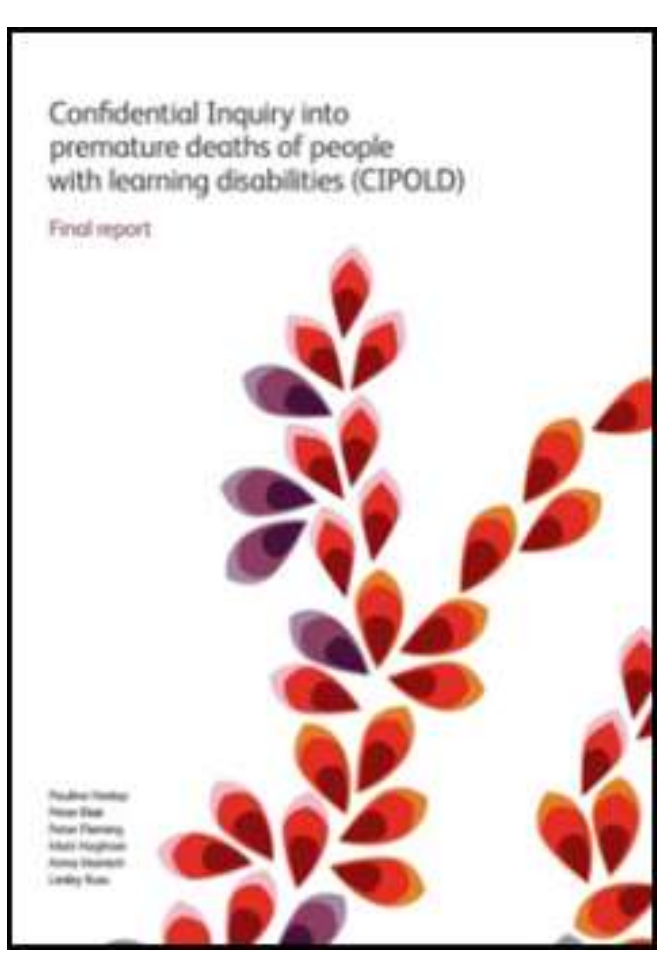
Hospital Mortality Review of Patients with Learning Disability

Adrian Simoes

Mencap - Death by indifference (2007)

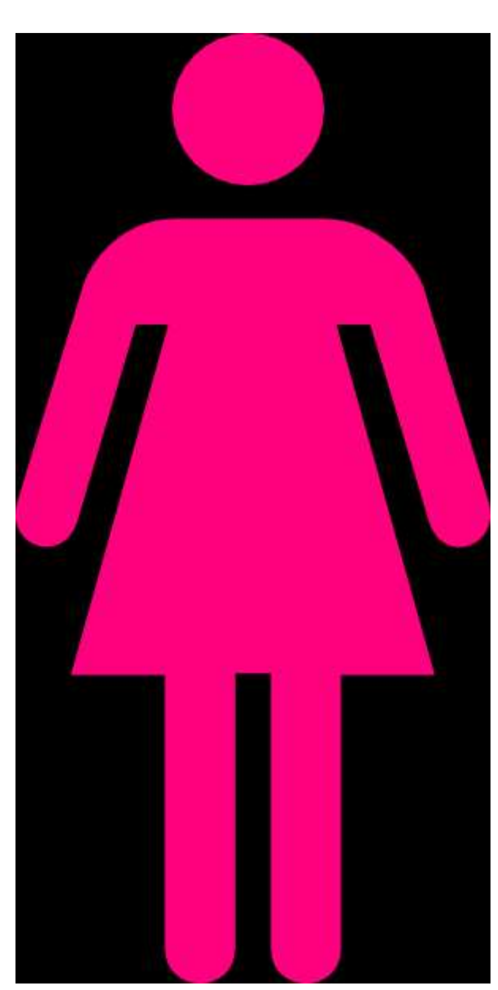
- Low Priority
- Diagnostic overshadowing
- Mental Capacity Act & Consent
- Inclusion of family, carers and friends
- Life Expectancy Estimation
- NHS complaints system

Confidential Inquiry into premature deaths of people with learning disability (CIPOLD)



- 2010 -2012
- 5 PCT in South West England
- 247 deaths in people with learning disabilities
- 58 cases of people who did not have learning disabilities were selected for comparison

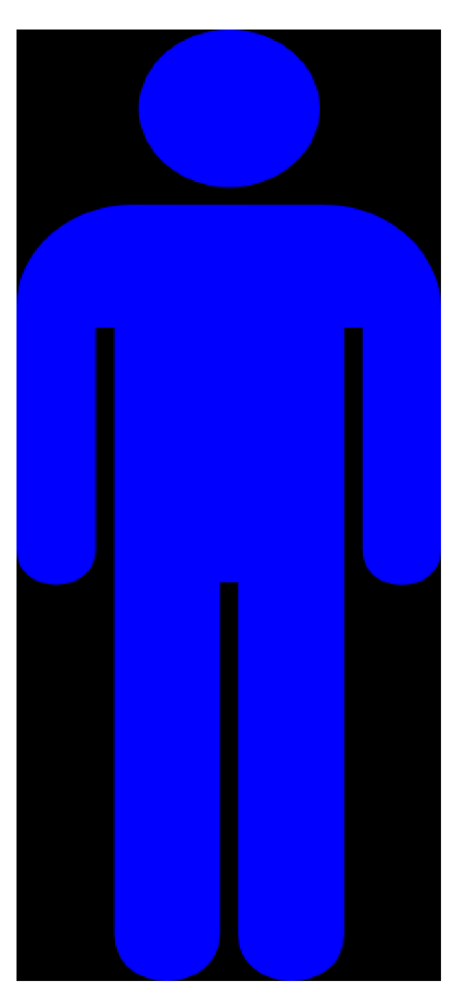
CIPOLD



CIPOLD found that on average women with learning disabilities

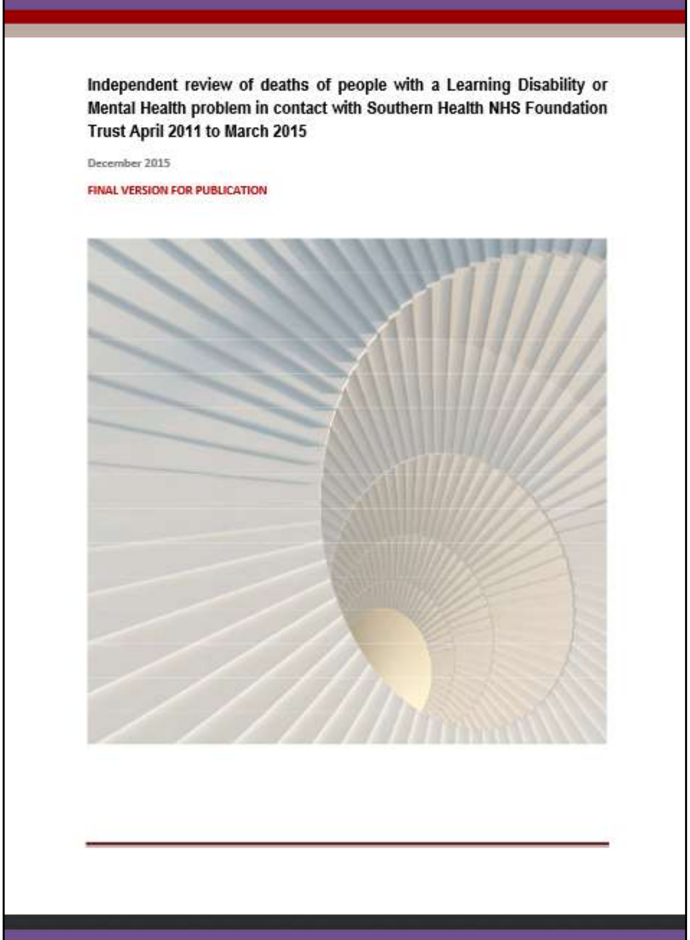
died 20 years sooner than women in the general population.

CIPOLD



CIPOLD found that on average men with learning disabilities died 13 years sooner than men in the general population.

Mazars' report 2015



Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015

December 2015

FINAL VERSION FOR PUBLICATION

Southern Health NHS Foundation Trust

- 23 recommendations directed at the Trust
- 9 recommendations directed at the commissioners
- 7 national recommendations were made

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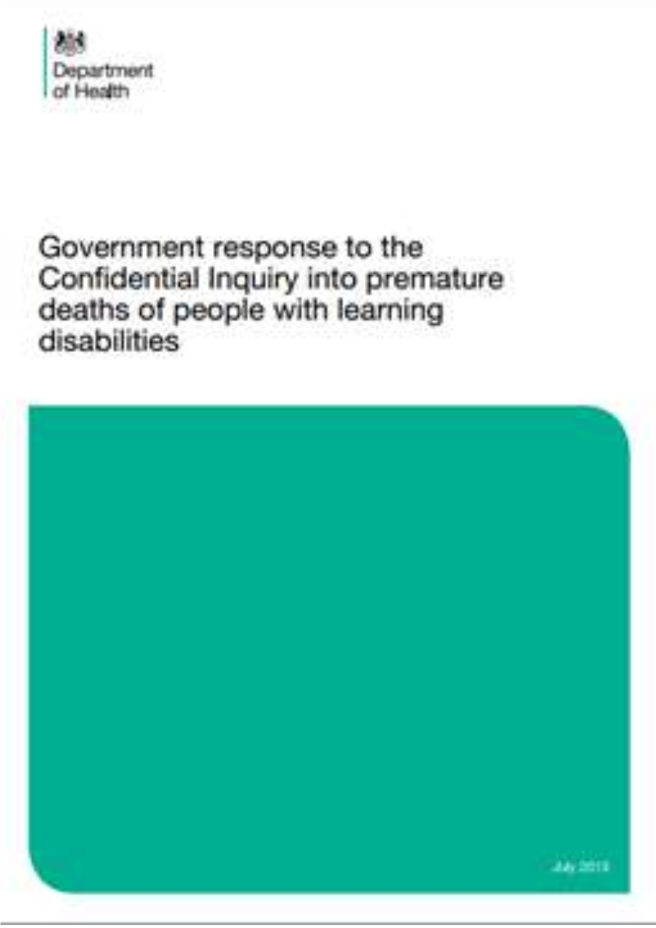
Review of deaths in adults under the age of 50 years at EKHUFT due to sepsis revealed that vulnerable adults were over-represented.

Governments response to CIPOLD



- 18 Recommendations

NHS England has commissioned University of Bristol and Healthcare Quality Improvement Partnership (HQIP) to conduct a 3-5year national mortality review.

AIMS

- Harms or quality of care shortcomings contributing to deaths
- Examine the extent of ‘reasonable adjustments’ made
- Assess the quality of completed DNACPR documentation

Methodology

- Global Trigger Tool for harms and the Preventability of death scale
- Reasonable Adjustment Tool Audit
- Completed DNA CPR forms

Preventability of death scale

1. Definitely not preventable.
2. Slight evidence for preventability.
3. Possibly preventable but not very likely, less than 50–50 but close call.
4. Probably preventable, more than 50-50 but close call.
5. Strong evidence for preventability.
6. Definitely preventable.

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22 people with learning disabilities died in 2014/15

Of these, 17 case notes were reviewed

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17 Case notes reviewed

13 Unexpected deaths

2 Preventable

4 Expected deaths

Four C Reasonable Adjustments Framework (Giles & Marsden, 2014)

Communication

Choice Making

Collaboration

Coordination

Putting patients first

In over half the cases the expected 'reasonable adjustments' were made

Reasonable Adjustment

Communication **7/17 had Healthcare Passport**	**Choice Making** **10/17 had evidence of assessment of capacity**
Collaboration 12/17 referrals related to best interest decision making.	Co-ordination 7/17 involvement of Learning Disability Link Nurse.

Do Not Attempt CPR

Do Not Attempt Cardio Pulmonary Resuscitation.

- 12 of the 17 had completed DNACPR
- 10 were completed adequately

Best Interest Meeting

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Mental Capacity Act 2005 Assessment

1) Does the individual have a diagnosed disturbance of mind or brain like dementia, learning disability, mental health problem, confused or unconscious?	Yes / No
2) What is the decision to be made?	
3) Does the individual understand the procedure, the alternatives, the risks and benefits? **Yes / No** Please comment	
4) Can the individual retain or remember this information? **Yes / No** Please comment	
5) Can the individual weigh up this information in context of their life? **Yes / No** Please comment	
6) Can the individual express a choice based on all of the above? **Yes/ No** Please comment	

Reviewed April 2016

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There were delays in Best Interest decision making, particularly in the nutrition pathway

Conclusion

- Decision making and initiating medical management not affected.
- Majority of DNACPR forms were up to standard

- Delays in setting best interest meetings in 3
- Delays in delivering adequate nutrition in 3
- Delays in recognition and treatment of sepsis in 2
- Repeated visits to the hospitals in 12

Learning Disability Nutritional Care Proposal

A multi-disciplinary nutrition support team to assess swallowing and to prevent delays in nutritional care

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Learning Disability Repeated Admission Pathway

Kent Community Health NHS

East Kent Hospitals University NHS

Learning Disability Repeated Admission Pathway

Rationale – In East Kent compared to the general population, people with learning disabilities are 5 times as likely be admitted via A&E, and 4 times as likely to experience readmission. For full details see www.ekhuft.nhs.uk/ldra

Pathway

- Alert of the repeated admission reaches the Ward.
- Anyone with learning disabilities who has been admitted more than 3 times or has been to A&E more than 4 times in the last 12 months will be referred to the Learning Disability Link Nurses.
- It may be beneficial to make phone contact with the Learning Disability Link Nurses
  - William Harvey Hospital - Steven Taylor tel 03000 410601
  - Kent & Canterbury Hospital - Cliff Elsdon tel 07789985197
  - QEQM Hospitals Margate - Penny Clarke 01304 828555
- Ward staff will share a copy of the easy to read letter with the patient and carer.
- Ward staff can make a referral in two ways
  - Using the form on the EDN system. For instructions click here.
  - Using a paper referral using the form kept here.
- Community Learning Disability Team will make contact with the patient in the most appropriate environment.

Reviewed September 2015

Treating patients with a Learning Disability – a 'what you need to know and how to' workshop

(Aimed at all Hospital Doctors, General Practitioners, Nurses and Allied Health Professionals)

WORKSHOP OUTCOMES AND OUTLINE:

- **In-depth understanding of Learning Disabilities**
- **Service User's personal perspective**
- **Interactive and Scenario based sessions**
- **Legal Duties of Healthcare Professionals**
- **Leadership and Service Improvement opportunities**

Venue: Canterbury Christchurch, Hall Place, Harbledown, Canterbury

Date: 27th March 2015

Time: 12:30 – 17:00

CPD POINTS APPLIED FOR - RCP

Lunch Included

R.S.V.P. Catherine.Kidd@nhs.net

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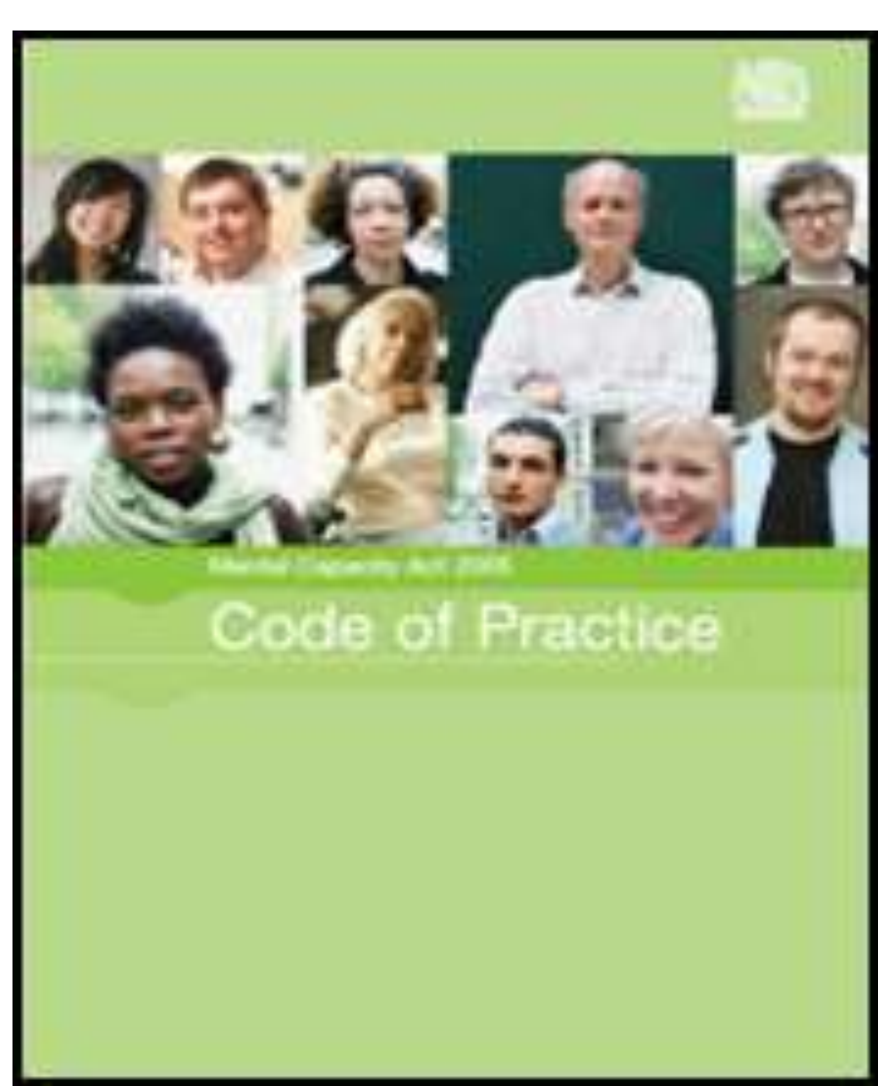
WORKSHOPS

- Education
- Awareness
- Information
- Personal stories

WORKSHOPS



Mental Capacity Act

Education and Training around the Capacity and Consent.

Leadership Role

Clinical Lead for Learning Disability Mortality Review

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Acknowledgements

Dr Michelle Webb

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Helen Cooke

Thank You