Adbolton Hall Ltd

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[redacted]
[redacted]

Response to Regulation 28

'Report to Prevent Future Deaths'

I am [redacted] - Operations Director for Adbolton Hall Ltd. I have been asked to submit this response by Jane Gillespie-Assistant Coroner, in response to a Regulation 28 – Report to Prevent Future Deaths following the inquest into the death of Mrs Joan Osborne.

On behalf of everyone at Adbolton Hall I wish to again express our condolences to Mrs Osborne's family.

Set out below is our response to those specific concerns identified by the Assistant Coroner for Nottinghamshire.

In addition to those actions outlined below, in the time after Mrs Osborne's death there has been a period of significant change at Adbolton Hall. On 6 November 2017 [redacted] was appointed as the new Home Manager, since then, bringing about significant improvements in the service provided to all residents.

The improvements relate to all those of concern identified by the Coroner but also extend beyond this to all aspects of the service provided at Adbolton Hall.

As a Registered Provider of Care Services, we take this responsibility seriously and are committed to the care of all residents at Adbolton Hall.

Coroner's Concerns:

During the inquest the evidence revealed matters giving rise to concern in that there is a risk that future deaths could occur unless action is taken, as follows:

(1) The nursing home staff did not seek assistance from the Dementia Outreach Team when Mrs Osborne's compliance with her blood glucose levels and insulin prescription deteriorated at the end of 2016 onwards
(2) The nursing home did not make any members of staff available for the pre-arranged appointment with the Diabetes Nurse on 28/11/2016, resulting in a missed opportunity to seek assistance with Mrs Osborne's compliance
(3) The nursing home staff did not seek medical assistance for Mrs Osborne when she refused to have her insulin prescription over an extended period, on two separate occasions, leading to her hospitalisation on 12/08/2017 and 22/08/2017
(4) The nursing home staff did not alert anyone in the management team to the fact that Mrs Osborne had refused to have her insulin prescription for a period of 3 days prior to her hospitalisation on 22/08/2017
(5) The nursing home records in respect of Mrs Osborne were inadequately completed
(6) The nursing home staff did not recognise the need, nor seek help, for Mrs Osborne's deteriorating condition on 22/08/2017 and did not seek the urgent attention of her GP upon his usual attendance at the home on that date
(7) Mrs Osborne was incorrectly given Lucozade on the morning of 22/08/2017 at a point when her blood glucose levels had not been obtained, and were 'HI'

(8) A member of staff at the care home was unable to accurately maintain Mrs Osborne's blood glucose level on 22/08/2017 when asked by the GP and did not recognise that the reading was incorrect

Response to Concerns:

(1) Since the appointment of the new Home Manager, [redacted], and the new Deputy Home Manager, [redacted], at 'Adbolton Hall', the nursing home staff now seek regular assistance from the Dementia Outreach Team. This assistance is sought as and when required, however on average takes place a minimum of once a month, ensuring regular communication with this Team. This can be evidenced upon review of the Professional Visits Book and Multi-disciplinary Team Communication Sheets where applicable in residents' care plans.

The Home Manager monitors the involvement of the Dementia Outreach Team with all residents who have been referred to them to identify any issues requiring a review of care provision. The Home Manager has spent time building a positive working relationship with the Dementia Outreach Team, which is mutually beneficial to both parties, and ensures that residents are referred and seen appropriately. Relationships have been strengthened with [redacted] (CPN), [redacted] (Occupational Therapist) and [redacted] (Assistant) of the Dementia Outreach Team.

(2) The nursing home ensures always that members of staff are made available for all pre-arranged appointments with all Multi-disciplinary Team staff members which are diarised in the Home Diary situated within the office. The home ensures that the Nurse-in-charge, Care Co-ordinators or the Home Manger are available for these appointments. There have also been occasions when Multi-disciplinary Team professionals have visited 'Adbolton Hall' unannounced, and staff have always been made available to see them.

(3) The nursing home staff have received Nutrition and Diabetes Management Training. There were three separate sessions of this training, delivered at 'Adbolton Hall', on the 30/10/2017, 07/11/2017 and 30/11/2017. This training was delivered by [redacted] a Community Dietician from the Clinical Commissioning Group. This training included Management of Type 2 Diabetes, Treatments of Hypoglycaemia and Dietary Needs.

Care planning with regards to diabetes management has been prioritised, as part of the lessons learned, and where required care plans include details with regards to when and how to seek medical assistance if insulin/medication is refused by a resident.

For all residents who were admitted to 'Adbolton Hall', with complex needs (this included any resident who is diabetic), until recently the Home Manager ensured that

their pre-admission assessments were sent to [redacted], Management Officer for the Quality and Market Management Team within Nottinghamshire County Council, and [redacted], Care Home Quality Lead Nottingham North and East, Nottingham West and Rushcliffe Clinical Commissioning Group, to ensure that they were confident that the home could meet each individual's needs. On 26 March 2018, [redacted] advised the home that they were not required to continue to send these to them, as they were satisfied that all the home's admissions, including those with individuals with complex needs, were safe. We are confident therefore that diabetes care is adequately assessed and provided for.

In addition to this, new Blood Glucose Monitoring Machines were purchased for individual residents on the 13 October 2017 to replace previous machines in use within Adbolton Hall. Staff have received training in the use of these new Blood Glucose Monitoring Machines.

(4) The Home Manager has ensured that she receives a daily handover with regards to all residents at 'Adbolton Hall'. The process regarding handover has been reviewed and revised by the Home Manager, to ensure that there is a greater volume and availability of written information. This includes a daily handover sheet, printed sheets for all care staff to carry with them on shift and care charts for all residents.

(5) Care plans with regards to diabetes management are now prioritised and reviews of care plans are directly monitored by the Home Manager and Deputy Home Manager, to ensure that the records are adequate.

(6) Diabetic charts are now put with the Medication Administration Record sheets, ensuring that they are in constant use and are used as a reference point. Instructions on these charts are written in red and are updated by the Nurses if the GP alters any care instructions. All care charts now also physically go with the residents wherever they are in the home. This helps to ensure that care charts are being completed accurately, in a timely manner and improves communication amongst staff.

(7) I refer to the points 3 and 4 above.

Additionally, on the 20 March 2018 the Home Manager met with the GP who visits Adbolton Hall to outline those many improvements that have been made as detailed above. This has provided valuable oversight and input from the GP and the Home Manager has also asked that he make her directly aware of any issues or concerns that he may have in the future.

(8) All Lucozade has been removed from the building, and fresh fruit juice is now given if a resident is experiencing hypoglycaemia (determined by an accurate blood sugar reading.), as instructed in the training mentioned above. The Lucozade on the 22/08/2017 was given by a Senior Care Assistant and not a Nurse. In conjunction with the care plans for residents with diabetes, it is now clear that intervention with these residents is always nurse-led, and not carer-led. The care home also now has a very

stable Nurse team, of permanent staff, which helps to ensure that interventions made with residents are safe and correct.

(9) New Blood Glucose Monitoring Machines were purchased on 13/10/2017, and staff have had their competency assessed for using these machines. The incident with regards to the incorrect reading of the blood sugar on the 22/08/2017 was isolated to one staff member who has not worked at Adbolton Hall since the 22/08/2017.

Since this incident, there have not been any further incidents where this has occurred. The home can additionally evidence that the one resident currently in the care home who is an insulin-dependent diabetic, has their diabetes well managed, and there have been no concerns raised by any agencies with regards to their care.

Timescale for Action: All steps already implemented, and to be kept under ongoing review.

I trust that the above provides a comprehensive summary of our response to those matters of concern outside within the Prevention of Future Deaths Report.

As set out above we have taken the opportunity to learn valuable lessons from Mrs Osbourne's death to improve the standard of care provided to all residents at Adbolton Hall.

Most importantly, we are confident in saying that the steps put in place will ensure that such an incident does not happen again.

Yours sincerely

[redacted]