HIGHLY CONFIDENTIAL

Significant Case Review

Adult Support and Protection Committee

In respect of Adult A

Lead Reviewers:

[Redacted] NHS Greater Glasgow & Clyde

[Redacted] Glasgow City HSCP

Table of contents

Notes on redaction of this Report

This document contains the conclusions and recommendations of the Significant Case Review relating to Adult A. In the interests of transparency, every effort has been made to disclose as much of the SCR as is lawfully possible. The only editing prior to disclosure is the redaction of personal data, disclosure of which cannot be justified under the General Data Protection Regulation (GDPR) and Data Protection Act 2018. The process of redacting the SCR has involved careful consideration of:-

- The need for transparency and the overall purpose of the SCR in the identification of any lessons learned.
- The public interest in disclosure.
- Considering whether information is personal data, and if so whether its inclusion in the SCR complies with data protection legislation.
- Balancing interests in terms of the right to respect for private and family life in terms of Article 8 of the European Convention on Human Rights, meaning that any information contained in the report relating to A herself and other people whose history was closely linked to B can only be released if it is lawful, necessary and proportionate to do so.

The full report of the SCR follows but with certain text (consisting of names) redacted for the reasons set out above. Any redactions are clearly marked with the word "[Redacted]". Text redacted is considered exempt from a request under section 1 of the Freedom of Information (Scotland) Act 2002 as a result of exemptions contained within that that Act.

Individuals whose names or biographical information have been redacted have been "de-identified" by the controller for purposes of section 171 of the Data Protection Act 2018, and attempting to re-identify these individuals is likely to constitute and offence under section 171(1). Requests for consent to re-identify should be addressed to dataprotection@glasgow.gov.uk.

Introduction

1. Why this case was chosen to be reviewed?

1.1 The case was referred to Glasgow City's Adult Support and Protection Committee following the death of Adult A, who was in hospital recovering from injuries sustained whilst receiving 24-hour care, purchased for her by Glasgow City Health and Social Care Partnership (HSCP).

1.2 Significant Case Reviews (SCR) are important for those individuals, families and agencies involved in critical incidents and to promote learning across agencies. This was conducted according to the criteria laid out in the Glasgow Adult Protection Committee Significant Case Review Protocol. This states that an SCR should be considered when a death of an adult, who is subject to adult protection procedures, occurs or where an adult deemed to be at risk of harm suffers significant injury through abuse or neglect. (Glasgow ASP SCR protocol Section 3.1) The injuries sustained by Adult A and her subsequent death indicate that she met the criteria for an SCR.

2. Succinct summary of case

2.1 This case concerns Adult A, a woman with a significant learning disability and severe physical disabilities who had been in residential care since she was 18 months old. She was a wheelchair user who was unable to verbally communicate and required 2:1 support to provide personal care.

2.2 Adult A resided in a home of multiple occupancy (HMO), with three other residents, maintained by a care provider commissioned by Glasgow City HSCP to deliver care and support to Adult A 24 hours a day.

2.3 On 4th July 2017, whilst delivering personal care to Adult A, staff failed to adhere to the practices laid down in the provider's Moving and Repositioning Policy, which resulted in Adult A falling from bed sustaining significant injuries. Staff did not follow the correct procedures after the fall and there was a delay of 2½ hours in seeking medical assistance. Adult A was taken by taxi to hospital and subsequently admitted under the care of the orthopaedic team.

2.5 The police were contacted and informed of the circumstances at the time and no criminality was established, as this appeared to be an accident. Nevertheless, the care provider suspended both members of staff to allow a full investigation to take place, the outcome of which resulted in their dismissal.

2.6 At the time of the incident a large-scale investigation (LSI) was underway which had been initiated because of serious concerns across different units in Glasgow with the same provider.

2.7 The following day, on 5th July 2017 Adult A had further x-rays which confirmed the presence of fractured left shoulder.

2.8 Adult A was known to have long standing difficulties in swallowing, and the speech and language therapy service reviewed her frequently during her stay in hospital. She was also reviewed by the stroke team, in view of an apparent change in neurological function and an alteration in her swallowing ability. However, a CT scan showed no new changes and consideration was given to alternative feeding.

2.9 On 27th July 2017 Adult A was transferred to an elderly care hospital to await the outcomes of a guardianship application by the local authority and assessment with a view to a nursing home placement.

2.10 Nursing staff became concerned about Adult A's overall condition on the morning of 29th July 2017. She was transferred by emergency ambulance with suspected aspiration to an acute care hospital and died thirty minutes after arrival.

3. Methodology

3.1 The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the case – what happened and why – to identify the "deeper", underlying issues that are influencing practice more generally. It is these generic patterns that count as "findings" from a case and changing them will contribute to improving practice more widely.

3.2 There are 3 questions at the heart of the learning Together model:

- **What happened?** Reconstructing the case and surrounding context as experienced by the professionals involved.
- **Why did it happen?** Analysing practice in detail, appraising individual practice, and looking at individual, local, and national influences on practice.
- **What are the implications for wider practice?** Exploring whether issues identified in the case apply more widely and their relevance to achieving better safeguarding.

3.3 Using this approach for studying a system in which people and the context interact requires the use of qualitative research methods to improve transparency and rigour.

The key tasks are data collection and analysis. Data comes from semi-structured conversations with involved professionals, case files and contextual documentation from organisations.

Review Team and Case Group

3.4 The learning review was undertaken by two trainee lead reviewers, who have been trained in using the SCIE's Learning Together methodology. The reviewers were supported by a Supervisor and Review Team whose membership was drawn from

across agencies involved in the case and had not held any decision-making responsibility in relation to the case. Collectively, their role was to contribute to the analysis of data and inform the final report. SCIE consultant, **[redacted]** provided methodological oversight and quality assurance. Ownership of the final report lies with the Glasgow City Adult Protection Committee as commissioner of the case review.

3.6 The SCIE model involves gathering and making sense of information about a case through meetings with the Review Team and a Case Group of practitioners who had been directly involved in the case. Draft research questions were shared and refined in consultation with the Review Team and Case Group, and the conversations with individual practitioners were reconstructed and shared with the Review Team and Case Group. Both groups were involved in the analysis of practice on the specific case and in discussions to identify the wider systemic findings. Attendance at all meetings was requested but not always possible.

3.7 The Lead Reviewers met the Case Group and Review Team on 17 occasions (Appendix 3).

3.8 12 conversations were held with 35 staff – some were individual conversations, and some were in small groups of two, three or four professionals (Appendix 2).

Research question

3.9 The research questions identified for this review were:

- What can we learn about the provision of training for staff in purchased services, and the systems in place to ensure that workers are learning and applying this training to practice?

- How effectively are care plans being communicated with all relevant staff involved in an individual's care?

Methodological comment and limitations

3.10 The focus of the review was the period from May 2017 – July 2017. There were issues that emerged from the review but are not presented as findings in this report because they were unable to be verified by Adult A.

3.11 The fact that the individual practitioners who were directly involved in the care of Adult A were unable to participate in the review process, a decision taken by Glasgow City HSCP, was a significant limitation on this review. Without their insights and information, it is not possible to have a full picture of their experience.

3.12 Due to sickness absences and holidays, it was not always possible that all members of the Review Team and Case Group could meet on all occasions however every effort was made to seek the views of colleagues.

3.13 The review process was very protracted, which is not the norm for this model; this was initially due to the conflicting demands of both co-lead reviewers and latterly due to the changes in co-lead reviewers' roles in response to COVID-19. Also, one of the lead reviewers took up a new position with a different health board. Undertaking a significant case review using this model needs protected time away from operational demands. There had also been an initial delay in the provider declining to meet due to their desire for a Health and Safety Executive (HSE) report to be completed first. However, after discussion with senior managers they agreed to participate as, in line with the SCIE model, the provider at that senior level, expressed commitment to learning from these events.

3.14 Medical staff involvement in the review process was severely limited as they were not able to commit to the schedule of meetings. The Lead Reviewers went to each hospital in the health board to meet front line staff. However, some nursing and medical staff still failed to engage with the process due to clinical commitments.

4. Sources of data

Conversations and case group

4.1 The Lead Reviewers conducted semi-structured conversations with staff in a variety of roles, who together formed the Case Group for the review (Appendix 2)

4.2 The review was also informed by the following documents:

- Electronic patient record for Adult A
- Multi-agency chronologies
- Significant Adverse Event Review (SAER) completed by the Health Board responsible for hospitals where Adult A was a patient

Perspectives of the family members

4.3 The Lead Reviewers were grateful for the opportunity to include Adult A's next of kin and his wife in this review. The perspectives of family members regarding Adult A's care through individual conversations provided useful qualitative data for the review. Adult A's cousin and his wife met with the reviewers. They thought that the placement had provided Adult A with good care for many years, and that Adult A very much regarded it as her home. More recently they expressed some dissatisfaction with changes in the care team who knew her less well than the longer serving staff group. This was their perception, based on regular but infrequent contact with the placement. Some of the staff, including one of the people involved in the incident, had worked there for at least ten years.

Adult A's cousin had been on holiday abroad at the time of the incident but subsequently visited her in hospital. He commented on her being in pain and that the reason for her being moved to another site was due to "bed blocking," and the

need to free up the initial bed within the acute ward which precipitated transfer to the elderly care unit.

5. Structure of the report

5.1 Guidance (Scottish Government 2015) for those producing SCR reports suggests a consistent structure to make it easier for people to read. The report structure and content of the SCIE Learning Together model is outlined in full in Annex 5 of Scottish Government Guidance and, in line with that, this report includes:

- A contextual introduction
- An appraisal of practice on the specific case
- Findings, categorised using a systems typology
- Considerations for the APC to help reach decisions about solutions and changes required

Findings

6.1 A case review plays an important part in efforts to achieve a safer adult protection system, one that is more effective in its efforts to safeguard and protect adults. Consequently, it is necessary to understand what happened and why in the particular case and go further to reflect on what this reveals about gaps and inadequacies in the adult protection system. The case acts as “a window on the system” (Vincent 2004, p.13).

6.2 Case review findings therefore need to say something about the Adult Protection Committee or about agencies and their usual patterns of working. They exist in the present and potentially impact the future. It makes sense to prioritise the findings to pinpoint those that most urgently need tackling for the benefit of adults and families; these may not be the issues that appeared most critical in the context of the case. However, they may present the most risk to the system if left unaddressed. In this review the prioritisation of findings is a matter for the Adult Protection Committee.

6.3 To help with the identification and prioritisation of findings, the systems model that SCIE has developed includes six broad categories of underlying patterns, each of which relates to different aspects of multi-agency adult support and protection work:

- Tools
- Management systems
- Professional norms and culture – incidents
- Professional norms and culture – longer term work
- Family – professional interaction
- Innate human biases (cognitive and emotional)

6. Appraisal of practice

Period 1 Decision taken to move Adult A into another bedroom to facilitate decoration and the immediate response by staff following Adult A's fall from bed (3rd - 4th July 2017)

7.1 As placements to the supported accommodation facility were temporarily on hold due to the large-scale investigation (LSI), the service provider decided to use this opportunity to refurbish the bedrooms and improve the surroundings. This was reasonable and with appropriate planning could have been undertaken safely to the benefit of the people living there.

7.2 To facilitate redecoration of her bedroom Adult A was moved into another bedroom on 3rd July 2017. Given that her own bed was too big to get through the doorway, staff made the decision to use the existing bed frame in the vacant room with Adult A's mattress, however safety checks to support this decision were incomplete; a comprehensive risk assessment should have been completed to support the use of another bed with Adult A's mattress in a different bedroom.

7.3 Adult A fell from her bed during the delivery of personal care by one worker. Both support workers, within the house responded quickly following the fall from her bed, however their judgement was not to leave her on the floor and call 999 as per the policy, but to ask her if she was okay. Then they lifted her manually from the floor on to a shower chair and take her for a shower, thinking this was an appropriate course of action; the provider's policy advises staff to leave service users on the floor after a fall and call 999 for assistance as movement may cause further injury. The reviewers were unable to interview the support workers so the rationale for their actions is not clear. From talking to managers at least one of the workers did not believe her injuries were serious and that person was keen to end the shift as soon as possible for other personal reasons. This was the worker who had the most experience of the two people delivering care to Adult A that morning and who may have appeared as more knowledgeable to a less experienced colleague.

7.4 In a phone call to the service manager to provide information about another service user the support worker reported that Adult A had had a fall, but indicated she was fine, was being showered and getting ready for breakfast. In response to this the service manager's instruction to take Adult A to hospital straight away were not specific to reflect policy, i.e., call 999 for assistance.

7.5 There was no evidence that the support worker attempted to assess Adult A's pain other than asking her if she was okay; questions should have specifically been asked her if she had pain anywhere, especially on her face and forehead where she had obvious bruising.

7.6 Instructions to take Adult A to hospital were ignored by the support worker which caused a delay in assessment and subsequent treatment. **The impact of these breaches in policy is explored in Finding 1.**

Period 2 Admission to hospital and initial assessments (4th- 5th July 2017)

7.7 Adult A was taken by a member of staff to the Emergency Department (ED) of the nearest acute hospital by taxi and on arrival at ED she followed a minor injuries pathway. Had staff at the unit called for a 999 ambulance the pathway of care for Adult A would have been no different; she was appropriately triaged and seen by a doctor and Nurse Practitioner. However, calling an ambulance would have allowed assessment by paramedics at the scene and possibly facilitated a quicker transfer to hospital.

7.8 An essential part of the assessment process during the admission to hospital was an evaluation of the safety of Adult A's home environment. This was quickly acknowledged by the Nurse Practitioner within the ED, who notified social work of the plan to discharge Adult A back to her supported accommodation. Social work expressed concerns about this and advised that Adult A must not be discharged home until the investigation into the circumstances of her fall had concluded. Accordingly, Adult A was admitted to hospital under the care of the orthopaedic service. At this point there was a missed opportunity to consider alternative, more suitable accommodation for Adult A; at the very least a discussion between the social worker and their team leader could have taken place about an appropriate interim care placement for an adult with learning disabilities rather than an in-patient stay in an acute hospital. An alternative unit out with an acute setting could have offered the opportunity for an assessment of longer term needs once initial clinical assessment and treatment were concluded.

7.9 An examination carried out by the orthopaedic doctor reported that Adult A had "suspected fractures of both knees". Given Adult A's normal functional ability it was appropriate that they were stabilised in knee immobilisers and instructions given not to weight bear. Several hours later further radiological images were taken of her left shoulder which confirmed the presence of a fracture of her clavicle. The reason why this injury was not picked up on initial examinations by the doctor or the Nurse Practitioner is not known.

7.10 There is no evidence from either medical notes or through observations by carers that doctors, or nursing staff had taken cognisance of details provided in Adult A's passport, or that they had much experience of assessing a patient with a learning disability. A hospital passport provides important information about a person with a learning disability, including personal details, the type of medication they are taking and any pre-existing health conditions. The passport also includes

information about how a person communicates and their likes and dislikes, which can be very important when they are first admitted to hospital. This can include any communication aids and how they can be used so health professionals can communicate clearly. It also shows how the person expresses things like happiness, sadness, pain, and discomfort.

7.11 There is limited evidence from the clinical notes and from conversations with key staff to suggest that there was any comprehensive assessment of Adult A's level of pain. Having a support worker at the initial admission allowed the assessment to take place with someone known to Adult A, who was familiar with how she communicated. The presence of support staff, working alongside the clinical team as her assessment and treatment progressed may have allowed a more accurate assessment of her level of pain. **The importance of considering all relevant information is explored in Finding 2.**

Period 3 Initial Adults Protection Case Conference (6th July 2017)

7.12 An Initial Adult Protection Conference took place on 6th July 2017. The reports submitted outline professional involvement to date and identified protective and risk factors. The discussion was described as comprehensive and productive and was chaired by an experienced manager.

7.13 The provider was instructed to cease providing any care or support and an alternative provider was sought. It was possible that this decision was influenced by the LSI, coupled with the views expressed by the provider at the conference. The effect of this was to prevent Adult A having contact with people she knew and with whom she was able to communicate. This occurred at a time when she required encouragement to eat, and communication with ward staff was difficult, but they had been assisted by the continued contact with staff from the provider who knew Adult A. No alternative to provider staff was available or fully explored. The approach of the provider at the case conference was perceived, as reflected in the minute, as being unhelpful and the provider had described the meeting as tense and considered themselves to be "grilled" by the meeting participants. In this context it may have been more difficult to consider a role for the provider.

7.14 Workers present at the case conference described a feeling of unease at this decision to the reviewers but did not express this to the chair at the meeting. The ongoing LSI may have contributed to the reluctance to discuss the potential for ongoing support in detail, as the decision to conclude the provider's involvement was seen as almost automatic, given the range of concerns which had emerged from the LSI about the provider in other units within the local authority area, as evidenced in the HSCP commissioning service review. This had been conducted by HSCP commissioning staff and was a comprehensive review of units managed by the provider across the city. Themes from service concern reports which have emerged within the SCR were also reflected in this report which summarised concerns over a three-year period between 2015 -2017. These included:

- Delays in acting when notified of a concern
- Inadequate support plans in place
- Inadequate delivery of care /poor recording
- Possible financial abuse
- Not reporting issues to the local authority timeously

It also highlighted the work conducted by the commissioning team with the providers, which suggested that at the end of the period improvements had been made in recording, financial management and in taking formal action to address poor care practice both in pursuing disciplinary proceedings where appropriate, staff training and support from the organisation to operational managers. The decision of the case conference reflected that a significant lack of confidence in the provider remained.

7.15 Representatives from the acute hospital team were not present at the case conference, and their view about the usefulness of ongoing contact with Adult A and support staff from the unit was not considered.

7.16 It was agreed that the Local Authority would seek Welfare Guardianship powers and a Mental Health Officer (MHO) was appointed to follow up guardianship application. The conference was careful to consider the legal basis of any future decisions about care and support for Adult A and this reflected good practice, as was the decision to involve the advocacy service.

Period 4 Swallowing assessments and ongoing care (8th - 28th July 2017)

7.17 Adult A had long standing difficulties with swallowing, eating, drinking, communicating, and taking medication. Meals were normally difficult; she was on a textured diet but the textured diet in hospital was a bit thicker than what she was used to. She refused to take her meals, drinks or medications from nursing staff and pocketed food in her cheeks. Initially, on admission to hospital her carers from her home visited and helped her with meals and medications but that stopped after the case conference on 6th July 2017, at which the decision to stop her carers having any contact with her was made.

7.18 On 11th July 2017 Adult A was seen by the speech and language therapist for a swallowing assessment however she was very drowsy and unable to cooperate with the therapist. In view of this, and an apparent change in her swallowing ability, Adult A was referred to the stroke team and arrangements made to conduct a formal swallow assessment. This was a good example of professionals coming together to assess Adult A's clinical and nutritional needs. Further attempts to assess her swallowing were done over the course of the next week, but intervention was limited due to her drowsiness, and so she was discharged from the service and referred on to the dietician.

7.19 On 26th July 2017 Adult A was reviewed by a Care of the Elderly Consultant who made the decision to transfer her to the elderly care unit to await the outcome of discussions regarding future guardianship and possible nursing home placement. Whilst such decisions are, however, always considered very carefully to ensure that appropriate patients are selected and known to be medically well enough to be transferred to an associate hospital site the reviewers have been unable to ascertain the rationale behind the choice of the elderly care unit as a suitable temporary location for Adult A other than that an alternative placement was not yet identified. Had the social work assessment been completed and a place identified consideration could have been given to applying Section 13ZA of the Social Work Scotland Act to an appropriate nursing home placement. At that point she was receiving a level of care which could be provided within a nursing home. Given the recent decision of the case conference to pursue a guardianship application, the potential for 13za may have been limited but it could have been at least considered. Practice in relation to other cases where someone is delayed in hospital would indicate that it is valuable to check regularly whether there is an alternative route other than a full guardianship application which might facilitate a safe discharge. This was a possible missed opportunity for social work staff to consider more suitable care options for Adult A, though negotiations had just commenced to find her long-term accommodation.

7.20 This case highlights the challenges of working with a vulnerable adult when those who were most familiar with the adult had been stopped from visiting and participating in decision-making about her treatment and care; their participation could have enabled a better understanding of what mattered to her and more comprehensive, meaningful risk assessments. **The challenges for professionals working with a vulnerable adult in these circumstances are explored in Finding 2.**

Period 5 Identification and management Adult A's deteriorating condition

7.21 Nursing staff within the elderly care unit had limited recall of Adult A but they encountered the same feeding difficulties and found her pocketing her food.

7.22 There was a dearth of knowledge amongst some nursing staff in the unit, which was reflected in their record keeping, incomplete observations and inability to identify signs of clinical deterioration. **The impact of this is explored further in Finding 1.**

7.23 There is no evidence that healthcare staff gave any consideration to discussing an anticipatory care plan or DNACPR with Adult A's family or carers, however the reasons for this are not known. This could have been explored during family contact while Adult A was on the ward and their contact details were available.

7. Good practice: what worked well?

8.1 Although good practice is acknowledged throughout the appraisal of practice, the Lead Reviewers wanted to highlight some aspects in particular.

- Timely reporting of the incident to the on-call Service Manager and completion of an Incident and Accident form by the Service Manager.

- Good, early detection by the Nurse Practitioner that Adult A was vulnerable and at further risk of harm if she was discharged back to her supported accommodation.

- Prompt identification of Adult A's swallowing difficulties and subsequent referrals to speech and language therapy and stroke team.

- Early recognition that Adult A was not meeting her nutritional requirements, so a referral was made to the dietician.

- The case conference considered the future care arrangements and their legal basis.

- We also recognise that some changes and developments to practice have taken place considering findings from the Initial Case Review. These include a new manager to oversee practice within the Elderly care unit and staff training by the care provider around moving and handling.

- The HSCP commissioning team were closely involved in detailing the incident and liaising with the provider. The service review report completed by the team analysed concerns over across range of units run by the provider, and put the issues which led to the SCR in the broader context of the Large-Scale Investigation. The interviews with the commissioning staff evidenced detailed knowledge of the provider and the concerns which needed to be addressed.

8. In what ways does this case provide a useful window on our systems?

9.1 This case highlights the challenges practitioners face in identifying and assessing risk and need in cases of neglect and how well health and social care systems support this. It highlights quality of care issues in purchased services, the experience of someone with complex needs in the acute hospital system and the impact of decision making at adult protection case conferences. These are issues which impact on service users and patients across the system.

9. Summary of findings

10.1 This significant case review has identified three system findings that have emerged from the review. The findings explain why professional practice was not more effective in protecting Adult A.

Finding 1 **Management systems**

Within some areas of acute health and some contracted providers, there is a gap in staff knowledge and skills, a disregard for policy and failure to work within a governance framework, which if insufficiently acknowledged or addressed, will compromise the safety adults who may be at risk of harm.

Finding 2 **Professional norms and culture**
Within some areas of acute health there is a tendency for professionals to focus only on physical injury and not consider how care and treatment should be adjusted to meet the needs of those with a learning disability, and this means there is no holistic assessment of risk.

Finding 3 **Professional norms and culture**
When an LSI is underway strained communication between the provider and agencies involved in the case conference or investigation can result in a limited exploration of support options involving the provider.

10. Findings in detail

Finding 1

Within some areas of acute health and some contracted providers, there is a gap in staff knowledge and skills, a disregard for policy and failure to work within a governance framework, which if insufficiently acknowledged or addressed, will compromise the safety of adults who may be at risk of harm.

11.1.1 Staff in statutory health and social care settings and in commissioned services need to make judgements about vulnerability and care needs, as well as treating a clinical condition, which if not included in their assessment, impacts on decision-making and their ability to deliver, safe effective care, leaving vulnerable adults at risk of harm.

How did it manifest in this case?

11.1.2 A week prior to Adult A being moved into the vacant bedroom, staff checked the bed to make sure it was in good working order and that Adult A's mattress fitted. In conversations with staff, they said that the bed was in working order the night before Adult A was moved on to it but there is no supporting documentation; the most recent risk assessment for the bed was completed on 6th December 2016. The care staff failed to follow the policy and review the risk assessment for use of the bed every 6 months and prior to any changes in use.

11.1.3 Despite a risk assessment being in place to identify where injuries could occur and how to prevent them during moving and positioning, one support worker, working alone repositioned Adult An in bed.

11.1.4 The support workers did not apply the principles of safe moving and handling which they were taught just a few weeks prior at moving and repositioning training as reported by the provider.

11.1.5 It was evident from the actions of the support workers that Adult A's level of pain was not fully assessed. Support workers asked her if she was okay and then continued to get her showered, dressed, and ready for breakfast, which could have put her at risk of further harm. Advice from the service manager who told them to "forget breakfast and get her to hospital to get checked out" was ignored.

11.1.6 There were examples, shared in staff conversations, where nurses recognised that Adult A had complex needs because of her learning disability, but because she was unable to call for help or get out of bed she was left alone until staff checked on her. By the nature of their needs priority was given to "absconders", or patients who were confused and/or who were at risk of falls.

11.1.7 Nursing staff at the elderly care hospital were aware that there was a new early warning score (NEWS) chart being rolled out across all the hospitals in the health board however nursing staff in this ward were still using the old GP NEWS chart with escalation, though there was no documented evidence of any escalation processes.

How do we know it's an underlying issue and not unique to this case?

11.1.8 The issues relating to the unit are unlikely to be a "one off" because staff told the Lead Reviewers during conversations that "it wasn't a particularly difficult decision… they had done this before……seemed a reasonable move". Staff had carried out "checks" on the functions of the bed but did not complete a risk assessment.

11.1.9 The support workers' interpretation of current policy and operational practices did not meet Adult A's needs, leaving her open to harm, therefore it is likely that their knowledge and practice would apply in similar circumstances. The feedback from staff throughout the review was that the support worker "had been there for years and did not follow processes…. very confident……. knew everything……...did whatever they wanted".

11.1.10 From conversations with staff and Adult A's nursing notes there is a lack of knowledge amongst nursing staff which was reflected in their poor record keeping, incomplete observations and an inability to identify clinical signs of a

deteriorating patient. The Case Group was clear that whilst there are clear policies and procedures in place there can be person dependent variations that go unchallenged.

11.1.11 The Service review conducted by the HSCP commissioning team and in discussion had demonstrated that staff in other units with the same provider had provided evidence where workers had not adhered to safety procedures and guidance.

How widespread and prevalent is this issue?

11.1.12 The range of issues raised at LSI indicates serious concern about the entire organisation and governance, not just a particular unit. Issues in relation to adherence to specific policies and procedures around moving and handling have featured in other LSIs within the local authority.

Why does it matter?

11.1.12 Social work recognised that Adult A's communication issues and other profoundly disabilities made her particularly vulnerable.

11.1.13 A moving and handling risk assessment identifies hazards to reduce the likelihood of incidents occurring that could cause harm or injury to carers and clients. If staff do not have the knowledge, training, and skills there is a risk that shortcuts will be taken in terms of the rigour of the assessment and analysis, which ultimately increases risk of harm to clients.

11.1.14 The purpose of using the National Early Warning Score (NEWS) is to improve the detection and response to clinical deterioration in adults, however if staff do not know how to use the tool then patient safety and clinical outcomes will be adversely impacted, especially in those patients who are unable to describe symptoms to staff.

Finding 1

Within some areas of acute health and some contracted providers, there is a gap in staff knowledge and skills, a disregard for policy and failure to work within a governance framework, which if insufficiently acknowledged or addressed, will compromise the safety adults who may be at risk of harm.

Whether the gap in performance is a result of lack of training, knowledge, and skills, or is a result of employees' behaviours, the consequences can have a detrimental effect on the provision of safe and effective care, particularly those at risk of harm, if not addressed by managers.

Questions for the Adult Protection Committee to consider:

- How confident is the APC that professionals working in services purchased by Glasgow City HSCP have easy access to training and continuing professional development?
- In what ways can the APC support the Commissioning Team to ensure that managers of a purchased service address staff knowledge gaps, devise improvements plans, identify milestones, goals and improve performance?
- Are there any ways the APC can assist acute health staff understand their role in complex social care cases and its importance for the safety and wellbeing of vulnerable adults?

11.2 Finding 2

11.2.1 **Within some areas of acute health there is a tendency for acute healthcare professionals to focus only on physical injury and not consider how care and treatment should be adjusted to meet the needs of those with a learning disability, and this means there is no holistic assessment, therefore not patient focused.**

The importance of making reasonable adjustments to the care of people with learning disabilities in hospital is vital in making sure their health needs are met, but failure to do so can lead to poor assessments, and intervention measures that can fail to support those at risk.

How did it manifest in this case?

11.2.2 The Nurse Practitioner noted that no pain relief had been given yet she recorded in the notes that Adult A flinched when her knee was palpated, indicating that she was in pain. Adult A's pain score is recorded as 0 in A&E, meaning she had no pain however this is at odds with behaviour exhibited by Adult A, reacting to pain by grimacing and constantly crying.

11.2.3 Several professionals recognised that Adult A was an adult at risk with learning disabilities and complex needs, but their actions showed that they did not fully understand how to respond appropriately. Staff from the provider described a "horrific experience" for Adult A after she was admitted to the orthopaedic ward. During a clinical examination the doctor was "forcefully pushing her shoulder to elicit a response from her but because she was unable to verbally communicate, he kept pushing. The worker from the provider indicated that the "Poor woman was in tears…. she was crying the whole time; the tears were falling down her face".

11.2.4 Acute health professionals did not refer to Adult A's hospital passport which would have enabled them to better understand her needs and help them make the necessary reasonable adjustments to the care and treatment they provided.

11.2.5 Adult A's next of kin visited her whilst she was in hospital, and in conversation told us, "she was in pain, but I felt reassured that she was well cared for". We got a call saying she was going to the elderly care hospital…. bed blocking, that's why she got moved….it takes lot of time to move and feed her, and they would need the time to spend with someone more able". There was a sense that staff did not have sufficient time to spend with Adult A given the demands from other patients on the ward.

How do we know it's an underlying issue and not unique to this case?

11.2.6 Nursing staff at the acute hospital site referred to a learning disability pathway and a Learning Disabilities Nurse Specialist, who is available to support clinical teams when caring for a patient with learning disabilities. The nursing staff at the elderly care unit had no knowledge of this, and when asked about their experience with patients with complex needs and learning disabilities such as Adult A, one nurse said that "they felt sorry for her, her fractures, reduced communication". Their gap in knowledge was further compounded by their lack of self-awareness.

How widespread and prevalent is the issue?

11.2.7 People with learning disabilities, whether or not subject to adult support and protection processes are regularly admitted to hospital for treatment and can remain there for a considerable period due to the complexity of their needs. It is also reasonable to assume that health professionals will be pulled towards the more demanding and clinically unwell patients in their care. Reviewing hospital discharge information provided by Trak Care within Glasgow, which one of the reviewers and other local managers are routinely monitoring, suggests that people in hospital with learning disabilities and other complex needs, often spend longer within the acute setting than people with similar illness but without additional needs. They remain in hospital, once medically fit for discharge, due to the need to arrange suitable future care arrangements or waiting for the legal mechanism to be in place to facilitate discharge. This highlights the need for additional support to be provided to ensure that the person's emotional and social needs are met, as well as receiving treatment for physical health conditions. There is also a requirement for the continued review of legal mechanisms used to ensure they both protect rights and facilitate discharge as soon as possible.

Why does it matter?

11.2.8 Healthcare professionals need to make judgements about vulnerability and unmet needs, as well as clinical matters every day. Professionals are reliant on good communication which, if not effective, impacts on decision-making, care and treatment, and the understanding of the levels of risk to the individual and how they are managed.

11.29 These themes are reflected in some of the literature with an emphasis on adopting a whole system approach (Keys to Life Scottish Consortium for people with a Learning Disability 2019), the need for mandatory training in learning disability for all NHS staff (Learning / Intellectual Disability and Autism transformation Plan Scottish Government 2021) and commissioners adopting a principle of "reasonable adjustments" to universal services so that the needs of people with a learning disability are included in planning (Ordinary and unique Lives for Adults with a learning disability and/or autism: a six steps approach, Institute of Public Care Oxford Brookes University 2020). Comprehensive guidelines on caring for people with a learning disability in a general hospital setting and for older people with a learning disability reflect the challenge and complexity across the system (Guidelines on caring for people with a learning disability in general hospital settings - Guidelines and Audit Implementation Network Revised June 2018), Learning Disability: Care and support of people growing older (NICE 2019). Both the local experience and reflections in the literature suggest this is an issue that matters in ensuring that people with a learning disability receive quality care which meets their needs for treatment and support during hospital admissions.

Finding 2

Across some areas of acute health there is a tendency for acute healthcare professionals to focus only on physical injury and not consider how care and treatment should be adjusted to meet the needs of those with a learning disability, and this means there is no holistic assessment.

It is vital that healthcare professionals understand the needs of the individual and make the necessary reasonable adjustments to the care and treatment they provide.

Question for the Adult Protection Committee to consider:

- How can health professionals be enabled to ensure their assessment work with adults who have learning disabilities and other complex needs adequately considers both risks and protective factors in an acute setting?

11.3 Finding 3

11.3.1 **When a Large-Scale Adult Protection Investigation (LSI) is underway strained communication between the provider and agencies involved in the investigation or case conference can result in a limited exploration of support options involving the provider.**

11.32 An LSI is initiated when the issues which emerge from individual cases indicate that there are more systemic concerns that are not addressed by focusing on an individual alone. It is important that all options for support are considered even when there might be questions about whether they can be implemented or not.

How did it manifest in this case?

11.3.3 The provider was subject to an LSI which covered supported accommodation for people with a learning disability across several units within Glasgow. The decision at the case conference to end all links between the providers and Adult A meant that she did not have contact with people who knew her well for most of her hospital admission. The consequence of this was that she had no voice or ability to clearly articulate her wishes during her time in hospital.

11.3.4 Workers present at the case conference described to the reviewers a feeling an unease at the decision but did not express this to the chair at the meeting, which gave the impression that there was more agreement amongst the participants than may have been the case. The LSI contributed to the reluctance to discuss this in detail, as the decision to exclude the provider was seen as almost automatic, given the range of concerns which had emerged about from the LSI.

11.3.5 The approach of the provider at the case conference was considered, as reflected in the minute, as being “unhelpful”. The provider’s perception was that their views were “not taken into account” because of the LSI and Adult A was denied access to people she knew.

11.3.6 The absence of acute health staff meant that the discussion about the potential role of the provider in supporting adult A in the hospital was limited. Had there been someone there a role for the provider may have been explored. They were not providing personal care to Adult A and their involvement could have been limited to assisting with communication and encouragement to eat.

How do we know it’s an underlying issue and not unique to this case?

11.3.7

The Review Team reported that there are 2-3 adult protection LSIs in Glasgow each year. These are usually accompanied by a moratorium on new

admissions, made on the recommendation of the Chair of the case conference. It is unusual and, in most cases, inappropriate to expand the role of a provider where there are serious concerns. Managing the tension between a provider who has evidenced systemic failings and the agencies involved in the investigation is a key skill of the Chair. In the absence of alternatives, it is often necessary to support a provider to continue delivering a service while areas of concern are addressed.

How widespread and prevalent is the issue?

11.3.8 People with a learning disability are regularly admitted to acute hospitals and can remain there for a considerable time due to the complexity of their needs. Whether there are adult protection concerns or not, contact with providers can be limited and this can have a negative effect on communication and emotional wellbeing.

11.3.9 Although the number of LSIs is relatively small similar tensions emerge in individual adult protection case conferences and in the discussion of service concerns with the HSCP commissioning team who are responsible for contract management. There is a routine requirement to focus on the issues relating to the individual being discussed and to wider systemic concerns about the ability of a provider to deliver a whole service. The personal care concerns highlighted in relation to Adult A are replicated in other case conferences and discussions about the ability of a provider to practice safely.

11.3.10 There is a weekly citywide purchased care home meeting within Glasgow which brings together the Care Inspectorate, NHS staff who link with care settings, commissioning staff, care, social work care management and Public Health. The discussions there regularly reflect similar concerns around providers and the need to take an approach which both challenges concerns and supports improvement.

Why does it matter?

11.3.11 Provider staff often have specific communication skills and a relationship with the person that has the potential to support clinical care being provided within the hospital.

11.3.12 The views of clinicians should be taken into account when considering how providers, even when subject to LSI, may continue to provide a level of support in a hospital setting.

11.3.13 Chairs at case conferences are faced with difficult and complex decisions in LSIs which are only instituted when there are systemic issues which need to be addressed. The Chair's role is to ensure there is a full sharing of information, to allow the participants to challenge proposed decisions, and make recommendations. Confidence to challenge potential decisions and the Chair being clear about the rationale for decisions is an essential aspect of practice in relation to case conferences.

Finding 3

When a Large-Scale Adult Protection Investigation (LSI) is underway strained communication between the provider and agencies involved in the investigation or case conference can result in a limited exploration of support options involving the provider.

It is important that all options for support are considered even when there might be questions about whether they can be implemented or not.

Questions for the Adult Protection Committee to consider:

- What would be the value of more shared conversations for case conference Chairs to reflect on their decision making, and share experiences when they are involved in individual ASP cases and in LSIs which focus on the organisation and wider systems?
- What is the potential to make greater the use of technology to enable more blended meetings to take place in the future that will enable a better contribution from acute clinicians and GPs?

- How adequate are supports from providers to assist communication with people with a learning disability when they are admitted to an acute hospital?

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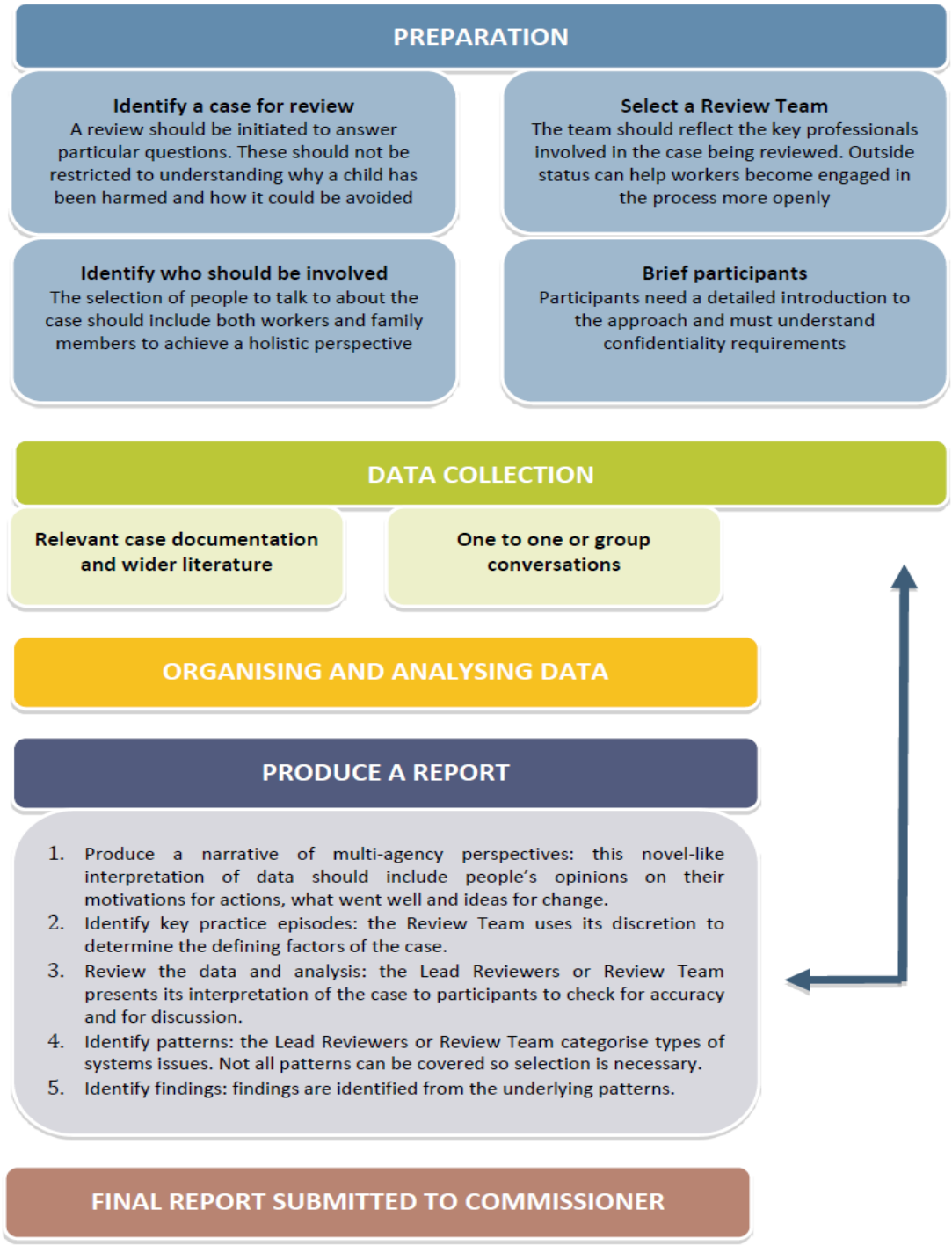
Appendices

Appendix 1

How the SCIE Model Works



30

Appendix 2

Membership of Review Team

Chief Nurse	NHS Lanarkshire
Service Manager	Glasgow City Health & Social Care Partnership
Commissioning & Performance Manager	Glasgow City Health & Social Care Partnership
Detective Inspector	Police Scotland
Operations Director	Advocacy Project
Service Manager Commissioning	Glasgow City Health & Social Care Partnership

Membership of Case Group

Service Manager Commissioning	Glasgow City Health & Social Care Partnership
Principal Officer Commissioning	Glasgow City Health & Social Care Partnership
Senior Officer Commissioning	Glasgow City Health & Social Care Partnership
Social Work Team Leader	Glasgow City Health & Social Care Partnership
Social Worker	Glasgow City Health & Social Care Partnership
Social Worker	Glasgow City Health & Social Care Partnership
Social Worker	Glasgow City Health & Social Care Partnership
Service Manager	Service Provider
Senior External Manager	Service Provider
Service Worker	Service Provider
Service Worker	Service Provider
Service Worker	Service Provider
Senior Support Worker	Service Provider
Service Manager (Investigating Manager)	Service Provider
Key Worker	Service Provider
Adult A's next of kin	Family
Nurse Practitioner	NHS Lanarkshire
Emergency Department Consultant	NHS Lanarkshire
Foundation Year 2 Doctor	NHS Lanarkshire
Orthopaedic Consultant	NHS Lanarkshire
Middle Grade Doctor	NHS Lanarkshire
GP Senior Trainee Doctor	NHS Lanarkshire
Clinical Fellow, Emergency Medicine	NHS Lanarkshire
Speech and Language Advanced Therapist	NHS Lanarkshire
Staff Nurse	NHS Lanarkshire
Staff Nurse	NHS Lanarkshire
Senior Charge Nurse	NHS Lanarkshire