SIGNIFICANT INCIDENT LEARNING PROCESS

“Miss H”

Referral Reference No. 04-17 D

Date of report: 29th October 2018

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1. Event overview:

1.1 Miss H is a 50 year old single, Caucasian female with a diagnosis of severe learning disability (LD). Miss H is non-verbal in communication. Her cognitive impairment impacts on her daily living whereby she requires support with all activities of daily living. She resides in supported living accommodation at AL1 where she receives 24 hours support and supervision.

1.2 On the morning of the 21st March 2017 at approximately 8am Miss H was provided with personal care and at 8.40am collected by mini-bus for transport to Day Centre 1. On arrival at the day centre, some minutes after collection, she was unable - or unwilling - to stand. There is no evidence of Miss H receiving an injury prior to or during transport.

1.3 At 9.20am AL1 records indicate that Miss H was returned to AL1 from the day centre by taxi. It is unclear why an ambulance was not called at the day centre. AL1 rang 111 and were advised to call the GP, however as no GP visit could be arranged, AL1 telephoned 111 again and an ambulance was despatched arriving at 10.30am.

1.4 At 11.43am Miss H arrived at the hospital accompanied by a carer from AL1 and spent four hours in A&E, until 3.20pm when A&E staff diagnosed that she had a chest infection, prescribed medication and requested her discharge. Miss H was x-rayed, however, the x-ray was only of her chest.

1.5 The intended discharge prompted telephone calls from her carer to Community Health and Social Care Services, who in turn attempted to contact the LD Nurse and Quality Matron for LD to assist. Unfortunately, both were on annual leave. It is clear from the records that the carer was expressing concerns that Miss H was not mobile and would not be able to return home due to her bedroom being upstairs and she was physically unable to access this.

1.6 At 3.35pm, Community Services recorded that they had received a call from A&E requesting an assessment for reduced mobility and were advised to contact the hospital therapy team. At 9.07pm AL1 manager telephoned out of hours GP as Miss H had been returned home and was unable to get out of her wheelchair and go upstairs to her room. They advised him to contact out of hours provision which he did and was subsequently advised to ring an ambulance. The ambulance service referred him back to out of hours.

1.7 At 10.36pm, Ambulance service received a further call from the out of hours service and a health care professional arranged a 4 hour transfer window for Miss H.

1.8 At 4.18am, Miss H returned to A&E and was seen by a doctor who referred her to the medical team and admission to the Acute Medical Unit. Unfortunately, there were no beds available and she was therefore referred to physiotherapy and a social worker.

1.9 At 2.30pm, Community Service records indicate that although physiotherapy had found no evidence of injury they concluded that discharge would be unsafe, as Miss H was not weight bearing. Miss H was referred to Adult Social Care for a temporary appropriate safe residence to be located.

1.10 Throughout the 10 hours that Miss H spent in A&E, there is no record of any food or drink being offered to her, however, she was given fluids intravenously.

1.11 At 9pm, Miss H arrived at Supported Living accommodation - AL2. She was accompanied by AL1 staff, who brought a change of clothes. These were placed in the wardrobe of the Miss H's allocated room, however a breakdown in communication resulted in staff at AL2 being unaware of this.

1.12 After the departure of the carers from AL1, the staff at AL2 struggled to cope with Miss H. She refused to allow them to provide her with personal care, despite being incontinent of urine and subsequently spent the night sat in a chair.

1.13 On 23rd March 2017 at 8.40am, a member of staff from AL2 staff telephoned Community Services to discuss Miss H's case and their concerns. This member of staff knew Miss H from previously working at AL1 and records indicate she was able to settle Miss H. The carer was concerned as Miss H had not passed urine since the night before and noted although she appeared dry she had arrived in wet clothes.

1.14 At 10.30am, a carer noticed Miss H had been incontinent of urine and took her to the bathroom; however, she refused to allow the carer to administer personal care. The carer was unaware of the clean clothes and contacted AL1 to request these. At around 2pm, assisted by staff from AL1, Miss H was provided with personal care and it was noted that she had bruising around the area of her hip.

1.15 Over the following days, Miss H continued to display unsettled behaviour and a reluctance to walk. Staff continued to provide care for Miss H, however it is clear from her notes, that at times she was reportedly uncooperative and uncomfortable.

1.16 On 31st March 2017, Miss H attended her GP surgery. Miss H was well known to her GP and he requested an urgent pelvis x-ray.

1.17 On 3rd April 2017, hospital records indicate that Miss H had attended for an x-ray, however no obvious fracture of the pelvis was identified at this point.

1.18 On 10th April 2017, Miss H attended her GP Practice and her GP identified that the x-ray was suggestive of a pubic ramus fracture. This was the first identification of a fracture. Miss H was prescribed analgesia and informed that healing time could take up to 6 weeks.

1.19 On 25th April 2017 it was agreed at an MDT held in the GP Practice to have a repeat x-ray to confirm fracture status.

1.20 On 11th May 2017, the x-ray was repeated and this confirmed that there was a large fracture through the right iliac wing.

1.21 Over the following weeks Miss H's condition improved and she appeared more settled in AL2. The only issue of note was on the 24th May 2017 when AL2 staff failed to take her for an appointment with the fracture clinic.

1.22 Miss H was eventually returned back to AL1 where she continued to improve.

2. Terms of Reference:

2.1 problem or issues to be addressed:

- Were the actions taken once D displayed reluctance/ability to weight bear appropriate
- Was the care and support provided during D's attendance at hospital satisfactory
- Was the medical assessment of D correct and sufficient
- Did D's LD affect her treatment and care
- Was D's hospital discharge appropriate in both cases
- Was the care and support post discharge after the second admission satisfactory

This review is to determine if the care provided and actions taken were appropriate and in line with current guidance/protocol.

2.2 Who commissioned the review (and at which level in the organisation):

- Director of adult social services on the recommendation of the Safeguarding Adult Board, Safeguarding Adult Review Group Chair.

2.3 Review panel/ Contributing Authors

- Designated Nurse for Safeguarding - CCG
- Head of Safeguarding – Hospital Trust
- Head of Safeguarding – Safeguarding Adults Team
- Chief Nurse - Community Health and Social Care Services
- Manager for MENCAP
- Manager - AL1
- Contracts Officer, CCG
- Assistant Practice Manager - GP Practice
- Specialist Nurse for Safeguarding - CCG
- SAB Business Manager & DASM – Local Authority
- Specialist Business Support Officer – Local Authority

2.4 **Aims and objectives of the review and desired outputs:**

- To understand how and why the incidents occurred.
- To review the circumstances pertaining to the episode of care to be able to establish the facts and contributory factors.
- Report on and record the outcomes of the investigation to all key stakeholders
- Determine how the learning can be shared from this incident

Desired Outputs:

- To identify any changes required to existing processes or any new processes which need to be implemented.
- To minimise the risk of recurrence.

2.5 Scope and boundaries beyond which the review should not go (e.g. disciplinary process):

- The incident review will focus on 'what went wrong, not who went wrong'. However, any emerging performance or capability concerns will be managed in accordance with individual agencies policies and procedures.
- This will be an inclusive review with all agencies involved members of the review team.
- The review will focus on the episode of care leading up to and after the incidents.
- Chronologies have already been provided by agencies prior to this review.
- Information sharing arrangements: All requests for information in relation to this incident will be dealt with in a timely manner and sent via the recommended and secure email domains.
- Any disagreements between the two parties which are not resolved through the joint meetings will be escalated to the Director of adult social services as the commissioner of the review.

3. Incident Review & Methodology:

3.1 Detailed chronologies were requested from each organisation involved and these were reviewed by the SAR, SILP and GP Group. The incident was then reviewed by a panel consisting of all the agencies involved utilising the timeline to identify the care/service delivery problems, contributory factors and the root cause(s).

3.2 In accordance with the Care Act Guidance, the review focused on "what went wrong" not "who went wrong" and for this reason the report has been anonymised although job roles are described to ensure that there is a context to the report.

3.3 Information used during the investigation included:

- Acute Hospital nursing and medical records
- Miss H's GP records
- Miss H's assisted living home records
- Community Services Records
- Ambulance records
- Adult Social Care safeguarding records
- SAB Multi-Agency Policies

4. Findings:

The review team identified the following:

- Clinical professionals were unaware of Miss H’s support needs and situation in AL1. The impact of Miss H’s inability to mobilise was given no due regard on her first hospital discharge. The carer’s objection to this discharge was not listened to or considered by the hospital staff

- Investigations in A&E focussed on a possible chest infection whilst no further explorations were undertaken to offer a differential diagnosis for the sudden immobility

- Upon the first discharge, Miss H was left in an inappropriate setting with no ability to move from a chair. This was not escalated or reported by the patient transport team

- No fracture was initially reported by the hospital. This caused a delay in the diagnosis of Miss H’s condition. This was reviewed internally by the hospital Radiology department

- Communication between residential providers had broken down, leading to the staff losing focus of Miss H needs

5. Contributing factors identified:

5.1 Contributing factors which resulted in this case were identified as:

- Miss H’s inability to communicate independently – Miss H was reliant on carers to convey her problems and advocate on her behalf

- Carer’s opinions and concerns not given sufficient credence and consideration by clinical professionals during diagnosis and discharge processes. As they were advocating on Miss H’s behalf, essentially the carers were Miss H’s voice

- Miss H’s immobility was given a secondary focus during the diagnosis – primary focus was given to the “chest infection” and the immobility was almost discounted from the diagnostic process

- Hospital staff hold assumptions rather than a clear understanding of supported living arrangements and the role and responsibility of the carers within these residences

- There is no clear “escalation process” to enable the concerns of carers to be escalated to relevant hospital staff

- Process driven tasks, such as patient transport, resulted in Miss H being left in a totally unsuitable location, followed by a 7 hour wait to be returned to hospital with no escalation of concern

- Inaccurate record keeping and sharing was not helpful, as the Miss H’s initial diagnosis was incorrectly relayed as a UTI, URTI and an chest infection within different organisational records

- Capacity assessments and best interest processes were not utilised or recorded within any of the documentation presented for this review

7. Notable practice:

7.1 The GP’s diagnosis of the fracture was excellent practice, as no fracture had been previously reported through the hospital.

7.2 AL1’s advocacy for Miss H and their efforts to challenge the poor discharge practice as well as the support they provided Miss H demonstrated a clear commitment to her care.

7.3 In response to this incident, AL1 recognised that they were unable to support Miss H during her immobility. To prevent any possible reoccurrence of this situation, the provider purchased a bungalow to ensure they are able to continuously meet the needs of their long term residents should their mobility decreases, which is a very positive development.

7.3 The ongoing work of AL1 and hospital staff to raise awareness and support staff to positively assist service users with a learning disability, is worthy of note.

8. Key Learning Points and Recommendations

8.1 Carers opinions should be actively sought and credence given to them during admission, diagnostic processes and discharge planning of service users with learning disabilities, particularly those who are non-verbal.

8.2 Recording keeping and documentation must be accurate. Relaying incorrect information as to a service user’s diagnosis could have serious consequences.

8.3 There is an apparent lack of understanding, and often assumptions are made by hospital staff as to the different levels of supported living arrangements which are available. Incorrect assumptions are often made of the roles and responsibilities of care provided by supported living staff. This can incorrectly influence discharge planning for patients residing in supported living placements.

8.4 There needs to be a clear, approved pathway for carers to escalate concerns with hospital staff. This could prevent unsafe discharges preventing further distress to often vulnerable service users.

8.5 Patient transport services require clear guidelines to provide a directive for cases such as this, when patients is left in unsafe/ unsuitable circumstances.

9. Conclusion:

9.1 Regrettably this distressful and painful experience for Miss H was the result of a culmination of errors and failings.

9.2 As carers did not know how if Miss H had an injury, or indeed how Miss H might have received her injury, they were unable to initially direct medical professionals to a possible cause of her presenting immobility. This was a contributing factor to medical staff concentrating on her chest infection and no further consideration or exploration of Miss H’s lack of mobility.

9.3 The failure of medical staff to comprehend the impact of Miss H’s inability to mobilise within her care setting and care arrangements at the time resulted in the first inappropriate return to her home setting and necessitated a further A&E attendance.

9.4 Although specific treatment was not forfeited due to the delay in diagnosing the fractured pelvis (confirmation has been received that conservative treatment would have been advised in this case), an earlier diagnosis of Miss H’s fractured pelvis would have enabled adequate pain management, supported appropriate residential placement, prevented further attendance at ECC, unnecessary journeys and afforded an overall improved outcome and experience for Miss H.