

# Wiltshire Safeguarding Adults Board

## Local Learning Review - Adult E

### Our review

This briefing outlines key themes and recommendations from a review carried out by the Wiltshire Safeguarding Adults Board.

The Care Act 2014 states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of, or is thought to have suffered, abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a SAR is to promote effective learning and improve action to prevent future deaths or serious harm occurring. The aim is to learn from serious incidents and improve the way agencies work together. The purpose is not to re-investigate an incident, nor is it to apportion blame - other processes exist for such investigations, including criminal proceedings and disciplinary procedures.

The methodology used for this review was our own Local Learning Review (LLR) process. Each organisation completed a report for the Board and these, along with other relevant information, were considered at desktop review session. That session was attended by those agencies and chaired by the Independent Chair of the WSAB. The Deputy Chair was provided by Wiltshire Police, an agency Adult E had no contact with. This report has been produced to capture that discussion and to share findings.

We encourage all those working with vulnerable adults, particularly those with learning disabilities, to read this briefing, and reflect on how you can challenge your own thinking and practice in order to better protect vulnerable adults.

This document includes a feedback sheet to capture how you have used this learning. This should be completed and returned to [LSAB@wiltshire.gov.uk](mailto:LSAB@wiltshire.gov.uk)

## **Executive summary**

WSAB received a referral from Wiltshire Council for a statutory review in June 2018. The SAR panel and the Chairman agreed that a review would be undertaken in July 2018. To reflect the fact that other analyses of the case were taking place, it was decided that a Local Learning Review was the most appropriate methodology.

Professionals referred this case to the Board because they had safeguarding concerns about Adult E's discharge from an acute hospital to a community hospital. After discharge from Royal United Hospital in Bath (RUH), to Savernake Community Hospital in Marlborough, Adult E was readmitted to Great Western Hospital (GWH), Swindon, the following day. Adult E died in GWH. The cause of death was Hospital-Acquired Pneumonia (HAP).

The review found that Adult E had received a good standard of care from health and social care professionals at times and, despite poor health, had been supported to live independently in the community. However, the review seeks to make recommendations to help ensure that agencies work together to protect those with learning disabilities by sharing information, through application of Making Safeguarding Personal (MSP), the Mental Capacity Act 2005 (MCA) and appropriate provision of advocacy services.

## **Background**

Several of the professionals involved in this review had worked closely with Adult E, either over the years or just in the last months of her life. At 67 years old, Adult E was described as jovial and determined and was generally quite active, although she had days when she did not want to engage with people.

Adult E had a learning disability, epilepsy, osteoporosis and scoliosis and was cared for in a supported living property. With the help of a care provider she was able to live as independently as possible and managed relatively well. However, Adult E's health began to decline and, in the last few months of her life, she was admitted to hospital on four occasions after fracturing her ankle, suffering from dehydration, having low food intake and reduced bowel movements. Adult E became less able to care for herself, even with support.

Following these four admissions, Adult E was admitted to RUH, discharged home and then readmitted following concerns that she was not eating, drinking or getting up from her seat. She was in RUH for just over a week before being discharged to Savernake Community Hospital. However, one day later, she was readmitted to GWH where she later died. The cause of death was Hospital-Acquired Pneumonia (HAP) with epilepsy, frailty and Learning Difficulties.

## **Other reviews**

As well as this review, a Learning Disabilities Mortality Review (LeDeR) is taking place. LeDeR reviews aim to improve the standard and quality of care specifically for people with learning disabilities. Locally a clinical review has been carried out by the RUH and an action plan is being implemented.

These reviews will assess clinical decisions made in relation to Adult E's discharge. This review adds broader learning about how agencies must work together to ensure that informed decisions are made to safeguard vulnerable adults in future.

## Findings

### 1. Adult E's healthcare and hospital stays

- 1.1 This case was referred to the Wiltshire Safeguarding Adults Board because professionals were concerned Adult E had been discharged too early from RUH to Savernake Community Hospital.

Following a fractured leg, Adult E was admitted to RUH because of concerns about leg pain and her reluctance to mobilise whilst wearing a cast, or eat at home. It is understood that, on this occasion, Adult E was admitted to an acute hospital because "no community hospital bed [was] available" at that time.

Nine days after admission to RUH, Adult E was transferred to Savernake Community Hospital. The last record of Adult E's National Early Warning Score (NEWS) at RUH showed a score of 4 - this was an increase of 1 from the morning score. The NEWS recommendation at the time was that the Registered Nurse must screen for sepsis if the score increased by 2 or more and consider increasing frequency of observations. The patient was on observations three times per day at the time of transfer.

On arrival at Savernake Community Hospital, Adult E is recorded as having a NEWS of 5. This score would indicate that she was not ready for discharge to a community hospital, however it is not known what her NEWS score at the time of discharge from RUH was, and no records were provided to the review to evidence that measurements were taken.

At Savernake Community Hospital the following morning, Adult E was assessed as having a NEWS score of 10 and was then taken by ambulance to GWH.

*"1.2 How Early Warning Scores work in practice: Patient's vital signs (blood pressure, pulse, respirations etc.) are routinely recorded in acute Hospitals. With the early warning score system, each vital sign is allocated a numerical score from 0 to 3, on a colour coded observation chart (a score of 0 is most desirable and a score of 3 is least desirable). These scores are added together and a total score is recorded which is their Early Warning Score. A trend can be seen whether the patient's condition is improving, with a lowering of the score or dis-improving, with an increase in the score. Care can be escalated to senior medical staff as appropriate."*

*Taken from National Clinical Guidance No. 1 2013*

The question of whether Adult E was medically fit for discharge will be considered as part of a Root Cause Analysis carried out by RUH and by a LeDeR Review. However, this review identified wider issues around the multi-disciplinary approach to safeguarding Adult E which impacted on that decision.

- 1.2 During the review, professionals who worked most closely with Adult E portrayed someone who could be quite independent and accessed the community, although she did have days when she was less inclined to do things for herself. This is essential to understand because, when Adult E was admitted to RUH, this understanding of what Adult E was usually able to do - or her baseline activity - appears to have been lost.

Healthcare Passports are designed to address this issue. Anyone with a learning disability can get a Healthcare Passport, which Adult E did. This document is:

*“...about you and your health needs. It also contains other useful information, such as your interests, likes, dislikes and preferred method of communication.”*

Professionals taking part in this review agreed that the Healthcare Passport is a “critical link”, particularly if a patient is moving from one healthcare setting to another. It provides a way for medical professionals to understand the person’s health in context i.e. what ‘well’ looks like for that individual. A Healthcare Passport can also provide the basis of a care plan.

The Initial Risk Assessments on arrival at RUH states that no passport was with the patient on admission, it was not indicated on the nursing plan that a passport was available, nor was this evident in the paper records. Consequently, Adult E’s Healthcare Passport did not follow her when she was discharged to Savernake Community Hospital. That meant it was harder for staff to see that Adult E was not behaving as she normally would have if she was well enough to be discharged from hospital.

*“The passport is their voice on a page”*  
Nursing Lead for Learning Disabilities, Hospital B

- 1.3 Diagnostic overshadowing describes a situation in which someone’s physical health needs are overshadowed by a mental health diagnosis. In this case, the failure to use the Healthcare Passport meant professionals believed that Adult E being lethargic and slow to respond may have been caused by her learning Disability rather than her deteriorating physical health.

However, it is important to note that whilst those taking part in the review stressed the difference the Healthcare Passport could make, there is no certainty that, on its own, it would have changed clinical decisions. In addition, review participants talked about a lack of wider communication between health and care providers during a time when Adult E was transferring in and out of hospitals. Poor communication from the hospitals to the care agency was a particular issue.

## **2. Caring for Adult E in the community**

- 2.1 Until the last few months of her life, Adult E was cared for in the community. She had support from a care agency although a new agency, Thera South West, had taken on that role in the last weeks of Adult E’s life.

Adult E was also in contact with some close family members, one of whom has been contacted as part of this review. Although the family member contacted did not want to take part in the review, she was able to tell the review team that it was difficult at times for both the family and carers to find out where Adult E was or what was happening to her when she was in hospital.

2.2 Before Adult E's discharge home from RUH, Thera South West staff expressed concerns that they could not provide the level of care needed to support her. Adult E did not seem herself - she was lethargic and wasn't eating or mobilising. However, hospital staff were reported to have contacted the care agency two or three times a day to say Adult E was ready for discharge. Care agency staff report feeling pressurised and a member of staff told the review "I felt like I was bed blocking... preventing someone from coming home". There appears to have been an impetus to help Adult E return home at a pace which is not supported by adequate assessment of Adult E's ability to make decisions in her own best interests, or by her family's or carers' wishes.

2.3 Those attending the review were also concerned that:

- a) Whilst in the RUH, Adult E underwent surgery after dislocating her ankle. Care agency staff were only advised after the operation had taken place.
- b) Care agency staff had asked Wiltshire Health and Care, the community health provider, for an Occupational Therapy assessment of Adult E's home to ensure the equipment there allowed them to better support her. This was not carried out.
- c) The Learning Disability Nurse at the hospital was not made aware Adult E was in hospital until a late stage. Key agencies represented at the review were not aware that they were required to inform the Learning Disability Nurse.

*"There is learning for us here. We need to contact the [Learning Disability Nurse] when someone with a Learning Disability comes in as an inpatient." Community Care Provider*

- d) Adult E's siblings were taken to hospital by the care agency when her health seriously deteriorated. When family members arrived at GWH, they did not know they had been asked to attend to make a decision about the withdrawal of medical care from Adult E.

### **3. Adult E's point of view**

3.1 Whilst Adult E was in RUH, Thera South West staff visited her despite commissioning arrangements meaning that they were not paid for this work. Where a domiciliary care package is in place, staff are paid for care provided in the community but are not paid under that contract for providing care in a hospital setting. Costs for care provided in a hospital setting are usually met by the Clinical Commissioning Group but no payment was made in this case. The review was told that hospitals can be reluctant to allow external care agencies to come in to provide professional care to a patient which they may be left to

pay for. However, arrangements can be put in place to enable external care workers to support patients on wards.

In this case, the provision of therapeutic care from those carers Adult E knew best only happened because the care agency was prepared to visit Adult E in hospital without promise of payment, to ensure that they retained contact with her. The presence of a familiar care worker in hospital was of particular importance in this case because the local advocacy service does not provide services to patients in RUH. RUH is in a different Local Authority area and therefore served by a different advocacy service. By the time a referral had been made and Adult E was offered advocacy support from the local advocacy provider, she had been discharged from the hospital's care.

- 3.2 Under the Mental Capacity Act (2005) the Local Authority has a responsibility to provide an Independent Mental Capacity Advocate (IMCA) and:

*“Local authorities and NHS bodies are expected to have a policy setting out the criteria for deciding whether an IMCA should be instructed to represent and support a person involved in safeguarding adults proceedings.”*

However, after repeated assessments at the RUH found that the patient had capacity to make a decision about discharge to a community hospital it was considered an IMCA was not required at this time.

#### **4. Mental capacity**

- 4.1 Agencies report missed opportunities in assessing Adult E's capacity to make decisions. Informal assessments took place but the formal assessments, which would have given agencies a legal framework for supporting Adult E, were not carried out at the time of discharge.

It was agreed that Adult E did not have capacity to make complex decisions but advocacy services were not made available at the right times in order to support this decision. It was also noted there was a tendency for staff across agencies to talk about an individual either having capacity or not having capacity rather than viewing capacity in terms of specific decision-making ability.

The lack of a formal capacity assessment on discharge was described as a “missed opportunity”. It was also noted that Deprivation of Liberty Safeguards (DoLs) may have applied to Adult E.

#### **5. Safeguarding Adult E**

- 5.1 A safeguarding concern was raised by RUH because Adult E was severely dehydrated on admission. Wiltshire Council's safeguarding team made enquiries and spoke to Thera South West. They found that everything was being done to encourage Adult E to drink plenty of fluids.

- 5.2 Adult E was prescribed pain relief after surgery at RUH. There is no record of a review of this pain management medication and it is uncertain whether Adult E was taking the medication as prescribed. There were conflicting views on whether Adult E responded well to codeine and the review was told that she had been prescribed laxatives, indicating that constipation may have caused additional pain. Pain levels were not consistently recorded on Adult E's NEWS chart and it is not clear whether this is because at times she was lethargic and not able to verbally express herself.
- 5.3 It was considered that the decision to discharge Adult E to a community setting may suggest a misunderstanding of what the provision of home care on a 24-hour basis means. Adult E had a supported living placement which review participants were keen to stress does not include nursing care. There was a view that there needs to be better understanding of community placements and how well those settings can safeguard a patient who requires nursing care from harm.
- 5.4 A second safeguarding referral was made and another Section 42 enquiry carried out following concerns about Adult E's discharge from Chippenham Community Hospital. Professionals from all the agencies involved met to review these concerns. Wiltshire Health and Care manages referrals into community services and intermediate care, and this service also managed Adult E's referral into Savernake Community Hospital. The second enquiry revealed that the information held by this service did not adequately reflect Adult E's 'baseline' - her ability to care for herself. The enquiry also found that better understanding of the communication and behaviour changes which may indicate a change in condition of someone with a learning disability would have helped safeguard Adult E.



# Key Themes and Recommendations

## Good practice

Whilst this review largely focuses on the areas of practice where we can make improvements, it should also be noted that:

- The review brought together a group of professionals, many of whom knew Adult E and others who knew her case well. Some of those involved had worked very closely with Adult E and all wanted to provide her with a high standard of care - this is evident in the role of Thera South West who visited Adult E in hospital, from the conversation with the GP who had known Adult E for decades and in the determination of social care for this case review to take place.
- The domiciliary care agency did do specific assessments of mental capacity, for example, finding that Adult E had capacity around choosing food and clothes, her ability to wash up and go to the toilet, but not around taking medication.
- On admission to GWH, “all efforts were made to save Adult E’s life”. The hospital had a pre-arrival alert that Adult E had sepsis and she was put on a pathway of treatment in line with national guidance and best practice.
- Adult E had experienced a generally high standard of care in the community. Her GP told the review that he “always felt the carers were caring in the truest sense”.
- Despite failures in the communications between agencies, the review did evidence notable dialogue between partner agencies about Adult E’s needs and how these should be met. For example, there was a meeting between RUH staff and other agencies about how the hospital staff could engage with Adult E more to establish her needs.



## Challenges for the partnership

Wiltshire Safeguarding Adults Board brings together key partners who are collectively responsible for safeguarding adults in Wiltshire, under the Care Act 2014. The most important function of the Board is to improve the way that services work together to protect adults at risk. Single agency actions have been addressed through single agency reviews. This review seeks then to identify specific points of action and learning for local partners to improve the way they work together.

## Recommendations

Where a patient has a diagnosed Learning Disability:

1. **Should a patient who is receipt of community care be admitted to hospital, there should be effective communication between the hospital and both the home care provider and patient's family.** Hospitals should identify a key named person – who can be the main point of contact during a hospital stay or on discharge. That contact must be willing and able to communicate with those individuals and organisations who provide care and support to the adult at risk in the community. The three acute Trusts who are members of WSAB should respond to this review by assuring the Board that existing or new plans will facilitate best practice in terms of identifying and communicating with those who provide care in the community.
2. Healthcare Passports are there to help professionals safeguard an adult at risk. **The Board should share information about Healthcare Passports with all agencies and undertake evaluation of current usage.** This should form part of a learning briefing which helps to increase understanding of diagnostic overshadowing and the importance of understanding a patient's baseline patterns of activity when assessing health needs.
3. **Greater use should be made of the Learning Disability Nurse role,** particularly in providing assurance that the hospital has considered the information provided on the Healthcare Passport. Hospital Trusts and Community Health and Care providers will be asked to evidence better engagement of this role. Adult Social Care and hospital staff need to be informed and reminded that they have a duty to inform a person's Learning Disability Nurse, if the individual is admitted to hospital.
4. **Commissioning arrangements should ensure that on admission to hospital, and in the absence of regular contact with family or close friends, regular carer workers are enabled to visit the adult at risk to provide consistency and therapeutic care.** Commissioners should evidence how this will be supported and inform provider agencies in order to remove barriers to effective care.
5. **Geographical provision of advocacy services should not leave those who are entitled to provision without an advocate to speak on their behalf.** Arrangements should be in place to ensure Wiltshire residents accessing hospital services in all local hospitals, including those in neighbouring Local

Authorities, can access advocacy services. Commissioners are asked to consider arrangements and provide the Board's Quality Assurance Sub-Group with assurance that those arrangements do not cause delays that leave patients unsupported in acute settings.

6. **The Board has undertaken three other reviews which highlight the need for improved application of the Mental Capacity Act (2005).** If Adult E was assessed not to have capacity to understand her own needs, a best interest decision could have been made before discharge. The new Multi-Agency Safeguarding Hub should arrive at plans to ensure professionals who raise safeguarding referrals have considered the application of the Act and that appropriate assessments have been or are carried out.
7. The learning from the is review should be reconsidered on the publication of the LeDeR review to ensure that the Board actively supports implementation of all available learning.

# Feedback

To further help us share this learning, please complete the short form below and send back to us at [lsab@wiltshire.gov.uk](mailto:lsab@wiltshire.gov.uk).

|   |             |
|---|-------------|
| <b>Name</b>   | <b>Date</b> |
| <b>Job title</b>  |             |
| <b>Agency</b>   |             |
|   |             |
| <b>Who was this briefing cascaded to (e.g. District Nurses, Social Workers)?</b>                                    |             |
|   |             |
| <b>Where was this briefing used (e.g. 1:1/group supervision, team meeting, training event with how many staff)?</b> |             |
|   |             |
| <b>Changes to your organisation's practice following the learning:</b>  |             |
| 1.  |             |
| 2.  |             |
| 3.  |             |
| 4.  |             |
| 5.  |             |
| <b>Other feedback:</b>  |             |
|   |             |