Adult Practice Review Report
Approved by Board May 2017

Adult Practice Review Report

North Wales Safeguarding Adults Board (NWSAB)

Concise Adult Practice Review

Re: APR2/2016/Conwy

1. Brief outline of circumstances resulting in the Review

1.1 Patient A died on 28/3/15. The cause of death recorded on her death certificate was bronchopneumonia, with cervical myelopathy and retro sternal goitre listed as contributing to the death, but not related to the condition causing the death.

1.2 In February 2015, Patient A's daughter made a Protection of Vulnerable Adults (POVA) referral to Conwy County Borough Council (CCBC). The subsequent POVA investigation concluded that, on the balance of probability, Patient A had suffered significant harm as a result of non-intentional neglect. CCBC made an APR referral on the 18/03/16 to the NWSAB.

1.3 The NWSAB APR subgroup first considered the referral on the 05/04/16 and agreed to request a full multi-agency adult practice review (APR).

1.4 An APR review was commissioned by NWSAB on the recommendation of the APR sub group, and in accordance with the guidance for APR's. The criteria for the review were met; being under section 3.4 first bullet point, (Page4). Due to the complex nature of the health issues, it was felt that two independent reviewers, with a professional background in health care, should be engaged.

1.5 An independent Chair was chosen from the members of the NWSAB (Morwena Edwards, Corporate Director and Statutory Director of Social Services, Gwynedd Council).

1.6 Mrs. Edwards identified two independent reviewers, and the first meeting between the Chair and the independent reviewers was held on the 5/8/16. The full APR group had their initial meeting on the 15/9/16.

1.7 Representatives from Betsi Cadwaladr University Health Board (BCUHB), Conwy County Borough Council (CCBC) and the North Wales Police (NWP) were invited. NWP did not respond to several requests for a panel member, and did not attend any of the APR meetings.

1.8 The APR group decided to review the case for 12 months prior to Patient A's death. The review period was agreed to be from March 2014 to March 2015.

2. Practice and Organisational Learning

2.1 Following the supplementary information received and discussions held at the learning event (17/03/2017) the APR group has agreed a number of learning points, which can be grouped into five key themes.

2.2 The five key themes are: -

- Communication
- Referral pathways for Clinical Concerns
- Clinical examination and treatment
- Care Coordination and Continuity of Care
- Strategic issues

2.3 Communication

2.3.1 There was inadequate communication between health professionals (Consultants, specialist nurses and district nurses).

2.3.2 On the 6th October 2014, Dr. 1 a vascular surgeon diagnosed significant vascular disease in Patient A's right leg. In his letter to the GP's he said he "hoped" something simple could be arranged, because he was concerned about Patient A's ability to cope with more surgery. Dr. 1 confirmed that Patient A "fell off the radar" after the 6/10/14 because no one came back to him once the abnormal U+E's, that he had detected, had been corrected. Dr. 1 had left it to the family/GP to contact him once Patient A's general condition had improved. The GP's completed blood tests in October and November 2014 and acted on any abnormalities identified.

2.3.3 Between October 2014 and February 2015, two vascular surgeons (Dr. 1 and Dr. 2) saw Patient A from different locations (initially Ysbyty Gwynedd (YG) and then Ysbyty Glan Clwyd (YGC), and four specialist nurses (vascular specialist and tissue viability specialist's) from each of the two locations (West and Central) were also involved in her care. All of which <u>independently</u> provided clinical advice regarding the management of Patient A's right leg, but no one coordinated the clinical care.

2.3.4 On the 3/1/17 when an independent APR reviewer met Dr. 1, he confirmed that he did not liaise with Dr. 2 regarding Patient A. Dr. 2 confirmed in correspondence dated 22/1/15 that he knew Dr. 1 had previously seen Patient A. The letter suggests there was no enquiry made by Dr. 2 as to any treatment plan started by Dr. 1. Dr. 2 also came to the conclusion that Patient A required an angioplasty and although the initial administration steps were made to implement this action it did not take place due to Patient A subsequent admission to YG.

2.3.5 During the period under review, Patient A received home care from a home care provider company. This was a package of home care commissioned by CCBC. The reviewers found that some concerns had been identified in the quality of care provided by the agency. These quality concerns were not communicated to the district nurses visiting Patient A. As a result they wound not have been aware of potential care problems.

2.3.6 The reviewers have seen no evidence of liaison between specialist nurses from the West and Central teams in BCUHB.

2.4 Referral Pathways for Clinical Concerns

2.4.1 The reviewers found that when the DN's had concerns about Patient A's condition, their route for referral was either via the GP or via the Central Specialist Team (either Tissue Viability or Vascular). The reviewers did not find a clear route that DN could take that ensured Patient A received immediate attention from a vascular surgeon.

2.5 Clinical Examination and Treatment.

2.5.1 Both reviewers feel the key issue here was the delay in making a decision on whether an angioplasty was required (and completed) immediately after the 6/10/14 and if not, whether the patient and family were told of the likely consequences if surgery was not undertaken. When one of the independent reviewers met Patient A's daughter (on the 20/12/2016) she made it very clear that the family blamed the district nursing team for not healing Patient A's tissue damage, whereas it might be reasonable to say that, without surgical intervention at that time, suboptimal wound healing and further deterioration was inevitable.

2.5.2 Following concerns raised by the DN and the GP, on the 5/2/15,
Patient A attended the emergency department (ED) of YGC and following examination was discharged home. The opportunity to investigate the damage underneath the necrotic tissue was missed.
The next day Patient A was admitted as an emergency to YG and following investigation and debridement of gangrenous tissue she was diagnosed as having a category 4 pressure ulcer to her right heel that was complicated by the presence of osteomyelitis.

Dr 1 needed to debride the heel and lower leg. This was done without the need for anaesthesia due to Patient A being semi-conscious and not showing any signs of pain during the procedure (the information in the last two sentences was obtained during the learning event on the 17/3/17).

2.5.3 There are a number of other interventions and omissions that, with the benefit of hindsight, the reviewers can comment on, but the reviewers are of the opinion that they were not critical to Patient A's care or this review. However, recommendations relating to them have been included in order to improve patient experience and care. (For example – DN do not have access to the most up to date equipment e.g. Doppler ultrasound machines that are able to measure toe brachial pressure indices. This would overcome the problem of completing an examination in patients with pain in the gaiter area (as was the case for Patient A). In addition, printing equipment including ink and paper, digital camera's etc in order to provide a visual record of the wound progress or deterioration.).

2.6 Care Coordination and Continuity of Care

2.6.1 The reviewers found that the DN team were referring their concerns on a regular basis to various specialist nurses and the GP, but were unsure of the outcome/action taken following their referral.

2.6.2 The reviewers found that several staff were trying to intervene, but no one person was taking responsibility.

2.6.3 The lack of continuity of care for Patient A resulted in various teams and consultants being involved and therefore a lack of coherent plan of action was the result. The family also referred directly to Dr. 1, Vascular surgeon, (outside of the normal catchment area for Patient A), but this was not communicated to the district nurses, resulting in a separate referral to the vascular team in the central area.

2.7 Strategic Issues

2.7.1 The independent reviewers have established that BCUHB accepted the recommendations made by Matron 1 in her report dated**28/11/15** and there is an action plan in place. The action plan (**dated 17/2/16**) has eight work streams. From the review document provided to the reviewers on the **15/12/16** the current RAG in full first scores are Red=2, Yellow=4, Green=2.

2.7.2 The reviewers did not see evidence that the action plan above was being given strategic importance. The reviewers were unable to establish how it was been actioned and who was responsible for its implementation.

2.7.3 As part of Matron 1 investigation process, an independent review was commissioned, however this was completed by a third vascular surgeon

from BCUHB and therefore in the opinion of the reviewers, this was not independent and this should not occur in further internal investigations.

2.7.4 The reviewers did not see evidence that matters relating to community prevalence and incidence of pressure ulcers were routinely collected or discussed as a Health Board.

3. Improving Systems and Practice

3.1 The following recommendations have been ordered within the themes identified above: -

3.2 Communication

Recommendation 1

BCUHB need to identify an Information Technology (IT) solution to ensure all patients are carried forward following a clinic appointment. The consultant must either discharge the patient (including to the care of the GP) or offer a future clinic appointment. The Care Coordinator along with the GP (see recommendation 13) should be copied into the decision.

This will ensure patients are not lost or fall off the consultants "radar".

Recommendation 2

Consultant letters sent to GP's must be copied to the patient and DN's. DN's need electronic access to hospital and GP records.

This will improve information sharing and clinical communication.

Recommendation 3

Conwy County Borough Council (CCBC) need to review their processes to ensure there is a robust quality monitoring system in place that links to commissioning decisions; each North Wales Local Authority should check their own systems in light of this recommendation.

This will ensure those commissioning care are aware of feedback on quality issues from clients and internal contract monitoring staff.

3.3 Referring Pathways for Clinical Concerns

Recommendation 4

BCUHB needs to ensure that DN's can refer to vascular surgeons outreach teams when DN's have a clinical concern. This must ensure that a patient is seen within 5 working days of notice of a vascular clinical concern.

This will improve communication between clinicians and reduce time taken to seek expert medical opinion. Currently DN in the west can link directly with the vascular team to ensure early assessment, support and intervention and this should be health board wide. The criteria used to trigger this action in the west is solely if the DN has a clinical concern regarding a patient with actual or suspected vascular issues .This criterion would be helpful if applied across the BCUHB.

Recommendation 5

All emergency departments across BCUHB need to adopt the same referral pathway to vascular teams thereby ensuring a vascular opinion is sought when a patient attends with vascular clinical concerns.

This will improve patient care and assessment in ED's.

Recommendation 6

DN's must seek expert vascular opinion (Consultant, specialist nurse, Doppler technician) if they are unable to complete a Doppler examination due to pain. (This could be classed as a clinical concern).

This will improve patient assessment.

Recommendation 7

The diabetic foot problems: prevention and management (2015) NICE Guidelines advise that all patients admitted with or develop diabetic foot problems whilst an inpatient should receive appropriate care from a multidisciplinary foot care service within 24 hours. The pathways and implementation of these principles should be utilized for individuals presenting with vascular clinical concerns.

This will improve care to patients with lower limb vascular problems.

Recommendation 8

Emergency department staff and DN's need to be trained to recognize vascular problems, raise clinical concerns and, make appropriate referrals.

This will improve patient care and communication.

3.4 Clinical Examination and Treatment

Recommendation 9

BCUHB need to ensure all district nursing (DN) teams and specialist nurses have immediate access to appropriate diagnostic equipment and appropriate digital cameras (including printing paper and ink etc.) along with education and training on, consent for photography, how to use, store, print and share digital images.

This will improve patient assessment, treatment and communication.

Recommendation 10

Tissue viability and vascular specialist nurses need to issue written and photographic instructions (similar to those used by Specialist Nurse 1 in March 2015) to DN's when treating patients with complex wounds.

This will improve patient care and communication.

Recommendation 11

A Senior Clinical Manager at YGC ED needs to review on the care given on 5/2/15. There was no x-ray completed, the GP letter requesting admission was lost, necrosis was hiding the true extent of tissue damage and infection. There was a missed opportunity to have investigated /explored this further. Patient A was sent home with a diagnosis of local infection/abscess cellulitis (GP notes page 5) only to be admitted the next day as an emergency to YG with a confirmed category 4 pressure ulcer, gangrene and osteomyelitis.
Once the clinical lead from YGC ED has reviewed the actions of the senior doctor involved in the consultation on the 5/12/2015 the clinical lead must prepare a written summary of the actions of the senior doctor and forward that report to the doctor wherever he is working. BCUHB must assist the clinical lead in establishing where the said doctor is working currently.

This will improve patient assessment and care.

3.5 Care Coordination and Continuity of Care

Recommendation 12

BCUHB needs to ensure that guidance is issued so that once the patient is referred to a consultant or any member of his team (e.g. Vascular Specialist Nurse) the patient remains under the care of that consultant, unless there are extenuating circumstances discussed and agreed between vascular surgeons.

This will ensure that future patients do not see consultants and specialist nurses from two areas, thus preventing communication problems and improving continuity of care.

Recommendation 13

Each district nursing team need to identify one district nurse who will act as the coordinator for all care provided to a patient once admitted onto the DN caseload.

This will improve communication and coordination of care.

Recommendation 14

Each district nursing team needs to identify a "link nurse" who receives additional training with regards to assessing and managing a patient with vascular problems.

This training will include spending at least 3 working days per year working with a vascular specialist nurse based in one of the acute hospitals.

This will improve patient care and communication.

3.6 Strategic Issues

Recommendation 15

BCUHB should review incidence and prevalence data (or Datix reports, TVN referrals, vascular referrals, POVA information) on pressure ulcers established in the community.

This will ensure managers monitor activity data and that this information ultimately results in leaders and managers making informed changes to practice and processes as required. This will ensure clinical treatment is continually improved. Geographical areas of high prevalence can then be identified and issues highlighted to ensure the environment is conducive to a reduction in the prevalence rates.

Recommendation 16

A named BCUHB executive needs to be nominated to take managerial responsibility for ensuring that the work streams from Matron 1's investigation/action plan that remain yellow and red are addressed immediately and that the recommendations listed within this APR are considered and an action plan developed to ensure full implementation across BCUHB in a reasonable timeframe.

This will ensure BCUHB learn from this APR and improve their services for patients.

Recommendation 17

The NWSAB should review whether the recommendations made in this report have been actioned after a reasonable period of time. The reviewers feel that 9 months should be sufficient time.

Based on the failure of BCUHB to implement in full the recommendations made in Matron 1's report, the panel would suggest external scrutiny is needed along with a rigorous and exact time frame set by the lead executive from BCUHB.

This will ensure action is taken in response to this report.

Statement by Reviewers			
REVIEWER 1	Peter Liptrot	**REVIEWER 2**	Trudie Young
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, nor have I given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, nor have I given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues	

issues as set out in the Terms of Reference.	as set out in the Terms of Reference.
Reviewer 1 *(Signature)* P. Lupton **Name** *(Print)* PETER LIPTON **Date** 28.3.17	**Reviewer 2** *(Signature)* **Name** *(Print)* TRUDIE TOUNS **Date** 03/04/2017

Chair of Review Panel *(Signature)*	M M Edwards
Name *(Print)*	Morwena Edwards
Date	…11/04/2017……

Adult Practice Review process

To include here in brief:

- *The process followed by the Board and the services represented on the Review Panel.*
- *A learning event was held and the services that attended.*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

The NWSAB have followed the process detailed in the Social Services and Well-being (Wales) Act 2014 – Working Together to Safeguard People (Volume 3 – Adult Practice Reviews).

The services represented on the Review Panel were Local Authority and Health Board.

The learning event was held on the 17th March 2017 and the services that attended were district nursing (health) and vascular surgery (health).

The family were informed of the APR and were interviewed as part of the process

on the 20/12/2016. Their views have been sought and were represented during the learning event. The family were given feedback following the learning event on the 06/04/2017
☐ Family declined involvement

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to Board Chair ……

Date circulated to relevant inspectorates/Policy Leads ……

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	