LM Learning Matters

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Special Regulated Services Edition

Introduction

Welcome to a special 'Regulated Services' edition of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care and we recognise that, to raise awareness and enhance learning a variety of ways to share learning are used. This special edition of the Learning Matters Newsletter, seeks to complement existing methods by presenting six learning articles on topics which have been recognised to be recurring themes in a number of SAIs which have occurred within our commissioned services.

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Management of patients on insulin

An elderly Nursing Home resident fell and was found on the bedroom floor. The staff on duty checked for injury and discovered the resident had sustained a small bruise on their forehead.

The resident had diabetes requiring insulin and blood sugars were recorded as significantly higher than usual for the rest of the day without being brought to the attention of their GP or diabetes team.

Key Learning

- All residents with a diagnosis of diabetes using insulin should have a personal diabetes management plan devised in conjunction with them and/or their families, the GP, Nursing / Residential Home staff, the District Nurse and the Diabetes Specialist team as appropriate.
- The plan should include an escalation process in the event of hyper/ hypoglycaemia becoming problematic to manage.

Denture Care

A resident with dementia in a residential care home reported having a sore throat to staff. The GP was contacted and prescribed antibiotics. The resident was monitored throughout the day and when the condition did not resolve, an admission to hospital was arranged. An x-ray was completed and found that a denture plate had become lodged in the resident's larynx which required surgery to remove it.

The Home reported that the resident was unwilling to remove their dentures and chose to sleep with them in place at all times. This routine led to the resident going to bed each night with dentures still in place.

Key Learning

- Early identification of residents with dentures and a clear recording of such needs should be made in the personal file and individual care plan.
- Individual assessment, including risk assessment, of denture care issues should form part of the care plan.
- Denture care and the location of dentures, particularly for people with dementia or other cognitive disability needs, should be carefully monitored.
- Missing dentures should be reported immediately.
- Key risks should be identified during periods of staff handover or at night time.
- Regular dental appointments are important to ensure correct denture fit over time.
- If a patient wears dentures and they are not accounted for you, consideration should be given to check the airway.

Caution with meal packaging

Whilst assisting a service user to eat their pre prepared meal in a day care setting, staff noticed a small shard of black plastic.

Subsequently it was noticed that the packaging was damaged.

On this occasion there was no harm to the service user, but the incident clearly demonstrated the potential risk, whereby the service user, may have choked on the shard of black plastic.

This would be particularly pertinent for those individuals with swallowing difficulties.

Key Learning

Catering/ domestic staff

- Packaging should be thoroughly checked
- If packaging is damaged, the product should not be used
- Damaged packaging should be reported to managers – day care /supported living /shortbreaks /hospital / catering departments

Support staff

- Meals must also be checked by staff who are assisting clients with eating

Equipment related issues

Research evidence suggests that there are a high proportion of residents in private nursing homes who use wheelchairs. Wheelchairs when used incorrectly or unsupervised, can lead to injury. There have been two recent SAIs in which the SAI findings have indicated the inappropriate use of wheelchairs and the need to improve communication between professionals about their appropriate use.

In one case a physically disabled resident in a Nursing Home with an above knee amputation and dementia fell down a stairwell while self-propelling their wheelchair. In this case there were issues surrounding the location and accessibility of the stairwell and the communication between health professionals relating to the appropriate use and precautions required when using the wheelchair.

In another case a nursing home resident suffered a fractured neck of femur following an unwitnessed fall. At the time of the fall the wheelchair was beside the client and was felt by the investigation team to have contributed to the fall, particularly as the resident tended to use the wheelchair to walk. A previous assessment carried out by the physiotherapist stated the client could walk 30 metres but recommended supervision of 1 person at all times when mobilising but the resident had fallen unwitnessed or unsupervised. To address this issue better communication between professionals and appropriate use of equipment was highlighted as a recommendation in this case.

Key Learning

- Ensure all equipment issued (or available for clients' use), are used for the purposes they are prescribed for, and in line with manufacturer's guidance and instructions. Professional advice and assessment should be sought from the relevant AHP professional if the client's condition changes.
- AHP staff should ensure staff within any registered setting including domiciliary care in the clients own home and nursing homes are appropriately informed on the outcomes of assessments, recommendations and precautions to be taken when using wheelchairs and equipment with clients, and that care-plans are updated as appropriate.
- Staff and Care Assistants supporting clients should receive relevant mandatory training on manual handling and should be aware how to safely use prescribed manual handling equipment.
- All staff should adhere to relevant regulations and care/minimum standards for regulated care settings (see link at end)

Falls in Nursing and Residential Homes

Falls are a common event in the nursing and residential care setting, with a recent thematic review showing that 50% of residents fall within a 12 month period.

This figure is significantly higher for residents with dementia where the figures can be as high as 70-80% in a 12 month period.[2]

The key issues from a review of cases identified for Nursing and Residential Care related to:

- Recognition of falls risk
- Assessment of falls risk
- Updating risk assessment in conjunction with changing needs of patients
- Communicating risk of falls to relevant staff/carers
- Environmental factors e.g. poor lighting
- Improper assessment, use or maintenance of equipment such as wheelchairs, walking aids or hoists
- Assessment of medication e.g. sedatives and anti-anxiety medicines
- Poor fitting footwear
- Delirium or confusion
- Time of falls - a high proportion of falls occurred at night time or out of hours particularly when residents needed to go to the toilet.
- Inconsistency in training on falls prevention
- Lack of appropriate post falls review

Key Learning

Key learning for nursing homes

- There should be a falls prevention policy in place within the nursing home which is reviewed regularly
- An assessment for the risk of falls should be carried out, using an evidence based assessment tool, no later than 24 hours after admission to the home
- The risk assessment should be reviewed regularly and updated in conjunction with changing needs of the resident and no less frequently than monthly and the care plan amended accordingly.
- If a resident is deemed to be at risk of falls, following risk assessment, a detailed care plan should be developed, documented and communicated to relevant personnel.
- Staff and Care Assistants supporting clients should receive appropriate training to manage residents who fall.
- All reasonable steps to accommodate residents' safety in relation to equipment and environmental factors should be put in place
- Residents' footwear should be checked to ensure their safety when walking.
- A post falls review should be carried out with 24 hours of a resident falling to determine reason for falling and any preventive action including reassessment of needs and ensuring the plan of care is amended accordingly.
- All staff should adhere to the Regional Standards and Regulations in place in relation to management of falls.[3]

Key learning for residential homes

- All staff should adhere to the Regional Standards and Regulations for residential care homes in relation to needs assessment.[4] Including:
- Assessment details obtained at the time of referral are revised as soon as possible and at the latest within one month of the resident's admission, to ensure there are comprehensive details of:
  - Specific needs and preferences if the resident is fom a minority group
  - Information about the residents life history and current situation.
  - Risks involved in the delivery of care and/or resulting from the resident's behaviour

Security at care homes

An older gentleman went missing from a Nursing Home late one evening and was found nearby the following afternoon. He was admitted to hospital but died later that day. The cause of death was recorded as hypothermia.

The gentleman was mobile and relatively independent. He went for daily walks accompanied by staff but the Home operated a locked door policy and he would normally have been unable to exit without staff knowledge or support.

The Home operated a keypad system and visitors were escorted in and out of the building. It appears that, on this occasion, visitors / relatives may have had access to the security codes.

It is not known if the main door of the building was left un-locked and if so, by whom, but the resident was able to exit the Home unknown to anyone.

Key Learning

- All homes should have a written 'Security Policy' that is known and adhered to by staff and is reviewed periodically to ensure that it remains fit for purpose.
- The policy must ensure a balance between the need for security while safeguarding the resident's right to independence and freedom of movement.
- Where a decision is taken to lock doors, the policy should clarify who can or cannot have access to any security codes.
- Where a member of the public / family member has access to the code, they should understand why the policy is in place (risk management) and be expected to adhere to it.
- The Care Homes Standards detail related policies which homes should have in place:
  - Resident's safety
  - Missing persons
  - Consent
  - Deprivation of liberty
  - Human rights
  - Use of restraint and / or restrictive practices
  - Risk assessment and management
  - Security of the home
- Nursing Homes Standards 5 (Human and Individual Rights) and 18 (The Use of Restraint and / or Restrictive Practices also refer

References

1. https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/care-standards-nursing-homes.pdf
2. Haralambous et al, 2010 A protocol for an individualised, facilitated and sustainable approach to implementing current evidence in preventing falls in residential aged care facilities. BMC Geriatrics 2010 10:8.
3. https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/care-standards-residential-care-homes.pdf

Contact us

Health and Social Care

If you have any comments or questions on the articles in the newsletter please get in contact by email at learningmatters@hscni.net or by telephone on **0300 555 0114 ext: 3446**

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