Gladys's story

Gladys was an 82-year-old lady who was a resident in a dual registered care home. She was diagnosed with Type 2 Diabetes, with advancing Alzheimer's dementia and was bed bound and unable to mobilise. Gladys was referred to the Community Nursing service by the GP on Monday 29th July 2019. In Oct 2020 she was relocated to another care home due to the closure of her original placement. She was placed in a residential care bed and so the Community Nursing Service supported care with insulin administration and latterly with wound care. Gladys died on Friday 29th January 2021 – the cause of death is to be confirmed and is subject to a Coroner's investigation.

Circumstances leading up to Gladys's death

The GP records show that Gladys was not for resuscitation and had a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form in place from October 2020. Her active problems were recorded as Alzheimer's disease, Type 2 Diabetes, essential hypertension and asthma.

On the three days leading up to her death, records show that blood glucose readings had been rising:

o 26th January 2021 the reading was 13mmols.

o 27th January 2021 the reading was 17.3mmols

o 28th January 2021 the reading was 19.2mmols

o 29th January 2021 the reading was 29.2mmols

These readings represented a marked difference from previous readings which ranged from 4.7mmols to 10.8mmols throughout January 2021.

For comparison the normal range for blood glucose is 4 to 7mmol/l before eating and under 8.5 to 9mmol/l 2 hours after a meal.

The blood glucose target range for Gladys was not known.

Emergent issues

- It was custom and practice that care home staff recorded residents capillary blood glucose prior to the nurse visiting.
- Staff were task focussed
- There was no “diabetes management plan” in place for Ms F.
- Increasing hyperglycaemia was not recognised, escalated or treated.
- Inadequate ownership of Ms F’s clinical condition was taken by nurses and placed instead on carers in the residential home.

Changes to practice following the lessons learnt

The case concerning Gladys occurred after a Serious Incident in 2020 involving a different patient and the management of insulin and diabetes. After consultation with front line staff a series of changes were rolled out from March 2021 across every District Nursing team. Since then, and since these events, further changes have been developed and implemented centring around hyperglycaemia recognition, escalation and management.

- Nurses no longer expect care staff to carry out capillary blood glucose monitoring prior to their visit. It is recognised that this important step is the nurse's responsibility. The readings must be carried out with an LPT issued meter that is calibrated and quality checked. Account is taken of past readings.
- Since March 2021 new insulin authorisations are in place and explicitly contain both target capillary blood glucose readings and management plans. Nurses are tasked with ensuring patients have access to prescribed and authorised rapid acting insulin.
- Since March 2022 a new hyperglycaemic pathway has been developed and implemented that sits in patient records and is carried by every nurse/ HCSW who administers insulin. The aim of the pathway is to identify hyperglycaemia as well as check for underlying reasons for hyperglycaemia using the NEWS 2 score. Treatment and escalation of hyperglycaemia will be in accordance with the pathway.

Changes to practice following the lessons learnt

- Since March 2021 the patient held documentation for those patients in receipt of insulin via a community nurse has been comprehensively overhauled and standardised across all GP practices and District Nursing teams. In addition to the recently introduced hyperglycaemic pathway changes also include:
- New A4 hard backed, professionally printed and branded documentation folders.
- New insulin electronically generated (in S1 and EMIS WEB) authorisations that include management plans and target capillary blood glucose ranges. The ranges prepopulate at 6-16mmol/l (this is seen as a safe range that suits most elderly type 2 diabetics on insulin) but can be changed by the prescriber.
- New Record of Insulin Administration Cards. These make it easy for nurses to document the insulin and dose given, the time and date of administration, the batch number together with the capillary blood glucose reading and when the patient last ate. These forms make review a simple process for a presciber.
- New insulin profile “at a glance sheets”. These are full colour and show a picture of the insulin/device, it’s profile action and when it should be administered. The insulin/s the patient is prescribed are the only profiles that are put into their documentation.
- New care plans have been developed to allow nurses to be accurate in describing the purpose of the visit. These must be individualised.
- NEWS 2 and Sepsis recognition sheets are available in each set of notes.
- The contract with Roache Medical to supply blood glucose monitors has expired. LPT now need to procure a new supplier ideally to provide meters that also record blood ketones. This will bring equipment in line with the hyperglycaemic pathway.
- Recognising Human Factors we are currently pursuing the purchase of standardised clearly labelled, lidded boxes to segregate rapid acting insulin from other insulins in order to mitigate as far as possible the risk of selecting and administering an incorrect insulin.

SERIOUS INCIDENT REVIEW 1 – Amy's Story

About Amy:
Amy is a 16 year old young lady who was admitted as an informal patient to the CAMHS Beacon unit on following a planned overdose of multiple tablets with the intent to end her life. During her admission the decision was made for her to become a formal patient under section 3 of the Mental Health Act.

Amy has a history of anxiety and depression, as well as concerns regarding her eating for which she has previously required naso-gastric feeds. She had recently disclosed that she had been groomed online and was known to ward staff to be extremely vulnerable.

Prior to this incident there had been a marked reduction in suicidal thoughts and Amy was managing to keep herself safe. She had not engaged in any self-harm behaviour for three months and was looking forward to her discharge.

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What happened to Amy:

During the evening of Friday the 23rd of April 2021, Amy approached a staff nurse and reported she needed to tell them "Something that happened made [her] feel uncomfortable". Amy then alleged that that morning a male Health Care Support Worker (HCSW) walked past her in the corridor, slapped her on the bottom stating that he "couldn't resist".

Note: Despite being a victim of grooming and on-line exploitation, Amy was able to recognise the behaviour of the HCSW was a concern and raise this with staff.

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Effect on Amy and her family:

Following the incident Amy was reported to be physically safe and well. she reported feeling anxiety and was supported appropriately by the ward staff. Psychological support was offered to her following the incident and she was supported to engage with the police investigation. Amy was also referred and accepted to 'United Against Violence and Abuse' (UAVA) and the ward facilitated his contact.

She is now being cared for in a health provision closer to her home.

Amy's mother was very upset regarding the incident and disappointed that this could happen when her daughter was in a healthcare facility. Staff kept her updated regularly.

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SERIOUS INCIDENT REVIEW 1 – Amy's Story

Good Practice:

CCTV: The CCTV footage was reviewed very soon after the event which showed clearly the HCSW making contact with Amy's bottom with his hand. This footage was saved and given to police when requested with no reported delays.

Support: Amy was given support immediately from the nursing staff and there were clear plans on how to ensure she had the correct ongoing support. Following this incident the patient became vocal about her being a victim and she was supported with managing her feelings around this.

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Learning:

Raising concerns: The junior doctor did address her concerns with the HCSW regarding this incident, however HCSW downplayed the incident leaving the junior doctor to doubt herself. This may have influenced their decision to wait to escalate this until the following week. It is positive that the junior doctor recognised that this was wrong initially however, important that all staff are aware if their responsibility in escalating concerns and ensuring the right people are notified to explore concerns further.

Escalation: The incident was witnessed by a junior doctor in the unit. They intended to raise this with the matron but were unable to find them so decided to notify them after the weekend. This member of staff was up to date with their safeguarding children training and their safeguarding supervision was delivered as part of their clinical supervision. Although the safeguarding training does cover raising concerns, his incident highlights that there is a need for staff to have more information regarding concerns about people in a position of trust. This training would have highlighted the need to take immediate action to safeguard the young person and other young people on the ward.

Action
The safeguarding team are currently delivering bi-monthly safeguarding supervision sessions and these have been expanded to include the whole of the multi-disciplinary team on the unit to ensure there is specialist oversight and support.

Amy notified senior nursing staff that evening and provided support for the child however, there was no escalation of the safeguarding concerns until the next day when this was picked up by the Acting Deputy Head on Nursing (FYPC.LD). This young person was provided support however, incident should have been escalated on the day and the LLR safeguarding Children procedures should have been initiated. The care was patient centred but the staff on shift did not recognise the need to escalate this as a safeguarding concern that day and to let the senior manager on call know so restrictions could be put in place.

SERIOUS INCIDENT REVIEW 1 – Amy's Story

Vulnerability: it is acknowledged that due to the age and the needs of the patient group, allegations against staff are high in this area of work. Staff have voiced that they are concerned about allegations being made against them and also the Local Authority Designated Officer (LADO) process. Further work has been completed on the unit to support staff in understanding the process and the support that they will be given if an allegation is made against them

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Actions & Transferable Learning:

Action: The allegation against staff policy was followed and referred to the police, social care and also the LADO.A full HR investigation was completed.

It was clear that staff listened to Amy and ensured that she was supported, however the safeguarding concerns were not escalated appropriately.

When working with patients who are unwell, it is paramount that shift action is taken to explore any concerns, to safeguard the patient, other patients and also staff. This learning has also been reflected in reports such as the Winterbourne report which highlighted prolonged abuse which was not acted upon. It is paramount that the safeguarding training outlines staff responsibility to act upon any concerns of abuse or poor practice, and follow local policies as well as the Safeguarding Childrens Partnership Procedures.

Recommendation: Consideration to be made to increase Beacon MDT staff awareness of Allegations that an Employee/Bank Worker may be Harming a Child, Young Person or an Adult at risk, Policy and Procedure and LADO processes.

Recommendation: To review induction and refresher training in relation to staff behaviour and maintaining safe professional boundaries to include reporting witnessed incidences.

Recommendation: Review information provided to Locum Medical staff in regard to escalating concerns in line with LPT policies.

Recommendation: Beacon Medical staff should access the current safeguarding supervision provided by LPT Safeguarding Team.

Leicestershire Partnership NHS Trust

Patient safety – learning from a CQC Concern

Directorate of Mental Health – Acute Inpatient

Learning from Jean
Through a CQC Concern

MEET JEAN

(named changed for confidentiality)

Jean is a 53-year-old lady, who was admitted to Bradgate Mental Health Unit on 1st February 2022 under Section 3 following a Mental Health Act Assessment in the Community.

Jean has a diagnosis of Bipolar Affective Disorder and has recently been diagnosed with low grade Non-Hodgkin's Lymphoma

Leicestershire Partnership NHS Trust

WHAT DID JEAN TELL US?

- Jean told us she was prescribed the wrong dose of medication
- Jean was upset about being on a mixed gender ward when she was first admitted
- Jean felt that her treatment for Non-Hodgkin Lymphoma had been affected by her admission
- Jean was distressed over incidents involving other patients towards her
- When stood outside of the glass office on the ward Jean said that at a certain point, patients notes can be read on a computer
- The ward garden and smoking was a theme of Jean's concerns particularly in relation to litter and ability to discard cigarette ends
- Jean told us about environmental concerns ie- exposed, nails and raised manhole covers
- Infection Prevention and Control – being offered a mask

WHAT DID WE DO

One of our acute Matrons met with Jean to talk through her concerns as soon as we received the information from the CQC and importantly said sorry for her experiences

We reviewed Jean's Electronic Record and liaised with the Ward Sister

We put together a thorough response that was sent to the CQC and also talked this through with Jean

WHAT DID WE FIND

- We found that staff and medics responded to Jean's concerns and wishes regarding medication i.e. the change to Lithium dose, preference regarding time of the day of certain medications and discontinuation of other medication.
- We explained to Jean how our admissions take place due to COVID-19. Our admission ward has specific gender bedrooms on opposite gender corridors and enhanced therapeutic observations based on risk
- A member of staff from the Ward contacted Jean's Lymphoma Specialist Nurse and it was agreed to postpone Jean's treatment until she was in better mental health. The ward undertook tests requested from the Specialist Nurse and kept in regular contact
- There was one incident identified that involved a patient taking Jean's phone without her consent. We said sorry to Jean that this happened, and we acknowledge the impact of this on her
- We looked at the ability to read patient information on the computers in the office and found that the only opportunity to view the screens would be from the opposite side of the office. Even though we are assured it is not possible to read the screens, privacy screen filters will be purchased by the ward sister as an additional protective measure to be placed over the computer monitors in the office.
- Regarding litter and smoking in the garden area, we found that Jean often would tidy the area herself. This is checked as part of regular checks we do, including an annual fire risk assessment. We said sorry for her experience of patient lighting cigarette in the wrong place
- We checked the environmental concerns Jean told us about and could not find the things she told us about. The environment is checks daily and recorded
- The use of masks for patients is risk assessed and unfortunately, we found no record of Jean being offered a mask or the outcome of a risk assessment.

WHAT DID WE LEARN

The importance of meeting and talking to a patient when a concern is received, feeding back afterwards, and saying sorry.

Positive practice in relation to listening and responding to Jean's concerns about her medication and liaising with her Lymphoma specialist nurse.

The promotion of professional curiosity or ward leaders and staff in relation to ensuring confidential information and environments.

The need to risk assess the use of masks for patients and for this to be documented.

Medication should be prescribed on admission with the involvement of patients so that they can influence times/actual dose taken