Education & Training:
Agencies varied in their approach to specific diabetes training, recognising that there were opportunities for improvement. There is no single agreed competency framework to manage diabetes (position statement Diabetes UK), however Diabetes UK recommend that organisations should demonstrate that staff have the appropriate time for continued professional development and that organisations identify all staff roles that could impact on the safety and quality of care for people with diabetes.

Overall this report illustrates that there were challenges in achieving the highest standards of practice in the provision of this multi-agency care pathway. However, all agencies have demonstrated through this Section 44 review, a significant willingness and commitment to learn and it is important to recognise this fact.

The author considers that whilst this report has identified a number of deficiencies in the care process, it cannot automatically be considered that they represent willful neglect. Neglect and acts of omissions are defined under the Care Act 2014 [1] and include '*ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating'.* Specifically, the clinical judgements involved at Nursing Home 1 in April 2017, whilst in the authors view were misjudged, these actions were not knowingly neglectful. However, the omissions of some staff not adequately monitoring and escalating the situation, did not provide timely medical intervention for Adult W. Based on the information made available to the review this could constitute an act of omission as defined under the Care Act 2014.

In considering the findings and conclusions of this report the following recommendations are made:

[1]Available at : http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

Recommendation 1. Northumberland and North Tyneside Safeguarding Adults Board supports the actions identified by the individual agencies in their IMR action plans and ensures an assurance framework that provides evidence of the actions listed having agreed target dates and those actions completed.

Recommendation 2. Northumberland and North Tyneside Safeguarding Adults Board should ensure lessons learnt are effectively disseminated within 3 months of the SAB approval meeting. Feedback to the family of Adult W should be within 2 weeks of this report being approved by SAB.

Recommendation 3. Northumberland and North Tyneside Safeguarding Adults Board should seek assurances from all agencies of the level of available diabetes / physical deterioration training and the assurance framework to monitor staff compliance to undertake such training supports the delivery of safe and effective care is compliant with organisational standards within 6 months.

Recommendation 4. Northumberland and North Tyneside Safeguarding Adults Board should seek assurances that:

a) within 12 months the Diabetic Patient Pathway has been reviewed across agencies and reflects standards of good practice and that accountabilities within the pathway are clear (this will require strong co-ordination through a lead agency to be determined locally).
b) within a further 6 months of the review being completed, a multi-agency diabetes pathway audit is undertaken to review the level of compliance to the revised framework.

Recommendation 5. Northumberland and North Tyneside Safeguarding Adults Board should seek assurances that within 3 months completion of the review of the Diabetic Pathway (recommendation 4a), organisational policies have been reviewed and updated if necessary.

Recommendation 6. Northumberland and North Tyneside Safeguarding Adults Board should within 1 month of publication share the findings of this review with the Care Quality Commission (CQC) to raise awareness of the lessons learnt in supporting their regulatory responsibilities and help to inform future inspections across the health and social care sector in Northumberland.

Recommendation 7. Northumberland and North Tyneside Safeguarding Adults Board should:

A) within 6 months, review their decision making pathway regarding the identification of a Section 44 Review in order to ensure timely decision making in the context of the date of when an incident actually occurs.
b) Provide to the family a regular (2 monthly) report on the progress relating to the implementation the recommendations of this report.

1.1 Introduction

1.1.1 Background:

On 11th October 2017 a decision was taken by Northumberland Safeguarding Adults Board to undertake a Safeguarding Adult's Review[2] (SAR) following the death of an elderly gentleman, referred to as Adult W throughout this report to ensure anonymity. Initially, concerns about the death of their father had been raised by the family of Adult W on 9th April 2017, after which a Section 42 review[3] had been initiated. The decision was subsequently changed as it was considered the criteria for a Section 44 review, as described in the Care Act 2014[4] had been met. This report therefore provides outcomes of a traditional Safeguarding Adult Review into the death of Adult W, utilising the Serious Case Review methodology[5].

1.1.2 Adult W was a 90 year old gentleman, who was born in South East, Northumberland and as a child had attended a Secondary School in Bedlingtonshire. After leaving school he worked for the London and North Eastern Railway Company before being "called up" for Army service between 1944 to 1948, later to return to working with the railways. Adult W also retained involvement with the army through membership of the reserves / territorials. Adult W married in 1950 and between 1952 to 1963 had 3 children, 2 sons and a daughter. During this period the family spent time living in South Shields, Heaton and Westerhope, before moving back to South East Northumberland. Adult W's wife died in December 2007 a week before her 79th Birthday.

1.1.3 On 8th April 2017 Adult W died in Nursing Home 1 in Northumberland where he had been admitted for a period of respite care, with the possibility of longer term care being considered. Prior to this admission for respite care on 31st March 2017, Adult W had maintained his independence at home with the support of a range of community services. Additionally, his family were greatly involved over a number of years in enabling Adult W to continue to live at home. During the earlier part of the

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[2] Section 44 of the Care Act 2014 places a duty on local Safeguarding Adults Boards to arrange a Safeguarding Adult Review when an adult, with needs for care and support,(whether or not the Local Authority was meeting any of those needs) in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

[3] Section 42 of the Care Act places a duty of enquiry on the Local Authority where there is a reasonable belief that an adult in its area has care and support needs is being abused or neglected (or is at risk of being), and is unable to protect themselves as a result of their care and support needs. The purpose of section 42 enquiries is to enable the Authority to decide what action needs to be taken to protect the person. It therefore does not apply to the situation where someone has died and may have been abused or neglected before that. The decision at a Safeguarding Adults Strategy meeting held on 24th April 2017 to follow a section 42 process has subsequently been acknowledged by NCC to be incorrect. It is acknowledged the Local Authority may need to make initial fact finding enquiries to consider whether the conditions for a Safeguarding Adults Review are met however this process should not be considered a section 42 enquiry.

[4] Care Act 2014 available at www.legislation.gov.uk

[5] As set out in Section 7 of North of Tyne Safeguarding Adults Review Policy and Procedure 2015

year (30th January 2017-1st March 2017) Adult W had required a period of in-patient hospital care. The admission to hospital followed a fall at home.

1.1.4 For approximately 50 years Adult W had a diagnosis of type 1 (insulin dependent) diabetes (type 1 diabetes is less common with approximately 10% of individuals with diabetes having type 1[6]). His medical background also included conditions[7] of hypertension, polymyalgia rheumatica, peripheral arterial disease, oesophagitis, diabetic neuropathy, diabetic retinopathy, chronic kidney disease, osteoarthritis, dysphagia, cataract (left cataract extraction and implant), myocardial infarction, ankylosing spondylitis and falls[8] .

1.1.5 The cause of death for Adult W was identified[9] as Diabetic Ketoacidosis[10] (hyperglycaemia) and Broncho-Pneumonia[11]. In addition Dementia[12], Ischaemic Heart disease[13] and left Ventricular Hypertrophy[14] were identified as contributing conditions to his death.

1.2 Purpose of Adult Safeguarding Review

The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake HR duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi agency and those of individual organisations);
- To inform and improve local inter agency practice;
- To improve practice by acting on learning (developing best practice);

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[6] Diabetes UK see https://www.diabetes.org.uk/diabetes-the-basics/what-is-type-1-diabetes

[7] A glossary is included for reference at appendix IV of these medical conditions

[8] Schwartz AV, Vittinghoff E, Sellmeyer DE, et al(2008)Diabetes -related Complications, glycaemic Control, and falls in older adult. Diabetes Care, 31 : 391-396

[9] University Department of Pathology, RVI, Consultant Pathologist Post -Mortem Report , 4th May 2017.

[10] Diabetic ketoacidosis (DKA) is a serious problem that can occur in people with diabetes if their body starts to run out of insulin. This causes harmful substances called ketones to build up in the body, which can be life-threatening if not spotted and treated quickly. See www.nhs.uk/conditions/diabetic-ketoacidosis

[11] Pneumonia is not a specific disease; it is a general term that pathologists use for several kinds of inflammation of the lungs. It is usually the result of microbial infection by some bacterium or virus. Bronchopneumonia is patchy inflammation of one or both lungs. See https://www.nhs.uk/conditions/pneumonia/

[12] Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning. See https://www.nhs.uk/Conditions/dementia/about/

[13] Ischaemic heart disease (often referred to as coronary heart disease) is the term that describes what happens when your heart's blood supply is blocked or interrupted by a build-up of fatty substances in the coronary arteries see https://www.nhs.uk/conditions/coronary-heart-disease/

[14] Left ventricular hypertrophy is enlargement and thickening (hypertrophy) of the walls of your heart's main pumping chamber (left ventricle) see https://www.mayoclinic.org/diseases-conditions/left-ventricular-hypertrophy/symptoms-causes/syc-20374314

- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There is a strong focus in this report on understanding the underlying issues that informed agency/professionals' actions and what, if anything, prevented them from being able to help and protect Adult W from harm.

1.3 Independent Review

Mr Phil Robertson was commissioned to write this report in January 2018[15]. In order to provide an independent overview report, by bringing together and analysing the findings from the various reports and associated information from each agency, He is an independent health and social care consultant and a registered nurse, having previously worked at Executive Director level positions in the NHS. He has a professional background in mental health and organisational governance. He has authored several independent reports relating to serious untoward incidents involving care services over the past 6 years.

1.4 Agencies Involved in providing Individual Management Reports (IMR)

A number of agencies were involved with Adult W and have contributed to this review through the provision of their own management reviews relating to the circumstances leading up to the death of Adult W. For the purpose of this report and in line with standard practice for SAR's, the agencies (below) and individuals providing information to the review are anonymised.

- Hospital & Community NHS Foundation Trust
- Adult Social Care Services
- Day Centre Services
- Home Care Services
- Nursing Home 1[16]
- Residential Home 1
- Doctors Urgent Care
- NHS 111 Service
- General Practice
- Mental Health NHS Foundation Trust

1.5. Structure of Report

1.5.1 The agreed Terms of Reference which are central to this overview report are replicated in full in the following Section (Section 2). The Terms of Reference have been agreed through the active contribution of the immediate family of Adult W and endorsed by the SAR committee. The report is then structured to provide a descriptive chronological summary of key events, between January 2017 to the date

[15] The delay in the report being commissioned was due to an initial decision to proceed with a section 42 enquiry in addition to adherence to local authority procurement procedures.

[16] Information from a number of staff was not available in formulating this report.

of Adult W's death on 8th April 2017. (Section 3). The author then provides key findings based on an analysis of the individual organisational reports. This section (4) systematically addresses the specific aspects as set out in the Terms of Reference. Conclusions are detailed in Section 5 and Section 6 identifies recommendations based on an overall appraisal of the findings.

1.5.2 During the course of this review the author has had access to a number of documents to support completion of the report relating to Adult W. A full list of the materials reviewed is provided for reference at Appendix I. Clearly, each organisational IMR author has utilised their own source material to enable individual reviews to be undertaken. Appendix II provides for reference, a collective list of source documents used by IMR authors in completing their own reports.

1.6 Acknowledgments

The author would like to record their thanks to all those who have assisted with the Overview Report process in acknowledging the assistance and co-operation provided by:

- the sons and daughter of Adult W in sharing their views regarding their fathers care, particularly at a time of ongoing distress associated with the loss of their father;
- the Individual Management Review authors for their organisational reports;
- the Adult Safeguarding Strategic Manager and Administrator who have provided support;
- the Independent Specialist Diabetes Advisor.

2. Terms of Reference

2.1 The Terms of Reference have been agreed through the active input of the immediate family of Adult W and endorsed by the SAR committee.

2.2 The Terms of Reference are:

On the 8th April 2017 Adult W, a 90-year-old gentleman, died in Nursing Home 1. One of the primary causes of death recorded was Ketoacidosis[17] (hyperglycaemia) as a result of Adult W's high blood glucose levels and Broncho-Pneumonia.

Adult W had a diagnosis of type 1 (insulin dependent) diabetes for circa 50 years. A Diabetes Management Plan[18] was established in 2014 by the Diabetes Service, highlighting a bespoke plan for Adult W to assist with management of blood glucose readings[19]. This plan included information on the signs and symptoms of hyperglycaemia, specific guidance on what action had to be taken in the event of an abnormal blood glucose level (including use of a Ketone meter issued to Adult W), information on the 2 set dosages of Humulin Insulin to be administered per day, as well as a sliding scale (corrective) NovoRapid[20] regime to be used to address high blood glucose readings.

Changes had been made to Adult W's diabetes plan, specifically the reduction of the dosage of corrective (PRN[21]) insulin (NovoRapid), which had, prior to reduction, proven effective in maintaining Adult W's blood glucose levels over a 3 year period. The circumstances relating to the death have raised concerns as to the way in which organisations / relevant individuals worked together to safeguard Adult W.

The purpose of this review is therefore to examine the circumstances surrounding the death of Adult W, scrutinising fully his care pathway from January 2017 up his death on 8th April 2017. In particular:

- To prepare a factual report that analyses and brings together the findings from the agencies involved in Adult W's care pathway to identify recommendations for future action.

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[17] Diabetic **ketoacidosis** (DKA) is a serious problem that can occur in people with diabetes if their body starts to run out of insulin. This causes harmful substances called ketones to build up in the body, which can be life-threatening if not spotted and treated quickly. See https://www.nhs.uk/conditions/diabetic-ketoacidosis

[18] The Bespoke plan was developed in 2014 as a result of concerns raised by Adult W's family regarding the ineffectiveness of their father's diabetes management. The last review date prior to January 2017 is to be determined through this review process.

[19] This was a collaborative process with Adult W and his family.

[20] NovoRapid being a fast acting insulin to lower a high blood glucose level.

[21] PRN: Abbreviation meaning "when necessary" (from the Latin "pro re nata", for an occasion that has arisen, as circumstances require, as needed).

- Establish whether there are any lessons to be learnt to inform and improve local inter-agency practice
- Review the effectiveness of procedures (both multi – agency and those of individual organisations).

The following questions form the framework for the review process.

Part A

- A1 Explain to what extent practitioners' demonstrated sensitivity to the needs of Adult W in their work, knew of potential indicators of neglect regarding Adult W's specific medical needs, or what to do if they had concerns about Adult W's condition?

- A2 Detail what policies and procedures individual agencies had in place to act effectively in response to such concerns in order to safeguard Adult W's health?

- A3 Detail any opportunities there were for risk assessment and decision making in response to a deterioration in Adult W's medical condition. Were any assessments and decisions reached in an informed and professional manner?

- A4 Was effective action taken in accordance with the assessments and decisions that were made? Specify whether appropriate services were provided or offered to Adult W, in particular on the 7th and 8th April 2017, in response to his declining health.

- A5 Detail what appropriate evidence based, person-centred care plans and risk assessments were in place?

- A6 How were Adult W's wishes and feelings ascertained and considered?

Specific issues are identified by Adult W's family, with the aim to support learning, the following questions in Part B are therefore also included:

Part B 1: Diabetes Plan

- B1.1 Who was responsible for the changes to the diabetes plan, identify when the changes were made, during the period January 2017 to March 2017 and what was the reasoning given for this change, what was the evidence upon which it was based?

- B1.2 Did the changes to the NovoRapid medication comply with manufacturer's instructions?

- B1.3 Were the Diabetes Specialist service advised or consulted regarding the changes to Adult W's diabetes plan?

- B1.4 What was documented in the Specialist Diabetes service clinical notes for Adult W during the period covered by this review from January 2017 to April 2017?

- B1.5 Were hospital staff and those staff involved, aware of a bespoke diabetes plan being in place or changes to the plan ?

- B1.6 What was the level of awareness of other agencies involved in Adult W's care pathway of a bespoke diabetes plan being in place?

- B1.7 How and by whom, were changes to the diabetes plan communicated in 2017?

- B1.8 What communication took place with Adult W and /or his family regarding changes to his diabetes plan?

- B1.9 Prior to the changes to the diabetes plan how regularly had the plan been reviewed since its creation?

- B1.10 Who was responsible for maintaining and reviewing the diabetes plan?

- B1.11 After concerns were raised regarding the change to the NovoRapid regime by the Day Centre on 29th March 2017, what action was taken and what feedback was given, by whom and to whom ?

- B1.12 How was the District Nursing written care plan updated following the changes to NovoRapid regime?

- B1.13 Why did the District Nursing service not identify any concerns as a result of the changes to the NovoRapid regime?

Part B2 Transition

- B 2.1 There is a need to understand what information was communicated and how effectively this was done so during all of Adult W's transitions from one setting to another, during the period between January 2017 and April 2017. In particular, there is a need to understand whether this information included specific reference to the diabetes care plan, administration of insulin medication and history of triggers to blood glucose instability?

  - from District Nursing Services to Hospital
  - from Hospital to District Nursing Services
  - from Hospital to other Community Services, including GP
  - from District Nursing to Day Centre Staff
  - from District Nursing to Nursing Home 1
  - from Adult Services to Residential Home 1
  - from Adult Services to Nursing Home 1
  - from Hospital to family
  - from District Nursing to family

- B2.2 Did handovers at the points of transition comply with policy/procedure and best practice?

- B2.3 Explain whether any concerns about the effectiveness of the change of diabetic care plan (NovoRapid) were identified and adequately recorded and if not why not?

- B2.4 Why was Adult W's ketone meter not available to support monitoring of his diabetes within each care environment?

- B2.5 Explain how ketone meter testing strips were out of date ?

- B2.6 Detail the process undertaken at the point of admission of Adult W to nursing Home 1 in order to ensure his medical needs were understood?

- B2.7 Explain what action was taken by the Social Worker, as a result of concerns raised on 24th March 2017 by the eldest son, of Adult W's diabetes management whilst in care?

Part B3 Organisational

- B3.1 What District Nurse and Home Care Services visits took place on 29th January 2017?

- B3.2 Detail what recorded times Adult W received his insulin and meals?

- B3.3 Explain whether the relationship between meal times and medication was clearly documented and reflected, by practice carried out, by Home Care Services and District Nursing services.

- B3.4 What pre-admission assessment took place prior to Adult W being admitted to Nursing Home 1?

- B3.5 What was documented in the care plan for the management of diabetes at Nursing Home 1, including the action to be taken in the event of an abnormal blood glucose reading?

- B3.6 Why did Nursing Home 1 nursing staff not raise concerns earlier than they did and subsequently not escalate the response of high glucose reading to emergency (999) status?

- B3.7 What specific training had nursing and care staff involved in Adult W's care across all agencies received in relation to Diabetes care, (in particular hyperglycaemia); how regularly and when was this last provided?

- B3.8 What algorithms were followed by the 111 service on 8th April 2017 relating to Adult W's clinical presentation and were these not receptive to identifying a high glucose level/hyperglycaemia and the associated risks?

- B3.9 What information was passed on by the 111 service to the on call doctor?

- B3.10 What information was considered (asked and received) by the on call doctor when they called Nursing Home 1 relating to Adult W's clinical presentation on 8th April 2017; did this include details of Adult W's high glucose level?

- B3.11 Why did the on call doctor not diagnose hyperglycaemia and recommend a 999 call?

- B3.12 Are there any chronological gaps in Adult W's care records? If so, what are the gaps and what are the reasons for them?

Part B4 Policies , Procedures and Best Practice Guidance

- B4.1 What were the policies, procedures & best practice guidance in place relating to Type 1 diabetes up to April 2017?

- B4.2 Do these specifically refer to hyperglycaemia and if so, to what extent?

- B4.3 If this information was in place, explain any areas of non-compliance in relation to Adult W's care.

- B4.4 Have there been any changes to Policies, Procedures and Best Practice Guidance since April 2017? If so what has changed?

- B4.5 Are there any planned changes to Policies, Procedures and Best Practice Guidance that have not yet been implemented? If so what are these?

The focus of this review is on understanding the underlying issues that informed agency/ professionals' actions to improve practice by acting on learning.

The review will be undertaken in accordance with the Traditional Serious Case framework set out in the appropriate Policy and Procedure relating to Northumberland[22]. The objective is to present the final report at the SAR Board on 26th June 2018.

[22] North of Tyne SAR policy, April 2015, Safeguarding Adults Review Policy and Procedure 2015.

3. Descriptive Chronological narrative of key dates and events from January to April 8th 2017

3.1 The author of this report received individual management review (IMR) reports from all of the agencies involved in Adult W's care. Of necessity, in reflecting the requirement to provide an overview report, this section can only include key dates / events in supporting a contextual understanding of Adult W's care pathway leading up to his death on 8th April 2017. Where necessary, specific details of relevance have been magnified by the author in the analysis / findings section to follow, in addressing the matters detailed in the Terms of Reference.

3.2 3rd January 2017 At the beginning of 2017 Adult W's care environment was his own home. As was routine Adult W's Blood Glucose Level (BGL) was checked and it was recorded as 3.3mmol/l at 8.30hrs. The District Nurse gave 2 digestive biscuits with a cup of tea. Adult W's son is recorded as being aware of "what to watch for" and would test blood glucose if his father appeared unwell whilst waiting for the Home Carer to arrive and prepare Adult W his breakfast.

3.3 13th January 2017 Adult W had a fall at his home (approximately 05.00hrs) and paramedics attended. No injuries were identified and Adult W wanted to attend the Day Centre when the District Nurse visited at 08.30hrs. Later the Practice Nurse carried out a review home visit with Adult W's daughter present. The reason for the visit was due to his continued cognitive decline.

3.4 14th January 2017 At 08.30hrs the District Nurse recorded that Adult W was in a lot of pain from his fall the previous day. The nurse attempted to contact Adult W's daughter to check whether any pain relief had been prescribed or if Adult W had been for an X-Ray "etc." There is no record of the daughter being contacted as the telephone was engaged, however it is noted that "Carer" would follow the matter up and request a GP out of hours visit if required. At 12.15hrs there is a further entry in the clinical record stating that Adult W's daughter had left a note for the nurse requesting that 2 of his own paracetamol be given to her father. The District Nurse telephoned and explained this could not be done due to no prescription, but she would leave 2 paracetamol near to him so that his daughter could telephone to prompt him to take them.

3.5 16th January 2017 Adult W received the first home visit from the Northumberland Memory Service (Mental Health NHS Foundation Trust) to enable them to undertake an initial cognitive assessment. This had followed referral from Adult W's GP on 30th November 2016, as a result of the reported deterioration in Adult W's short term memory over the previous year. Additionally on the 16th January 2017, there was a telephone review between the GP and District Nurse regarding Adult W's recurrent falls and significant back pain. The GP carried out a home visit that day and prescribed codeine with paracetamol for pain. Medication was also prescribed due to potential constipation with the codeine medication. The GP also referred Adult W for a spine lumbar X ray.

3.6 17th January 2017 Adult W was recorded as feeling stiff and was waiting for his daughter to drop off his codeine medication which she did later that day. Adult W's Home Carer was encouraging him to go to the Day Centre as it is recorded there were no carers available for day time calls for him that day.
3.7 18th January 2017 The assessment outcomes from the Northumberland Memory Service were communicated by letter to Adult W's GP, with an outline of the plan communicated by letter to Adult W's daughter.

3.8 20th January 2017 Adult Social Care discussed concerns around risks relating to falls, admissions to hospital and unstable diabetes with Adult W's son. The social care record indicates Adult W as appearing to be "keen to go into care." However, it was noted that Adult W's sons were keen for their father to remain at home. Adult W's daughter held the primary caring role on a day to day basis and it was noted that she was becoming increasingly weary in her caring role.

3.9 27th January 2017 Adult W was still in bed when the District Nurse visited at 8.30hrs as he had felt unwell overnight and remained unwell. He had declined to go to the Day Centre. His BGL was recorded as 2.8 mmol/l and he was given a biscuit and lucozade, with his BGL eventually rising to 4.6 mmol/l. The District Nurse arranged a GP home visit and a message was left on Adult W's daughter's answer machine. The Home Carer also arranged for a lunchtime visit. Adult W had improved by the afternoon visit from the GP. The Physical health examination carried out by GP identified no concerns. No changes to the insulin regime were to be made at that time, however it is noted that if Adult W continued to have low BGL's then his GP may consider a decrease in his evening dose of insulin. The District Nurse was to monitor and inform the GP of any concerns.

3.10 29th January 2017 Two home visits were carried out by the District Nurse; 09:15hrs and 16:30hrs the purpose to check the BGL and ensure medication compliance. Also during the day 4 care and support visits took place by the Home Care Service

- First call between 09.13-09.48hrs.
- Second visit – 12.11-12.40hrs
- Third Visit – 17.16-17.40hrs
- Fourth visit – 21.10-21.35hrs

There is a specific requirement within the Terms of Reference to consider visits on this date in further detail and this will be covered in paragraphs 4.28.1 and 4.28.3 to follow.

3.11 30th January 2017 Adult W had had a fall at home at 02.15hrs and was subsequently admitted to the Specialist Emergency Care Hospital due to feeling dizzy and unsteady when standing with a zimmer frame. He was assessed as requiring admission due to "falls risk T1 diabetes". Following admission his physical observations were recorded as stable, he was in no pain, could move all 4 limbs and was not dizzy. Assessment documentation was completed and insulin regime was agreed following review of Adult W's previous A&E documentation dated February 2016, with a review planned the following day after monitoring of his BGL's.

3.12 31st January 2017 Adult W's nursing assessment indicates that he had experienced tachycardia the previous night and atrial flutter, therefore he was commenced on bisoprolol[23] . The clinical record indicates that his insulin dose was clarified with the specialist diabetes team. Adult W stated that he felt unwell but was unable to clarify what he meant by this; he was documented as looking well. At 12.00 hrs the in patient record indicates that Adult W had a fall in the bathroom, hitting the back of his head. It is documented that there was "no need for a CT scan and that all observations were stable. Adult W had pain at the site of his head injury but could not remember falling and hitting his head. It was communicated to him later that the Specialist Emergency Care Hospital wanted to transfer him to General Hospital 1. Adult W's daughter was informed of the fall and is recorded as being unhappy as this was the reason he had been admitted. She also reported that her father had dementia and memory problems, at which point the staff nurse reported that she was not aware Adult W had dementia as there was no record of this. Adult W's BGL's were recorded as being high. Adult W was referred to the diabetes team.

3.13 1st February 2017 The District Nursing Service and ward communicated on Adult W's usual diabetes care and BGL ranges. The clinical record also states that Adult W sometimes forgot that he had eaten due to dementia and therefore has a second meal. It is recorded that Pharmacy also contacted the District Nursing Service to check the diabetes regime at home. Adult W had a chest X-Ray and was seen by the diabetic specialist also.

3.14 2nd February 2017 Adult W was transferred from Specialist Emergency Care Hospital to General Hospital 1.

3.15 3rd February 2017 The previously requested GP X-Ray report on the lumbar spine stated that there was no evidence of a fracture, only degenerative changes. On the ward at General Hospital 1, Adult W had an unwitnessed fall. He had been found sitting at the side of his bed. There were no obvious signs of injury noted and a message was left on his daughter's answerphone to contact the ward. Adult W did not remember falling and stated that he "just sat down", he was recorded as being "bright and chatty" and a mobility assessment was completed. No head CT was required and the cause of the fall was questioned as to whether it was due to mechanical or hypoglycaemic reasons (as referenced earlier the risk of frequent falls is increased with recurrent hypoglycemia). The insulin regime was reviewed and changed by a Junior Doctor in consultation with the diabetes specialist nursing team.

3.16 6th February 2017 Adult W had a further fall on the ward and therefore a falls nurse review with physiotherapy involvement was carried out and the care plan updated, including: increase of 'care rounding' to one hourly as Adult W forgets to use his buzzer, a wheeled zimmer when mobilising and review of an eye test, (this was to be checked with family as to when his last one was carried out).

[23] Bisoprolol is a medicine that can be used to treat atrial flutter see https://beta.nhs.uk/medicines/bisoprolol/

3.17 8th February 2017 Adult W was reported to be medically stable and was transferred to Ward 3 of Community Hospital 1.

3.18 10th February 2017 It is noted that Adult W was mobilising alone at times and that the physiotherapist advised that he was not to walk unaided due to high risk of a fall. It is also recorded that Ward 3 had contacted the nurse manager of the Specialist Emergency Care Hospital to check "what to give if blood glucose high". The plan was noted as being "recapped" and for Ward 3 to contact them again if necessary.

3.19 15th February 2017 Adult W was reviewed by the Diabetes Specialist Nurse who advised to keep the insulin regime as it was currently documented. A note indicates that the nurse manager of the district nursing service was informed of this.

3.20 16th February 2017 Adult W was prescribed anticoagulant medication, 24 hour tape and ECG were to be checked.

3.21 21st February 2017 A telephone discussion between GP and Adult W's daughter took place regarding hospital admission, X Rays and care plans.

3.22 22nd February 2017 Pre discharge meeting was held today with the outcome being that Adult W was "bright and alert" with improving mobility, although his BGL's continued to fluctuate. It is recorded that it was felt to be a long term problem and could be monitored by the District Nursing Service. Adult W's high falls risk plan was updated to include an increase of care calls. The care manager was to inform the ward when the date of the care package was to start. Adult W did not want to attend his discharge planning meeting but is recorded as being happy for his daughter to speak on his behalf. There was no record of the diabetes management plan changing.

3.23 24th February 2017 Discharged from Community Hospital 1 was agreed for 28th February 2017.

3.24 27th February 2017 Adult W had another fall on the ward. He was transferred to the Specialist Emergency Care Hospital by ambulance and a CT scan concluded that there was no intracranial bleed. Adult W is noted as saying he had not hit his head, but was complaining of pain on his right buttock. Home Care support was increased pre discharge with the addition of a daily evening call and a mid-morning call on a Saturday and Sunday.

3.25 28th February 2017 Adult W returned to Community Hospital 1 and his physiotherapy care records state "managed well, no concerns for discharge tomorrow, no further physio input."

3.26 1st March 2017 The clinical record entry states that Adult W was discharged home with a detailed discharge summary.

3.27 2nd March 2017 Adult W's daughter rang his GP stating that her father had been discharged the previous day but was now unwell again. She described him as

pale, had a cough and had been incontinent of urine and faeces (diarrhoea). The GP carried out home visit and records that although Adult W had improved, he was still confused and unable to understand questions. The GP suggested to Adult W's daughter that Adult W would benefit from a period in respite care. The Hospital & Community NHS Foundation Trust forwarded the MDT care plan to Adult W's GP.

3.28 3rd March 2017 Pre-admission assessment and subsequent admission for respite placement at Residential Home 1 took place. Adult W was located in the Elderly mental Illness (EMI) area of the residential home. Responsibility for the management of insulin remained with the District Nursing Service. There was no observed deterioration in Adult W's medical condition reported during his short stay at Residential Home 1.

3.29 6th March 2017 Adult W returned home after the respite placement at Residential Home 1 broke down due to concerns from Adult W and his daughter regarding suitability of placement in the EMI unit.

3.30 8th March 2017 At 08.30hrs Adult W had appeared much brighter, had managed to get himself up and dressed before the Home Carer had arrived and was going to the Day Centre. However, later in the day at 16.30hrs it is recorded that Adult W had had another fall at home although no injuries were apparent and he stated that he had not hurt himself.

3.31 9th March 2017 A Carer from the Home Care Service administered NovoRapid in error.

3.32 10th March 2017 Care Manager 1 undertook a home visit following concerns raised by Adult W's daughter regarding falling and general deterioration in health and well-being due to diabetes being unstable. Attendance at the Day Centre was also becoming problematic due to mobility issues. Care Manager 1 referred Adult W to Social Worker 1 in order to carry out an assessment. The entry states that there is no record of the District Nurse or GP being involved in the discussions. The Adult Social Care record also references the previous evening (9th March 2017) where the Carer had inadvertently administered NovoRapid. Appropriate steps were followed and the incident was recorded as a Safeguarding Adult Concern Notification.

3.33 13th March 2017 A second home visit was carried out by the Northumberland Memory Service for further assessment and a DAT[24] scan was to be requested, with a further appointment offered once the results of the scan were received. Adult W's daughter had also been concerned about an itchy rash her father had when the District Nurse had visited. The District Nurse recommended that Home Care Services used Adult W's hydromol[25] that evening and to contact the GP in the morning if still concerned.

3.34 14th March 2017 The GP undertook home visit to review the rash after being contacted by the Day Centre.

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[24] A DAT (Dopamine Active Transporter) scan assists in differentiating between mixed dementia and dementia of Lewy Body.

[25] Hydromol cream is used for dry skin and eczema see http://www.hydromol.co.uk/hydromol-cream.html

3.35 20th March 2017 The Assessment visit by Social Worker 1(SW1) resulted in a 2 weeks respite placement being agreed with the possibility of permanent care to follow identified**.**

3.36 23rd March 2017 A pre admission assessment was carried out by Nursing Home 1 in Adult W's home, with his daughter present. A 2 week respite admission was confirmed from 31st March 2017. There is a note in Adult W's District Nursing record for this date indicating that Adult W's diabetes plan had been changed for NovoRapid, with the plan now recorded as "only 2 units if BM over 20mmol." It is also noted that the Home Care Service plan still reflected "the old one" and the District Nurse therefore requested that Home Care staff should be informed of the change.

3.37 24th March 2017 Adult W's eldest son E mailed SW1 to highlight a number of concerns about his father being admitted into a nursing home. There is a specific requirement within the Terms of Reference to consider this matter in further detail and this will be covered in paragraphs 4.27.1 and 4.27.5 to follow.

3.38 27th March 2017 The Home Care Services care plan was updated with revised instructions relating to Adult W's BGL and the use of NovoRapid medication.

3.39 29th March 2017 Home Care Services reported to the District Nurses that Adult P was Hypoglyaemic and they managed this until his BGL was "regulated". On the same day the Day Centre contacted the Specialised Diabetes Team regarding the change to NovoRapid and were advised to contact the District Nursing Service or GP as they were informed the recorded dose was not changed by Specialist service.

3.40 31st March 2017 Adult W had had a fall during the night, had been checked by paramedics and no injuries were apparent. His daughter had attended and is documented as stating that her father was to be admitted to Nursing Home 1 after attending day care. The District Nurse contacted Nursing Home 1 and was informed that Adult W was being admitted as "residential". Due to her concerns she advised that she believed he should be admitted as nursing care due to his risk of falls and diabetes and would therefore contact the Care Manger to confirm; the Care Manager confirmed that Adult W was to be admitted for nursing care. The District Nurse informed Nursing Home 1 by telephone of Adult W's insulin regime. Nursing Home 1 asked for the regime to be sent by fax but the nurse stated that this could not be done due to the information being confidential. Nursing Home 1 were advised that Adult W's daughter would take Adult W's home care plan and all relevant information would be on the care plan. Any further questions were to be directed to the District Nurse. It is noted by the District Nurse that as Adult W was to go into nursing care, then they would no longer require District Nurse input and that the insulin chart would be "dropped off to Nursing Home 1".

3.41 1st April 2017 04.35 hrs. Adult W was found on the floor of his bedroom, he was checked for injury and assisted up from floor. An accident form was completed and 24 hour observations were put in place. A care record states that the family were to be informed the next morning and that it was thought that Adult W had avoided the fall sensor mat. A later entry documents that bruising was noted to the left side of

Adult W's back and that pain relief was used to good effect. Also water was encouraged as Adult W's BGL's were not lowering (a record of the BGL's for the period of stay in Nursing Home 1 is included at an appropriate point for reference at paragraph 4.32.2 later in the report). Adult W reported to the nurse that he had avoided sweet foods all day, this was despite an earlier entry stating that Adult W had consumed a dessert at lunch and that diabetic preparation of the food had been queried.

3.42 2nd April 2017 Adult W's daughter was informed of the fall and requested that a call bell and sensor mat were introduced during the day, which they were.

3.43 3rd April 2017 Adult W's daughter informed his GP that her father was at Nursing Home 1 for 2 weeks respite which could be made permanent following review.

3.44 4th April 2017 Nursing Home 1 records reference that desserts and snacks had been consumed (as had been noted the previous day) with "query diabetic preparation".

3.45 5th April 2017 Adult W continued to have difficulty passing urine. Once again there was a query of the desserts consumed being of diabetic preparation, there was still no bowel movement recorded although urine was being passed.

3.46 6th April 2017 Adult W attended the day centre. It is noted in Nursing Home 1 records that he ate a good breakfast, little tea and declined supper although he had been able to open his bowels that day.

3.47 7th April 2017 There is a requirement within the Terms of Reference to consider events of 7th & 8th April 2017 in detail and this will be covered later in the relevant section of this report. In supporting the chronological pathway to conclusion however, the following narrative is included for reference. At 11.50 hrs Adult W's Glucose level before lunch at the day centre was recorded as 24.7mmol/l and as a result 2 units of NovoRapid was self-administered in accordance with the revised guidance. On returning to Nursing Home 1 it is recorded that Adult W's BGL was high (16.35hrs BGL 29.9 mmol/l) and a further 2 units of NovoRapid was administered. At 19.30hrs BGL was >33.3 mmol/l[26] a further 2 units NovoRapid was administered. It was noted in the care record that NovoRapid was not effective. Adult W vomited twice during the night, physical observations were taken and were said to be within normal range. There is no record available of the BGL ranges or the physical observation levels overnight.

3.48 8th April 2017 At 08.25hrs Adult W's BGL remained high at 24.1 mmol/l and 2 units of NovoRapid was administered. His nausea continued (no vomiting**),** at 11.30hrs BGL was 33.1 mmol/l and a further 2 units of NovoRapid administered. At this point Adult W's daughter had been contacted and visited her father expressing concern at his state of ill health. On arrival she had observed him to be sitting in a chair, breathless (which was unusual for him) and to have poor pallor. Following

[26] The Blood Glucose meter has a maximum reading of 33.3mmol/l therefore if the meter is indicating this it is not possible to determine an accurate Blood Glucose reading above this level. This reading represents a situation that requires emergency medical intervention.

prompting from Adult W's daughter at 11.48hrs an initial call was made to the 111 service by Registered Nurse 1 from Nursing Home 1. This was dealt with as a Health Care Professional call and not triaged. The nurse requested a GP call back within 60 minutes. The GP called the nursing home back at 12.15 hrs, triaged the call and communicated to the home that a GP would visit within 6 hours. Prior to leaving Adult W's daughter indicated her father had been moved to his bed and appeared to be sleeping. At 16.58hrs a second call was made to the 111 service by Carer 1 from Nursing Home 1 asking if a time could be given for the GP visit. The call handler gave Nursing Home 1 the option of escalating the call to 999 but the Registered Nurse at the home declined this. At 17.42hrs a third call made to the 111 service by Registered Nurse 1 from Nursing Home 1 stating Adult W had died, the death was a sudden death and she required medical verification.

4. Analysis and Findings

4.1 This section of the report brings together and analyses the evidence from the IMR reports and associated information submitted by the agencies previously identified. These materials are listed in Appendix I. In order to ensure the Terms of Reference are addressed comprehensively, all aspects are replicated for ease of reference in this section *(highlighted in italics*).Findings, as determined from the analysis process, are then correlated systematically to enable conclusions in Section 5 of the report to be reasoned.

4.2.1 Part A Explain to what extent practitioners' demonstrated sensitivity to the needs of Adult W in their work, knew of potential indicators of neglect regarding Adult W's specific medical needs, or what to do if they had concerns about Adult W's condition?

4.2.2 A synopsis of the information collated to support this review leading up to Adult W's admission to Nursing Home 1 on 31st March 2017, generally supports a sensitive and collaborative approach to considering the needs of Adult W. It appears that Services aimed to place Adult W centrally in all decision making regarding his holistic needs. Ordinarily, Adult W was fully involved in all decisions impacting upon himself through the assessment and review process of the various agencies involved in providing care and treatment. Although Adult W had early onset dementia and had poor recall, he was able to understand his Diabetes Management Plan which was central to his long term health needs.

4.2.3 Specifically in relation to diabetes, once Adult W was discharged from Community Hospital 1 on 1st March 2017 responsibility for diabetes management was seen by the Hospital & Community NHS Foundation Trust to be the responsibility of the GP and District Nursing Service. Adult W was described as being "very visible" within the General Practice. The General Practice held weekly meetings with clinical staff including the District Nurses to discuss patients and handover any concerns. Adult W was discussed regularly at these meetings from January 2017. The General Practice also held multi-disciplinary monthly meetings to discuss the patients on the High Risk Register within the practice (patients with complex health and social care needs) and update staff. Adult W was discussed at these meetings. There are also twice yearly safeguarding review meetings held within the practice to facilitate updates, reviews and relevant learning. Adult W was not discussed at these meetings as this was not seen as relevant.

4.2.4 In relation to specific medical needs and what to do if there were concerns about Adult W's condition, there appeared to be a good level of awareness of the needs of Adult W in that if primary care services had concerns about any deterioration in Adult W's condition, they were aware that they could escalate to the

Specialist Diabetes Service for further input. Other community services, with the exception of the residential and nursing homes, had a sound understanding of the need to contact specialist/emergency services as set out in the 2014 bespoke diabetes plan.

4.2.5 In considering the final respite placement in Nursing Home 1, practitioners were aware of the general needs of Adult W in relation to his diabetes management such as diet required and the revised medication regime. However, by their own admission, they were not fully familiar with or sensitive to Adult W's holistic needs in the context of his wellbeing. Specifically, the instructions regarding acting on concerns previously listed in the 2014 bespoke diabetes plan were unfamiliar.

4.2.6 In supporting staff more generally to identify concerns in relation to neglect, there was evidence presented of staff undertaking training in relation to safeguarding adults at risk, Mental Capacity Act and associated Deprivation of Liberty legislation.

4.3.1 Detail what policies and procedures individual agencies had in place to act effectively in response to such concerns in order to safeguard Adult W's health?

4.3.2 Health and Social Care organisations have a statutory duty to have in place appropriate policies, procedures and guidelines to enable staff to fulfil the requirements of their role safely and competently and achieve the best possible patient care. Safeguarding and the associated policy frameworks are seen as essential elements of training / induction. A key policy that is generic is the North Tyneside and Northumberland Multi-Agency Safeguarding Policy. In addition, Individual agencies have a number of policies and procedures that they identified as being relevant to support good safeguarding practice in relation to Adult W's health. A summary of the responses by organisation are included in Appendix III.

4.4.1 Detail any opportunities there were for risk assessment and decision making, in response to a deterioration in Adult W's medical condition. Were any assessments and decisions reached in an informed and professional manner?

4.4.2 There is evidence that the General Practice regularly reviewed ongoing risks throughout the period of this review. This was evident in clinical documentation where risks of falls were included in assessments as well as the impact of specific medication. The GP suggested respite care as a result of the increase in falls. Adult W was offered an annual health check by the practice, there was a system operational at the Practice for automated invitation to attend, Adult W's last attendance was in May 2016.

4.4.3 Type 1 diabetes is a lifelong condition that is not curable and can cause serious long term health problems with associated risks that are longitudinal in nature[27]. There is evidence that the increasing risks associated with Hypoglycaemic

episodes and the number of falls experienced by Adult W in February 2017, influenced the decision to reduce the Novorapid. There was a pathway whereby the inpatient team liaised with the Specialist Diabetes Service about the best way forward to treat Adult W's blood glucose. Collectively, it was agreed that the amended dosage was in the best interests of Adult W in supporting the aim to maximise his BGL stability. The family consider the risks associated with the impact of the change of Novorapid in relation to hyperglycaemia were not fully considered. They feel strongly that the condition is not understood by professionals and have indicated the importance of recognising the risks associated with, and specialist training required, for the successful treatment of this condition.

4.4.4 When at home a significant risk as a result of Adult W's medical deterioration was identified relating to his mobility/falls risk and it was therefore agreed post discharge from hospital to increase the level of home support which was put in place. However, Adult Social Care in partnership with Adult W (Adult W was deemed to have the mental capacity to make his own decisions) and his daughter subsequently identified the need for respite care, in the short term, to provide support and mitigate aspects of risk associated with mobility/ falls. Residential Home 1 and Nursing home 1 completed their own assessments and care planned to provide interventions in relation to mobility/falls.

4.4.5 Assessments and decisions reached in relation to the risks associated with Adult W's level of cognitive impairment were made in an informed and professional manner. Following Adult W's initial cognitive assessment, the decision was made to obtain a DAT scan, due to the differential diagnosis relating to his symptoms of memory impairment, incontinence, unsteady gait and repeated falls alongside Adult W's cardiovascular risk factors.

4.4.6 Having considered more longer term risk, there is a need to focus on the reactive short term risk associated with the significant deterioration in Adult W's medical condition on the 7th/8th April 2017. The post mortem evidence indicates that Adult W had experienced Diabetic Ketoacidosis (DKA), which can be life-threatening if not identified and treated quickly, this was alongside Bronchopneumonia. The detail of what occurred during this period of time forms a significant part of this report and will be discussed in detail later. The clinical judgements associated with assessing short term risk relating to Adult W's deterioration and the subsequent decisions made, represent a missed opportunity to provide earlier intervention for the treatment of DKA.

4.5.1 Was effective action taken in accordance with the assessments and decisions that were made? Specify whether appropriate services were provided or offered to Adult W, in particular on the 7th and 8th April 2017, in response to his declining health.

4.5.2 Following assessment post admission to Hospital 1 action was taken to change medication to reduce the risk of Hypoglycaemia[28] and the effects of a Hypoglycaemic episode on Adult W's overall health when in hospital in February 2017. In supporting

[27] See: https://www.nhs.uk/conditions/type-1-diabetes/

[28] Hypoglycaemia occurs when the level of glucose present in the blood falls below 4/mmol/l (Diabetes UK)

continued independence, additional home based support was facilitated through the Care Management/Social Work assessments, in addition to being responsive to provide respite care; although the placement at Residential Home 1 was ineffective being influenced by Adult W's placement in the EMI unit. When assessed by Northumberland Memory Service, effective action was taken in response to Adult W's irregular heartbeat and an Electrocardiogram[29] (ECG) requested. Following the results of the 24 hour cardiology report, a decision was made that a DAT scan was needed.

4.5.3 As identified earlier there will be further detailed discussion in considering the events of 7th and 8th April 2017 later. However, this narrative should be considered alongside those findings discussed then. In considering decisions and the service response, what is evident is that on 7th April 2017 Adult W attended his day centre as planned. His BGL prior to lunch and was 24.7 mmol/l. The day centre acted in accordance with revised guidelines from the District Nursing Service (not confirmed until 29th March 2017) and oversaw the self-administration of 2 units of NovoRapid.

4.5.4 On returning to Nursing Home 1 on 7th April 2017, Adult W's condition is as described in the earlier chronology (paragraphs 3.38-3.39) and over the course of 7th and 8th April 2017deteriorated significantly.

4.5.5 In Nursing Home 1 there was no detailed diabetes management plan/ care plan (not solely the revised medication regime) that contained specific instructions, (as set out in the 2014 bespoke plan), on what symptomology indicated acute declining health as a result of hyperglycemia and what action to take if NovoRapid was not effective. This situation was compounded when the decision not to escalate concerns and contact Emergency (999) Services (as was offered by the 111 service) was taken. This decision was not appropriate to Adult W's declining health.

4.5.6 The information provided to the on call doctor and their triaging of the situation resulted in action arranging a home visit within 6 hours being arranged. They provided interim management advice for the staff to follow and gave safety netting instructions, in case the patient's condition deteriorated.

4.6.1 Detail what appropriate evidence based, person-centred care plans and risk assessments were in place?

4.6.2 At the time of Adult W's death on the 8th April 2017 his care plans within Nursing Home 1 were not comprehensive and specific risk assessments had not been completed. In particular, a specific diabetes management care plan was not completed for Adult W.

4.6.3 The medication changes made whilst an inpatient in February 2017 were considered an effective plan for dealing with hyperglycemia, when Adult W was not acutely unwell. As stated in 4.4.3 above the family consider the impact of the change of Novorapid in relation to hyperglycaemia to be ineffective. There was not however, a formal revision of the 2014 document (bespoke diabetes plan) to include the

[29] An electrocardiogram (ECG) is a simple test that can be used to check your heart's rhythm and electrical activity.

revised medication changes alongside the other information that the plan contained, such as the circumstances to request 999/ attend Accident and Emergency department, checking of ketone level and monitoring.

4.6.4 In reviewing the Local Authority position, the Care Act compliant assessment was in place which included risk assessment information. The assessment referenced that the community nurse visited daily regarding diabetes management for Adult W.

4.6.5 There is evidence within the primary care records of person centred care plans and risk assessments including diabetes and falls. The diabetes care plan within the GP record is the bespoke plan developed in 2014 and not updated following the changes made in February 2017. In relation to falls, Adult W was referred by the GP to the Community Rehabilitation Team (CRT) in August 2016 for assessment. Adult W was subsequently seen at the day centre and then reviewed regularly.

4.6.6 The out of Hours GP service indicated there was a special patient note on Adult W's Adastra record that had been accessed on 8th April 2017. This record is managed by Adult W's General Practice. This was last updated on the 20th March 2017 and the review date for this document was 20th March 2018.This noted that the patient had type 2 diabetes (incorrect), on insulin and was at risk of hypoglycaemia. It also stated that he lived alone with carer support 4 times a day but may progress to long term care. He was at risk of falls and was increasingly frail.

4.6.7 Home Care services developed a live Care and Support Plan which was reviewed regularly and involved Adult W determining his care delivery preferences. Risk Assessments were intrinsic within the Care and Support Plan.

4.6.8 The Northumberland Memory Assessment service followed NICE guidance[30]. A core assessment and FACE[31]risk assessment tool was completed to inform their core plan, however this did not contain any information regarding a Diabetic Management Plan, although a letter from the GP made reference to "serious episodes of hypoglycaemia" and that diabetes was "sub-optimally controlled". The GP medical history was also shared with the memory service.

4.7.1 How were Adult W's wishes and feelings ascertained and considered?

4.7.2 Historically, there is evidence in the development of Adult W's Diabetes Management plan in 2014, that Diabetes Specialist Service responded to concerns and actively involved Adult W and his family in formulating an agreed framework for the management of his diabetes. Information from the Hospital & Community NHS Foundation Trust provided evidence from hospital admissions and from District Nursing records that Adult W was actively involved in decision making. There was also reported evidence in records that Adult W's family were involved and consulted in discussions around his care and treatment in both the hospital and in the community. This included discharge planning.

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[30] https://www.nice.org.uk/guidance/qs1/chapter/quality-statement-2-memory-assessment-services

[31] Functional Assessment of Care Environment Risk assessment tool cited in the Department of Health best practice guide Department of Health, 2007, Best practice in managing risk, Department of Health London

4.7.3 When in contact with Northumberland Memory Services, Adult W's wishes and feelings were ascertained and considered during his contact with their staff. The assessment evidences Adult W's views of his presenting cognitive difficulties, what he liked to do, and his past employment. Staff discussed Adult W's wishes regarding consent to share information, this was recorded and adhered to during his contact with the Mental Health NHS Foundation Trust.

4.7.4 Other examples that demonstrate a high regard for Adult W's wishes and feelings were:

- through discussion relating to his moves into the two respite settings and pre admission assessments. This also involved Adult W's daughter as did the discharge planning from hospital.
- discussion with his GP in January 2017 regarding resuscitation status.
- the completion of "This is me" document to facilitate the establishment of person centred home support services. The document was discussed and reviewed as needs changed.
- Informal dialogue on a 1:1 basis during day centre attendance

4.8.1 B1: Diabetes Plan: Who was responsible for the changes to the diabetes plan, identify when the changes were made, during the period January 2017 to March 2017 and what was the reasoning given for this change, what was the evidence upon which it was based?

4.8.2 The Diabetes Specialist Team worked with Adult W and his family to individualise a care plan for the management of Adult W's diabetes in 2014. His insulin regime at that time was: Humulin M3 34 units in the morning and Humulin I 20 units at night. Additional corrective pre-meal NovoRapid : 2 units if Blood Glucose Level (BGL) >15 mmol/l; 6 units if BGL >20 mmol/l; 8 units if BGL >25 mmol/l, was also included with the target blood glucose range being 6-15 mmol/l. The regime developed in 2014 is described as working reasonably well, however there had been intermittent hypoglycaemia leading up to the end of January 2017. The Hospital & Community NHS Foundation Trust describe intermittent contact with the Specialist Diabetes Service throughout 2015 to January 2017, also referencing an episode of hyperglycaemia that required ward review on Ward 6 at the Specialist Emergency Care Hospital. Throughout this period, Adult W had twice daily recorded visits from District Nursing staff.

4.8.3 Adult W was admitted to hospital (Ward 4 Specialist Emergency Care Hospital) on 30th January 2017 as a result of a fall and hypoglycaemia alongside his general frailty at that time. The inpatient team considered several documented episodes of hypoglycaemia and a clinical decision was made by the inpatient team to focus on reducing further hypoglycaemia episodes, which were seen as being particularly risky, alongside his associated falls, for Adult W's health.

4.8.4 Adult W was seen several times by the Diabetes Specialist Nurses (DSNs) and the insulin regime was reviewed. It was confirmed on 3rd February 2017 (following transfer to ward 4 General Hospital 1) by the DSNs that only 2-4 units of insulin should be given if glucose >20mmol/l due to the hypoglycaemia risk. On 15th February 2017 this was simplified to 2 units if glucose level > 20mmol/l. The initial change to Adult W's medication regime therefore took place on 3rd February 2017. This was completed by a Junior Doctor in consultation with the Diabetes Specialist Diabetes Team.

4.8.5 The change was subsequently reviewed/endorsed by the Specialist Diabetes Team on 6th February 2017 when it was agreed to continue with the regime. On the 8th February 2017 Adult W was transferred to Community Hospital 1. On 10th and 15th February 2017 the Modern Matron at Community Hospital 1 checked with the Specialist Diabetes Team if the regime ought to change and was advised to continue without further change.

4.8.6 Following discharge on 1st March 2017 Adult W's insulin regime was now: Humulin M3 34 units in the morning and Humulin I 20 units in the evening
and 2 units of NovoRapid if BGL >20. The rationale for the changes was that it was considered the previous medication regime was no longer suitable as there was a need to reduce the frequent hypoglycemia episodes[32] which were considered a significant risk for Adult W.

4.8.7 Changes to the diabetes plan were not noted by the Home Care Support service until 22nd March 2017 or the Day Centre until 29th March 2017.

4.9.1 Did the changes to the NovoRapid medication comply with manufacturer's instructions?

4.9.2 The family of Adult W consider the dosage change in the reduction of NovoRapid to be inappropriate and ineffective in the treatment of Hyperglycaemia.

4.9.3 The Hospital & Community NHS Foundation Trust considered Clinical Teams undertook decisions about medication regimes and manufacturers were not responsible. Their view was that the instructions were quite clear regarding NovoRapid and that regimes needed to be adaptive. Once the revised regime had been implemented, it was considered to be a "safe" regime. The view was that hypoglycaemia was a major risk in Adult W's situation and there was an absence of the need for frequent corrective insulin doses for glucose levels >20. They believed that there was reduced hypoglycaemia and continuing with the revised regime was a reasonable decision.

4.9.4 The Overview report writer sought expert advice regarding this matter and the Independent Specialist Diabetes advisor agreed with the position presented by the

[32] The youngest son of Adult W did not consider his father as having frequent hypoglycaemia. In January 2017 there were 5 occasions when Adult W's BGL was below 4 mmol/l which would be considered a normal pre-meal figure. The hospital admission the BGL of 2.7mmol/l was one of these 5 occasions. The other 4 BGL's were 3.3 mmol/l , 3.6 mmol/l , 3.7 mmol/l, 3.8 mmol/l. There is limited evidence that these correlated directly to falls.

Hospital & Community NHS Foundation Trust. NovoRapid is a fast acting insulin and was beneficial as an integral part of the individual insulin regime for Adult W. It would appear from the documentation reviewed that given the rapid elevation of Adult W blood glucose on the evening of the 7th April through to the 8th April and the decline in his condition then the 2 units of NovoRapid were not effective during what escalated into a medical emergency. The action required would have been outside the normal prescription of insulin on the care plan.

4.9.5 The manufacturer information leaflet for use by healthcare professionals[33] for NovoRapid indicates NovoRapid dosing is individual and determined in accordance with the needs of the patient. The glucoregulatory response to any given dose may vary significantly between individuals with type 1 diabetes. In addition the manufacturer directs to the more detailed information provided by the European Health Agency[34]. This position is supported by the NICE/British National Formulary (BNF)[35] that provides prescribers with information on medicines indicating dosage is as required by the prescriber.

4.10.1 Were the Diabetes Specialist service advised or consulted regarding the changes to Adult W's diabetes plan?

4.10.2 There is evidence of consultation with the Diabetes Specialist Team. On 3rd February 2017, the Junior Doctor consulted with the Diabetes Specialist team regarding the change in the medication regime. The team endorsed the change of plan. They were also consulted following the initial change in validating the changes.

4.11.1 What was documented in the Specialist Diabetes service clinical notes for Adult W during the period covered by this review from January 2017 to April 2017?-

4.11.2 The specialist diabetes service considered there was no reason to bring Adult W back to clinics for a review unless the success of the diabetes plan changed. Adult W had been discharged from the Specialist Diabetes Service in February 2015 to his General Practitioner (with responsibility to review the plan) with the District Nursing Service having responsibility to deliver the plan. There is evidence of intermittent support for District Nurses being provided by the specialist service without formal re-referral to the specialist diabetes team until Hospital admission in 2017.

4.11.3 There are a number of entries made in the Specialist Diabetes service notes these are replicated in this paragraph as follows (There are no specific references to the bespoke diabetes plan):

- 31st January 2017 16.30hrs : BM's consistently high throughout the day. (In-patient) Referral to Diabetes Team to review on-going hyperglycaemia.

[33] https://www.medicines.org.uk/emc/product/7920/smpc
[34] http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Product_Information/human/000258/WC500030372.pdf
[35] https://bnf.nice.org.uk/drug/insulin-aspart.html

- 6th February 2017 11:00hrs: Diabetes Nurse Review. Continue with regime, encourage oral drinks and ensure he eats snacks.

- 10th February 2017 14:55hrs Telephone call from Senior Nurse from Ward 3 Community Hospital 1: Discussion: wanted to check what to give if blood glucose high. Recapped plan- if BGL greater than 20mmol/l-2-4 units NovoRapid to correct, check urinary ketones. If hyperglycaemia following hypo treatment to avoid correction for this. Check injection sites to ensure no lipohypertrophy .To ring back if any problems.

- 15th February 2017 12:19hrs Telephone encounter from Doctor – Community Hospital 1. Telephone call e; a patient.
  PLAN:
  Advised no changes to current regime. District nurses aware of this regime. Will phone if any further concerns.
  Discussion:
  Type 1 currently on Humulin M3 34 units am and Humulin I 20 units pm
  Plan for NovoRapid to correct BGL if over 20 and check for ketones.
  Had 2 hypos am last week Humulin I reduced to 18 units pm but later increased as BGL high am.

  Ward round: BM's remain erratic. Advised by Diabetes Specialist Nurse to keep current dose of Humulin 3 and Humulin 1 and give 2 units if BM>20
  Eating well (This regime was detailed on Diabetes Blood Glucose monitoring and Daily Subcutaneous Insulin chart).

- 8th March 2017 08:40hrs BM 6.7mmol. BM check & Medication. BM's sent over to DSN. All equipment just recently ordered. Carer present, Adult W looks much brighter in himself this morning. Carer states Adult W had managed to get himself up and dressed before she got there this morning. Adult W is going to the day centre today. Humulin M3 - 34 Units.

- 29th March 2017 10:42hrs Discussion: Telephone encounter - carer at day centre ? over how much novorapid to give if BGL over 20 it used to be 6 units but now states only 2 units to be given, advised to contact District nurses or GP.

4.12.1 Were hospital staff and those staff involved, aware of a bespoke diabetes plan being in place or changes to the plan ?

4.12.2 Hospital Staff were aware of the bespoke plan and clearly, through the nature of Adult W being an inpatient were involved in the changes to the medication regime in that plan. There is evidence of discussions around the plan at the Specialist Emergency Care Hospital, at Community Hospital 1 and with District Nurses following discharge, evidencing they were using the revised medication regime. What did not occur, is that the changes were formatted into the style of the bespoke original plan and a new version produced and distributed / communicated to all agencies.

4.12.3 The GP Practice did receive the diabetic plan from the Diabetes Specialist Team, updated 7th October 2014. No subsequent diabetic plan was evident in the records. Information provided by the GP safeguarding lead is that the GP was not always informed of changes to diabetic plans by the Diabetes Specialist Team (DST). The GP's practice considered the District Nursing Team/ Diabetes Specialist Team lead on diabetic plans.

4.13.1 What was the level of awareness of other agencies involved in Adult W's care pathway of a bespoke diabetes plan being in place?

4.13.2 In relation to those agencies not listed in paragraph 4.16.2- 4.16.3 above the following provides an overview of awareness relating to the bespoke diabetes plan developed in 2014 and subsequent changes.

4.13.3 The Day Centre had a high awareness of the diabetes management plan prior to it changing in hospital and they demonstrated a good understanding. In particular, the importance of reporting high or low blood glucose readings to facilitate further intervention, was evident. Consent was in place to enable Day Centre staff to test Adult W's blood glucose if he was unable to check his own. Day Centre staff only found out by chance about the changes to the medication regime and following discussion with the Specialist Diabetics Team had to confirm with family and District Nursing service that there was a change.

4.13.4 The Care Manager/Social Worker were not made aware of any changes made to the plan. The patient's bespoke diabetes plan was not entered into Adult W's special patient note.

4.13.5 Home Care Services had a high level of awareness of the bespoke diabetes plan and retained a written copy. The service were not aware of the changes to the plan until 22nd March 2017. The service understood the importance of contacting the family if any medical intervention was required or if Adult W was admitted to hospital.

4.13.6 Nursing Home 1 staff were not aware of a 'bespoke' diabetes plan. Although the District Nurse home care records that had been left at Nursing Home 1 and were returned to Adult W's daughter after his death, did contain a copy of the 2014 bespoke plan inclusive of the action to take in response to hyperglycemic symptoms. Indications would suggest that the care Adult W received was no different to that of any other resident with type 1 diabetes. The only individualised aspect of his diabetes care being that of his particular medication requirements which were in accordance with the prescribed regime at that time.

4.13.7 The out of hours doctor service indicated that the patient's bespoke diabetes plan was not entered into Adult W's special patient note on the Adastra (electronic GP record).

4.14.1 How and by whom, were changes to the diabetes plan communicated in 2017?

4.14.2 There was variable information regarding communication relating to the revision to the diabetic plan following the changes made in 2017. The understanding

of the Hospital and Community NHS Foundation Trust was that each successive team had a copy and enacted the plan (the new medication regime), and they considered communication to be effective. There is evidence from documented discussions, including with Adult W's daughter on 28th February 2017, that she and carer services understood the revised care plan.

4.14.3 Information from primary care indicates that there was no evidence of changes to the diabetic plan in 2017 being communicated to the GP Practice. The Practice indicated that no updated diabetic care plan had been received, although they did receive a discharge letter with update of medication. Adult Social Care Services indicated they were not aware of any changes to Adult W's diabetic management regime as this was not discussed specifically when plans for discharge from Community Hospital 1 were being discussed .The Day Centre also received no communication. Indeed, they were still following the old regime, as evidenced by Adult W receiving 6 units (rather than the revised 2 units) of NovoRapid on 28th March 2017 when the his BGL was 23.8 mmol/l. This was not addressed until the Day Centre contacted Specialist Diabetes Service / District Nurses for clarification on 29th March 2017. The Home Care Service were not informed of the changes until sometime after they had occurred.

4.15.1 What communication took place with Adult W and /or his family regarding changes to his diabetes plan?

4.15.2 The only evidence presented was there are documented discussions on 28th February 2017 relating to pre discharge from Community Hospital 1 that included Adult W's daughter although it is unclear what specific discussions took place.

4.16.1 Prior to the changes to the diabetes plan how regularly had the plan been reviewed since its creation?

4.16.2 The original 2014 Diabetes plan was based on discussions 10th January 2014 and developed jointly by Adult W, his son, daughter and Dr 1. It was revised 6th June 2014, 2nd September 2014 and last updated 1st October 2014. It is recorded in the plan that it is recognised that it may need modification as Adult W's situation evolves and therefore needs to be updated. It was recognised within the plan that periodic review might be required. There is no evidence the bespoke plan was reviewed after 2014.

4.17.1 Who was responsible for maintaining and reviewing the diabetes plan?

4.17.2 The original diabetes plan was signed off by Dr 2 and the key professional contacts on the plan are Dr 1 and the Diabetes Specialist Nurse. The plan indicates that when the specialist diabetes nurses were informed of high (above 3) ketone levels they were responsible for reviewing the diabetes care plan. The Hospital & Community NHS Foundation Trust however, considered Adult W to be under the care of his GP and the District Nursing service. This was confirmed with the GP practice in letters dated 27th January 2015 and 12th February 2015 where it is clear the District Nursing Service were responsible for highlighting and disseminating issues relating to the diabetes plan. Whilst there had been regular fax and telephone communication documented in the specialist diabetes team record, responsibility

was seen to rest with the primary care team (supported through active family involvement), with specialist diabetes support when needed.

4.17.3 The GP's practice considered the Specialist Diabetes Team /District Nursing team lead on diabetic plans.

4.18.1 After concerns were raised regarding the change to the NovoRapid regime by the Day Centre on 29th March 2017, what action was taken and what feedback was given, by whom and to whom ?

4.18.2 Adult W returned to the Day Centre on the 8th March 2017. The Day Centre were not aware of any changes to the NovoRapid regime; it was when one of their staff was looking in Adult W's day care diary that they observed Adult W's NovoRapid dose had changed. The Specialist Diabetes team records indicate the Day Centre was seeking clarity whether Adult W's regime needed to be reviewed since it had changed following his admission to hospital. The Day Centre were advised to contact the GP or District Nurses to clarify, as the Specialist Team considered Adult W was under the care of the Primary Care Team. The Day Centre confirmed with the District Nursing service (and Adult W's daughter) that only if Adult W's BGL was over 20 mmol/l then Adult W should administer 2 units of NovoRapid.

4.19.1 How was the District Nursing written care plan updated following the changes to NovoRapid regime?

4.19.2 There was no updated written care plan similar to that produced in 2014.The District Nursing Service administered medications according to the prescription. In this instance of Adult W they utilised the Community Services Insulin Administration Record (CSIAR).

4.20.1 Why did the District Nursing service not identify any concerns as a result of the changes to the NovoRapid regime?

4.20.2
There were no concerns highlighted by the District Nursing Team as they considered the revised regime was working. The District Nursing Team adhered to the CSIAR which advised what amount of insulin to give according to Adult W's BGL.

4.21.1 B2 Transition: There is a need to understand what information was communicated and how effectively this was done so during all of Adult W's transitions from one setting to another, during the period between January 2017 and April 2017. In particular, there is a need to understand whether this information included specific reference to the diabetes care plan, administration of insulin medication and history of triggers to blood glucose instability?

4.21.2 from District Nursing Services to Hospital
It is unclear specifically what communication took place in the case of Adult W. At a general level when a patient is admitted to hospital the patient and/or family may take the copy of their patient held records but this does not happen often. District Nursing staff would give a verbal handover to the paramedics only if they are present

in the house when the paramedics have been called. The District Nursing staff may only become aware of a patient being admitted to hospital if the patient is not at home when they go to visit. They rely on being informed by relatives, Out of Hours Service or GP's. If the District Nursing staff become aware that a patient has been admitted to hospital and is due an intervention, they will ring the ward to ensure this is highlighted. The CSIAR record and the patient held record does not go with the patient to hospital, in the same respect the DN service do not receive a copy of all of the hospital records on discharge.

4.21.3 from Hospital to District Nursing Services

All patients that are discharged from hospital that require District Nursing Intervention have an SBAR (**S**ituation, **B**ackground, **A**ssessment and **R**ecommendation) document completed by nursing staff on the ward. A detailed Discharge Summary and plan was provided to the District Nursing Team to administer insulin. The Community Nurse Communication sheet (SBAR) was sent with details of the insulin regime – this clearly noted that if BGL is more than 20 mmol/l to administer 2 units of NovoRapid. This is also documented in the Daily Subcutaneous Insulin Record Chart and the Community Services Insulin Administration Record. The SBAR for Adult W was received by District Nursing Team on 1st March 2017.The other documents received were an Occupational Therapy Assessment also on 1st March 2017 and the Comprehensive Geriatric Assessment received on the 9th March 2017. If there are changes to the patients care required, occasionally a copy of the discharge summary will be sent with the SBAR form which is very informative, but this is not standard practice and did not occur in the case of Adult W. The Community Nurse was in charge of the regime but was not invited by the ward staff to the hospital discharge planning meeting. The Diabetic Specialist Nurses record their consultations on electronically (on System One) which the District Nursing team can access. The Diabetes care plan (2014) was not part of this process.

4.21.4 from Hospital to other Community Services, including GP

The Care Manager was unaware of the change in the medication regime to manage Adult W's diabetes. This information was not shared by staff at Community Hospital 1 when plans for discharge were being discussed at the discharge planning meeting. The Care Manager presumed that there was no change and that Adult W would be discharged as per usual discharge policy with the community nurses being informed of discharge by the hospital. The Home Care Support service were used to assisting with medication and the only requested change to the care plan was to have additional 'welfare checks' to manage and monitor the falls risk. The Diabetes care plan (2014) was not part of this process.

4.21.5. The GP practice received a hospital discharge letter dated 1st March 2017 which included a medication list, however there was no specific information with regards to changes to Adult W's bespoke diabetic plan which they had previously received. The most up to date version held being 7th October 2014.

4.21.6 *from District Nursing to Day Centre Staff*

There was no proactive communication with the Day Centre regarding any change to the diabetes plan; this is not standard practice. The care provider and/or the organisation who arranged the Day Centre would usually communicate this, however

the Care Manager on this occasion was not aware of any changes. Adult W had returned to the Day Centre on the 8th March 2017 and it was not until 29th March 2017 when the day centre observed the dose of NovoRapid had changed. The Day Centre staff confirmed this was the case with the Family and District Nursing service.

4.21.7 ***from District Nursing to Nursing Home 1***

A comprehensive verbal handover by telephone was completed by District Nursing Staff Nurse on 31st March 2017. There were telephone discussions documented between community nursing team and the Deputy Manager in the nursing home records of that date. In addition, the Community Matron hand delivered the District Nursing Care plan documentation, although this was given to a Carer and not a Registered Nurse (neither actions were recorded in Adult W's District Nursing record). The bespoke diabetes plan from 2014 was in the District Nurse care file but it does not appear that this was ever updated, nor 2014 version highlighted to Nursing Home 1. Nursing Home 1 do not appear to have used this information in the District Nurse care record to inform their care planning process. Nursing Home 1 also received the Community Services Insulin Administration Record. The ketone meter, which was part of the bespoke diabetes plan, does not appear to have been referenced during transition nor was it ever received by Nursing Home 1.

4.21.8 from Adult Services to Residential Home 1

The general care management assessment information was shared. This did not detail the diabetes care plan, administration of insulin medication or history of triggers to blood glucose instability, as it was considered the District Nursing Service would maintain responsibility for diabetes management.

4.21.9 from Adult Services to Nursing Home 1

The information shared was the general care management assessment information which did not detail the diabetes care plan, administration of insulin medication or history of triggers to blood glucose instability. Prior to admission, Nursing Home 1 carried out their own assessment which included medication management.

4.21.10 from Hospital to family

When Adult W was in hospital conversations with Adult W's daughter relating to his care are documented.

4.21.11 from District Nursing to family

There does not appear to have been any specific discussion regarding the update or status of the 2014 diabetes care plan (that contained the previous administration of insulin medication and historical triggers to blood glucose instability) with the family from any service not only the District Nursing Service**.** Home records were in situ for the family to read at all times with the contact number for the District Nursing Team if needed. Historically the District Nursing Team were fully aware that if there were any concerns then they had to contact the son, which changed to Adult W's daughter when the son moved away.

4.22.1 Did handovers at the points of transition comply with policy/procedure and best practice?

4.22.2 There are challenges in achieving excellent practice in the transition of care**.** At the points of transition in regard to Adult W handovers of care were varied, took

different forms and could not always be considered best practice (paragraphs 4.21.2-4.21.11 above). Of significance, on 31st March 2017, a District Staff Nurse spoke to a male nurse at Nursing Home 1. A verbal handover was provided over the phone regarding Adult W and his insulin regime. This was noted that this was unable to be faxed as it was considered that there was not a confidential pathway to do this. It was agreed that all of the care plan information would be delivered to Nursing Home 1. The home were advised to contact the District Nursing Team at any time if they had any further questions or support required. The District Nursing care plan, which contained information regarding the District Nursing management of Adult W's diabetes and insulin administration, was later that day delivered to Nursing Home 1. This was given to a Carer who was advised to hand the information to staff in charge of Adult W's care. The Modern Matron offered to speak to the staff but was informed that it was not necessary. Records from the Nursing home suggest that the handover was not comprehensive. Detailed guidance of Adult W's presentation, when stable, hypo or hyperglycaemic was not discussed specifically and there was no awareness of the wider actions (non medication), as described in the 2014 bespoke diabetes plan.

4.22.3 In relation to the short admission to the respite placement, this was to avoid repeat hospital admission and was "hurried". There was no pre-admission assessment recorded at that time. The admission was based on previous assessment information that was used but it was unclear which category of care that Adult W required at that time, nursing or residential. The placement broke down because of the EMI environment which was not a suitable placement for Adult W.

4.22.4 The process of Discharge from Community Hospital 1 highlighted weaknesses in communication with Adult Social Care services.

4.23.1 Explain whether any concerns about the effectiveness of the change of diabetic care plan (NovoRapid) were identified and adequately recorded and if not why not?

4.23.2 Following discharge there were no concerns over the effectiveness of the diabetic care plan identified by either the GP or District Nursing Service. Their rationale being there was no basis for recording concerns as there were none identified. Nursing Home 1 considered that they were not aware that there had been any changes to the diabetic care plan as they had not been involved prior to the changes made in February 2017. Nursing Home 1 did not consider they had information provided to assist staff to identify triggers for instability of Adult W's condition.

4.23.3 The Day Care Service did raise concerns about the change to NovoRapid. The matter is discussed earlier in the report at paragraph 4.18.2.

4.24.1 Why was Adult W's ketone meter not available to support monitoring of his diabetes within each care environment?

4.24.2 Adult W had a Ketone Meter which was kept in a cabinet in his home. This was part of the 2014 bespoke diabetes plan with replacement strips on repeat

prescription. The Ketone meter was considered Adult W's property (although the family understood this was issued by the District Nursing service). This does not appear to have been packed with Adult W's personal belongings prior to movement to another service. At Nursing Home 1 it is not known why this was not available. As a respite resident they would have expected that Community Services would have provided any equipment required for his stay and clearly this had not occurred.

4.25.1 Explain how ketone meter testing strips were out of date ?

4.25.2 It has not been possible to identify why these were out of date. Apparently the strips were not used that often and no one appears to have been responsible for ordering/checking the expiry date of the strips. The Ketone testing strips were on repeat prescription, they were last ordered in March 2016.

4.26.1 Detail the process undertaken at the point of admission of Adult W to Nursing Home 1 in order to ensure his medical needs were understood*?*

4.26.2 A Pre-admission assessment by the Nursing Home 1 was completed 4 days prior to Adult W's admission and as much detail as possible was acquired. The Assessor identified that further information and documentation was required and requests were made to obtain this information from the relevant professionals:

- Updated emergency health care plan and Medical records/ prescription information from GP
- CSAR from District Nursing
- Care and Support plan from Adult Social care

The Care Manager was informed that the nursing home had carried out their assessment and were satisfied that they could meet Adult W's needs.

4.26.3 A verbal handover, as described earlier in the report, was provided over the phone by the District Nursing Service regarding Adult W and the insulin regime. District Nursing care records were left at Nursing Home 1.

4.26.4 The GP practice were informed of Adult W's admission by his daughter and were not directly involved in admission.

4.27.1 Explain what action was taken by the Social Worker (SW1), as a result of concerns raised on 24th March 2017 by Adult W's eldest son, of Adult W's diabetes management whilst in care?

4.27.2 In responding to the concerns that were raised in the email, SW1 stated that they advised PH that Adult W had indicated that he was lonely and would like to be around people more, which was his main reason for wanting to go into a care home setting. SW1 advised PH that Adult W disliked Respite Home 1 because it was 'full of women', which is why he wanted to leave early. Also, if Adult W was unhappy and

did not want to stay in Nursing Home 1 other options would be explored. If Adult W had wanted to return home and had the mental capacity to weigh up the risk of returning home, services would have to support him in returning home and make possible changes to his care plan. At that point SW1 explained respite was not permanent and that a review and further assessment would take place if Adult W wished to remain at the care home.

4.27.3 Specifically in relation to diabetes care SW1 stated that there were qualified nursing staff at Nursing Home 1 to manage the diabetes. Also that Nursing Home 1 completed a pre-assessment prior to admission and District Nurses gave a hand over as well as faxing information to the home regarding the management of Adult W's diabetes. SW1 stated that Nursing Home 1 would advise at the pre-assessment if they concluded that they could not meet the needs of Adult W. SW1 also indicated that Adult W would have more supervision day and night in Nursing Home 1 than what he had at his own home and staff would be able to respond quicker if Adult W fell. SW1 had added that if Nursing Home 1, family and SW1 felt Adult W needed something to detect falls a sensor matt would be provided to alert staff when Adult W was up out of bed or out of his chair.

4.27.4 SW1 could not recall exactly how the response was provided to the eldest son, recollecting that this was either by E mail or telephone. There is no record of any response to the eldest son. SW1 however had provided a response to a number of questions raised by the youngest son following his father's death. A number of the themes identified in 4.27.2 and 4.27.3 above are referenced in this e mail which may be a source of confusion. In this e mail of 12th April 2017 SW1 acknowledged she had received the eldest son's e mail and had not responded to it.

4.27.5 The eldest son of Adult W has consistently stated that they did not receive a response to the concerns raised in their E mail on 24th March 2017.

4.28.1 B3 Organisational: What District Nurse and Home Care support visits took place on 29th January 2017?

4.28.2 On 29th January 2017 two home visits were carried out by the District Nurse; 09:15hrs and 16:30hrs the purpose being to check the BGL and ensure medication compliance. The district nursing record at 09:15 states:

- "Humulin M3 self-administered. BM 5.8. Unable to unlock Adult W's front door this morning. Returned when carers arrived at 09:15hrs. Tried to contact Adult W's daughter but unable to get an answer. Carer managed to unlock door. Insulin administered".

The recording at 16:30hrs states:

- Humilin I 20 units. Self-administration abdomen. BM 8.4.

There is incongruity within the CSIAR recording sheet for the time of administration for the afternoon dose of Humilin 1 which states 14.30 hrs. No explanation can be offered for this. The BGL of 8.4 does correlate on the CSIAR.

4.28.3 During the day 4 care and support visits took place by the Home Care Service and their records highlight the following .

- First call between 09.13 to 09.48hrs: BGL 5.8 mmol/l. Staff assisted with TED Stockings and socks and slippers, made breakfast and hot drink and gave fresh water, Medication administered as per blister pack and opened blinds and emptied the commode. Dishes washed. Adult W was still eating when staff left.
- Second visit between 12.11to12.40hrs: BGL 8.6 mmol/l. Medication administered, fresh water given. Prepared and cooked meal and a hot drink of quiche and beans, bread and butter. Dishes washed and dried. Commode emptied.
- Third Visit between 17.16 to 17.40hrs: BGL 8.4 mmol/l. Medication administered and Paracetamol refused. District Nurse administered Insulin. Fresh water given. Eggs and bacon on toast and a cup of tea. Dishes washed, blinds closed, lamp put on, commode emptied and a snack left.
- Fourth visit between21.10 to 21.35hrs: BGL 6.5 mmol/l. Medication administered as per blister pack. TED Stocking removed and washed. Assisted Adult W into nightwear, creamed legs and put slippers on. Cup of tea and fresh water, emptied commode, dishes done, Adult W watching TV on leaving and secured property on leaving.

4.29.1 Detail what recorded times Adult W received his insulin and meals?

4.29.2 Table 1 below summarises the recorded position in relation to insulin and meals for the 29th January 2017.

Table 1 : Recorded insulin and meal times for 29th January 2017

Insulin administration time	9.15hrs		16.30hrs*	
Meal time	09.13-09.48hrs.	12.11-12.40hrs	17.16-17.40hrs	21.10-21.35hrs**

Footnote: *recorded at 14.30hrs on CSIAR
** no food recorded

4.30.1 Explain whether the relationship between meal times and medication was clearly documented and reflected, by practice carried out, by Home Care Services and District Nursing services.

4.30.2 The District Nursing service were responsible for the insulin and the carers for supporting Adult W with his meals. Home Care Services had clear guidance from the Care Manager in relation to when calls were required for Adult W to coincide with meal times. This approach was evident in their client records and had been agreed with the District Nursing Team.

4.31.1 What pre-admission assessment took place prior to Adult W being admitted to Nursing Home 1?

4.31.2 A standard pre admission assessment was completed by the Deputy Manager with Adult W (his daughter was present) on 23rd of March 2017. SW1 was not present at the pre-admission assessment. This is usual practice following the sharing of written information in advance. The assessor identified the need to obtain further information and contacted SW1, District Nursing team and General Practice. The Community Services Administration Record, copy of Medical Records / Prescription and Care and Support plan were obtained (dates unspecified). It remains unclear whether a up to date Emergency Health Care Plan was obtained.

4.31.3 On 31st March 2017 telephone discussions took place between the District Nursing service and the Care Manager of Adult W. There was confusion over the initial registration of whether Adult W's needs were residential or nursing needs, the outcome confirmed Nursing.

4.32.1 What was documented in the care plan for the management of diabetes at Nursing Home 1, including the action to be taken in the event of an abnormal blood glucose reading?

4.32.2 There was no specific diabetes care plan. Documented in the Medical Diagnosis section of the pre-assessment form was that 2 units of NovoRapid were to be administered in the event of abnormal blood glucose reading of >20 mmol/l. These details were transferred in to the Medication Care Plan. There was nothing documented in relation to the action to be taken in the event of an abnormal blood glucose reading. The BGL recordings and NovoRapid administration for Adult W's period within Nursing Home 1 are provided for reference in table 2 below. There are occasions where the BGL was not recorded and where the BGL was < 20mmol/l and there is no evidence of NovoRapid being administered.

Table 2 : Nursing Home 1 BGL recordings and NovoRapid administration for Adult W

April Date	Pre breakfast BGL mmol/l	Pre lunch BGL mmol/l	Pre Tea BGL mmol/l	Pre Bed BGL mmol/l
1st	11.8	24.1*	23.3*	23.1
2nd	9.3	15.4	19.3	N/R
3rd	6.5	8.9	N/R	N/R
4th	8.9	14.7	10.6	N/R
5th	9.5	18.8	14.5	N/R
6th	16.9	N/R	19.5	N/R
7th	8.8	24.7**	29.9*	>33.3***
8th	24.1*- 08.25hrs	33.1*-11.30hrs 28.4-13.00hrs	23.3 -14.45hrs >33.3* - 16.50hrs	

Footnotes : 1.N/R -Not recorded
2. * NovoRapid 2 units administered

3. ** NovoRapid 2 units administered at Day centre
4.*** Not recorded on Blood sugar monitoring form

4.33.1 Why did Nursing Home 1 nursing staff not raise concerns earlier than they did and subsequently not escalate the response of high glucose reading to emergency (999) status?

4.33.2 Nursing Home 1 staff considered they did not have information that described Adult W's usual presentation when his BGL was within normal range and his presentation when abnormal. The nursing staff are described as using their clinical judgement[36] based on Adult W's vital signs, which were stated to be within normal range. These vital sign observations recorded are replicated in table 3 on the following page. Whilst recognising Adult W was deteriorating, Registered Nurse 1's clinical judgment was such that their assessment of the situation was that it did not require escalation to a 999 response. The NEWS[37] tool developed nationally to improve the detection and response to clinical deterioration was not in use within Nursing Home 1.The option of escalating to a 999 ambulance status was offered by the 111 service when the second call was made by Nursing Home 1, however Registered Nurse 1 chose not to do this on the understanding that the GP was informed of Adult W's deteriorating health. (There is no evidence that the GP was informed by the 111 service call handler).

Table 3: Adult W's vital signs on 8th April 2017

Time	Temperature C (oral)	Blood Pressure	Pulse	Resperation
11.30hrs	36	Systolic 96 Diastolic 50	96	Not recorded
15.00hrs	37	Systolic 100 Diastolic 60	100	26
17.10hrs	36	Systolic 100 Diastolic 60	100	38

4.34.1 What specific training had nursing and care staff involved in Adult W's care across all agencies received in relation to Diabetes care, (in particular hyperglycaemia); how regularly and when was this last provided?

4.34.2 The level of training varied across agencies and this is summarised below:

- At Nursing Home 1 there is no evidence of any diabetes training or clinical updates (post registration) for Registered Nurses. Care staff had not received any diabetes training at any time.
- There is evidence that the Day Centre had requested training in relation to basic diabetes care, however this had not taken place.

[36] Clinical Judgement is the process by which the nurse decides on data to be collected about a patient, makes an interpretation of the data, arrives at a nursing diagnosis, and identifies appropriate nursing actions; this involves problem-solving decision-making and critical thinking see https://medical-dictionary.thefreedictionary.com/clinical+judgment

[37] NEWS (National Early Warning Score) is a tool developed by the Royal College of Physicians

- All of the specialist diabetes team, Acute Trust and District Nurses are expected to maintain their standards of practice in keeping with their NMC code[38]. The Hospital & Community NHS Foundation Trust facilitates this, through individual reading and learning from journals, attending local and national symposia and scientific and other specialty specific meetings, gaining externally accredited qualifications, team discussions about individuals, joint consultations, specific personal development identified in annual appraisal and collective team training. Individual learning needs are identified at appraisal and supported by the Trust.
- Within the Mental Health NHS Foundation Trust the organisation has a Physical Health care training programme which is being rolled out across the organisation and includes diabetes awareness.
- Within the Home Care Service where an individual has diabetes, the service accesses Health Care Professionals to deliver client specific awareness to the Home Care Team for staff involved, to ensure they have the skills and abilities to care for the individual safely and respond to their changing needs accordingly. Staff are trained on who to contact in an emergency situation which requires the input of the Health Care Professionals.

4.35.1 What algorithms were followed by the 111 service on 8th April 2017 relating to Adult W's clinical presentation and were these not receptive to identifying a high glucose level/hyperglycaemia and the associated risks?

4.35.2 No algorithm was used and no triage completed by the 111 call handler when the initial call was placed on 8th April 2017 at 11.48hrs. This is standard procedure when a healthcare professional contacts the 111 service. Registered Nurse 1 requested a GP service and this request was passed on to the Out of Hours doctors service. When an individual calls the 111 service and they are not a healthcare professional there are algorithms that would be followed by the call handler that identify both hyperglycaemia and hypoglycemia as a result of triage being carried out.

4.36.1 What information was passed on by the 111 service to the on call doctor?

4.36.2 The on call doctor service, at the point of the case being referred from the 111 service, were informed that Adult W was " generally unwell, insulin dependent diabetic, blood sugar way higher than normal, unable to get it down". The Registered Nurse 1 had requested a call back within 1 hour and the return call from the doctor took place within 15 minutes.

4.37.3 In relation to the second call, Carer 1 at 16.58hrs, asked if the call handler could obtain an estimated time of arrival (ETA) from the doctor for the home visit . The call handler was informed by the Out of Hours doctors service there was no ETA and the visit remained outstanding. The call handler updated Carer 1, explaining that the other option was to request a 999 ambulance. Carer 1 discussed this matter with Registered Nurse 1 and then Carer 1 informed the call handler of the outcome of the discussion, indicating that Registered Nurse 1 would wait for the GP home visit, however they requested that the call handler inform the Out of Hours doctor that

[38]Available at : https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Adult W's condition was worsening. As stated earlier there is no evidence that the 111 call handler passed on this information to the Out of Hours doctor service.

4.38.1 What information was considered (asked and received) by the on call doctor when they called Nursing Home 1 relating to Adult W's clinical presentation on 8th April 2017; did this include details of Adult W's high glucose level?

4.38.2 There is no record within Nursing Home 1 relating to information from their perspective concerning this matter.

4.38.3 Prior to calling Nursing Home 1 the on call GP 1 accessed the Adastra (electronic GP record) at 11.51 hrs. There was a special patient note on Adult W's record which was last updated on 20th March 2017. The special patient note contained the following information:

- The patient had type 2 diabetes*(this is incorrect)* on insulin and was at risk of hypoglycaemia.
- He lived alone with four times per day carers but may progress to long term care.
- He was at risk of falls and was increasingly frail.
- There was a Do Not Attempt Cardio Pulmonary Resuscitation order in place and in the event of expected death the surgery was prepared to issue a certificate.

4.38.4 There were also 2 previous encounters with the out of hours service for which GP 1 would have access to these records.

- September 2015 – Adult W had high BM with vomiting and ketones. The district nurse felt that the patient required admission to hospital however the patient was reluctant. A routine home visit was arranged. The GP who visited Adult W noted that he was alert and smiling. Full mental capacity and did not want to go to hospital. BM was 29 and had fluctuations in recent weeks. The DN visited 3 times daily. GP discussed with a Consultant who advised 2 extra units of insulin in the morning and evening. The patient was also to liaise with the diabetic clinic that week.
- November 2013 - Adult W self-injected his insulin and monitored his own BM. Felt unwell and BM was 3.1. Carer gave him Lucozade and small pot of rice. Now in bed and felt well. Advised to see own GP and call back over week end if any worse.

4.38.5 GP (1) noted in the patients triage notes that Adult W had dementia. GP 1 then accessed the patient's Summary Care Record and noted all of the patient's medication and previous history. This included the details:

- September 2014 – Hyperglycemia

- October 2013 – Ketoacidosis

4.38.6 GP 1 called Nursing Home 1 back at 12.05hrs. The triage Adastra record indicates GP 1 noted the Adult W's BGL had been taken by the nurse and was 24.1 mmol/l . Adult W also had some nausea and was described as sleepy. When he woke he was alert and talking. He had vomited the day before. It is recorded he was passing urine okay at the time of the call (although Nursing home 1 records indicate he had earlier in the week experienced problems with micturition. Additionally the daughter of Adult W recalls when she was at the home on 8th April 2018 the staff had attempted to obtain a urine sample but could not). Drinking a little but not eating. Adult W was not short of breath and had no cough. The nurse was planning to test his urine. GP 1 recorded possible infection. Safety net instructions (what to do if the patient became worse, were given especially around the signs of sepsis). A routine home visit was arranged to Nursing Home 1, which had a time frame of 6 hours.

4.38.7 A further call was made to 111 from the Nursing Home 1 at 16.58hrs to query whether the GP was on route, indicating that the home considered Adult W was getting worse. The call recording of this call from 111 confirm that the 111-call advisor spoke to a member of the dispatch team at the Out of Hours service to request a time frame for the visit. The despatcher advised that the patient was allocated a home visit but could not give a time frame. The fact that the patient had deteriorated was not discussed on this call to the Out of Hours service.

4.38.8 A further call was placed by the Nursing Home to the 111 service a 17.42hrs to advise that Adult W had passed away. This information was not passed onto the Out of Hours Service. GP 2 arrived at the home at 18.07hrs, this was 6 hours after the triage call. They were advised by the staff that the patient had rapidly deteriorated; he had died 30 minutes prior to GP 2 arriving. GP 2 verified death and the police were informed as per policy as it was deemed an unexpected death.

4.39.1 Why did the on call doctor not diagnose hyperglycaemia and recommend a 999 call?

4.39.2 The review by the out of hours GP service indicates the doctor did acknowledge that hyperglycaemia was present although did not feel that this should have led to a 999 call. The GP's decided to allocate a home visit, to allow further assessment of the situation. The triaging GP provided interim management advice for the staff to follow and also gave safety netting instructions, in case the patient's condition deteriorated (to re-contact 111). The nursing home staff member made it clear to GP1 that they were trying to collect a urine sample, which would be tested for ketones in ascertaining the severity of the hyperglycaemic episode.

4.40.1 Are there any chronological gaps in Adult W's care records? If so, what are the gaps and what are the reasons for them?

4.40.2 There was no specific diabetes care plan created in the Nursing home. The management of Adult W's diabetes was included in the Nutrition and Hydration Care Plan and Medication Care Plan. There was no comprehensive care plan developed following admission.

4.40.3. The bespoke diabetes plan last updated on 7th October 2014 had not been updated.

4.40.4 There are no chronological gaps, within the System 1 District Nursing records with the exception of the details relating to the handover of care to Nursing Home 1 not being contemporaneously recorded and the incongruity between the times on the CSIAR and the district nursing record on 29th January 2017. No explanation can be offered for the discrepancy.

4.40.5 Concerns raised by the eldest son of Adult W on 24th March 2017 and subsequent actions were not recorded contemporaneously in the Adult Social Care management record. This was an avoidable omission.

4.40.6 Whilst not a gap the entry on the Adastra system indicating Type 2 rather than Type 1 diabetes was not accurate.

4.41.1 B4 Policies , Procedures and Best Practice Guidance: What were the policies, procedures & best practice guidance in place relating to Type 1 diabetes up to April 2017?

4.41.2 The Hospital & Community NHSFT have guidelines and these are updated in line with NICE[39] / Joint British Diabetes Societies guidelines (usually some local adaptations where appropriate), inclusive of the management of hyperglycaemia in adults. The majority of these are on the Trust intranet / internet and are orientated towards hospital or community care. The guidelines are managed by a nurse consultant in the Specialist Diabetes Service.

4.41.3 Information provided by the General Practice is that they have a number of policy / pathway documents. They include, for example, newly diagnosed diabetic patients being managed by practice staff. They receive regular reviews, visits and blood tests until stable, then the patients are reviewed in clinic annually. This is achieved by 'read codes[40]' added to the patient's records and thus generating an invite for annual review.

4.41.4 Within the out of hours GP service there is an expectation that clinicians are up to date and use national guidelines for managing Type 1 diabetes[41]. (The special

[39] The National Institute for Health and Care Excellence (**NICE**) is an independent public body that provides national **guidance** and advice to improve health and social care in England see : https://www.nice.org.uk/process/pmg20

[40] Read Codes are a coded thesaurus of clinical terms. They provide a standard vocabulary for clinicians to record patient findings and procedures, in health and social care IT systems across primary and secondary care. See https://digital.nhs.uk/services/terminology-and-classifications/read-codes

[41] Nice Guidelines see: https://cks.nice.org.uk/diabetes-type-1#!diagnosissub:2.

patient note accessed by the out of hours GP incorrectly stated that Adult W had a diagnosis of type 2 diabetes mellitus)

4.41.5 The Mental Health Trust NHS Foundation Trust did not have a policy for Type 1 Diabetes up to April 2017. The policies which staff would have referred at that time were: Mental Health NHS Foundation Trust (c) 29 Trust Standard for the Assessment and Management of Physical Health was implemented in July 2015 and includes Practice Guidance on a number of physical health issues and Mental Health NHS Foundation Trust (c) 38 Pharmacological Therapy policy

4.41.6 Within Nursing Home 1 there was a policy and procedure in place, however having been reviewed this was deemed as inadequate and more detailed information and guidance was identified as being required.

4.41.7 The Day Centre and Day Service did not have any generic policies relating to Type 1 diabetes, only bespoke guidelines relating to Adult W. They both had the guidance from the bespoke Diabetes Plan 2014, although this had not been updated following medication review in 2017.

4.42.1 Do these specifically refer to hyperglycaemia and if so, to what extent?

4.42.2 All guidelines in relation to Type 1 diabetes specifically refer to hyperglycaemia within Hospital & Community NHSFT, as does the NICE guidance utilised by the out of hours GP service.

4.42.3 The Policy and Procedure in place in Nursing Home 1 in April 2017, only refered to hypoglycaemia. Evidence suggests that it was not clear whether staff at the time were familiar with the detail of the policy. The position within the Day Centre and Day Care Service related to the guidance from the bespoke Diabetes Plan (2014) that did identify what actions to take should Adult W have hyperglycemia (and hypoglycemia) symptoms. Nursing Home 1 also had this plan contained within the notes received from the District Nursing Service, however there was no evidence that this had been communicated to or identified by Nursing Home 1.

4.43.1 If this information was in place, explain any areas of non-compliance in relation to Adult W's care.

4.43.2 The Hospital and Community NHS Foundation Trust did not identify any areas of non-compliance through the review process in relation to policy, procedure and best practice guidance. The plan was followed according to Adult W's healthcare needs following an inpatient review and subsequent change to his medication regime.

4.43.3 The guidance within the bespoke diabetes plan regarding what emergency action to take in relation specific symptoms relating to hyperglycaemia was not complied with at Nursing Home 1 (the home did not have awareness of the plan). This had included the use of the Ketone meter which had not been available.

4.44.1 Have there been any changes to Policies, Procedures and Best Practice Guidance since April 2017? If so what has changed?

4.44.2 There has been a new diabetes policy developed within the organisation who has responsibility for Nursing Home 1. The policy is more comprehensive and includes signs, symptoms and actions for hyper as well as hypoglycaemia.

4.44.3 In October 2017 a Practice Guidance Note, Guidelines for the Safe Prescribing, Administration and Monitoring of Insulin and oral anti-diabetic drugs was introduced within the Mental Health NHS Foundation Trust . This guidance note makes specific reference to what hyperglycaemia is, causes, short and long term complications, and what happens if hyperglycaemia is not addressed. This guidance includes information on administration, hypoglycaemia, hyperglycaemia, considerations for care planning and monitoring and dose charts. The Mental Health NHS Foundation Trust has a Safer Care Bulletin which is disseminated to all staff and has included Learning Through Incidents. The bulletin has included the subject of Diabetes.

4.44.4 The Hospital and Community NHS Foundation Trust have introduced a Team Lead post for Safeguarding Adults. This has increased the day-to-day management supervision of the Safeguarding Adults service, alongside the Operational Lead for Safeguarding. A centralised Safeguarding Duty System from May 2017 means there is a Safeguarding Lead available 9-5pm Monday-Friday for advice and support to staff. The Hospital & Community NHS Foundation Trust have a recognised safeguarding adults referral system (PROTECT) that has been embedded in policy and practice since 2008. This has been strengthened by the electronic referral form which was rolled out in September 2017 and means that the referral goes directly to the receiving Local Authority and a copy also goes to the Safeguarding Team at the trust which is triaged. This means that the Trust Safeguarding Leads have an overview of all cases and have oversight of cases progressing into the Safeguarding Adults procedures.

4.45.1 Are there any planned changes to Policies, Procedures and Best Practice Guidance that have not yet been implemented? If so what are these?

4.45.2 The Hospital and Community NHS Foundation has a continuous planned programme of updating guidelines on diabetes in line with best practice operational.

4.45.3 The Safeguarding Leads at the Hospital & Community NHS Foundation Trust deliver mandatory supervision every 6 months to the community nurses and specialist teams. The communication regarding the safeguarding process and the central referral point has been cascaded via the Community Leads and within supervision during Quarter 3 supervision (Oct-Dec 2017).Learning from this case review will be further communicated following this case review to all of the community leads.

4.45.4 Additional training to support best practice relevant to diabetes management is planned by the Nursing Home's parent organisation.

4.45.5 Home Care Services plan to develop a Diabetes Policy in order to ensure clear responsibility in relation to their approach to support high standards of diabetes care. A plan to liaise with a Consultant Nurse in order to assure the policy in relation to the diabetes has been identified.

5. Conclusions

5.1 The conclusions to follow reflect an approach that has focused on learning lessons in order to make recommendations for future action. The benefit of hindsight has been imperative as it has enabled the author to not only to develop a more comprehensive account of Adult W's pathway that led up to his death on 8th April 2017, but also to consider issues that could have been improved, being cognisant of hindsight and outcome bias[42].

5.2 The conclusions, based on an overview of IMR reports and other available and relevant information, are structured around a number of salient key learning themes. In being respectful to Adult W and his family, the author is mindful that Adult W died and as such, it may be difficult for family members to consider what was done well. However, in acknowledging the distress and loss suffered by family members, it is an important aspect to consider what went well, in addition to what could have been done better, so that these findings can support the evidence base of the development of care and practice across organisations in the future.

5.3 The learning themes are listed as:

[42] Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgment and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. (NPSA 2008)

- Management of Adult W's deteriorating condition in April 2017
- Review of Adult W's diabetes plan
- Communication & Integration of the care pathway
- Policy and Procedure
- Education & Training

These themes will form the structure to the conclusions of this report.

5.4 Management of Adult W's deteriorating condition in April 2017.

5.4.1 On the morning of the 6th April 2017 the Adult W's pre breakfast BGL was elevated at 16.9. mmol/l. The next blood glucose recorded that day was pre tea and was further elevated at 19.5mmol/s slightly higher than usual. Administration of the twice day insulin was given which was compliant with the revised medication regime. No further blood glucose was recorded on the 6th April 2017 when it would have been good practice to do so, either pre dinner or pre supper.

5.4.2 On the 7th April 2017 Adult W's physical health deteriorated and his insulin regime was managed as per revised instructions. By 16.30hrs Adult W's pre tea blood glucose had been recorded as 29.9 mmol/l, and prescribed Humulin I and a further 2 units of NovoRapid were administered, but no further blood glucose readings had been recorded. This would have been expected. On the same evening Adult W's physical health deterioration continued and he experienced some vomiting. There should have been a clear documented care plan of what 'sick day rules' were to be followed at the point that Adult W became unwell and blood glucose became significantly elevated. The care plan should have included an increase in the intensity of blood monitoring utilising ketone testing (the IMR for Nursing Home 1 concluded that the best appropriate equipment was not available, therefore reliance was placed upon urine being passed by Adult W, rather than using his own ketone monitoring machine). The care plan should have specified the recognition and action for supportive urgent medical intervention from the GP initially and escalation to 111/999 should have been detailed. It is important to identify that Adult W's condition had medically deteriorated and that this was outside normal clinical management as corrective action had been ineffective for some time.

5.4.3 It is concluded that when Adult W became unwell on 7th April 2017, his condition worsening the following day, nursing staff at Nursing Home 1 used their clinical judgement to manage his symptoms, however this failed to recognise the severity of the presentation. Acknowledging that there was no care plan in place, the Nursing staff did not demonstrate knowledge of Type 1 diabetes in relation to hyperglycaemia and failed to escalate the situation to emergency status when the presentation warranted such a response. (NICE guidelines indicate that a blood glucose over 11 mmol/l with other precipitating factors may point towards a diabetic emergency[43]).

5.4.4 It would have been essential to have a care plan in place that indicated appropriate management/direction of what to do during ill health (sick day rules) as had previously been in place in the bespoke diabetes plan in 2014. This may have alerted the nurse to manage Adult W in respect of him being unwell and at the onset

[43] Available at : https://cks.nice.org.uk/diabetes-type-1 - !diagnosissub:2

of high blood glucose. The fact that there was no up to date diabetes care plan in place that provided a framework for the management of Adult W's diabetes, inclusive of hyperglycaemia, was a significant omission.

5.4.5 Following Adult W's daughter attending Nursing Home 1 the 111 service were contacted and the call was directed to the Out of Hours GP service. Based on the information provided to GP1 and their triaging of the situation, this resulted in arranging a home visit within 6 hours, a position the healthcare professional (Registered Nurse) accepted. GP1, based on the information available to them, provided interim management advice to the Registered Nurse to follow and gave safety netting instructions based on escalation in case Adult W's condition deteriorated. It is concluded that GP1's decision was reasonable, appropriate and proportionate to the presenting information received by the them regarding Adult W's declining health.

5.4.6 Positive Practice was evident in the timeliness of dealing with the initial 111 call and initial out of hours GP response. The initial call was returned in 15 minutes and GP1 had accessed the patients summary care record. This appraised him of Adult W's medical history and current medication/allergies at that time. GP1 also undertook a structured and detailed history from the Registered Nurse who presented information to answer the doctor's questions including Adult W's insulin regime and also the doses of fast acting insulin that the Adult W had received.

5.4.7 As Adult W's condition worsened, the 111 service was contacted again by Nursing Home 1. There were clear opportunities to escalate the ongoing situation to a medical emergency and not to do so was misjudged.

5.4.8 Whilst there was an awareness of Adult W's situation deteriorating and a request for the 111 service to relay this information to the Out of Hours Doctor, there is no evidence that this occurred and therefore represents an omission of communication. (111 have taken action to ensure call handlers contact the Out of Hours Doctor service with any information regarding a patient's worsening condition, even if it is a Healthcare Professional managing the patient.)

5.5 Adult W's diabetes plan

5.5.1 The aim of a care plan is to ensure a seamless service (Personalised care and support planning[44]) demonstrating effective communication between health and adult social care services. NICE guidance would indicate that care plans should be provided by a range of professionals with skills in diabetes care together, in a coordinated approach and recommend that the care plan is routinely reviewed annually, as well as at any point of change.

5.5.2 It is clear that there was a bespoke, formal written, diabetes care plan developed in 2014 (last updated in October 2014) by the Specialist Diabetes Service. This is not standard practice of every patient with Diabetes and was developed as a result of concerns raised by the family of Adult W at that time. This was good practice in responding to concerns and involving Adult W and his family in

[44] NHSE Personalised care and support planning handbook: The journey to person-centred care. Core Information 2015

decision making around Adult W's Diabetes Management plan. The plan demonstrated that Adult W and his family were involved in all of the decision making and resulting in a person centred diabetes care plan. The formal written diabetes plan was a comprehensive document and was clearly identified by the family, General Practice and a number of support agencies as the framework for the management of Adult W's diabetes.

5.5.3 The plan recognised that there may be a need to modify the document and update it as Adult W's situation evolved, it did add that further discussions, where possible, would be with the Consultant within the Specialist Diabetes Service. The plan also stated where Adult W experienced ketones above 3 the Diabetic Specialist Nurses were to be informed in taking responsibility to review the diabetes care plan. Subsequently, when Adult W was admitted to Hospital in 2017 a decision was made, in consultation with the specialised diabetes team to change the medication regime (one element of the overall plan). Communication from 2015 confirms that it was clearly the responsibility of the District Nursing Service to highlight and disseminate changes to the plan. Whilst this had historically been clear, what is concluded is that in reality there was no consistent view regarding responsibily for the diabetes care plan, its review, or its updating. This lack of understanding and clear responsibility led to the bespoke plan not being updated or the changes to medication being incorporated. The earlier referenced NICE guidance for patients with Type 1 diabetes does not indicate whether an annual review needs to be completed by primary or secondary care services. What is concluded, is that there should have been a common understanding of accountability across all agencies of the bespoke diabetes care plan which was seen as being central to the care of Adult W by a number of agencies and his family but there was not. The formal review of the bespoke plan had not taken place in accordance with best practice standard as a result.

5.5.4 Acknowledging that the bespoke diabetes plan was not updated when the medication regime changed, the medication change was documented in the Discharge Summary, the Community Nurse Communication sheet, the Daily Subcutaneous Insulin Record Chart and the Community Services Insulin Administration Record.

5.5.5 The priority identified through discussion by the clinical teams in hospital, indicates that the avoidance of hypoglycaemia was the clinical priority within Adult W's diabetes management and this was the reason for the changes to the medication. This was deemed to be a reasonable and appropriate decision given Adult W's history of falls. However, while hypoglycaemia avoidance would be appropriate, it would be important to identify the management of 'sick day rules which are imperative to manage Type 1 diabetes care particularly in the context of Adult W's hyperglycaemia. This was not integrated into an updated diabetes plan for Adult W, the family, General Practitioner or other relevant agencies, following medication changes to the plan in 2017. Whilst it is acknowledged by the author that the bespoke plan was not standard practice for all patients, it was the standard set in relation to Adult W, a standard the family, General Practice and other support

services had worked within for a 3 year period. No service took responsibility for this action.

5.5.6 Adult W had daily intervention from the District Nurses and Home Support staff who on an ongoing basis managed his diabetes well. As part of Adult W's insulin regime he received 3 different types of insulin. For both the Humulin M3 and Humulin I this would need to be given 30-40[45] mins before food . NovoRapid can be given immediately with food[46]. However, whilst this is best practice to optimise long term glycaemic control, there needs to be the acknowledgement that this might not always be achieved given the different care settings or reliance on health care professionals to support diabetes care. This may be due to restriction caused by different routines, staffing levels and dietary accessibility which arise in different care environments. Whilst it is acknowledged that the bespoke diabetes care plan was not updated, this did not impact within the District Nursing service on their implementation of the revised insulin regime. However, the changes made to Adult W's medication regime were not effectively communicated across all agencies with responsibility for Adult W's care in a timely manner. There was some evidence that non statutory agencies, on occasions, felt poorly informed.

5.5.7 The family consider the risks associated with the impact of the change of Novorapid in relation to hyperglycaemia were not fully considered. They feel strongly that the condition is not understood by professionals and have indicated the importance of recognising the risks associated and specialist training required for the successful treatment of this condition. The importance of ensuring high standards of evidence based knowledge has been identified within the recommendations to follow.

5.6 Communication & Integration of care

5.6.1 Good communication is fundamental at any point of handover of care to ensure a seamless service is achieved[47]. Effective communication can be modelled differently depending on local agreement. What would be expected to be seen in any practice however, would be:

- clear legible notes with clarification of individual needs and requests;
- Past history such as blood glucose management;
- involvement of relatives (as appropriate);
- any particular relevant information to meet the needs of the individual in current or new care settings;
- anticipation of any new support required given a change in environment and health and social care needs;
- undertaking discussions with and by the most appropriate/senior member of staff.

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[45] http://live-diabportal-uk.cp-access.com/_Assets/files/Humulin-M3-patient-booklet-v2.pdfc

[46] European Medicines Agency Novoraid Insulin Aspart (accessed May 18)

[47] Care Planning in Diabetes Care : Report for the joint Department of Health and Diabetes UK planning working group 2006

These expectations would need to be carried out at the most appropriate time as near to transition as possible and relay accurate details that support the transition of care for the individuals and their families. This communication is not evident in respect of Adult W's admission to Nursing Home 1.

5.6.2 The pre admission assessment by Nursing Home 1 identified information gaps and the need to acquire further information from General Practice and the District Nursing Team. The transfer of care responsibilities from the District Nursing service to Nursing Home 1, as stated above, was not comprehensive. These communication deficits contributed to a poor level of understanding in relation to Adult W's diabetic and holistic care needs in the week leading up to his death. The limited development of a person centred care plan to meet his medical needs was below the standard expected.

5.6.3 Communication at the point of contact with the 111 service was influenced by the call being initiated by a Healthcare Professional and as such standard algorithms were not followed. (The author has been assured algorithms are in place that would be receptive to hyperglycaemia should the call be from a non-healthcare professional). The verbal interaction that took place between the 111 service and the out of hours GP was influenced primarily by the clinical judgment of the Registered Nurse who, whilst recognising Adult W was deteriorating, failed to recognise the urgency of the situation.

5.6.4 A well planned discharge significantly improves health and wellbeing, reduces risk and likelihood of harm and mitigates inappropriate readmission[48]. Discharge for Adult W following his period of inpatient care was self-limiting. The regime and the diabetes plan had been perceived as unchanged for a long while, therefore the Care Manager assumed that there would be no change necessary to the written information about the diabetes management in the home care environment. There was also a weakness in the detail around the Home Support Workers' role in managing the diabetic regime, the focus having been on increasing visits. The discharge did not recognise the relevance to other agencies of Adult W's bespoke diabetes plan.

5.6.5 The weekly General Practice clinical meetings and monthly multi-disciplinary meeting where patients are discussed and concerns raised, demonstrated effective communication within the GP practice regarding higher risk individuals such as Adult W, who had been discussed in such meetings. This is good practice. However, the General Practice indicated that they were not always informed of changes to a patient's diabetic care plan/management and no agency had taken responsibility to review this regularly.

5.6.6 The effects of physical health to presenting mental health issues (Memory loss) is an important consideration in contributing to the formulation/ diagnosis. The Mental Health NHS Foundation Trust recognised that limited information was obtained within their initial assessment of Adult W regarding the management plan of Adult W's diabetes. Further information should have been obtained to ensure that sufficient detail was obtained regarding physical health care issues, however this

[48] Discharge Planning : Best Practice in Transitions of Care, The Queens Nursing Institute, 2016.

deficit did not inhibit timescales for referrals to diagnostic tests as outlined in the chronology of this report.

5.6.7 On the basis that good record keeping is essential to facilitate safe care, treatment and support, the author concludes from reviewing the IMR reports, that overall, the standard of record keeping varied in relation to Adult W. As identified elsewhere adequate care planning, risk assessment and risk management are fundamental and the lack of a specific diabetes care plan and other associated risk assessments did not provide clarity on the specific interventions that were being carried out, particularly in emergency situations. As a result, the care record was not conducive to supporting the provision of a coordinated care and treatment programme for Adult W's diabetes.

5.6.8 What is clear to the author is there was a strong person centred value base evident in each organisation and it concluded that there was an intention to provide services for Adult W in maximising his independence in relation to health and social care needs. What was not evident was that there was a seamless service and robust co-ordination across the full pathway. This would be essential for long term intervention and co-ordination in providing safe and supportive care.

5.6.9 Overall, within the provision of care to Adult W, services did demonstrate a commitment to work in collaboration with him through active involvement in decision making and listening and responding to his wishes. There is evidence of family involvement, particularly more recently with his daughter, who was the main carer during the period covered in the Terms of Reference (at this point both sons were living abroad). Adult W's daughter therefore, held a central role in supporting her father in maintaining his independence at home which placed significant psychological, as well as practical demands on her. Adult Social Care were responsive to the needs of Adult W's daughter aiming to provide support to her quickly and reduce the risk of a re-admission to hospital by arranging alternative respite care which can be identified as good practice. There is however, no evidence that Adult W's daughter was offered a Carers assessment in providing proactive support. Regarding the specific concerns raised by the eldest son of Adult W, there was no action taken by Adult Social Care to address these issues with him. Assurance has been provided to the author in relation to this issue being retrospectively addressed. Although it should be recognised that in this digital age logistical barriers to communication have been significantly mitigated and the ability to communicate is somewhat easier.

5.7 Policy and Procedure

5.7.1 It was evident to the Overview Report Writer through contact with the family of Adult W, that the time delay in initiating the Section 44 review process has added to the distress faced by the family, in addition to not being supportive to them in being able to seek assurance and closure to their unanswered questions and ongoing concerns.

5.7.2 The GP practice has a strong governance policy/process in place to ensure patients with long term conditions are reviewed regularly. Clinics are held frequently by practice based staff to review patients with chronic conditions to ensure best possible treatment and prevent the condition worsening. The practice also runs a

comprehensive service for care of the elderly, including health checks and patients may be visited at home if they are not well enough to attend the surgery; the doctors and nurses liaise with Adult Social Care services as necessary. The practice routinely use READ codes and alerts on patients' electronic records to trigger review. There is evidence of Adult W's records being coded and reviewed regularly in relation to chronic health conditions/surveillance checks and annual reviews. The General Practice provided routine and acute health assessments, annual reviews for chronic conditions and advice and support to Adult W which included an his annual elderly care health check and dementia annual review. All of these are good practice. This did not however include a formal review of the bespoke written diabetes care plan as it was considered by the General Practice that this was not their lead responsibility.

5.7.3 A number of organisations had in place policies and procedures in relation to diabetes with a governance framework operational to regularly review these and update in supporting evidence based practice. A number of other organisations had identified either policy deficits or areas for improvement and as a result of their IMR, had initiated action to address these matters.

5.7.4 Specifically within Nursing Home 1 a number of policies/ procedures were not robust:

- Pre-admission, admission and review assessments
- Diabetes policy
- Specific Diabetes Management Risk Assessment and Care Plans
- The use of individual Blood Glucose and ketone monitoring meters
- Internal Investigations as a result of sudden death, irrespective of whether or not there is an investigation by the Safeguarding Team or any other Professional Organisation.

The parent organisation of Nursing Home 1 has identified these matters and initiated action to address them in advance of this report being finalised. If this had not been the case, recommendations would have been made in these areas. There is however, a broader recommendation made in this report that places a responsibility on the SAB to be assured of completion of these (and other actions identified by other agencies).

5.7.5 Contemporary Safeguarding information and the policy is available on the statutory agencies websites for the general public. This is good practice.

5.7.6 The Modern Matron involved in Adult W's care from Hospital & Community NHS Foundation Trust attended the Safeguarding Strategy meeting on 24th April 2017. However, a Trust Safeguarding Lead did not attend the Safeguarding or have oversight of the case. A revised process has been introduced since this case and now a Safeguarding Lead would have oversight within the safeguarding procedures which represents good practice.

5.8 Education & Training

5.8.1 There was an acknowledged lack of adequate diabetes training within Nursing Home 1. Other agencies varied in their approach to specific diabetes training, recognising there were opportunities for improvement. There is no single agreed

competency framework to manage diabetes[49] (position statement Diabetes UK), however Diabetes UK recommend that organisations should demonstrate that staff have the appropriate time for continued professional development and that organisations identify all staff roles that could impact on the safety and quality of care for people with diabetes. For diabetes care, the essential knowledge would be to support/ intervene where necessary for individuals to continue to safely manage their diabetes care, e.g. supplement blood monitoring when independence lost, follow a prescription for insulin/medication management and recognise the signs symptoms for hypoglycaemia and hyperglycaemia and seek medical treatment/attention as appropriate. This should be covered through appropriate training and whilst not at the level of specialist knowledge, it would be essential to know where and how to seek the most appropriate help.

5.8.2 Additionally, in relation to Registered Nurses, the NMC[50] indicate that there is also a level of individual responsibility to ensure knowledge and skills are up to date taking part in appropriate and regular learning and professional development activities that aim to maintain and develop competence and improve performance.

5.9 In drawing the conclusions together, what this report illustrates is that there were challenges in achieving the highest standards of practice in the provision of this multi-agency care pathway. All agencies have demonstrated a significant willingness and commitment to learn and it is important to recognise that all agencies involved have fully co-operated with the review process. Individual Management Reports have been completed to a good standard, displaying candour and a willingness for self-analysis. Clearly, reflection associated with such a process for family members on the loss of their father, is extremely distressing. Their ultimate focus however, has been any lessons to learn are identified and being assured action has or will be taken to support a process of continuous improvement in the provision of future services.

5.10 The author considers that whilst this report has identified a number of deficiencies in the care process, it cannot automatically be considered that they represent willful neglect. Neglect and acts of omissions are defined under the Care Act 2014 [51] and include '*ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating'.* Specifically, the clinical judgements involved at Nursing Home 1 in April 2017, whilst in the authors view were misjudged, these actions were not knowingly neglectful. However, the omissions of some staff not adequately monitoring and escalating the situation, did not provide timely medical intervention for Adult W. Based on the information made available to the review this could constitute an act of omission as defined under the Care Act 2014.

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[49] Diabetes UK Position Statement Competency Frameworks in Diabetes 2014

[50] NMC The Code Professional standards of practice and behaviour for nurses and midwives 2015

[51] Available at : http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

6.Recommendations

The following clear, specific, and actionable recommendations provide clarity for the agencies to which they are directed[52] and are made with the aim to support continued improvement action.

Recommendation 1. **Action:** Northumberland and North Tyneside Safeguarding Adults Board supports the actions identified by the individual agencies in their IMR action plans and ensures an assurance framework that provides evidence of the actions listed having agreed target dates and those actions completed.
Rationale: A key purpose of the Safeguarding Adults Review is to consider what the relevant agencies and individuals involved in the case might have done

[52] ADASS, Learning from SARs report, 2017

differently that could have prevented death. The aim being to learn lessons and to ensure those lessons are applied in practice to mitigate the risk of similar harm occurring in the future. Individual organisations have a responsibility to take action, where appropriate, in advance of the publication of this report. There is a need for N & NTSAB to be assured those actions have been completed.

Recommendation 2.
Action: Northumberland and North Tyneside Safeguarding Adults Board should ensure lessons learnt are effectively disseminated within 3 months of the SAB approval meeting. Feedback to the family of Adult W should be within 2 weeks of this report being approved by SAB.

Rationale: There is a duty to be open and transparent and ensure that all lessons learnt are shared widely.

Recommendation 3.
Action: Northumberland and North Tyneside Safeguarding Adults Board should seek assurances from all agencies of the level of available diabetes / physical deterioration training and the assurance framework to monitor staff compliance to undertake such training supports the delivery of safe and effective care is compliant with organisational standards within 6 months.

Rationale: The case of Adult W highlights a need for further training in diabetes awareness and management.

Recommendation 4.
Action: Northumberland and North Tyneside Safeguarding Adults Board should seek assurances that:
a) within 12 months the Diabetic Patient Pathway has been reviewed across agencies and reflects standards of good practice and that accountabilities within the pathway are clear (this will require strong co-ordination through a lead agency to be determined locally).
b) within a further 6 months of the review being completed, a multi-agency diabetes pathway audit is undertaken to review the level of compliance to the revised framework.

Rationale: The transition of Adult W across inter agency boundaries in some instances was weak, there was confusion regarding some responsibilities within Adult W's care pathway, there was confusion about what constituted the 'diabetes plan' and the quality of diabetic care planning in some areas was poor.

Recommendation 5. **Action:** Northumberland and North Tyneside Safeguarding Adults Board should seek assurances that within 3 months completion of the review of the Diabetic Pathway (recommendation 4a), organisational policies have been reviewed and updated if necessary.
Rationale: The review of the pathway to reflect best practice standards may have policy related implications.

Recommendation 6 . Action: Northumberland and North Tyneside Safeguarding Adults Board should within 1 month of publication share the findings of this review with the Care Quality Commission (CQC) to raise awareness of the lessons learnt in supporting their regulatory responsibilities and help to inform future inspections across the health and social care sector in Northumberland and North Tyneside.
Rationale: Acknowledging CQC are represented on the SAB it is important lessons learnt at a local level are formalised through the publication of this report and are utilised to influence the regulation of care elsewhere across the county.

Recommendation 7 . Action: Northumberland and North Tyneside Safeguarding Adults Board should: a) within 6 months, review their decision making pathway regarding the identification of a Section 44 Review in order to ensure timely decision making in the context of the date of when an incident actually occurs. b) Provide to the family a regular (2 monthly) report on the progress relating to the implementation the recommendations of this report.
Rationale: The delay in initiating the Section 44 review deferred the process of identifying lessons to be learnt in informing practice to support service improvement.

Appendix I : Overview Author Materials Reviewed

Individual Management Review reports (IMR's) and supplementary information requested from:

- NHS 111 Service
- Mental Health NHS Foundation Trust
- Adult Social Care Services
- Hospital & Community NHS Foundation Trust
- Day Centre Services

- Home Care Services
- Nursing Home 1
- Doctors Urgent Care
- General Practice

A range of e mail communications provided by Adult W's family

A range of records provided by Adult W's family

Consultant Pathologist Post Mortem report

Voice recording of 111 calls

Information provided by Section 42 Lead Investigating Officer

Report from Independent Specialist Diabetes Advisor

Appendix II: IMR Authors Source Documents

NHS 111 Service

- NEAS Service chronology
- Transcript/ voice recording of 111 calls of 8th April 2017
- Minutes of Section 42 enquiry

Mental Health NHS Foundation Trust

- RIO clinical records including Assessment and Progress Notes
- Referral letter from GP
- Letters to GP
- Letter to Daughter
- CT /DAT scan requests

- Consent documentation

Adult Social Care Services

- SWIFT Contact Notes and CSP 1 Assessment Documents
- Client based paper file
- NHCT Patient Discharge and Clinical Handover of Care Policy -Clin Gov 45
- North Tyneside Multi-Agency Safeguarding Policy

Hospital & Community NHS Foundation Trust

- Acute hospital electronic records
- Acute hospital paper records
- Community Nursing System 1 records
- Community Nursing paper records

Day Centre Services

- Adult W's Personal Record and associated documents
- Adult W CSP1
- BGL records

Home Care Services

- CSP1
- Diabetes Plan (2014)
- Care And Support Plan
- Staff Rota's
- Client Rota
- Quality Service Reviews
- Communication Daily Record
- Range of Policies and Procedures
- Review of Support plan
- Personal Profile
- Medication Chart
- Generic Risk Assessment
- Medication Risk Assessment
- Medication Profile

Nursing Home 1 (Information from a number of staff was not available in formulating this report.)

- Daily Progress Notes
- Pre-admission Assessment
- A range of Monitoring Charts
- A range of Risk Assessments
- Residential Home 1
- Medication Administration record
- BGL Monitoring Record
- Community Service Insulin Record
- GP records
- Care and Support Plan
- Safeguarding notification

- Care Plan
- Company policy and procedures

Doctors Urgent Care
- Adastra Electronic case record
- Voice recording

General Practice
- GP electronic records

Respite Care Home 1
- Care Plan documentation
- Company Policies and Procedures

Appendix III: Individual Agencies Safeguarding Policies and Procedures

Organisation	Policies Listed to safeguard Adult W
Hospital & Community NHS Foundation Trust	• North Tyneside and Northumberland Multi-Agency Safeguarding Policy • Safeguarding Adults Policy and Procedure • Mental Capacity Act and Deprivation of Liberty

	Safeguards Policy • Safeguarding Adult Board's Multi agency Thresholds Document used to assess risk in Adults. • Information sharing agreements
Adult Social Care services	• North Tyneside and Northumberland Multi-Agency Safeguarding Policy • Northumberland Safeguarding Adults Board Risk Threshold Tool
Doctors Urgent Care	• Safeguarding training policy • Safeguarding supervision policy • Vulnerable adult form • Safeguarding adults policy • Verification of Death policy • Guidelines Home Visiting
Mental Health NHS Foundation Trust	• North Tyneside and Northumberland Multi-Agency Safeguarding Policy • Trust Standard for the Assessment and Management of Physical Health • Care Coordination and Care Programme Approach Policy • PGN Hypoglycaemia – Acute – In hospital without on-site duty Dr • PGN Insulin, Safe Prescribing and administration • Mental Capacity Act (MCA) Policy • Safeguarding Adults at Risk Policy.
Nursing Home 1	• Diabetes policy
Home Care Services	• Medication • Safeguarding • Data Protection Policies, • Equal Opportunities and Diversity policy, recruitment and Selection Policy, Training Policy, • Care Planning Policies, • Quality Assurance Policy, • Safeguarding policy sits comfortably within that of the Local Safeguarding Adults Policy

	for Northumberland County Council Mental Capacity act and DOLS. (Deprivation of Liberty Safeguards). complaints policy
General Practice	• Practice Safeguarding Policy
Day Centre Services	• Not specified
Residential Home 1	• Not specified
NHS 111 Service	• Not specified

Appendix IV: Glossary of medical conditions

hypertension is high blood pressure see https://www.nhs.uk/conditions/high-blood-pressure-hypertension/

polymyalgia rheumatica is a condition that causes pain, stiffness and inflammation in the muscles around the shoulders, neck and hips see https://www.nhs.uk/conditions/polymyalgia-rheumatica/

peripheral arterial disease is a common condition, in which a build-up of fatty deposits in the arteries restricts blood supply to leg muscles see https://www.nhs.uk/conditions/peripheral-arterial-disease-pad/

oesophagitis (Reflux) is an inflammation of the oesophagus. In most people it is caused by the digestive juices from the stomach, repeatedly moving upwards (reflux) into the lower oesophagus producing redness and ulceration. see https://www.nhs.uk/conditions/heartburn-and-acid-reflux/

diabetic neuropathy is a type of nerve damage that can occur if you have diabetes. High blood sugar (glucose) can injure nerve fibres, **diabetic neuropathy** most often damages nerves in the legs and feet seehttps://www.nhs.uk/conditions/peripheral-neuropathy/

diabetic retinopathy is a complication of diabetes caused by high blood sugar levels damaging the back of the eye (retina) see https://www.nhs.uk/conditions/diabetic-retinopathy/

chronic kidney disease is a long-term condition where the kidneys don't work as well as they should see https://www.nhs.uk/conditions/kidney-disease/

osteoarthritis is a condition that causes joints to become painful and stiff. It's the most common type of arthritis in the UK see https://www.nhs.uk/conditions/osteoarthritis/

dysphagia is swallowing difficulty see https://www.nhs.uk/conditions/swallowing-problems-dysphagia/

cataracts are when the lens in the eye develops cloudy patches see https://www.nhs.uk/conditions/ctaracts/

myocardial infarction (MI) is a heart attack which is a serious medical emergency in which the supply of blood to the heart is suddenly blocked, usually by a blood clot see https://www.nhs.uk/conditions/Heart-attack/

ankylosing spondylitis is a long-term (chronic) condition in which the spine and other areas of the body become inflamed see https://www.nhs.uk/conditions/Ankylosing-spondylitis/

Appendix V :Summary of agreed actions identified within individual management review reports

Organisation	Identified Actions
Hospital & Community NHS Foundation Trust	• The process between the District Nursing Service and Trust Safeguarding Team for attendance at safeguarding meetings and overviewing safeguarding cases • To re-iterate the importance of defensible

	communication, handover of care and recording documentation for patient centred care. • Safeguarding team to get access to System 1 to enable direct access to district nursing and community notes
Adult Social Care services	• To highlight that good multi-disciplinary working is essential to best practice and in order to achieve the best outcomes for service users • To highlight the importance of good written assessment and clearly define the role between care Manager and Social Worker • To highlight the Importance of Robust carer assessments • To ensure all appropriate information and equipment is transferred into care homes with individuals
Day Centre Services	• No actions identified
Home Care Services	• Specialised training for all staff involved with clients who have a specific need such as diabetes
Nursing Home 1	• Development and implementation of comprehensive pre-admission, admission and review assessments framework • Review and update of diabetes policy • Diabetes management training for all care staff • Internal investigations to be completed following safeguarding incidents • Individualised blood glucose and ketone monitoring machines for all residents • Risk assessment and care plan documentation to be improved
Residential Home 1	• Ensure individualised care plans are developed for any resident with diabetes includes correlation between meal times and medication
Doctors Urgent Care	• Refresher training for all staff regarding the importance of record keeping
NHS 111 Service	• Developmental action in relation to individual member of staff
General Practice	• GP Practices should ensure there is a process in place to scan / upload any hand written templates or documents to a patients electronic record to ensure

	effective communication and up to date information sharing • GP Practices need to ensure there is a process in place to receive up to date copies of diabetic plans or other care and treatment plans from other agencies.
Mental Health NHS Foundation Trust	• Ensure when assessments are completed sufficient detail is obtained regarding physical health care issues • Clarification of investigations undertaken regarding falls should be obtained and where appropriate liaison with the falls service should occur