NHS Resolution

# Case story

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This case story is based on real events and the NHS Resolution is sharing the experience of those involved to help prevent a similar occurrence happening to patients and staff. Although the incident may have happened sometime in the past, as you read about it, please ask yourself:

- Could this happen in my organisation?
- Who could I share this with?
- What can we learn from this?

**Topic:** Effective Integrated Working for patients with vulnerabilities

Key points:

- Close collaboration of care agencies provides a safe system for patients who are vulnerable.
- Specialist staff are needed to support patients with learning disabilities
- Early intervention by specially trained staff can make a positive difference.

## Jackie's Story

Jackie (not her real name) suffered from severe learning disabilities and lived in a care home. After experiencing diarrhoea and vomiting for four days she was taken to the local A&E department at just after 8pm on a Friday night in March. Although she did not have a fever, her stomach was slightly distended, which could have indicated an underlying problem.

Jackie was referred by the Senior Registrar for an x ray and blood tests but unfortunately she was anxious and distressed and the staff found it impossible to carry out the tests. She was diagnosed with gastroenteritis and discharged back to the care home. A letter was sent to her GP and a referral made to the Community Learning Disability Support Service.

Tuesday two months later, Jackie was taken to her GP. She had also seen her GP in the intervening period. She had been experiencing stomach pains with vomiting for two days, had lost weight and suffered a collapse. After an examination the GP did not refer her to hospital and sent her back to her care home.

Just after 10pm she was taken to A&E by the care home staff and was admitted for further investigations. She developed a fever and was later diagnosed with sepsis. She deteriorated over the next few hours and despite the efforts of the staff to stabilise her, sadly died at 7pm on the Wednesday evening.

## The Claim

Jackie's family brought a legal claim against the Trust, the GP and the care home. It was their view that there should have been an immediate referral made to the surgical team on Jackie's first hospital attendance in March and that there should have been an effective system in place for supporting patients with severe learning difficulties. If this had happened then they argued prompt investigations would have been carried out resulting in treatment and a better outcome. After negotiation and the involvement of the NHS LA, the family were awarded damages.

Throughout the claim process the Trust, GP and care home worked collaboratively to achieve a positive outcome for the family, which also saved money for the NHS. One of the lessons of this case is that if this collaborative approach had been evidenced throughout Jackie's care then the claim process may not have been necessary.

## Lessons learned

Among the many lessons learned by all involved in this case, two dominant themes emerge:

1. The need for collaboration;
2. The importance of specialist support.

Greater collaboration, and in particular improved communication between the hospital, the GP and the care home, would have led to better care for Jackie. In addition, establishing lines of communication with other relevant agencies would have provided more support.

For example, if a more detailed and urgent referral to the Community Learning Disability Support Team had been made following the episode in March, which had been followed up by the Trust in the event of any delay by the Community Team, then intervention would have been provided earlier. This would have assisted Jackie, her carers, the family and the hospital staff.

Specialist support is needed for patients with severe learning disabilities who attend an acute setting. It was impossible for the staff to carry out the clinical tests they deemed necessary in March. Investigations proved impossible due to Jackie's distress and non-compliance. As a result, the existence of underlying problems were not picked up at that stage. Had appropriate support been available, investigations may have been able to take place and this situation could have been managed differently.

## What has changed as a result?

Following a detailed investigation a number of areas of practice have changed. The Trust now has two nurses with specific responsibility for patients with learning disabilities. One leading on adult patients, the other on children. They train staff, provide direct assistance to patients, support families and lead on liaisons with external organisations. Across the various Trust sites they ensure that a proactive approach is taken and that support systems are activated and are robust. They have championed the use of hospital passports to assist communication and developed easy read information. They have also set up alerts to identify patients who might need particular support due to their vulnerability.

Policies have been updated to reflect the new approach and a Learning Disabilities Working Group established to oversee and continually improve the delivery of care for those with learning disabilities. A Safeguarding Vulnerable Adults Team has been created to provide additional support and new systems introduced to ensure that there is appropriate briefing for locum clinicians.

The Trust now produces an annual Safeguarding Adults Report, and has set up effective pathways for patients with learning disabilities that are monitored and reviewed regularly.

Two specific pathways for patients with learning disabilities exist:

- Emergency Pathway: Patient admitted via A&E, and passed to Medical Receiving Unit. Within 12 hours patient is either discharged or if passed to ward then the Learning Disability Liaison Nurse is notified and reviews the patient. The Pathway below is then followed.
- Learning Disability Good Practice Care Pathway: A care plan to ensure the correct learning disability is identified, the Community Learning Disability Team are notified and the Hospital Passport (which belongs to individual) is reviewed. Plus information is provided to the hospital so that needs are considered and reasonable adjustments made.

The Learning Disabilities Working Group meets six times a year to ensure continuous improvement and the safe delivery of care.

## Conclusion

Greater and more proactive collaboration between different care organisations now exists. The Trust has introduced systems that enable more specialist support to be activated and targeted earlier for the individual patient's needs.

The system is safer and it is hoped by the Trust that they can continue to make a positive difference to those individuals who are vulnerable and need help.

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