1 Background

63 Year Old Martin was a resident of a Care Setting with complex medical issues. He passed away as a result of an injury sustained when falling from a recliner on 6/8/18.

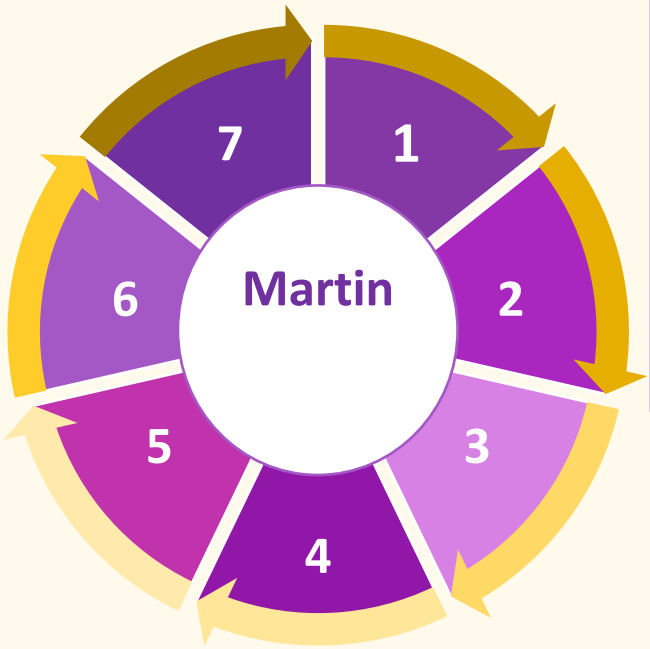
Links:

- SAS Guidance On Mental Capacity Act
- Escalation Policy

2 Context and Initial Treatment

Martin had been a resident in the Care Setting for 18 years. He had a complex medical history including diabetes, peripheral vascular disease resulting in bilateral below knee amputations, morbid obesity and Schizophrenia resistant to treatment. Martin's only next of kin was his elderly father.

On 7/6/18 Martin sustained a shearing injury to his sacrum, likely after falling from his recliner chair. He would not comply with wound care from staff and claimed to be following instructions from the voice of 'Jovah', a symptom of his illness. Following two conflicting capacity statements from two separate GPs, it was noted that Martin had fluctuating capacity and 11 days after the injury saw the Tissue Viability Nurse (TVN) for the first time. The wound had become malodorous.



3 Further Treatment

Over the next 10 days, Martin was assessed and treated by multiple care staff. The wound became infected. A Best Interest Meeting (BIM) was held with a third GP, Community Psychiatrist Nurse and Martin himself. However, the TVN, surgical team and Father were not present. Furthermore, an Independent Mental Capacity Advocate (IMCA) was neither involved or considered. Several key communications relating to treatment were sent by fax rather than e-mail, potentially delaying information dissemination.

It was agreed to be in Martin's best interest that he undergo debridement (the removal of damaged tissue or foreign objects from a wound).

4 Communication and Documentation Process

Following the BIM, Martin was subject to five sessions of debridement, with the wound steadily deteriorating. In each session there was consistently no formally documented capacity assessment. In each session, no IMCA was sought despite initial raised concerns. Frequently, the TVN was not informed of Martin being admitted to hospital and staff from the Care Setting were not provided with information on how to treat Martin post-discharge. In one debridement session, Martin claimed to experience pain which was not responded to by the staff performing the treatment.

5 Findings

The Single Agency Health Review states that agencies did consider how Martin's mental health impacted his capacity to make decisions about his care, but these were not formally documented by either GPs or within hospital records. Furthermore, no valid consent process seems to have taken place, however the TVN has provided good evidence of involving Martin in decisions. The lack of Independent Advocates was sub-optimal and little consideration of Martin's comfort was made during debridement, even after challenges from a carer from Martin's Care Setting.

6 Further Findings

The TVN suggested conducting osteomyelitis investigations which were not actioned. Multiple agencies believe there was a lack of ownership of Martin's care. Whilst much communication between agencies was of a high standard, there are ample examples of it being unsatisfactory.

7 Learning

- Capacity assessments should be thorough and undertaken in context of and individual's changing mental health.
- When an individual lacks capacity, IMCAs should be involved, best interest discussions should happen and be properly documented.
- NHS Foundation Trust consent policies need reviewing.
- Communication and referral pathways between health services should be reviewed, with fax no longer being a suitable medium.
- Onward urgent referral to another surgical speciality should be performed by someone familiar to the patient.
- Detailed Discharge Planning should take place regarding equipment, medication and dressings to assist carers outside a hospital setting.
- NHS Foundation Trust should promote continuity of care.
- Consider analgesia for debridement sessions and ensure analgesia is available when dealing in pain management.
- Since the learning review, practice has been reflected on, and both NHS Foundation Trust and GPs are working collaboratively to work within the recommendations.

7 Minute Briefing

Safeguarding Adults in Stockport