Learning Together from Significant Case Reviews (SCRs): Mr A – serious injury and complex frailty

The Perth and Kinross Adult Protection Committee (APC) has recently completed a Significant Case Review (SCR) which explored the circumstances leading up to the death of an 85 year old man, who is referred to in the report as Mr A.

This briefing summarises the key findings and improvement actions that the APC will be taking forward in response to this SCR.

Sharing learning is a key priority of the Perth & Kinross APC.
This includes developing strategic learning across the multi-agency partnership and learning from national best practice and SCRs.

All staff and managers are encouraged to discuss this briefing and reflect on the findings, to ensure that the learning outcomes are used to consolidate existing best practice and make improvements where required.

Background to the Review:

Mr A died at the age of 85 having had involvement with a number of services and professionals in the 3 month period leading up to his death. Mr A was identified as an 'adult at risk' in December 2018.

Following Mr A's death, the Perth and Kinross Adult Protection Committee received a request for consideration of an Initial Case Review (ICR) on the grounds that Mr A was in receipt of services, was an adult at risk and that Mr A's experience of services provided an opportunity to learn and improve how we work. Following completion of an Initial Case Review (ICR), the Perth and Kinross APC agreed a SCR was necessary to explore key events leading up to Mr A's death.

The Perth and Kinross APC's goal is to share learning from this review by identifying best practice and that this is built upon and ultimately improvements are made to support positive outcomes for vulnerable adults.

Family views
Throughout the SCR contributions have been sought from the family and they have been kept informed of key aspects and progress.

Key findings

Research Question 1: Explore the effectiveness of multi-agency working on admission and discharge from in-patient care.

The importance of discharge planning and information sharing were highlighted as key requirements for the promotion of person centred care.

Improvement in communication between the acute hospital and the residential care home, as well as district nursing and primary care were identified as essential to minimise unplanned admissions and support person centred care. NHS Tayside does not have an up to date Admission and Discharge Policy which sets out roles and key principles, which contributed to poor documentation and transition of care.

The acute hospital now has enhanced daily multi-disciplinary discussions to facilitate information sharing and effective discharge planning.

Research Question 2: Explore the barriers and challenges that were experienced by staff in hospital setting in relation to adherence to policies and consistency across ward areas.

A range of clinical policies are available within NHST, however adherence to and a knowledge of these was inconsistent.

There was lack of recognition in both residential care home and acute services staff around assessment and escalation to reflect changes in the physical condition in someone with complex needs. This has highlighted a need for a range of training and development across the multi-agency workforce.

Improvement work was undertaken within the acute hospital and care setting to support the management of pressure ulcers and changes in clinical presentation. The review has highlighted the requirement for further work around assessment and escalation of physical and mental health in individuals with complex needs.

Research Question 3: Explore the governance structure in hospital setting to ensure improvements are implemented, embedded and regularly reviewed to provide assurance that changes are sustainable.

It was recognised that at the time of this incident, not all staff within the clinical setting were up to date with the knowledge and skills required for safe pressure ulcer care and that this did not comply with the NHST policy. It is recognised that a recent restructuring of the clinical team, less reliance on use of agency staff and the reintroduction of monthly clinical and care governance meetings have delivered improvements. In addition, the senior nurses meet to discuss the data from the pressure ulcer audits and identify improvement actions.

The introduction of clinical and care governance meetings and forums represents a modernisation of the approach to quality assurance and will require to be sustained over a period of time and monitored by senior managers and clinicians.

Research Question 4: Explore who retains responsibility for the care of a person with complex issues when discharged to the community or care setting.

There was a lack of professional curiosity within the residential care home following a number of unwitnessed falls by Mr A, a deterioration in his mobility and a change in general presentation and behaviour. There was no evidence to support how any of this was escalated, reviewed or monitored.

The quality of handovers and documentation in both hospital and care settings was variable and did not always reflect changes in care needs.

In line with changes to the GP contract, responsibility for identifying and escalating any health needs sits with the wider multi-disciplinary care team. This recognises that complexity of care is often too great for carers to manage without specialist support and input.

The review recommends future training opportunities for all staff should consider how all agencies work together effectively with an awareness of each other's roles and responsibilities.

The use of Anticipatory Care Plans (ACPs) should be further developed to ensure adults are able to share their personal values and preferences regarding their care.

Improvement Actions:

An improvement plan has been developed by the APC to take forward the recommendations within this review and includes:

- Review current discharge arrangements and communications from inpatient hospital settings to ensure effective co-ordination and communication
- Consider how district nurses have greater clinical oversight of residents in care settings
- Review how NHS Tayside pressure ulcer policy is implemented within clinical settings
- Review the training requirements across the multi-agency workforce in relation to protective legislation and issues relating to the deteriorating patient
- Further consideration in relation to specialist input into care settings to ensure person centred care and provide additional support to care setting staff in relation to enhancing knowledge and skills

Further reading and resources

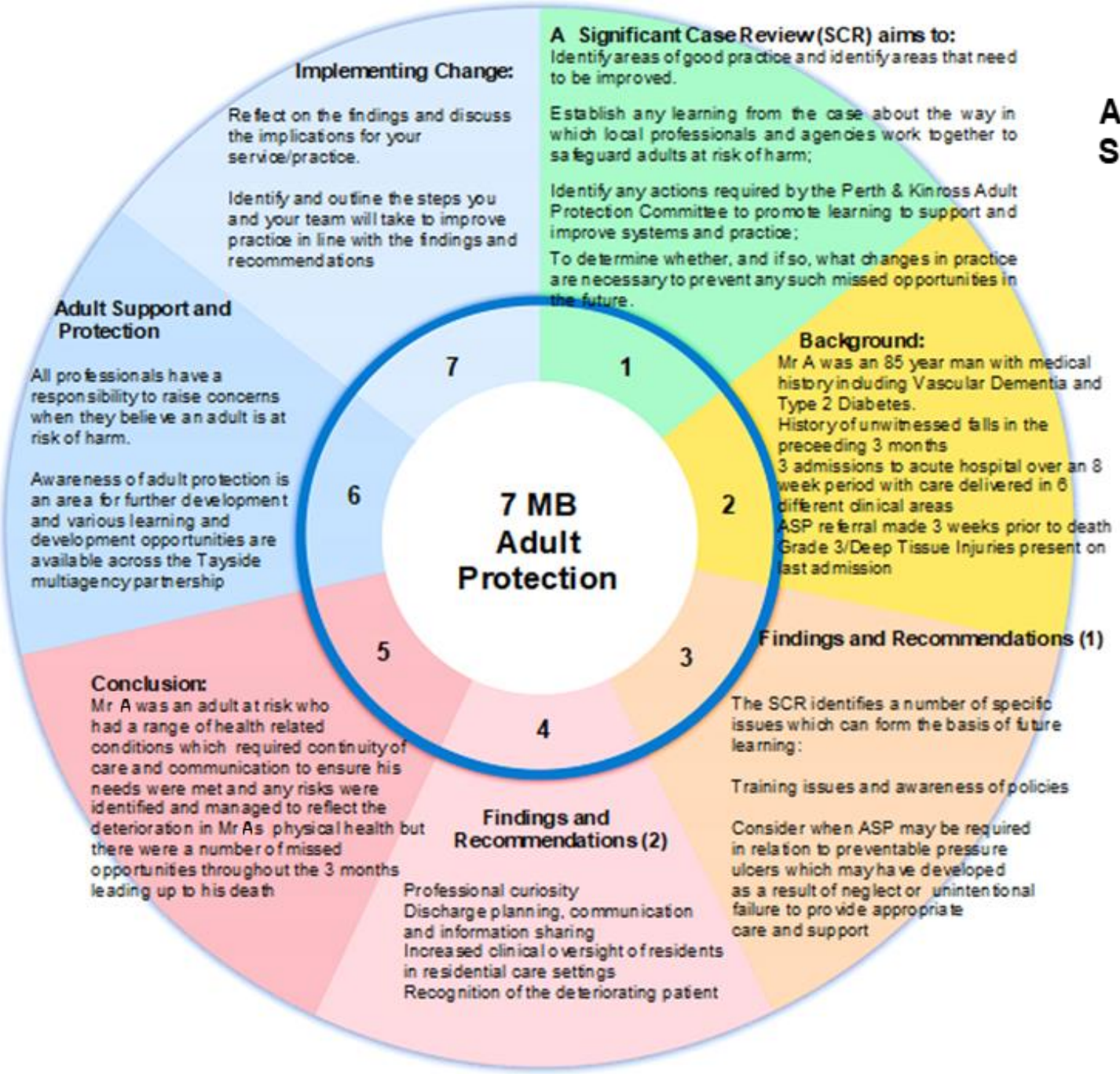
- Tayside Multiagency Guidance
- Tayside SCR Guidance (page 69)
- NHST Pressure Ulcer Policy

Across Tayside, there are a range of learning resources available to the multiagency workforce and further information is available via locality ASP leads and within Perth and Kinross here

All staff and managers are encouraged to reflect on the issues outlined within this briefing. Together with your teams consider how you can challenge your own thinking and practice in order to support continuous learning and development. Ask yourself:

- Can I make changes to my own practice?
- Do I need further support, supervision and training?
- Is there anything in my organisation that needs to change so that it can support best practice?

7 minute briefing
Adult Protection – SCR Learning
Serious Injury in Complex Frailty



Learning Summary:

The SCR was conducted under the terms of the local Framework for Conducting SCRs, based on the Scottish Government's Framework for Adult Support and Protection SCR s published in 2019 to support a consistent approach to conducting such reviews to improve the dissemination and application of learning locally and nationally.

7 minute briefings are intended to be simple so that the reader can absorb the information easily and that teams can use them within meetings as a team based learning exercise with a mixture of new information or a reminder/repeat of basic information which can help teams think about the application to practice.