Our Vision
To provide every patient with the care we want for those we love the most

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NHS Foundation Trust

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Private & Confidential
Ms Y Blake
Area Coroner
Carrow House
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Our Ref: [redacted]

9 April 2021

Dear Ms Blake

Response to Regulation 28 report – Death of Michael Yemm

I am writing in response to the above Regulation 28 report (Report) that I received on 10 February 2021. I hope that this letter and the accompanying documents will satisfy you and Mr Yemm's family that the matters of concern raised in the Report have been carefully considered by the Trust and appropriate action has been or is being taken.

The Report raises three matters of concern. The Trust's response in relation to each one is set out below.

1. The care home placement

Mr Yemm was admitted to the Trust on 24 May 2020 and discharged on 17 June 2020 to Melton House Care Home. Mr Yemm was discharged on a D2A3 (Discharge to Access) pathway for a short term community bed for the assessment of his long term needs. [redacted] was involved in the discharge planning arrangements. It was initially hoped Mr Yemm could be discharged home with a package of care. However, his increased needs and falls risk meant a short term community bed was the most appropriate option. [redacted] requested a bed close to home. A referral was raised on 10 June 2020 suggesting a "*Residential/Nursing home*". The placement at Melton House was sourced by Social Services and confirmed on 15 June 2020.

Mr Yemm was readmitted on 18 June 2020 from Melton House following a fall. Concerns were raised by Mr Yemm's Community Care Nurse about the suitability of Melton House due to a lack of adequate supervision. A new D2A3 discharge referral was raised on 23 June 2020. The referral states: *"Please assess for short term bed. Wife wishes to be involved in planning as feels Morton House [sic] was unsuitable."* It was subsequently agreed that Mr Yemm could be discharged back to Melton House but with 1:1 supervision funding for 2 weeks. This was to allow time for the needs

assessment to be undertaken. Social Services has confirmed the 1:1 supervision was provided but is unable to provide any information about arrangements beyond the initial two week period.

Mr Yemm was readmitted again on 26 July 2020 from Melton House following another fall and with a urinary tract infection. Melton House informed the Trust it was unable to meet Mr Yemm's needs. A further D2A3 discharge referral was therefore made on 29 July 2020. The referral states that: *"He is unable to return to Melton House as they are unable to manage his falls risks and unable to manage his diabetes."* Unfortunately, Mr Yemm deteriorated and a new fast track referral was completed on 16 September 2020. This referral stated that: *"patient was in residential care, they are no-longer able to meet his needs so requires a new placement".* Sadly, however, Mr Yemm passed away in hospital.

2. The hospital discharge despite being told they couldn't send him back, and just leaving him there

The Report states that:

"The hospital dropped Mr Yemm off back at the care home without any warning after being informed that they could not have him back. He was also discharged on insulin which the home could not administer as they do not have trained nursing staff."

It also states that:

"*After his second admission the manager of the care home told the hospital that they would not accept him back as his needs could not be met by them. Despite this without notifying the care home, Mr Yemm was dropped off by hospital transport and the home had no option but to keep him as he was left there. They did manage to obtain extra help, but his care needs increased, and he was again admitted to hospital.*"

Mr Yemm was started on insulin during the May 2020 admission. A District Nurse referral was made on discharge as Mr Yemm was unable to manage his own injections. On 17 June 2020 a "*verbal handover*" was given to Melton House including confirmation that the District Nurse referral had been completed in respect of Mr Yemm's "*insulin administration*".

After Mr Yemm's admission on 18 June 2020, the Manager of Melton House was informed during discussions between 24 and 26 June 2020, that Mr Yemm was on long acting insulin and that the District Nurse would administer his regular doses. It was also confirmed that 1:1 supervision had been requested and approved by Social Services. Both [redacted] and Melton House agreed the discharge to Melton House on this basis.

Mr Yemm's discharge was delayed pending the return of his Covid-19 swab test results. Both [redacted] and Melton House were notified that the discharge had been moved to 27 June 2020 and transport was arranged for 12:00 hours. The Trust does not have its own non-emergency transport facilities, and all such transport is arranged via ERS Medical.

3. The in-patient fall and care of dementia patients

Mr Yemm's fall on 3 September 2020 has been the subject of a Serious Incident (SI) investigation. I confirm that work has been undertaken in accordance with the actions recommended in the SI Action Plan attached to the SI Report (see attached). The relevant teams have also been notified of your concerns so they can ensure these are covered by the work being carried out.

The relevant issues identified in the Action Plan are referenced below, together with details of the associated actions that have been undertaken:

The patient was not referred to the Dementia Specialist Team

There are a number of actions being taken to address this issue:

1. Ward Manager, [redacted] has issued a reminder (see attached email) to all ward staff requiring them to ensure they are familiar/up to date with (i) the "Memory Matters" page on the Trust intranet which contains a range of educational resources; and (ii) Dementia awareness and DOLS training, both of which can be accessed via the Trust's online training facility (ESR).

2. Ward Manager [redacted] has met with and organised ward based education sessions with the Dementia Support Team (DST) (see attached emails). Some ward based sessions have already been delivered via the Clinical Educator and this is ongoing. Arrangements are also being made for ward staff to spend a day with the DST.

3. Funding is being sought for the implementation of a ward based Dementia Support Worker post. Regular support is being provided to the ward by the DST in the meantime.

The Falls Risk and Safety Sides assessments are not adequate and require review

The Falls Risk and Safety Sides assessments are under review as part of an ongoing project. [redacted] has been working with [redacted] Deputy Chief Nurse on the project. A NICE compliant Falls Risk assessment has been trialled and a final draft has been put together (see attached). The assessments and the associated policy are currently at the final adjustment/review stage. It will then be a question of implementing the roll out of the documents. These presently form part of a risk assessment booklet which means complete roll out is dependent on other risk assessment documents being reviewed. There is no final completion date at the moment. Alongside the change in risk assessments, it is planned that there will be an education package to support staff through the changes and to recognise the multifactorial elements of falls prevention.

The patient had a prolonged stay in hospital due to delay in acquiring a suitable placement

The SI findings have been shared with the complex discharge team.

I confirm that in addition the following steps have been taken to ensure that learning is shared as a result of the SI findings:

1) The SI learning was shared at the Endocrinology Clinical Governance meeting for January 2021 (see attached slides). It was also shared in the Team Medicine Newsletter for February 2021 (see attached) and with the Governance leads via Divisional Governance in January 2021 (Agenda attached).

2) A ward newsletter was sent to all staff (see attached).

I hope that this information provides you with the assurances you require that the Trust has implemented changes in practice and put in place training to ensure that the risk of future deaths from similar circumstances will not occur again.

Yours sincerely

[redacted]

[redacted]
Chief Executive

[redacted]
Medical Director

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