Trafford Strategic Safeguarding Board

PRACTITIONER LEARNING EVENT

Purpose of a Safeguarding Adults Review

- Promote effective learning and improvement action to prevent future deaths or serious harm occurring again.
- Provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.
- Explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

Timeframe for the SAR

A period of 10 months.

Significant events which took place prior to the start date should also be included within the scope of the review.

Lines of Enquiry – John's Voice

- Did practitioners listen to the voice of John? Were his wishes and feelings heard and understood?
- Did John have/should John have had access to advocacy? As an unbefriended person how effectively was John supported? Were there any missed opportunities for advocacy support?

Lines of Enquiry – MCA/DoLS

- Did practitioners work with John in accordance with the principles of the Mental Capacity Act? Did practitioners act in John’s best interests?
- Was John deprived of his liberty during the time period covered by the SAR? If a deprivation occurred, was this managed in accordance with relevant statutory frameworks and practice guidance?
- To what extent were safeguarding adults procedures followed in John’s case?

Lines of Enquiry - Medication

- John’s GP responded to changes in John’s presentation by altering his medication. Were the reasons for the changes in John’s presentation fully explored and were alternatives to altering his medication fully considered?
- Did agencies consider the impact of changes in medication for John on his care and support needs, particularly any increased risk of falls?

Lines of Enquiry – John’s placement

- How appropriate was John’s placement? Did the care and support provided to John in his placement fully meet his needs? Was the physical environment of the placement appropriate for John? What action was taken by the provider when John began to fall repeatedly in the placement, including any contact with the commissioner of the placement?

Lines of Enquiry – Hospital Care

- How effective were agencies in considering the needs of John when it was necessary to place him in an out of area hospital following the Manchester Arena attack?
- When John suffered significant injuries, apparently as a result of falls, were those injuries recognised, documented and treated appropriately?
- How effective was discharge planning from hospitals for John?

Lines of Enquiry

- How effective was information sharing between agencies involved in providing treatment, care and support for John?
- To what extent were agency interventions with John informed by relevant prior concerns?
- To what extent did agencies make reasonable adjustments for John, given his learning disability?

‘John’

- Diagnosis of learning disability and schizophrenia
- Specific needs around communication. He could easily be misunderstood by people who do not know him well.
- Finds changes of routine difficult and becomes frustrated if he feels too restricted.
- He finds health appointments difficult, particularly injections.

‘John’

- Did not directly contribute to the SAR due to cognitive impairment and mental health issues. It was also thought that he may find the process quite stressful.
- His advocate shared insights with the SAR on his behalf.
- He told her that he fell down the stairs and broke his neck, that he was in hospital for a couple of months and that they treated him horribly.
- A support worker says health appointments make him more agitated and upset now.

Case Overview – earlier events

- Supported by care provider.
- 24 hour support to John and another service user within Trafford.
- During 2014 – ‘had a few falls due to mobility’.
- During 2015 – referred for assessment for walking aids because of shuffling gait. Placed on physio waiting list two months later.
- During 2016 – taken by ambulance to MRI after fall at home and sustaining laceration to head. Not admitted.

Case Overview – earlier events

- 2016 – CLDT (social work) assessment – lost motivation, become verbally abusive, appeared gaunt and having trouble sleeping. Was to be referred to CMHT but no record of this happening.
- 2016– CLDT physio tried to contact John's care provider about the 2015 physio referral but received no reply and John was discharged.

Case Overview – over medication

- During 2017 – saw GP as was not sleeping. Oxazepam increased from 10mg to 15mg.
- Later that year – saw GP as ‘hyperactive’ at night. Oxazepam increased from 15mg to 20mg for one month. Prior repeat prescription of Oxazepam 15mg not cancelled and so John took 35mg daily for 2 weeks.
- A fortnight later – taken to TGH urgent care centre over excessive sleeping concerns. UCC doctor reduced Oxazepam to 20mg.

Case Overview – first hospital admission

- Admitted to MRI after falling from sofa and suffering head injury. Earlier fall ‘three weeks earlier’ mentioned. CT scan disclosed acute on chronic subdural haematoma. To be transferred to Salford Royal Neurosurgery. Safeguarding referral to be made re lack of medical attention to earlier fall.
- Diverted to Royal Preston after Manchester Arena attack. CLDT (health) and care provider aware.
- John had a mini craniotomy and plan was to transfer him back to a Manchester hospital.

Case Overview – first hospital discharge

- John discharged home from Royal Preston.

➢ OT assessment indicated back to prior baseline.

➢ Physio observed John mobilising and decided no follow up required.

➢ Neuro observation – needed supervision when walking to bathroom.

➢ Care provider transported him home. CLDT (health) advised of discharge.

Case Overview – second hospital admission

- 2 days after discharge from Royal Preston – John fell down stairs at home, striking his head multiple times. Taken to Salford Royal by ambulance. Admitted and CT Scan disclosed subdural haematoma and fractures. Admitted to Trauma Assessment Unit. Safeguarding referral submitted to Trafford Council where it was noted.
- Hospital OT and carer concluded that John back to prior baseline.
- After arriving home not complying with bed rest or wearing of cervical collar.

Case Overview – second hospital discharge

- Concern over whether staying in hospital environment was good for John.

- Hospital physio assessed he was at high risk of falls.
- Moving him to downstairs bedroom 'so he wouldn't have to use stairs' was discussed with CLDT (health).
- No ill effects from his fall were noted and he was discharged home.

Case Overview – third hospital admission

- Day after hospital discharge– John fell out of bed and taken to Salford Royal by ambulance. Admitted as fall had re-opened surgical head wound.
- Verbally and physically aggressive to staff. Seen by mental health liaison team which attributed John's aggression to unfamiliar setting/staff.
- Care provider requested to support John whilst in hospital. Care provider made a safeguarding referral but NFA.

Case Overview – third hospital discharge

- Care provider contacted CLDT (social care) to say that John's falls indicated change in care needs. Mattress to be placed on first floor bedroom floor as interim measure. Increase in support hours to be discussed.
- Discharged home on the same day. 'Wasteful' to keep John in an acute bed. Social care concerns could be resolved in the community. CLDT (social care) to make home visit.

Case Overview – fourth hospital admission

- CLDT (social care) home visit. Referral to physiotherapy for falls management and extra bannister to be fitted to stairs.
- A few days after discharge from Salford Royal) – taken to Salford Royal by ambulance after becoming unsteady and unable to bear weight. Admitted. No surgical intervention necessary and condition to be managed with cervical collar.
- Discharge planning meeting decided to repatriate John to TGH for complex discharge planning.

Case Overview – fourth hospital discharge

- John transferred to TGH and moved to complex discharge unit.
- Safeguarding referral made in respect of initial MRI admission
- John’s placement no longer suitable and ground level alternatives sought.
- Whilst in hospital, John’s agitation increased and there were several incidents involving aggression and/or violence towards staff.
- A month later, John discharged to temporary alternative placement, where the care provider would support him 1:1.

Case Overview – Mental Capacity

- Preston Royal – No MCA or Best Interests
- Salford Royal - No MCA during first admission, some MCA during second and third admissions. Repeat MCA appeared to have been cut and pasted. No Best Interests discussions during any of admissions.
- Trafford General – missed opportunities for MCA and MCA re final discharge challenged and repeated.

Case Overview – Deprivation of Liberty

- Royal Preston – no DoLS as John's admission not prolonged, not wandersome, did not object and no restrictions necessary
- Salford Royal – no DoLS for any of three admissions. First two admissions relatively brief but DoLS should have been completed for longer third admission.
- Trafford General – no DoLS until submitted after 3 weeks

Case Overview – Good Practice

- Care provider taking John to urgent care centre following concerns about excessive sleepiness.
- Salford Royal referral to mental health liaison to better understand why John was agitated in hospital
- Care provider support to John whilst in hospital.
- Managing John's discharge within TGH complex discharge unit

Learning Themes – John's voice

- Not prominent.
- Majority of colleagues involved in his care didn't know him well
- Staff found it difficult to communicate with him or assess the level of pain he was experiencing
- Relevant prior incidents not always communicated by carers
- When regular carers arrived in hospital, he became more settled
- No patient passport until TGH transfer

Learning Themes - Advocacy

- Advocacy (IMCA) not considered by Royal Preston or Salford Royal
- TGH referred John for advocacy but there was a waiting list and difficulty experienced in providing IMCA support at the right times.
- Carers from the care provider advocated for John but may have needed more support to do this consistently.

Learning Themes - MCA

- John’s learning disability recognised by hospital staff but impact of this on his capacity to consent to care & treatment etc. often not considered.
- Consent often inferred by hospital staff because John did not object.
- MCA may have been misunderstood by some hospital staff as applying primarily to patients deemed uncooperative or attempting to leave.

Learning Themes - DoLS

- Hospitals reacted to challenges of DoLS in subtly different ways
- Omission of MCA assessments, Best Interests meetings, IMCA referrals left John in quite a powerless situation

Learning Themes – Safeguarding Adults Procedures

- Safeguarding referral following John's admission to MRI and transfer to Royal Preston overlooked.
- Safeguarding referral submitted by Salford Royal not logged locally and therefore not followed up.
- Care provider, then TGH submitted further referrals.
- Trafford ASC did not follow policy and the referrals absorbed into overall response to John's case.

Learning Themes -medication

- Were John’s symptoms fully considered by his GP before the dosage of Oxazepam was increased?
- The potential increase in falls risk of increasing the medication does not appear to have been considered.
- Very concerning that John’s repeat prescription of 15mg Oxazepam not discontinued which put John’s life at risk.
- Care providers did not question the situation although they took him to the UCC when concerns about excessive sleeping arose.

Learning Themes – placement suitability

- John’s risk of falling identified around 6 years ago.
- ‘A few falls’ were responded to the following year and concerns about his mobility led to a physiotherapy referral a year later but after waiting for 10 months, his carers did not take him to the appointments.
- A fall 3 years ago was not followed up.
- Measures to reduce his falls risk were not put in place quickly when his admissions to hospitals began.
- Falls recording and falls risk assessment was deficient.

Learning Themes – Discharge Planning

- In a period of 7 days, John was readmitted to hospital three times shortly after being discharged.
- Considered to medically fit for discharge on each occasion.
- Lack of:
  - attention to the mechanism of injury
  - curiosity about the risks John may be exposed to in his placement.
  - attention to prior safeguarding concerns

Learning Themes – discharge planning

- Hospital and community services operate at a different pace
- Challenging to co-ordinate efforts of CLDT (health), (social care), care provider and commissioner
- Recognised that unnecessarily prolonging John's hospital admission would increase his agitation
- Lack of clarity over how to commission care provider support in hospital
- TGH not an acute hospital so Trafford residents often discharged from out of area hospitals.

Learning Themes – Reasonable Adjustments

- All public authorities must make reasonable adjustments to ensure their services are accessible and effective.
- TGH commissioned the care provider to supply carers familiar to John
- TGH used a patient passport to inform care planning for John
- Post traumatic amnesia assessment not carried out as John unable to answer questions.
- John provided with major trauma leaflet as unable to understand information provided by trauma co-Ordinator.

Changes arising from the SAR

- Monitor & analyse unsafe hospital discharges and admissions
- Ensure effectiveness of links between CLDT and out of area hospitals so that patients with a learning disability receive necessary support
- Ensure local safeguarding processes triggered by falls and that necessary professionals meetings taking place
- Task & Finish group to work up plan for provision of support for adults with a learning disability when in an acute setting.

Changes arising from the SAR

- Self assessment i-tool for providers to include additional questions re falls policy & practice
- CCG and GP practice meeting to address errors in prescribing
- Learning from SAR in respect of MCA to be shared with each acute hospital
- Action plan requested from acute trusts re DoLS and advocacy support.

Changes arising from the SAR

- Patient passports – range of measures to ensure they are initiated and maintained for all adults with learning disability.
- SAR shared with agencies to ensure reasonable adjustments in place.

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MOHANDAS GANDHI