17th July 2019

Private and Confidential

Mr Roger Hatch
HM Senior Coroner for North West Kent
Maidstone Coroner's Court
Archbishop's Palace
Maidstone
Kent, ME15 6YE

Miles Scott
Chief Executive
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital
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Dear Mr Hatch

Re: Inquest – Jonathan McCarthy Response to Prevention of Future Deaths Report

I write to acknowledge receipt of the Prevention of Future Deaths report from the court dated 22 May 2019, received by the trust on 6 June 2019.

I have set out below the concerns you have raised in relation to this matter in the same order as they are contained within the report. I have provided the trust's response to each concern in turn.

The response to the concerns outlined in the Prevention of Future Deaths Report is as follows:-

(1) The Trust failed to correctly monitor the blood sugar and ketone testing of Jonathan Richard McCarthy

It was identified during the Serious Incident investigation that the staff concerned were unsure of the appropriate procedures relating to the monitoring of blood sugar and ketone testing therefore a Trust Guideline for capillary blood glucose monitoring for inpatients and day cases with Diabetes Mellitus over the age of 16 years has been written and approved by the Medical Specialities Directorate. This guideline is in keeping with the standard set by the National Inpatient Diabetes Audit. The guideline has been out for wide consultation with comments from clinicians across the trust being received. Contained within the Guideline is a coloured "traffic light" risk tool to assist staff on the wards to interpret the results of blood sugar and ketone testing, with recommended actions to undertake and escalation as appropriate. This algorithm for inpatient management of hypoglycaemia is based on best practice (JDS guidelines).

Ongoing monthly training has been in place for new Clinical Support Workers and Registered Nurses and this is undertaken during their first weeks on induction to the trust where diabetic management is highlighted in bite-sized sessions. This is delivered by the Diabetes Specialist Nurses on both sites. This demonstrates the use of equipment (by the Point of Care Team), the new algorithm for the recognition and management of hyper- and hypo-glycaemia and how to request in-patient referrals to the Diabetes Team and escalate for medical attention. The Blood Glucose Guideline also forms part of the Junior doctors induction programme which is also undertaken by the Diabetes Team.

We have ensured that there are “Hypo boxes” on every ward which contain the new algorithm, oral and IV medications for the treatment of patients having hypoglycaemic attacks. There is also an audit form for completion so that the Diabetes Specialist Nurses can follow these cases up and identify any trends.

In addition two further specific study days have been booked for Registered Nurses and a half day for Clinical Support Workers where the above will be discussed in more depth and the use of Mr McCarthy’s case and any other related Serious Incidents used as teaching scenarios.

The Trust has also been out to tender for a blood glucose and ketone testing meter that has the capability of linking into the existing clinical observation monitoring tool (Nervecentre) which would record and escalate results accordingly. In addition blood ketone testing machines have been purchased and assigned to key locations in the trust with the aim to ultimately have them on each ward. The Emergency Departments on both sites have these in place and appropriate training has been rolled out to the nursing staff. In addition the Diabetic Nurse Specialists also carry ketone testing machines to support access and training to the ward staff as and when required.

(2) The Trust failed to administer the correct doses of insulin

This was highlighted with the medical team at the time of the Serious Incident investigation. A presentation of Mr McCarthy’s case was delivered at the joint Medicine Clinical Governance Meeting in June 2019.

The Pharmacy Department are undertaking a review of the auditing process in regard to Drug charts as this was not identified in the case of Mr McCarthy and is being discussed and addressed at their team meetings. The Serious Incident findings are being highlighted in their monthly learning editorial (Medicines Safety News).

Junior doctor induction programmes will now include dedicated training in the Blood Glucose monitoring guideline and the key learning points from Mr McCarthy’s case.

(3) There was inadequate nursing care and a failure to escalate to the medical team when it was clear this should be carried out

As outlined in response to question (1), this aspect of Mr McCarthy’s care has been addressed directly with the staff concerned and those on the ward with specific training and the learning from Mr McCarthy’s case has been shared. The introduction of the algorithm, the raised awareness of the importance of testing and acting/escalating abnormal results have been outlined and incorporated into the new guidance. This includes the element of how and when to escalate to medical teams or diabetic nurse specialists for assistance and review.

The Point of Care Team have been the leads in regard to the project to introduce new connectivity blood glucose meters across the trust. These meters will be able to test glucose and ketones on all wards. They will also support our Diabetes Specialist Nurses to access a “live dashboard” and view results in real time. This will immediately flag patients of concern who have results that are above or below target and help prompt an early review by the Diabetes Specialist Nurses.

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This will offer support to the nursing staff on the wards in their escalation processes and also support adhoc teaching and education on the management plans devised and outlined by the specialist nurses. These new meters will replace the existing meters and a comprehensive training programme will then follow to ensure staff understand the function of the equipment.

Ongoing adhoc ward training is to be delivered by the Diabetes Specialist Nurses to raise awareness of the new Blood Monitoring guidance on the wards with support from identified link nurses. In addition we have worked with the Directorate and Communications team to develop a strategy to raise awareness throughout the organisation in regard to the importance of close diabetic monitoring. Some of this work included the use of the Patient Safety Calendar to focus on the key elements of diabetic management, a launch of the Blood Monitoring Guideline and bespoke Training days for Nurses and Clinical Support Workers.

The new guidance will continue to be disseminated throughout the Trust by way of short presentations at the remaining Trust Clinical Governance days over the coming months delivered by either the Diabetes Specialist Nurses or the lead Diabetic Consultants.

Thank you for bringing this matter to my attention and I hope this response is of assistance and addresses the concerns you and the family have raised.

Yours sincerely

Miles Scott
Chief Executive