



Health Services Safety
Investigations Body

Investigation report

Medication not given: discharge from an acute hospital to the community

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Theme:

Medication, Communication and decision making, Continuity of care

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A note of acknowledgement

We would like to thank the patient whose experience is documented in this report. We would also like to thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements in this area of care.

About this report

This report is intended for healthcare organisations, patient safety leads, healthcare staff, patients and their families and carers to help improve patient safety in relation to medications being given when a person is discharged from an acute hospital to a community setting. For readers less familiar with this area of healthcare, medical terms are explained in section 1 of the report.

The report presents findings from a patient safety event and identifies factors relevant to learning in other NHS organisations. It is intended to support local improvements in patient safety in relation to medications being given when a patient is discharged from an acute hospital to a community setting. It also identifies learning in relation to electronic prescribing and medicines administration (ePMA) systems. This learning, alongside learning from previous HSSIB investigations, will be used to inform a future national investigation into the safe use of ePMA systems in acute hospitals.

Terms used in the report

Diabetes is otherwise known by the scientific name 'diabetes mellitus'. This report refers to the condition as 'diabetes' throughout.

Insulin was provided as a disposable pre-filled pen device and is referred to as an 'insulin pen' in the report.

Executive summary

Background

This is the third in a series of investigations exploring why medications intended to be given to patients were not given. Patients who need medications can suffer harm if they are not given.

[Visit the HSSIB website for more information about this investigation theme.](#)

This investigation explored the systems and processes in place to support staff when a patient spends time in hospital and is then discharged into the community with medications. The investigation also explored the role played by electronic prescribing and medicines administration (ePMA) systems and electronic patient record (EPR) systems in supporting care in this area.

To examine these issues, the investigation explored a patient safety event involving a man aged 53 years who was discharged from hospital to his home. He had type 2 diabetes and used medications to manage his blood glucose levels.

The patient safety event

On day 1, the patient was admitted to an acute hospital following a fall at home. During his time in hospital, a change was made to his diabetes medication regimen from metformin (one form of medication used to treat diabetes) to insulin (a hormone that helps the body to use glucose for energy). On day 4, education was provided to the patient in hospital to support him to administer his own insulin (self-administer) after discharge. On day 7, the patient was discharged home. District nursing support was arranged for wound and catheter (a tube used to drain urine from the bladder) care.

On day 13, 6 days after discharge, the patient had a follow-up call with the hospital diabetes team. The patient told the diabetes team he was unable to remember all of the information about his insulin medication and he had not been self-administering. The diabetes team referred the patient via his GP for district nursing support to help with this. The district nursing team continued visits to the patient for wound care but were unaware a referral from the GP for insulin support was awaited.

On day 22, 17 days after the patient was discharged, the district nursing team visited the patient out of hours for a catheter issue. During this visit, the patient disclosed he had not taken any insulin since leaving hospital. The patient's blood glucose reading was high and a decision was made to re-admit him to hospital because of this. He was taken to the hospital by ambulance, stayed overnight for observation and was discharged the following day.

The investigation

This is one of a series of investigations exploring patient safety events that took place in NHS organisations to understand the local factors that may impact on patients not receiving medications as planned. This investigation shares findings from the patient safety event and identifies opportunities for local-level learning across the NHS to improve patient safety in relation to medication when a patient is discharged from an acute hospital to a community setting.

Findings

- On the patient's admission, conflicting information in his patient records created challenges for staff in understanding whether he was taking any medication to manage his diabetes.
- The patient's individual circumstances were considered by the hospital diabetes specialist nursing team when arranging education for self-administering his insulin. However, there was no documentation available to establish whether the patient was able to effectively self-administer his insulin after the education and manage his diabetes during the rest of his inpatient stay.
- The patient's need for district nursing support for insulin administration was understood and documented differently by different hospital teams, and between hospital and district nursing teams. The patient received support for wound care only and did not receive support in administering insulin after being discharged.
- The processes for managing medications on the ward and in the hospital's discharge lounge did not identify that the patient was discharged home with two different insulin pens, including one he did not need. This resulted in confusion for the patient about which one he should use.
- Post-discharge, follow-up processes from the hospital diabetes specialist nursing team identified that the patient was not taking his insulin; this provided an opportunity for further support to be arranged.
- Unlike hospital ward staff, the hospital diabetes nurse specialist service could not refer the patient directly to the district nursing service to arrange support. Instead, they had to contact the GP for a referral to be made. This delayed the patient receiving insulin support in the community.
- A mismatch between demand and capacity within the district nursing service often led to visits being overscheduled and time restrictions during patient visits. This limited the wider interaction staff could have with patients outside of the specific focus of their visit.
- District nursing services identified that the patient was not taking his insulin by chance during a routine wound care visit before any additional referral for insulin support, to district nursing services could be made by the GP practice.

- Due to commissioning arrangements, there was an inequity in the availability of post-discharge specialist diabetes nursing support in the community that could be offered to the patients in the region, resulting in this patient not being able to access a specialist community diabetes service.
- Multiple healthcare providers were involved with the patient's care. They used different electronic patient record (EPR) systems that did not interact to share information about the patient's care and referral status.

Local-level learning prompts

HSSIB investigations include local-level learning where this may help organisations and staff identify and think about how to respond to specific patient safety concerns at the local level.

The following prompts are provided by HSSIB to help organisations improve the safety of patients who need insulin and are being discharged from an acute hospital to the community.

Care in hospital

- How does your organisation support staff to quickly and easily identify what medication a patient is currently taking and their medication history?
- How does your organisation make sure that patients have access to specialist diabetes support including out of hours?
- How does your organisation support staff to gain an understanding of the care patients with diabetes need?
- How does your organisation ensure that education given to patients emphasises the importance of taking insulin and is appropriate and tailored to their individual needs?
- How does your organisation support patients to feel confident and safe in self-administration of insulin?
- How does your organisation support patients to understand how to raise concerns about self-administration of insulin?
- How does your organisation consider family, carer or living arrangements when providing education on self-administration?
- How does your organisation support staff to ensure that medications for an individual patient that are no longer needed are disposed of safely?

Planning for discharge in hospital

- How does your organisation support staff to complete medication checks before patients are discharged home with medications?
- How does your organisation follow up with patients post discharge, whose insulin regimen has started or been changed while in hospital?
- How does your organisation work with other services to help provide co-ordinated care for patients discharged home who need insulin support?
- How does your organisation support staff to identify and be able to refer to local diabetes specialist services when patients are discharged home?
- Does your organisation support staff to make timely and effective referrals to district nursing services to support insulin administration?

Care in the community

- How does your organisation enable staff to understand that a patient referral has been received, actioned, and completed?
- How does your organisation ensure enough time is allocated to district nursing visits based on individual patient needs?
- How does your organisation support staff to take rest breaks and reduce the risk of staff fatigue?

1. Background and context

1.1 Introduction

1.1.1 This investigation focuses on the processes and the workflows that support staff to ensure patients who are discharged from an acute hospital to a community setting receive their prescribed medications. It also explores how electronic patient record (EPR) systems, including electronic prescribing and medicines administration (ePMA) systems, support care in this area.

1.2 Diabetes management

1.2.1 There are 4.3 million people living with a diagnosis of diabetes in the UK (Diabetes UK, n.d.). Diabetes occurs when a person's body does not naturally regulate its blood glucose (sugar) levels, either because it cannot make insulin (type 1 diabetes) or does not produce enough insulin or does not respond to insulin (type 2 diabetes). Insulin is a hormone that helps the body to use glucose for energy.

1.2.2 With type 2 diabetes, if diabetes medications (for example in tablet form) or treatment plans (such as nutrition and exercise) no longer work well enough to keep a person's blood glucose within a healthy range, insulin can be prescribed to regulate their blood glucose levels.

1.2.3 Insulin can be used as a short-term or long-term treatment option. It reduces the chance of a person having the symptoms of high blood glucose (hyperglycaemia) and serious long-term problems that can damage other organs in the body (NHS, 2023).

1.2.4 Insulin can be administered using a 'pen' (an injection device) or a pump. People with diabetes who use a pen are supported, where possible, to administer their own insulin (self-administer). Insulin regimens vary from person to person depending on different factors. A person's regimen will be determined by healthcare professionals and usually involves administration between one and five times per day. Insulin is considered a time critical medication and taking it at the required times is vital to managing diabetes effectively (Royal College of Emergency Medicine, 2023). Healthcare teams may set customised target ranges for a patient's blood glucose levels according to that person's needs, and blood glucose levels may need to be regularly monitored. There are guidelines (National Institute for Health and Care Excellence, 2022a) to support staff in doing this.

1.2.5 The complexity of diabetes and managing it can be challenging for healthcare professionals and those living with the condition. It has been described by Cvirn (2024) as a 'dilemma' combining a 'complex web of factors'. An approach that brings together awareness, prevention, early detection and effective management is needed to support those living with diabetes. National guidance (National Institute for Health and Care Excellence, 2022b) emphasises the importance of an individualised care plan.

1.3 Planning a patient's discharge from hospital

1.3.1 The Department of Health (2024) issued 'Hospital discharge and community support guidance' which provides a framework for NHS trusts and local authorities to work together for safe discharge of patients. The principles underpinning the guidance focus on planning for discharge on admission, involving patients and carers in discharge decisions, having the right infrastructure in the community to support patients after discharge and sharing information across different healthcare teams in a timely way.

1.3.2 To support discharge, the Department of Health and Social Care (2024) sets out four pathways (pathways 0 to 3) under the 'discharge to assess' model. This categorises a patient's support needs and takes into account where the patient is being discharged to.

1.3.3 National guidance exists (National Institute for Health and Care Excellence, 2015) to support organisations to safely share information about medication between health and social care providers. This requires organisations to have 'robust and transparent' processes so that when a person is transferred between care settings, the new provider receives a complete and accurate information about the person's medication, and acts on it.

Discharge planning for people with diabetes

1.3.4 The Joint British Diabetes Societies for Inpatient Care (2023a) outlined that almost one fifth of hospital beds in England and Wales are occupied by people with diabetes. Poor discharge planning can lead to poorer outcomes for patients and increased rates of readmission. The key elements of a safe and effective discharge include making sure it is well planned, made in agreement with the person who has diabetes and their carers, and documented and communicated.

1.3.5 National guidance (Joint British Diabetes Societies for Inpatient Care, 2023a) highlights the importance of a multidisciplinary team working early after a patient's admission to make sure the right people are involved in their care during their hospital stay and in the discharge planning process.

1.3.6 Referral to the hospital diabetes team is also recommended early during the patient's admission if it is likely that they will need some assistance with their diabetes management either during the stay or on discharge.

1.3.7 Additional tools and prompts are available within national guidance (Joint British Diabetes Societies for Inpatient Care, 2023a) to support staff during discharge assessment, and a general diabetes discharge checklist is also provided.

Discharge considerations for adults who need insulin

1.3.8 There is national discharge planning guidance (Joint British Diabetes Societies for Inpatient Care, 2023a), and specific guidance to support safe discharge for people who have changed to insulin medication during their stay in hospital. As well as a referral to the diabetes inpatient team to provide education and equipment before discharge, there is a requirement for all patients to have the necessary information about managing their diabetes and details of who to contact for any queries they may have.

1.3.9 If a patient is unable to manage their own insulin injections and needs support from a district nursing team, there should also be:

- a referral to the district nursing team

- a copy of the discharge summary communicated to the district nursing team 24 hours before discharge
- early referral to the diabetes specialist team to resolve any equipment issues
- assurance that appropriate medication and safety needles are sent home with the patient (Joint British Diabetes Societies for Inpatient Care, 2023a).

1.4 Diabetes specialist nursing services

1.4.1 In 2019, the Joint British Diabetes Societies for Inpatient Care provided guidance on what a good inpatient diabetes service should look like. This was in response to themes identified through surveys and intelligence gathering, which concluded that hospitals were not as safe as possible for people with diabetes. One of the emerging themes was a lack of diabetes care from non-specialist staff.

1.4.2 Recommendations to support safe hospital care for people with diabetes included all hospitals having a fully staffed diabetes inpatient team with senior medical support, sufficient diabetes specialist nurses to run a daily and weekend service, and access to more specialist support (such as podiatry or dietetics). This was further supported by the Getting It Right First Time diabetes programme national speciality report (Rayman and Kar, 2020).

1.5 District nursing provision

1.5.1 Community nursing teams are made up of registered and non-registered staff with a range of different skills. This includes district nurses, who provide care in or close to people's homes. They have the knowledge and skills to support people to manage their long-term conditions and maximise their independence (NHS England, n.d.).

1.5.2 Typical reasons for district nursing visits include palliative care, wound management, catheter and continence care and medication support. District nurses also have prescribing rights which are specific to the district nursing profession, allowing them to prescribe certain medications (The Queen's Institute of Community Nursing, n.d.).

1.6 Electronic patient record (EPR) and electronic prescribing and medicines administration (ePMA) systems

1.6.1 An EPR is an electronic platform that brings patient information together in one place with the intention of making it more easily accessible for patients and healthcare professionals. This includes all medical information and history, test results and prescribed medications.

1.6.2 An ePMA system is defined as follows:

'The utilisation of electronic systems to facilitate and enhance the communication of a prescription or medicine order, aiding the choice, administration and supply of a medicine through knowledge and decision support and providing a robust audit trail for the entire medicines use process.' (NHS Connecting for Health, 2009)

1.6.3 The Healthcare Safety Investigation Branch previously investigated [the role of ePMA systems in weight-based medication errors in children](#) (Healthcare Safety Investigation Branch, 2022) and [ePMA systems and safe discharge](#) (Healthcare Safety Investigation Branch, 2019) and HSSIB is currently carrying out a thematic review focused on EPR (Health Services Safety Investigations Body, 2025a).

2. The patient safety event

This investigation used the following patient safety event to explore the patient safety risks posed by missed or delayed medications when a patient is discharged from an acute hospital to a community setting.

The safety event involved a patient aged 53 years who had type 2 diabetes. He managed his condition by taking a tablet medication called metformin, which helps to improve the body's sensitivity to insulin. The patient used a wheelchair to get around and had other medical issues including a history of depression and sensory loss. He had ongoing wound care needs.

Day 1

2.1 The patient was admitted to hospital following a fall at home. On admission the patient's observations (routine checks of his health status such as temperature and blood pressure) showed signs of a possible infection and he was given antibiotics. His blood glucose was noted to be 'unrecordable high'. The patient was seen by a member of the diabetes specialist nursing team. Because his body was unable to control his blood glucose levels, he was prescribed insulin to help manage his diabetes.

Day 4

2.2 The diabetes specialist nursing team visited the patient on the ward and taught him how to self-administer his insulin. The patient's partner was present during this. Education included when to administer the insulin, the doses and how to use the blood glucose meter. How to adjust the insulin dose was discussed, as well as injection technique. The patient was given leaflets which detailed injection technique and what to do in the event of illness, and type 2 diabetes and healthy eating booklets were also provided.

2.3 The patient was advised that the diabetes specialist nursing team would follow up during the week to help with altering the insulin dose if needed. The patient was discharged from the care of the diabetes specialist nursing team to the general medicine care team.

Day 6

2.4 The patient continued to receive general medical treatment to support his wellbeing in readiness for his discharge home. It was noted in his records that discharge would likely be planned for the following day.

2.5 A note was added to the patient's records in relation to his diabetes which included a plan for his discharge. This was to:

- 'continue with prescribed insulin of 10 units in the morning and 10 units in the evening, 20 minutes before food
- titrate [adjust] the insulin [dose] 10% to 20% if blood glucose high or low
- continue with oral diabetic medication
- monitor blood glucose levels before meals
- arrange a post discharge telephone review'.

Day 7 (discharge home)

2.6 At around 18:00 hours the patient was discharged home from the hospital and a referral was made to the district nursing team. The referral was made via a message taking service (which involves the healthcare professional calling a phoneline service and leaving a message with details of the referral, which is then passed on to the community team to action) and the patient was already known to the district nursing service. The referral was sent to the community trust's planned service team.

2.7 The referral stated that the patient had a catheter which needed changing every 9 weeks, that he required insulin 'twice daily 8am and 6pm', and would need wound care. The visits were requested to start from the day after discharge. The records stated that a medication directive (instructions for administering medications when a patient has a specific need) was given to the patient to pass to the district nursing teams, along with a discharge letter.

Day 8

2.8 The message taking service followed up with the district nursing team to check that the referral had been received. It was confirmed that it had and no further action was taken. A visit from the district nursing team did not take place on this day. The patient contacted the district nursing service to request a visit for wound care and the patient was scheduled a visit.

Days 9 to 20

2.9 The patient was seen by the district nursing team for wound care starting on day 9. Home visits continued every 2 days by different members of the district nursing team to provide wound care. The patient required additional care for some catheter issues between planned visits. The visits did not include administration of insulin.

2.10 On day 13 the hospital's diabetes nursing team had a follow-up telephone call with the patient. It was noted during the conversation that the patient was 'unable to remember all the information after discharge' and since going home, had not taken the insulin or monitored his blood glucose.

2.11 The patient was asked to contact his GP to arrange for his blood glucose to be checked and to arrange district nursing support to administer the insulin. In the meantime the patient was advised to continue taking oral (taken by mouth) medication to help manage his diabetes.

2.12 Following this conversation, a letter was also sent by email to the patient's GP requesting the patient be reviewed 'urgently' and district nursing support be arranged 'as soon as possible' to help with insulin administration.

2.13 Plans were made for the patient to have a diabetes review but there were no entries in the GP records to suggest the district nursing team's referral had been actioned.

2.14 The district nurses continued to provide wound care. There was no documentation in the patient's records about any discussion relating to his insulin medication.

Day 21

2.15 The patient had a fall at home and the urgent community response team visited him. The records stated that a 'review of meds undertaken and metformin [a type of medication used to treat diabetes] identified and confirmed'. The patient did not have any injuries following his fall and was supported to stay at home.

Day 22

2.16 In the early afternoon, the patient was visited at home. He had requested a visit via the district nursing unplanned service because he was having issues with his catheter (a tube used to drain urine from the bladder). A bladder washout was done and no further concerns were noted.

2.17 Later that evening the patient contacted the out of hours service again because of issues with his catheter. A member of the district nursing evening service visited him. During this visit it was identified that the patient had been prescribed insulin following his recent stay in hospital

but had not had any since he was discharged home. It was noted in his records that he 'was unsure how to administer. Was shown in hospital but unsure of doses'. The nurse documented there was an 'odd' insulin pen in the patient's discharge bag from hospital and this was not prescribed.

2.18 The district nurse took the patient's blood glucose reading, which was high. The nurse arranged for him to be taken to hospital by ambulance. The patient was assessed and kept in overnight for observation before being discharged home the following day. The patient was initially supported at home by the district nursing service to self-administer his insulin, and now continues to self-administer insulin himself to manage his diabetes.

3. Analysis and findings

The investigation explored the factors that may have led to the patient not receiving his insulin for 15 days after he was discharged from hospital. The investigation met with a range of staff involved in the patient's care, not all of whom could recall the specifics of the patient's care because of the length of time that had passed since the event. Therefore, the investigation mainly used documented information and an exploration of how care is usually delivered.

The investigation explored the care given under the following headings:

- Care in hospital
- Planning for discharge in hospital
- Care in the community
- Electronic patient record (EPR) and electronic prescribing and medicines administration (ePMA) systems.

This section includes local learning prompts, which aim to help organisations improve the safety of patients who are being discharged from an acute hospital to the community.

3.1 Care in hospital

Medication checks on admission

3.1.1 Differing information was obtained on admission about how the patient was managing his diabetes. One of the hospital records stated he was not taking any medication for his diabetes before his admission, while other hospital records stated he was prescribed metformin. It was not clear from the records where the history was obtained. The investigation heard from several staff interviewed that it was not unusual for there to be conflicting information due to how up to date different healthcare records are.

3.1.2 Hospital staff described using a two-source checking process when a patient was admitted to hospital to determine an accurate history of their medications. For example, staff would check with the patient as well as checking against their GP records. This was described as being time consuming for staff as they would often have to check records in multiple places or speak to different people involved in a person's care. While time consuming, it was said to be an essential step to ensure a patient's safety. In the patient safety event, following the two-source checking process, it was confirmed that the patient had been taking metformin in tablet form.

Care input from the diabetes specialist nursing team

3.1.3 The investigation learned that the diabetes specialist nurse (DSN) reviewed the patient soon after his admission. The DSN team received referrals from different wards across the hospital and supported patient care by carrying out diabetes medication reviews, providing education to patients and helping them to prepare for a safe discharge.

3.1.4 The DSN service was funded to run on weekdays only between 08:00 hours and 16:00 hours. Out of hours diabetes support was accessed via the medical team on call. Although it was not a specific factor in this case, the investigation heard that this often meant varying levels of diabetes specialist support was available during those times. Staff also explained that this increased the DSN team's workload on Mondays as there would often be patients to see who had not been seen at the weekend as their medical need was deemed non-urgent.

3.1.5 It has been recognised nationally that healthcare staff who interact with people with diabetes do not always fully understand the care needed to keep them safe, and that trusts should work towards providing base-level specialist diabetes cover at weekends (Rayman and Kar, 2020). The Joint British Diabetes Societies for Inpatient Care (2023b) developed a staffing calculator which can help to determine suitable staffing levels.

3.1.6 In addition, changes to the patient catchment area and service provision for the hospital had increased the DSN team's workload. Capacity challenges were exacerbated by a high prevalence of diabetes in the local population. The patient received input from the DSN team on two occasions during his inpatient stay. The investigation did not have evidence to suggest whether the capacity challenges had a direct impact on this patient's care but acknowledges the wider implications this can have for patient care.

Changes to medications

3.1.7 A decision was made on admission to prescribe the patient insulin to manage his diabetes. The decision to prescribe insulin was not explored as part of the investigation.

3.1.8 The patient was initially prescribed a type of long-acting insulin pen but this did not adequately control his blood glucose. Therefore, during his stay this was changed to a different type of combination insulin pen to be used twice a day. This was a combination of short and intermediate acting insulin which provided better control of his blood glucose.

3.1.9 While it was not possible to confirm definitively what happened to the patient's medications, the investigation understands that the patient was discharged home with two different types of insulin pen in his belongings. Finding both pens when he arrived home added to his confusion about taking his insulin and he did not take any.

3.1.10 Staff told the investigation that when a patient's medication regimen changed, medication that was no longer needed was placed in secure bins on the wards for return to the pharmacy. Staff acknowledged that a full check might not always be carried out of the patient's lockable bedside cabinet or their personal belongings to remove any old medications.

3.1.11 The approach to checking for medications was described as being inconsistent, with staff not always having time to regularly check a patient's belongings for old medications. An example of when this might not happen is what staff called a "lift and scoop", where a patient and their belongings are moved to another ward or bed and their belongings, including medications, are taken as they are. There might not be time to do a full medication check before this, particularly if it happens during a busy time or if the patient move is urgent.

Summary

3.1.12 The medication check for the patient ensured he was on the correct medication. This was despite conflicting information and the time taken to do a two-source check. There were capacity challenges for the DSN team due to changes in the patient catchment area and service provision for the hospital, but there was no evidence to suggest this directly affected the patient's care. The DSN team saw the patient on two occasions during this stay. The patient's diabetes medications were changed to insulin on his admission to hospital, and the type of insulin medication was changed during his stay. The evidence gathered during the investigation suggests the he was discharged from hospital with two types of insulin pen. Once at home, this added to his confusion about what he should take and he did not take any.

3.2 Planning for discharge in hospital

Diabetes education

3.2.1 Three days before the patient was discharged, the DSN team spent time with him and his partner, providing diabetes education on his amended insulin regimen. This covered when to administer the insulin, the doses and how to use the blood glucose meter. How to adjust the

insulin dose was discussed, as well as injection technique. The patient was given leaflets detailing injection technique and what to do if he became unwell. Booklets on type 2 diabetes and healthy eating were also provided.

3.2.2 There was no detail in the medical record of how it was checked that the patient had understood the information he had been given. Given the length of time that had elapsed since the event, staff could not recall this specifically for the patient. Staff described that usual practice involves asking patients to repeat back the information provided during any education given, to make sure they have fully understood it.

3.2.3 The investigation was told by pharmacy staff that if a patient has the capacity to understand instructions and carry out tasks they can be supported to self-administer with supervision. Supporting people to look after and take their own medications, unless a risk assessment suggests otherwise, has been highlighted as good practice by the Care Quality Commission (2019). The safe self-administration of medication was recognised as a challenge in the first in HSSIB's series of investigations into [medication-related harm](#) (Health Services Safety Investigations Body, 2024).

3.2.4 Following the diabetes education, the patient was supported to self-administer while in hospital, for 3 days, in preparation for discharge. There was no detail within the medical records to confirm whether the patient was supervised during his self-administration or what checks were done to make sure he felt confident about self-administering after his time with the DSN team. Staff described that they would usually supervise a patient self-administering on several occasions to make sure they were able to do it correctly.

3.2.5 A key component to successfully teaching patients to self-administer insulin is focusing on 'why' they need to do this and the importance of it, as well as 'what' to do (Chin and Robins, 2019). There was no entry in the medical record to indicate whether the reason for taking insulin, and the importance of it, was conveyed fully to the patient.

3.2.6 The hospital trust have a policy in place for self-administration of medications but acknowledged that improvements were needed to support patients to safely self-administer medications as this was noted to be an area where it had had concerns. One of the local integrated care boards that commissions services in the area, was supporting the trust, along with other local trusts, as part of a wider piece of work to support patients to self-administer their medication during hospital stays.

3.2.7 The patient told the investigation that he felt confident in administering his medication until he got home. Once at home, he found two different types of insulin pen in his belongings and was confused about which he should use. It was unclear to the investigation what prevented the patient from seeking help and advice, or if his partner was aware of his confusion about his insulin medications.

3.2.8 The investigation learned that consideration was given to individual patients' circumstances when providing insulin/diabetes education, so that they could be best supported in readiness for discharge, which was tailored to their needs. An example given was if a family member was with a patient during any diabetes education, but they did not live with the patient, staff would make sure that the patient felt confident to administer medication on their own.

3.2.9 It was not clarified in the patient's medical records what role his partner would have in supporting the self-administration of insulin. Some patients may have complex family arrangements and therefore clarifying the role of family members or carers may assist in understanding the level of support a patient needs.

Patient confusion

3.2.10 In the patient's GP record after the safety event, it stated the patient 'initially couldn't remember to administer insulin'. The investigation explored how hospital staff assessed a patient's capacity to understand information, and their ability to retain it. Staff described that on admission a medical assessment was undertaken which included a review of a patient's capacity.

3.2.11 While a patient's capacity would not be formally assessed again during the admission unless there was a specific need to, staff said that they would dynamically assess whether a patient was able to retain information sufficiently. This would be based on their clinical signs and symptoms. During any education, patients would be asked to repeat the instructions they had been given to show they had understood. HSSIB ([2023](#)) has previously reported on the challenges staff face in assessing patients' capacity to consent to routine bedside tasks, as often the training staff received focused on major interventions such as surgery. In the safety event there was no formally documented assessment of the patient's capacity or ability to understand and retain information.

3.2.12 The investigation acknowledges that a patient's ability and confidence to self-administer while in the supportive environment of a hospital ward may differ from when they are at home. The investigation saw evidence that the challenges around self-administration of insulin and adherence to a new regimen were acknowledged by staff at the hospital, given that a follow-up call with the patient from the DSN team was planned for the week after discharge. HSSIB ([2025b](#)) has also acknowledged this challenge and a wider piece of work is underway to explore how self-administration of medications in the community can be supported.

The discharge lounge

3.2.13 A discharge lounge is a dedicated area within a hospital for patients who have been medically discharged but are still waiting for things such as medication or transport. The investigation was informed that the patient involved in the safety event was discharged via the

hospital's discharge lounge. The patients records included a discharge record, although staff could not recall any specific detail about the discharge given the length of time that had passed since the event. The discharge paperwork did not clearly show when the patient left the ward to go to the discharge lounge or whether discharge arrangements were made by the ward or the discharge lounge staff. The investigation therefore explored usual practice.

3.2.14 The discharge lounge at the hospital operated daily from 07:00 hours until 19:30 hours. Approximately 25 to 30 patients accessed the discharge lounge each day.

3.2.15 Safety meetings took place three times a day. A senior nurse led the meeting and nursing staff from different wards gave updates on possible discharges, admissions and any barriers to patients being discharged home. Since the patient safety event happened, many of the processes at the hospital have changed following a significant environmental change and staff described that the safety meetings have helped to manage patient flow effectively.

3.2.16 The discharge lounge team described how they played a role in "vetting everything" in the discharge lounge and that they "unblock barriers". They had also recently employed a doctor to work in the discharge lounge and said this had helped to support safe discharge. This demonstrated the additional roles and responsibilities taken on within the discharge lounge; rather than providing a holding area for patients before they went home, there was more of a requirement to get involved in patient care and tasks such as medication checks.

3.2.17 The investigation saw the complexities involved in managing patients' discharge from the discharge lounge. While the national discharge framework suggests a clear process to follow, in reality often this is more challenging for staff due to additional arrangements that might need to be made that are only identified once the patient is in the discharge lounge.

3.2.18 During the investigation's observation of care, the discharge lounge team manager appeared to have oversight of care and the ability to support effective patient flow. Numerous staff told the investigation they would go to that person as a single point of contact for information and advice.

3.2.19 Staff described the standard process for a patient awaiting discharge from the discharge lounge. This included a review of medications against the discharge summary of medications, to make sure the patient had everything they needed. The investigation attempted to understand whether it would be identified in the discharge lounge if a patient had an additional medication in their belongings that they no longer needed.

3.2.20 Staff said they would normally check a patient's medications in the discharge lounge before they went home. However, it was acknowledged that a patient could have additional medications in their own belongings that might not be checked, as staff would not routinely go through a patient's personal belongings. An additional check at this point could provide a barrier to a patient accidentally going home with incorrect medication.

3.2.21 In the patient safety event, the investigation saw evidence of the steps within the discharge framework being followed with a discharge plan made for the patient, this being discussed with the patient and his partner, and arrangements for follow-up care being made. A discharge checklist was completed; this was in a yes/no/NA (not applicable) format with no supporting detail. There was no question in the checklist about whether all the medications the patient had had been checked. Questions related to medications were:

- 'TTO [to take out] meds given to patient?
- Personal meds returned?
- Directive given to patient?'

3.2.22 There was conflicting information within the patient's medical records about the nature of the district nursing support that had been arranged by staff, in terms of what was required or whether any insulin medication support was needed. The referral notes within the district nursing records stated: 'Patient has a ... catheter which requires 9/52 (9 weekly) change, Patient requires insulin twice daily 8am and 6pm, Wound care needed to sacrum and heel.' The discharge paperwork stated a referral had been made to the district nursing team to support with insulin administration and a directive had been sent with the patient to give to the district nursing team for administration of insulin. It was not clear what prompted the nurse making the referral to think the patient needed additional support with insulin administration at home.

3.2.23 Within the DSN records there was no suggested expectation that the district nurses would be administering insulin; the expectation was that the patient would self-administer. At the point of discharge, the patient's records contained two different expectations of how he would manage his diabetes. Ensuring full and clear instructions on discharge for other healthcare professionals who may be involved in a patient's follow-up care has been explored as part of HSSIB investigation '[Workforce and patient safety: electronic communications on patient discharge from acute hospitals](#)' (2025c).

Referrals for diabetes support in the community

3.2.24 At the point of discharge from hospital, no specific specialist diabetes input was requested for the patient as he had received diabetes education in hospital to enable him to self-administer insulin at home.

3.2.25 Members of staff from the DSN service told the investigation that when a patient was discharged from hospital, any further diabetes support was often provided by the district nursing teams or by a GP practice nurse. The investigation learned that prior to this admission, the patient had received frequent diabetes support from his GP and the diabetes nurse at the practice.

3.2.26 The DSN team told the investigation that they did not have access to a community diabetes team as this was not funded in the area. Staff felt this would improve the service available to patients by being able to offer further diabetes support in the community after discharge. The investigation heard this was something some other trusts across the country have access to and staff said that this had worked well in other places they had worked. On consultation, the community provider told the investigation there was access to a community diabetes specialist service. There appeared to be confusion amongst local teams as to what was available for all patients to access.

3.2.27 People's experience of community diabetes care has been 'good overall' (Care Quality Commission, 2016) but was not always flexible and responsive enough to meet individual patient needs. Having diabetes specialists available to support people living with diabetes was recognised in the Care Quality Commission (2016) report 'My diabetes, my care' as important in enabling people to self-manage their condition. It also had benefits in providing more person-centred care and in enabling services to work together effectively when a patient had multiple care providers. Supporting and developing diabetes knowledge and understanding across other healthcare professionals was also a known benefit of having specialist diabetes services.

3.2.28 During discussions with one of the integrated care boards that commissions services in the patient's locality, a community diabetes service was identified which provided short-term specialist expert advice. This service was only available to adults registered with a GP in a particular locality within the region and demonstrated inequities in the level of service offered to patients depending on where they lived. This service was seen to be promoted within another hospital in the region but did not appear to be known by all staff in other hospitals. This meant patients who may be able to access the service if they were registered with the GP may be missed if they went into other hospitals.

Summary

3.2.29 The patient received education in hospital on how to self-administer insulin; it was unclear how much support he received after his education. Self-administration of insulin can be complex and often needs multiple education sessions and follow-up. The patient was discharged via the discharge lounge where a check was done to make sure he had the correct medications for discharge.

3.2.30 Hospital staff had differing expectations about how the patient would manage his diabetes at home. Records from the DSN team show an understanding that the patient was confident to self-administer his insulin and a follow-up call would be made after discharge. Nursing staff facilitating the patient's discharge included insulin support in the referral to the district nursing team and it was not clear what led them to believe he needed this.

3.2.31 The discharge lounge had taken on additional roles and responsibilities to help keep patients safe, including having a doctor available for medical support. Referrals for further specialist diabetes support on discharge vary depending on where a patient lives and no specific diabetes follow-up was arranged for this patient.

3.3 Care in the community

Referral from the DSN team for district nursing support via the GP

3.3.1 During a phone call between the hospital DSN and the patient 6 days after discharge, the patient described that he had not felt confident administering his insulin and had therefore not taken any since discharge. A referral was made to the patient's GP for a diabetes review and for the GP to arrange for the district nursing team to support the patient with his insulin administration.

3.3.2 The investigation was told that the hospital DSN team cannot make direct referrals to the district nursing team and therefore the referrals go through the GP practice. The reason for this was unclear and other nursing staff within the hospital were able to make direct referrals. On consultation, the community provider stated that any professional can refer to the district nurses. This did not reflect the understanding of staff at the acute hospital.

3.3.3 The process of DSNs having a follow-up call with patients post-discharge demonstrates an acknowledgement of the complexities associated with self-administering insulin and the need for patients to have support and reassurance. The mechanisms to provide that support, should it be needed, appeared to be restrictive for the DSNs, with referrals needing to go via the GP. In this instance, the referral process was not effective in providing the patient with district nursing support for his insulin administration and after the follow-up call, the patient remained without insulin for a further 9 days.

3.3.4 The referral process from the DSN team was described by staff at the GP practice. Referrals were reviewed by administration staff on an hourly basis and allocated to the relevant team, for example the prescribing team if medications were needed or the secretarial team if other assistance was needed such as district nursing support.

3.3.5 In the scenario described in the patient safety event, the GP secretarial team would complete a referral for the district nursing team to support the patient to take his insulin. This would be done via a telephone messaging service which involves an individual taking the details of the referral and then passing them to the district nursing team. Using an external provider to manage referrals relieves capacity challenges, as otherwise the community trust would need to run this service itself. However, it does add another step to the referral process and another handover of information. The risks to patient care associated with clinical handover of information, particularly across care providers, is well researched (Raeisi et al, 2019; Sujan et al, 2014).

3.3.6 There was no feedback mechanism built into the referral process to enable staff to know if the referral request had been actioned and confirmed. In the patient safety event there was no entry in the patient's medical record to reflect that a referral of this nature had been made. This meant there was no way of tracking the referral or checking it had been made, creating the potential for referrals to be missed. HSSIB ([2025c](#)) recently made a safety recommendation relating to processes supporting healthcare providers to complete safety-critical actions for ongoing patient care within required timeframes.

3.3.7 Staff at the GP practice described that they were able to see the electronic district nursing records to see if there was any support in place at that time. Checking this was described as being an ad hoc process rather than routine, and in the patient's case it was not possible to determine whether his district nursing records had been accessed before a new referral was made. Checking the district nursing records would have shown he already had district nursing support in place, though this was for wound care.

3.3.8 The investigation was not able to confirm whether the additional district nursing referral request for insulin support had been made on the day the hospital's diabetes specialist nurse requested it. There was evidence that other parts of the request had been actioned, such as requesting a diabetes review with the patient. Initially records showed that the patient was informed that a diabetes review was not due as it was less than 12 months since his last one. Additional messages could then be seen about arranging the review sooner. The diabetes review did not take place until after it had been identified that the patient had not been taking his insulin.

3.3.9 Staff at the GP practice told the investigation that each letter about patient care was reviewed and actioned by one individual and there was not an additional check to make sure everything had been actioned. There was an audit process in place to check some letters on a monthly basis. If any actions in the letters were found to have been missed, they were actioned and learning shared across the practice.

3.3.10 There were multiple care providers involved in the patient's care after his discharge home, and opportunities through safety netting (mechanisms to ensure patients are monitored and followed up in a timely way) such as the DSN follow-up call and referrals, to support him in receiving his insulin. A lack of co-ordination between everyday primary and community services in the NHS is known to be leading to sub-standard care (Health Services Safety Investigations Body, [2025d](#); House of Lords, 2023) and this was evident in the patient safety event. Despite the best efforts of staff, there was a breakdown in communication and handover of information which contributed to the patient not receiving his insulin for 15 days.

Managing referrals in the district nursing team

3.3.11 Because of where the patient lived, the hospital he went into and the district nursing support he received were run by different trusts. The referral paperwork received by the district nursing team was not available for the investigation to see. While it was summarised on the district nursing team's system that the 'patient requires insulin twice daily' as well as catheter and wound care, it was not specified whether district nursing support was required to give the patient insulin. As a result of how the referral was interpreted, the referral was actioned for wound and catheter care only. The patient received these as planned.

3.3.12 Locally, the trust providing district nursing care to the patient ran a planned and an unplanned service. At the time of the patient safety event, the planned service operated between 08:00 hours and 18:00 hours. Outside of these hours the unplanned service managed and processed referrals to the out of hours service (18:00 hours to 08:00 hours) This also applied at weekends and on bank holidays.

3.3.13 Staff in the planned team generally worked a 7.5-hour shift. They were allocated a 30-minute lunch break, 30 minutes for paperwork and administrative tasks and 30 minutes for handover each day. The investigation heard that most of the time staff did get their lunch break, although the office environment where they were based was challenging, with no separate area away from the workspace where staff could take their break, other than a kitchen area that was part of the office. The investigation heard that managers often ended up working past the end of their shift finish time and on days off to try and keep on top of workload. HSSIB (2025e) has investigated [the impact of staff fatigue on patient safety](#).

3.3.14 There were often vacancies in the planned team and difficulty in recruiting to these roles, despite efforts across the team to fill these. The team often relied on agency workers; however, the investigation heard that a change was due to be introduced at the trust which would mean the use of agency workers would no longer be permitted. This was part of a national drive to reduce NHS expenditure on agency workers (NHS England, 2024).

3.3.15 Managers described working together in the different geographical areas of the community to share staff where possible and using bank staff (staff registered to take on temporary shifts) to make sure there was enough cover.

3.3.16 Referrals received by the planned team were allocated via an electronic system to different staff on shift that day. The allocation would also depend on the nature of the visit and which staff member was suitably qualified for it. Time was allocated in multiples of 15 minutes per visit depending on the reason for the visit. Some of the allocation was automated but managers would often amend the schedule as they could use their knowledge and experience to schedule the visits more efficiently. For example, the manager might know that certain patient visits would not take as long as the system had allocated. A 6-minute travel time was also built in automatically between visits and again, staff recognised this was sometimes unrealistic and would amend the schedule accordingly.

3.3.17 Staff described visits being “overscheduled” on the system, with more visits often being allocated for the day than staff could undertake. This was often due to demand outweighing capacity and a hope that some visits may not take as long as the scheduled time. Any visits staff were not able to complete were rescheduled for another day and this was done based on assessment of clinical priority.

Undertaking home visits

3.3.18 The patient involved in the safety event was seen by the district nursing team who provided wound care, as planned, every 2 days following his discharge from hospital, for 13 days before he was re-admitted to hospital. There were also additional visits from the district nursing team during this time, when the patient self-referred because his wound dressings had fallen off or when he needed help with his catheter.

3.3.19 The patient was seen by different members of the district nursing team. All visits were noted to be uneventful, with the patient’s wound cared for each time. There was no entry in the records of any discussion during any of the visits about the patient’s diabetes or his insulin management, until the day when it was identified that the patient had not been taking his insulin and he was re-admitted to hospital.

3.3.20 The investigation spent time shadowing district nursing visits in the community with a senior nurse. These included visits for wound care, insulin administration and pain relief.

3.3.21 The nurse received details of the next patient visit electronically on a handheld device. These included the patient’s address, the reason for the visit and previous visits undertaken. Staff said that whether or not they had a chance to read all of a patient’s history before going into their home depended on how the day was going in terms of timeliness of visits. There was sometimes continuity in the care giver, though this could not be guaranteed.

3.3.22 At the start of each visit, information was gathered through conversation with the patient and/or family members and paper records were reviewed. Staff said this was sometimes a challenge because some records may be missing from a patient's paper records and these may include additional information to the electronic records, or staff would have to try and unpick a history, particularly if there had been a recent discharge from hospital or a change in medications.

3.3.23 During one of the investigation's observation visits, an additional insulin pen was found in a patient's home and the nurse had to spend time trying to understand why it was there. This included checking with the GP practice and adding notes on the district nursing system for this to be followed up later in the day when the evening district nurse visit took place. This demonstrated to the investigation that scenario in the patient safety event of an additional insulin pen being in the patient's belongings was not unique.

3.3.24 The investigation tried to understand whether it was standard practice, and whether there was enough time, to have discussions with patients during visits about their wider wellbeing and care.

3.3.25 It was evident to the investigation that often other issues, aside from the primary reason for the visit, would be raised by a patient or a family member. During the investigation's observations, examples of this included mental health concerns, a request to review a wound and a request for the nursing team to speak to the GP practice. Staff said they sometimes felt "rushed" and with their "thoughts on the next patient" if visits took longer than planned.

3.3.26 Staff described that sometimes there was the opportunity to talk with a patient about other elements of care and sometimes not. Sometimes a patient would raise an issue themselves, in which case a discussion would take place. The investigation heard that whether or not such discussions happened would also depend on the grade of staff member who was seeing to the patient. For example, some staff who visited patients for wound care were not registered nurses and it would therefore not be within their scope of practice to discuss things such as medication dosage or changes to prescriptions.

3.3.27 In the patient safety event, during the visit where it was identified that the patient had not been taking his insulin, the staff member could not specifically recall how the issue was raised, whether it was from a conversation with the patient or from reading the discharge paperwork. The staff member said it was "pot luck" that it was picked up that day.

3.3.28 The investigation observed that additional work was often needed following a visit. Examples included a telephone call with a GP practice, advice being sought from a tissue viability nurse, escalation of a care need to a local authority care team and arranging an

additional district nursing visit. Staff said that administrative tasks often took longer than the 30 minutes allocated per shift. They would do as much as they could that day and pick up the rest on the next shift or hand tasks over to someone else.

3.3.29 A record of each visit was made on the handheld device which updated the central patient record system. The investigation learned that depending on the connectivity where a nurse was working, sometimes records would need to be updated when staff got back to their base. This was an additional task that would take extra time to complete.

Summary

3.3.30 The original referral from the hospital to the district nursing team was processed with the understanding that the patient needed wound and catheter care only, and no support for insulin administration was arranged. The diabetes specialist nursing team made a referral for insulin support when a follow-up phone call 6 days after discharge identified that the patient had not been taking his insulin. This referral was sent to the GP practice, but the patient did not receive support in taking his insulin. Challenges and complexities associated with handover of clinical information between different services and professionals has the potential to contribute to this. The patient received visits for wound care during this time, but during these visits it was not identified that he needed insulin support. District nursing visits are often overscheduled due to demand outweighing capacity and this can affect patient care.

Local-level learning prompts

HSSIB investigations include local-level learning where this may help organisations and staff identify and think about how to respond to specific patient safety concerns at the local level.

The following prompts are provided by HSSIB to help organisations improve the safety of patients who need insulin and are being discharged from an acute hospital to the community.

Care in hospital

- How does your organisation support staff to quickly and easily identify what medication a patient is currently taking and their medication history?
- How does your organisation make sure that patients have access to specialist diabetes support including out of hours?
- How does your organisation support staff to gain an understanding of the care patients with diabetes need?

- How does your organisation ensure that education given to patients emphasises the importance of taking insulin and is appropriate and tailored to their individual needs?
- How does your organisation support patients to feel confident and safe in self-administration of insulin?
- How does your organisation support patients to understand how to raise concerns about self-administration of insulin?
- How does your organisation consider family, carer or living arrangements when providing education on self-administration?
- How does your organisation support staff to ensure that medications for an individual patient that are no longer needed are disposed of safely?

Planning for discharge in hospital

- How does your organisation support staff to complete medication checks before patients are discharged home with medications?
- How does your organisation follow up with patients post discharge, whose insulin regimen has started or been changed while in hospital?
- How does your organisation work with other services to help provide co-ordinated care for patients discharged home who need insulin support?
- How does your organisation support staff to identify and be able to refer to local diabetes specialist services when patients are discharged home?
- Does your organisation support staff to make timely and effective referrals to district nursing services to support insulin administration?

Care in the community

- How does your organisation enable staff to understand that a patient referral has been received, actioned, and completed?
- How does your organisation ensure enough time is allocated to district nursing visits based on individual patient needs?
- How does your organisation support staff to take rest breaks and reduce the risk of staff fatigue?

3.4 EPR and ePMA systems

3.4.1 Because the patient received care in different care settings and delivered by different service providers, there was a challenge in all healthcare professionals being able to consistently see previous healthcare records.

3.4.2 Hospital staff described challenges in being able to accurately understand a patient's medication history. Obtaining an accurate history often took time and involved checking multiple records.

3.4.3 The acute hospital trust had moved to an ePMA system more than 5 years ago and described that this was now well embedded within the hospital and assisted in the safe and effective prescribing of medications.

3.4.4 Within the discharge lounge a mix of electronic and paper records was used to manage patient flow. During safety meetings, details of activities to assist with patient flow that day were written on paper and would not be entered onto an electronic system to allow others to see them. This created reliance on the individual managing the lounge that day to monitor workflow using the paper record.

3.4.5 The GP practice used EPR. Practice staff were also able to access some other electronic patient records. Checking different care records was a manual process.

3.4.6 Within the district nursing systems some records were electronic while some records were paper records that stayed with the patient. This created duplication for staff, who had to make a note of the care given in two sets of records. Staff also described how sometimes because of connectivity issues they would not be able to access the electronic system and they would need to access a list of patient visits from the office before their visits. If they could not access the electronic system during visits, they would have to spend additional time writing up records once they had connectivity again.

3.4.7 This safety event involved different care providers: the acute hospital trust, the community trust, the district nursing service and the GP practice. The different EPR and ePMA systems in use were not fully integrated or visible to all the different providers. This created a reliance on manual transfer and handover of information.

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5. Appendix

Investigation approach

A review of patient safety insights suggested a theme of medication-related harm. The investigation reviewed:

- reports to prevent future deaths
- reports to the Strategic Executive Information System (StEIS)
- reports made directly to HSSIB by the public
- previous Healthcare Safety Investigation Branch reports related to medication
- discussions with stakeholders to identify areas of concern.

Once a decision was made to proceed to investigation, further stakeholder discussions were held to identify more specific areas of concern and to understand the current patient safety landscape in relation to medication-related harm. Analysis of all the information obtained suggested a theme of medication not given, with three topic areas:

1. time-critical medication in the emergency department
2. anticoagulants before and after a procedure
3. discharge to the community.

A further theme emerged regarding electronic prescribing and medicines administration (ePMA) systems.

HSSIB's Chief Investigator authorised an investigation into each of these topics.

Evidence gathering and verification of findings

A local investigation was undertaken. This meant identifying and investigating a single patient safety event that involved medication not being given following discharge from an acute hospital to the community. The investigation visited the acute trust and the community trust where the patient safety event took place. Meetings and interviews were held with staff involved in the patient safety event and key staff in the management of patient flow, medication safety, discharge planning, GP referrals and district nursing. The investigation also observed practice within the acute hospital and the district nursing service. The following practices were observed:

- safety meetings in the hospital discharge lounge
- routine care on an acute general medicine ward
- district nursing visits

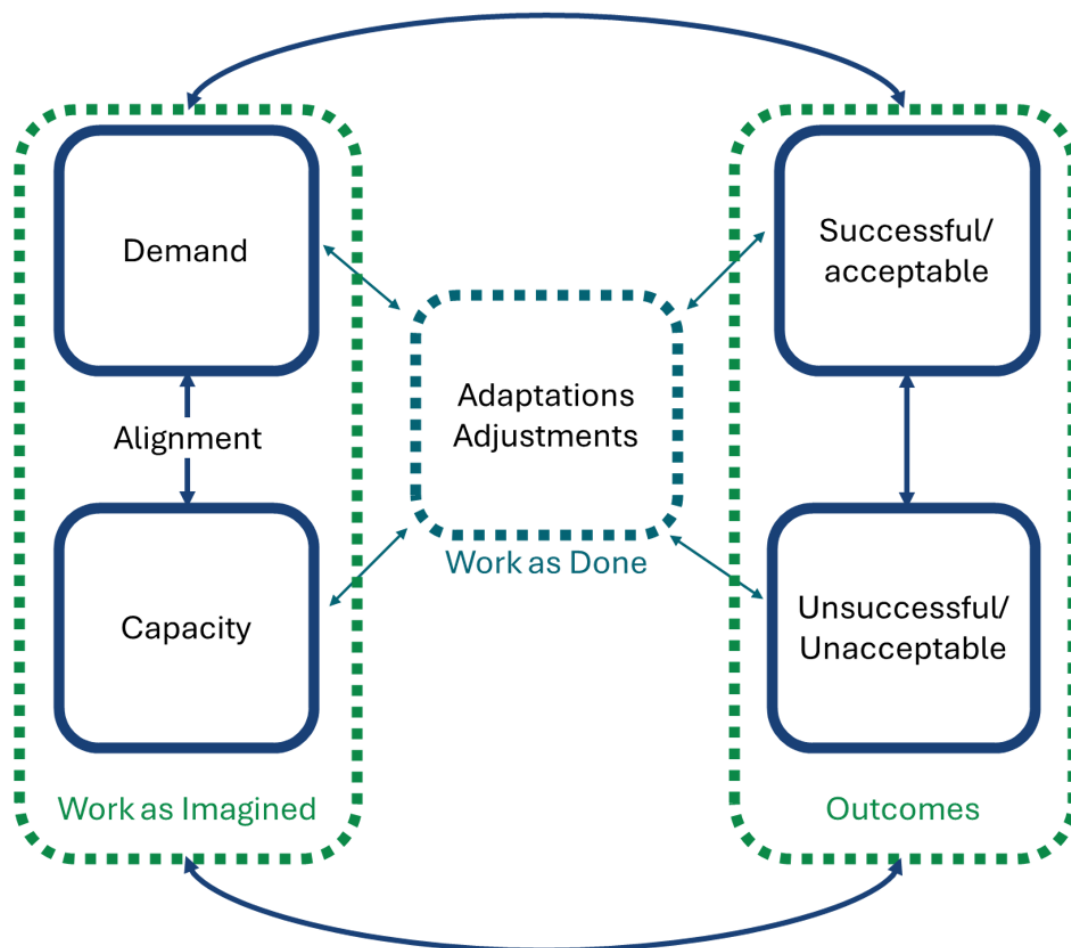
- handover of patient care within the district nursing service.

The investigation contacted the patient who spoke to the investigation team to share his experience.

Evidence gathering took place between February 2025 and May 2025.

The investigation used the CARE model (see figure A) to identify adaptations and adjustments that staff had made to bridge the misalignments between unforeseen and/or anticipated demands and capacity (Anderson and Ross, 2020). Using the resilient healthcare approach helped identify opportunities where the trusts may support the use of adaptations by staff, within safe limits, to cope with these challenges. Such supported adaptations enable the dynamic management of pressures and challenges in a safe way (Anderson and Ross, 2020).

Figure A The CARE model



Stakeholder engagement and consultation

The investigation engaged with national organisations to gather evidence at the beginning of the investigation, to determine the scope of work across the theme of medications not given.

The local investigation then engaged with a range of organisations and staff involved in the patient safety event. Local stakeholders were consulted on the local investigation. This also enabled checking for factual accuracy and overall sense-checking.

Investigation stakeholders

Local organisations	Patient and staff	National organisations
Acute trust where the patient safety event took place	The patient	NHS England
GP practice where the patient was registered	District nursing staff x 7	Royal College of General Practitioners
Community trust where the patient safety event took place	Acute trust staff x 5	Healthwatch
Two integrated care boards which commission services in the local trusts' areas	Quality and safety leads, integrated care board	Medicines and Healthcare products Regulatory Agency
	GP practice staff x 3	Independent Health Providers Network
		Community Pharmacy Patient Safety Group
		The Patients Association
		Academics
		Royal Pharmaceutical Society
		National Institute for Health and Care Excellence