Learning from a Recent Review

The Kirklees Safeguarding Adults Board has recently been involved in a review concerning a 46 year old White British man with learning disabilities and other complex medical conditions (Adult K). The review was carried out using methodology used for Learning Disability and Mortality Reviews

A nursing home bed was sought in his local area, which was outside Kirklees but none was available for him at the time. The nearest care home with capacity and the nursing skills to meet his needs was a care home in Kirklees.

On the 22nd December 2016 he was discharged to the care home in Kirklees from hospital in North Yorkshire. On admission the manager of the care home had concerns about him and raised these with the Care Quality Commission and reported a Safeguarding Adults Concern.

Three days after his transfer to the care home on the 25th December 2016 he was admitted to a Hospital Trust in the Kirklees area, but after a period of recovery was discharged back to the care home in Kirklees on 31st December 2016. On the 4th January 2017 he was re-admitted to the Hospital Trust in Kirklees and he sadly died the following day

As the gentleman had learning disabilities a review was initiated in 2017 on the Learning Disability and Mortality Review (LeDeR) Programme instituted by NHS England and delivered through local reviews coordinated by Clinical Commissioning Groups (CCGs) The overall aim of the Learning Disabilities Mortality Review (LeDeR) Programme is to drive improvement in the quality of health and social care services delivery and to help reduce premature mortality and health inequalities

All deaths of people with learning disabilities aged 4 years and over are reviewed. The purpose of reviewing deaths is to identify if there are any potentially avoidable contributory factors associated with the deaths of people with learning disabilities. As part of each review, an action plan is developed to take forward any improvements

A trained LeDeR reviewer undertook the review. It was agreed by the Kirklees Safeguarding Adults Review (SAR) subgroup that as a LeDeR review had commenced it would seek to utilise any learning from the review.

The Review concluded that there had been a lot of positive partnership working in caring for the man and that the caring work had been very focused on supporting him to give the best care possible.

Whilst initially during the LeDeR process there appeared to be gaps in Adult K's medical records and questions about his care these were comprehensively addressed as part of the review.

No abuse or neglect was identified. In contrast, the review identified positive partnership working in caring for the gentleman

The following specific areas of good practice have been fed back to North Yorkshire:

- The Community Learning Disability Physiotherapy Team worked closely with the hospital in North Yorkshire to support the gentleman's comfort and feeding posture. The hospital employed carers from the residential home where he had lived for a long period, so they could support the gentleman throughout his hospital stay. This was an example of good Person Centred Care.

- There was recognition that Adult K's quality of life in the residential home in North Yorkshire had been very good.
- 'Best Interests' meeting was held on the ward regarding a decision to insert a feeding tube (after establishing Adult K did not have mental capacity to make this decision).
- The carers had received training about posture care by the Community Learning Disability Physiotherapy Team.
- The gentleman's quality of life was supported by all agencies involved in his care
- Although he had friction issues caused by managing his posture, the gentleman did not have any pressure area damage.
- The Hospital in North Yorkshire use the VIP scheme[1] for people identified as having a Learning Disability.

The Learning for the Kirklees Safeguarding Adults Board is threefold:

- It confirmed the view that using the LeDeR process as the primary way of reviewing the case was the most appropriate
- Our learning has mainly been about possible overlapping processes and we have updated our policies to reflect this.
- There is a need for consistency in the coordination of a review when the individual remains the responsibility of the primary placing authority (Leeds) but is placed in a neighbouring authority for much of their care.

[1] The VIP card holds lots of very useful information about patients, which helps staff when patients seek medical help