LSAB

Making safeguarding personal

Safeguarding Adults Review

Hilda

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1. Background and the Commissioning of a Safeguarding Adult Review

1.1 Safeguarding Adults Reviews (SARs) are commissioned through local safeguarding adults boards under Section 44 of the Care Act 2014. They should be considered in those circumstances where there is reasonable cause for concern about an identified adult with needs for care and support and where partner members of the Safeguarding Adults Boards (SAB) consider there may be issues about how they worked together to protect them. The purpose of SAR's is to:

- Identify the lessons to be learnt from the adult's case, and
- Applying those lessons to future cases

The purpose of a SAR is to gain, as far as is possible, a common understanding of the circumstances surrounding the cause for concern, to identify if partner agencies, individually and collectively, could have worked more effectively and to suggest how practice could be improved. The Review is about learning, not blaming, and aims to improve future practice.

1.2 Hilda died in hospital in June 2016. She was 91 and had been admitted a few days earlier from the nursing care home where she had been living for four years. According to the Post-Mortem the cause of death was stated to be threefold: infected pressure ulcers, a coronary artery thrombosis and Alzheimer's disease. United Lincolnshire University Hospitals NHS Trust (ULHT) made a safeguarding referral and referred their concerns to the Police. Subsequently Lincolnshire Safeguarding Adults Board agreed that the concerns about Hilda's care be the subject of a multiagency SAR. Through Lincolnshire Safeguarding Adults Board information was requested from those agencies that were thought to have contact with her. When this initial information was received and analysed it was believed that the presence of several pressure ulcers was likely to have contributed to her death and the Independent Chair of the Board commissioned a Safeguarding Adult Review and requested that the Board's SAR Panel oversee the work.

1.3 There was some delay in initiating the SAR as there was also a Police investigation into the circumstances of Hilda's death. At the end of that the evidence was reviewed by a Senior Crown Prosecution Service (CPS) lawyer. It was concluded that whilst the evidence demonstrated the failures of staff performance at the nursing care home may have contributed to her death, the evidence was not sufficient to establish that the cause of Hilda's death was as a result of gross negligence by any one or more of those identified as responsible for her care. The advice from the CPS was that the evidence did not provide a realistic prospect of conviction.

1.4 Inquest proceedings, which relate to the death of Hilda who died on the 30th June 2016 at Lincoln County Hospital were held on the 7th of January 2019.

The coroner presiding stated " my conclusion is that Hilda died from natural causes, her cause of death be contributed to by neglect. And I say for the avoidance of doubt that it is neglect on the hands of Cheney House rather than the GP practice". The SAR covers in significant detail a period of just over 11 weeks from 4th April 2016 when it was recorded that Hilda had all pressure areas intact until her death on the 30th June. The Panel identified those agencies that had or may have had information about Hilda during this period. They are listed under Appendix 1. The agencies were also asked to include any information known subsequent to the date of her death that related to the period and facts under review in this case. Agencies were also invited to include any other information they considered relevant outside the time period identified and also draw it to the attention of the Panel. The nursing care home was no longer in operation at the time of this review, but the nursing care home's notes were accessible through Lincolnshire Police and were reviewed by a senior member of Lincolnshire Clinical Commissioning Group (CCG).

1.5 For most of the 11 weeks Hilda lived in a nursing care home. The nursing care home was regulated through the Care Quality Commission (CQC) - the national body responsible for regulating health and social care provision. The role of the CQC is as an independent regulator, is to register health and adult social care service providers in England and to inspect whether or not fundamental standards are being met. They had last inspected the nursing care home in September 2015 and the report was published in January 2016. The overall judgement was that it 'requires improvement'. More information about the findings and their significance is covered in Section 4 of this report.

1.6 The multiagency Panel set up to oversee the review commissioned an independent author to complete a report – Alan Coe. I am an independent social care consultant and have authored several

Safeguarding Adult Review reports. I qualified as a social worker and at various points in my career been an Assistant Director of Social Services, inspected social care services in both England and Scotland and have been an independent chair of both a Safeguarding Adults and Children Board.

2. Key Findings

2.1 Hilda was a frail elderly person and had a range of significant health problems. Her physical and mental deterioration was inevitable but her health care needed to be well-managed. Despite no direct contribution to this Review from the nursing care home's owners or staff there is sufficient evidence to conclude that in the nursing care home there were several significant shortcomings in the professional care she was offered. Inspections and evidence from the agencies who visited the nursing care home indicates that although there were some concerns about the quality of care at the nursing care home these were not of a magnitude that would have indicated Hilda or other residents were at serious or immediate risk. In that sense her death could not have been predicted.

2.2 There is also some evidence that greater professional curiosity from the GP practice might have brought to light concerns slightly earlier than they were.

3. Methodology

3.1 The process of gaining an understanding of how and why Hilda died and the circumstances surrounding that, was threefold. Firstly, each agency reviewed their own records, produced a chronology and offered a critique of what they did including whether it followed procedures and represented good practice. Each was undertaken by a senior representative from the relevant agency who had not been directly involved in her care or responsible for the immediate oversight of it. Where there were concerns about practice the individual agencies took immediate action to address them and produced an action plan to support any necessary changes. Those agency recommendations are contained as Appendix 2 (p. 19) to this report. Secondly, the individual chronologies were made available to the author who reviewed them and identified issues about how the combined partnership of services operated to assist Hilda and where that partnership could have done more to assist her. The independent author also spoke with relatives. Finally, there was a presentation event involving all agencies concerned and chaired by the chair of the Panel overseeing this review. The author of this report also attended and participated. This helped clarify and understand the reports produced by each agency. The group also had access to a combined chronology of key events to better understand the interrelationship of actions of each individual agency with those of other agencies.

3.2 Representatives of the nursing care home were invited to participate in the review but did not respond to the offer to do so. That absence of direct evidence from the nursing care home's management, owner, or the staff limited aspects of this Review. However, representatives of the CCG had access to the nursing care home's notes and reported on what they found but were unable to offer explanations about any gaps in the records or talk about the day-to-day experience of staff there. Furthermore, it has been possible to include evidence from the Inquest in early 2019 where the Coroner had the opportunity of taking evidence directly from witnesses which included ex-staff members and the home owner. In the table below is a summary of which agencies were involved and what their specific engagement in the review was:

Organisation	**Involvement**
Lincolnshire Police	Referred to Police for investigation as a safeguarding concern in June 2016. Investigated the circumstances of Hilda's injuries and eventual death. Reviewed evidence from the nursing care home, GP and NHS providers and Lincolnshire Council. The evidence was reviewed by the Crown Prosecution Service and a decision made not to pursue criminal charges.
Adult Social Care	Involved in initial advice to Hilda and family concerning care options in 2012. The Council contributed to the Continuing Health Care review undertaken by NHS Arden on behalf of Lincolnshire West CCG. Adult Social Care Commissioners were involved with the nursing care home in setting and monitoring standards of care for residents funded by the Council.

	Adult Social Care oversaw the safeguarding referral made about Hilda's care from June 2016 onwards.
United Lincolnshire Hospitals NHS Trust	Provided care for Hilda following her admission to hospital in June 2016 until she died.
Lincolnshire West CCG	Reviewed the involvement of the CCG in commissioning care for patients from the nursing care home.
Lincolnshire Community Health Services NHS Trust	Reviewed the involvement of community health services supplied to Hilda in the nursing care home – specifically, the Tissue Viability Service.
Glebe Medical Practice	Reviewed the involvement of the surgery and the identified GPs who had responsibility for Hilda's care.
South West Lincs CCG (reviewed nursing care home records)	Undertook a review of the nursing care home's records on behalf of this Safeguarding Adults Review.
Care Quality Commission	Reviewed records to determine whether there had been any concerns raised about the nursing care home subsequent to their 2015 inspection.

4. The Context of Care

4.1 People who are looked after in residential homes require personal care and support. Those people with more complex needs, requiring frequent nursing support receive care in a registered nursing care home where qualified nurses are always part of the staff group.[1] In both instances they require to be registered with the CQC. Nationally, the residential and nursing home sector is a challenging one and Lincolnshire is no different in this regard. In broad terms demand for care is rising and the availability of nursing home beds are reducing.[2] Levels of dependency in older and disabled people are rising and the people that nursing and care homes now care for are generally more dependent than a decade ago. The recruitment and retention of staff remains a challenge. The quality of nursing homes and nursing staff varies and the CQC notes that the problems of poor quality care are worst in this sector with almost a third of all nursing care homes inspected 'requiring improvement', or being rated 'inadequate'. This report refers to the CQC's assessment of the quality of care in the nursing care home in question and speculates about the capability of the nursing staff at the nursing care home at the time.

5. Personal History Family Perspective

5.1 Hilda had lived in the nursing care home for approximately four years. This was partly privately funded but nursing care was funded nursing care (FNC) through the CCG. She was extremely frail and had Alzheimers.

5.2 I met Hilda's relatives – her daughter, granddaughter and son-in-law. They described a strong and resilient person who had lived through the 1939-45 war contributing directly as an ARP warden as one of the people repairing damaged planes. She was proud of her appearance and 'didn't suffer fools gladly'. Having to see her becoming frailer and more forgetful was inevitably difficult and the family supported her in their own home for a number of years. When this became impossible, they considered residential care despite their inevitable misgivings about not being able to support her as they would have wished. At this stage a social worker was involved to give advice and support in determining what options might be available to Hilda. Of the nursing care homes that were available and affordable they chose the nursing care home which is the focus of much of this report. They were initially satisfied with the care she received. They had confidence in the manager who was there

[1] The Care Quality Commission provides more specific definitions.
[2] The Care Quality Commission: The State of Health Care and Adult Social Care in England 2016-17.

initially but after her departure they became far less so. They also mentioned a particular carer who took a personal interest in their relative but after a while they left to work elsewhere.

5.3 After a while they perceived a decline in the quality of care. During the early to middle part of 2016 the family saw five different managers preside over the nursing care home as well as other staff changes. Some of these may have been temporary short-term staff as the panel could identify three reported changes of manager.

5.4 The family noted a reliance on bank and agency staff to replace them. As one relative said: 'you did not know who was in charge'. During that time, they identified a series of problems the cumulative effects of which caused them considerable concern. The family had always seen Hilda as a person but felt the indignities of poor care rendered her as just another resident. They noticed allergies and dietary likes and dislikes were not consistently followed. There were concerns about missing clothing and her overall cleanliness. There was a lack of social stimulation. They mentioned that the activities coordinator was not replaced when they left. They considered personal choices were not respected: 'everybody was pulled out of their bedrooms and plonked in the lounge'. However it is noted that Hilda was allowed to stay in her room with the TV or radio on.

5.5 The attitude of some staff was a point of concern. The family felt Hilda was not encouraged to eat or drink and they saw no choice of diet. On one occasion they noted retrospective recording when they pointed out she had not eaten her tea. By April they saw considerable changes in Hilda including weight loss and her becoming less cooperative. They pointed out that they felt that if staff had explained what they wanted her to do this would have helped. Hilda's decline and admission to hospital are outlined in greater detail elsewhere in this report. Although the family regularly reported concerns to the office within the home, they did not escalate their concerns beyond the nursing care home itself and there is no information that tells us what they did about their concerns or how formally it was handled.

5.6 The family were struck by the contrast to the attitude towards care between staff at the nursing care home and those of the hospital where they witnessed a personal and caring approach which extended not just to their relative but to the whole family.

6. Summary of Hilda's Care April to June 2016

6.1 During the period covered by this review Hilda was in poor health. She had advanced Alzheimers and was doubly incontinent. She was reluctant to eat and drink. Her degree of ill health and incapacity meant that she met the criteria for funded health care. The nursing care home had identified that there was a high risk of tissue viability issues which indicated that preventative measures were necessary to maintain skin integrity. In early April there was an annual review to determine whether she might be eligible for a higher level of NHS support in view of the complexity of her needs. This was completed through Continuing Health Care (CHC) arrangements.[3] Eligibility for CHC is assessed by a combination of health and social care staff and then reviewed on a regular basis and at least annually unless the manager of the nursing care home or interested party trigger a more frequent one. Hilda was not well enough at this time to make her own decisions about matters such as her care or the management of her finances. At that time financial decisions were managed on her behalf by a family member who had Enduring Power of Attorney.

6.2 The review of Hilda's care arrangements included a social worker from Lincolnshire County Council (LCC) and involved the deputy manager of the nursing care home, Hilda's daughter and a nurse responsible for CHC assessments from a Commissioning Support Unit provided by NHS Arden and GEM Commissioning Support Unit, a service commissioned by Lincolnshire West Clinical Commissioning Group (LW CCG). The outcome was confirmed in a letter two weeks later from the Continuing Health Care Team which stated that her needs were not sufficiently complex, intense or unpredictable to justify CHC funding. However, in the section of the letter it comments on skin integrity saying that she was vulnerable to skin breakdown which was further compromised by her continence needs. The letter concluded that she required: 'regular monitoring and intervention when appropriate to maintain comfort and avoid infection'.

6.3 During April there is evidence of some oversight with sixteen entries in the nursing care home records relating to monitoring of her skin and intervention to avoid possible pressure ulcers. However, the

[3] Continuing Health Care is a national arrangement whereby long-term health care needs are funded by the NHS.

oversight was not entirely regular and either reflects an incomplete record or variable monitoring or failure to meet her health needs consistently. Included in this are references to her skin reddening and barrier cream being applied later in the month, when there are more specific references to pressure damage. This included a reference to a linear blister above her right hip on the 17th April and reference to a Grade 1 pressure ulcer – the lowest and least severe grade – on the 24th April. Similarly, on the 27th April there are references to pressure ulcers on the sacrum and right hip being noted and dressed. These references to pressure ulcers were not reflected in the care plan or the tissue viability risk assessment.

6.4 By the 19th of April there is a reference to her as now having a pressure-relieving mattress. At this time the nursing care home records also confirm she required two people to assist with moving and that she was doubly incontinent. The nursing care home record dated 19th April mentions that she had very limited understanding of her situation and was frequently 'non-compliant' and therefore unable to make informed choices concerning her care and treatment. Social care records indicate that she had been referred for and had been assessed under the Deprivation of Liberty Safeguards (DoLS).[4] The assessments had been completed and the application was being processed so not yet in effect. The referral was made in April 2015 by the nursing care home. They should have therefore been particularly vigilant about how choices were offered and respected.

6.5 During May there were four direct references in the nursing care home's notes to Hilda's skin integrity. A monthly assessment of her eating and drinking on the 21st May indicates that she was continuing to refuse food and drink. On a routine visit to the nursing care home on 26th May her daughter was informed of her mother's breakdown of her mother's sacrum causing tissue problems and blisters in her groin. However, there is no evidence to suggest they informed her about a recorded Grade 4 pressure ulcer which is a significant failure.

6.6 From the first of June until her admission to hospital in the late hours of the 22nd the severity and persistence of Hilda's pressure ulcers is a continuing element of the nursing care home's recording, so the completeness of that record is open to question as indicated in 6.3. On the 4th of June they recorded a grade 4 pressure ulcer saying that there was moisture damage to her right hip. In two separate entries on that date the size of the wound is recorded as 6x5.5mm and 6x5cm. The records indicate that the Tissue Viability Nurse should be contacted. The records do not indicate who was assigned to do this. However, from information gained at the Inquest the manager made clear she identified a specific member of staff to do this. The pressure ulcer was photographed, and reference made to contacting the GP on the following Monday – June 6th for fresh dressing supplies. There was a copy of the photograph of the pressure ulcer in the nursing care home records but other than the date there was no other information linked to the photo on the size or severity of the wound. There was recorded advice about turning her and also not putting her to bed at the unusually early time of 6pm. The tissue viability wound care plan dated 4th June refers to the wound as grade 2-3. The plan refers to contacting the Tissue Viability Nurse but there was no confirmation that this was done at the time. The recommendation on Hilda 's care plan was that she should be turned every two hours. The evidence that this was followed is variable with documented reference in the nursing care home's notes only on the 4th and 20th June although it may have been done more frequently. There was a revised tissue viability wound care plan from 6th June with specific advice about the frequency she should be turned and when the Tissue Viability Nurse should be involved. As previously indicated the GP was contacted for the first time on the 6th June and on the basis of information shared in the phone call, a prescription for antibiotics issued. From evidence gained at the Inquest the home Faxed the referral and described the pressure ulcer as a grade 4. However, the GP was not requested to visit by the nursing care home until the 17th.

6.7 There is a further reference to the pressure ulcer in the nursing care home's notes from the 8th June. This was described as grade 3 but as a grade 4 on the wound chart. Also, in the notes were two different care plans for tissue viability. Also, on the 8th the nursing care home sought advice from the NHS 111 service in response to a possible intolerance to the prescribed antibiotics. They provided an alternative prescription. The wound assessment and pressure ulcer dressing record confirmed the pressure ulcer as grade 4 measuring 2 inches by 2 inches. From information gained at the Inquest it

[4] 'DoLS ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests'. https://www.scie.org.uk/mca/dols/at-a-glance

is clear that a referral to the Tissue Viability Nurse had yet to be made but that there was some confusion as one staff member wrongly believed that it had.

6.8 Her daughter and grand-daughter visited on the 11th June and noticed a strong odour but was informed this was either coming from another room or as they had just had lunch and were in the process of toileting the residents. Hilda's grand-daughter noticed one of her feet was purple in colour after Hilda's sock had come off and was told by care staff it was bad circulation.

6.9 Evidence gained at the Inquest indicates that on the night of 16th June a staff member had noted in nursing records that Hilda had a grade 4 pressure ulcer which was necrotic. She identified the need for a referral to the GP and Tissue Viability Nurse and passed information on to the day shift for this to be done. Again, this was not acted upon.

6.10 Hilda's dressing was changed on the 17th June but reapplied on the 18th due to leakage. By the 19th the night staff recorded that Hilda was: '(…) very poorly and frail'. Pressure ulcer on right hip is leaking and looks very nasty indeed. Dressing changed last night. She is drinking but not taking food. Antibiotics continue. Needs urgent referral to Tissue Viability Nurse'. During this time it was noted by the family that Hilda regularly consumed fluids with their support. On the following day that referral is recorded as completed and contact made with the GP to request a new prescription for antibiotics as the current course had been completed. The GP did so and requested the Community Nursing Service to visit to review the tissue viability. The GP also requested to be contacted again should the wound deteriorate. The records show that the dressing continued to leak on the 20th through to the 22nd June.

6.11 Hilda's daughter states that the home never contacted her about her mother except for one occasion in May when the owner contacted her to ask her to take part in a review of her mother's care plan. She went on holiday a week prior to 21st June and Hilda's grand-daughter was the nominated point of contact for the home. Both were concerned at this time about Hilda's condition but they were not informed of Hilda's pressure ulcers nor the antibiotics she had been prescribed. On the 21st Hilda's daughter visited and found her mother in bed. She recalls that she helped Hilda drink some water from a beaker which she emptied. She was told they had tried to get the Tissue Viability Nurse to assess her but, according to the nursing care home staff the doctor had been obstructive and unhelpful. However, there is nothing in the nursing care home's records alluding to this.

6.12 On the 22nd the nursing care home requested a visit from the GP and the GP, having visited requested that she be admitted to hospital. Prior to the request for hospital admission the visiting GP had sought advice from a more senior practice member about appropriate care options.

6.13 There was a delay in transfer to hospital by the ambulance service. In their management report, East Midlands Ambulance Service (EMAS) acknowledged they had not met their target but that at the time they were facing very high demand including 10 'Red' requests that required an immediate response and over 40 'Green' calls. They also had ambulances stacking at the hospital. An appropriate Capacity management plan agreed by commissioners was put in place. The report states that the request to transfer Hilda to hospital was monitored and that resource logs were checked regularly.

6.14 On admission to hospital on the 22nd the staff conferred with a family representative who confirmed concerns about Hilda's care and a referral was made to the Lincolnshire Local Authority Safeguarding Team in line with agreed local procedures and also contacted the Police.

6.15 The nursing care home was suspended from receiving new placements in July 2016, by Lincolnshire County Council and Lincolnshire West CCG following a review of the nursing care home. By February 2017 the nursing care home was insolvent and voluntary closure took place in April of the same year.

6.16 In 2019 the Coroner recorded a narrative verdict stating that Hilda died from natural causes but that neglect on the part of the home was a contributory factor.

7. Analysis

7.1 The service with substantial contact with Hilda was the nursing care home. A limitation of this review has been that it has not been possible to directly engage the owners of the nursing care home. However, it has been possible to access their records and for them to be independently analysed by a

CCG representative. The records indicate that the nursing care home was experiencing difficulty in looking after her a view confirmed by the experience of her family.

7.2 Additionally, the GP surgery was in contact twice by phone but that contact was not face-to-face until immediately prior to her hospital admission. In view of the severity of the pressure ulcers identified in April and continuing into May it is concerning the nursing care home did not specifically request a visit earlier than they did in view of the fact that they had identified a grade 4 pressure ulcer. They also had a duty to notify a Grade 3 & 4 ulcer to the CCG, the Care Quality Commission and the Local Authority Safeguarding Service in line with multiagency procedures. Although the nursing care home did not request a visit the practice might have recognised that a visit was needed for a full assessment including overall physical health assessment. This this covered in more detail in 7.14.

7.3 All nursing and care homes have to be registered with and are subject to inspection by the CQC.[5] This is to ensure they conform to the Health and Social Care Act and associated regulations and standards. Associated with requirements about the number, quality and training of staff – including having a registered manager. They last inspected the nursing care home in September 2015 and their report was published in January 2016. At that time, their overall judgement was that the nursing care home: 'requires improvement'- the third lowest of four grades. This is defined by the CQC as: '[t]he service is not performing as well as it should and we have told the service how it must improve'.[6] There was an individual assessment of each criterion and found as follow:

- Safe – requires improvement
- Effective – requires improvement
- Caring – requires improvement
- Responsive – requires improvement
- Well-led – requires improvement

Given the service was rated 'requires improvement' CQC would be expected to inspect the service within 12 months of the date the inspection report was published. However, if concerns and risks were identified they would inspect at any time.

7.4 At the time of the inspection the nursing care home did not have a registered manager but there was an acting manager in place. Nursing care homes must recruit staff with appropriate skills and knowledge to carry out the care and support they offer. The nursing care home employed qualified nurses who had a professional responsibility for ensuring that health care was appropriate for their residents and also to take responsibility for seeking additional specialist health support if required as it clearly was in the case of Hilda. There was nothing in the CQC report to suggest that they were understaffed or that they had failed to undertake necessary recruitment checks. Two particular findings are of significance in respect of this review. They were that: '[t]he registered provider did not have systems in place to monitor the effectiveness of the care and treatment people received' and '(…) the provider finds out more about best practice guidelines for the special care needs of people living with dementia'. The report noted that the nursing care home did not have a Dementia Champion and that 35% of staff had not received training in dementia care. The CQC report referred to an internal audit in August 2015 that identified omissions in some individual residents' care plans. Although the concerns above were identified they fell short of the CQC threshold of requiring immediate enforcement action. During the period this report covers there were no concerns from other agencies logged with the CQC.

7.5 As Hilda had sufficient resources to fund her own care, the Council rightly participated in an assessment of her needs, but did not directly provide services or commission services on behalf of Hilda. However, it had a responsibility for the quality of residential care (i.e. excluding all forms of nursing care) as it commissions such care for other residents within the home. Such contracts are routinely managed by the Council with finding from contract management of the residential care being shared with those who are responsible for commissioning and contract managing nursing care. This is an example of good practice. As part of the process the Council's contract management service

[5] All homes must register under The Care Act 2014 and The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2014

[6] This can be found on the CQC Website as follows: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/ratings

visited the nursing care home in late April 2016. They identified a number of areas for improvement. Of relevance to this Review they found that there were significant gaps in staff training and commented that: 'no one appears to have Tissue Viability or Pressure Awareness training'. The Council required that this should be rectified with a plan in place by the 17th of June. The contracts team also noted that the nursing care home's infection control audit was incomplete and required that it should be rectified by the end of May. The Council was proactive insofar as it shared this finding with the CCG and the Public Health Service demonstrating an appropriate awareness of partnership in addressing concerns about care. Following Hilda's death, the Council Contracts' Team made a further unannounced visit which led to additional requirements for improvement and a further action plan was requested which incorporated both new and existing requirements.

7.6 The response to Hilda's declining health is of concern in a number of ways. Firstly, the nursing care home included qualified nurses among its staff and they, along with senior managers of the nursing care home, should have realised that they are required under regulation to report serious pressure ulcers to local NHS colleagues in the CCG, the CQC and as a safeguarding concern. This is and was a statutory responsibility and a clear responsibility for nurses to follow and supported by national good practice guidance.[7] Local multiagency safeguarding procedures are unequivocal in emphasising the point. 'All Grade 3 and Grade 4 which occur in patients in receipt of NHS Funding are reportable as a serious incident in accordance with NHS England's Serious Incident Framework (2015)'.[8] Once more, with that reporting there is an opportunity for greater specialist intervention to review the care arrangements and to reduce the pain and discomfort. This was a serious omission by the nursing care home.

7.7 There is evidence, described in detail in 6.6 and 6.7, of inconsistent monitoring of her care. Had that been in place it would have been easier to identify a decline in her skin integrity and taken earlier action to prevent further decline.

7.8 Depending on the outcome of initial enquiries such a referral might have led to a subsequent adult safeguarding referral, which the nursing care home could also have done themselves. In view of the findings of contract officers following their visit in late April the nursing care home should have been particularly concerned that their identified training deficit meant any issues concerning pressure ulcers were addressed with great care and in line with procedures. This also is an indicator of the deficit in governance in the nursing care home identified by the previous CQC report.

7.9 Secondly, the severity of the pressure ulcers, particularly in June, must have been evident to all staff that saw them. Nurses and care staff have a professional responsibility to report poor and dangerous care that can affect their patients.[9] The pressure ulcer was photographed on the 4th of June – which is standard practice - and in a staff comment on her records on the 19th it was described as 'very nasty indeed'. On the 4th June a referral to the Tissue Viability Nurse was proposed and yet a referral was not received until 18 days later, on the 22nd. It raises the question whether the nursing care home fully understood the significant role of the Tissue Viability Nurse in advising and supporting.

7.10 Thirdly, the analysis of the nursing care home's records identifies significant shortcomings in practice. These include:

- variations in the assessment of the severity of the pressure ulcer and lack of clarity about which of two ulcers notes refer;
- poor communication with other healthcare professionals;
- poor nursing care in regard to care and treatment of pressure ulcers;
- failure by the nursing care home staff to understand and apply the principles of the Mental Capacity Act in relation to identifying quickly when an assessment needs to be made concerning a possible deprivation of liberty;
- gaps in recording and failure to keep a full and comprehensive set of records;
- insufficient clarity on what treatment was proposed or carried out;

[7] Pressure Ulcers – prevention and management National Institute for Health and Care Excellence – April 2014
[8] Lincolnshire Adult Safeguarding Procedures- November 2017
[9] Nursing and Midwifery Council – The Code for Nurses and Midwives 16.1

- the Waterlow[10] pressure ulcer risk assessment was not routinely applied; when Hilda was assessed on 1st April 2016 she was considered to be high risk.
- failure to escalate Hilda's deteriorating health;
- an absence of evidence that food and fluid intake were monitored and recorded daily; and
- delayed implementation of care plans which potentially led to further deterioration in health.

7.11 By early June the nursing care home knew that Hilda had pressure ulcers yet failed to contact the family and other agencies to inform them of this. Had they done so, this would have given further opportunities to raise concerns. The nursing care home had a duty of candour to do so.[11] The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

7.12 On the 6th June the GP practice received a telephone call asking for their support in treating Hilda's pressure ulcer. Antibiotics were prescribed but there was no visit arranged to see her. Although the nursing care home did not specifically request this, greater professional curiosity by the GP service should have alerted them to the severity of the concern. Although the specifics of what was discussed are not precise any interrogation of the referrer would have elicited information that the nursing care home possessed at that time. This included recent assessments of the wound – variously described as a grade 3, or grade 4 ulcer. The GP could have learnt that there was a photograph of the wound and its dimensions and the fact that it was described as giving off an offensive smell. As such a wound is reportable it might reasonably have triggered such a report and prompted a visit to see their patient. The management report from the surgery implicitly accepts this point insofar as it says the risks to her were 'not sufficiently identified or addressed'.

7.13 The nursing care home contacted the GP surgery again 14 days later requesting a repeat prescription for antibiotics which was arranged, and a GP requested the involvement of community nurses to ensure further support and advice was offered to the nursing care home. However, an opportunity was missed to obtain more information which might have led to a visit on that day. Once the GP visited, at the nursing care home's request, two days later it was apparent that Hilda could no longer be cared for there and a hospital admission arranged.

7.14 There were delays in providing ambulance transport to hospital. The GP requested an ambulance through East Midlands Ambulance Service (EMAS). The GP identified that there was not an immediate life-threatening emergency and it was expected that EMAS would convey Hilda to hospital within a four-hour period. Almost an hour after the expiry of that time period the nursing care home called the ambulance service to enquire when she would be collected. Following that second call an ambulance arrived at the nursing care home 30 minutes later. In total the waiting time was five and a half hours. There was no evidence to indicate that pain relief was offered during that period. According to family members they understood that the ambulance staff who conveyed her to hospital were concerned and they felt angry that her medication had not been organised in advance which led to a delay in transporting her. Evidence from the East Midlands Ambulance Service (EMAS) indicates that it took an hour between arriving at the nursing care home and leaving to convey her to hospital which indicates Hilda was not ready to travel immediately.

8. Professional Practice Issues

8.1 There were examples of good practice in relation to partnership working once the scale of the problems Hilda was experiencing became clear. It involved the council's contracts team, the CCG and public health partners.

8.2 Both the Council and health partners work together to identify any regulated services that might be causing concern. Shared information feeds into a risk rating. The nursing care home had a 'medium' risk rating based on what was known about it. Only high risks were discussed at the meeting.

[10] This is an established tool used by health professionals which helps staff identify the likelihood of a person acquiring pressure ulcers.

[11] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

8.3 It was also good practice that when initially Hilda required care and support the Council's Adult Social care services assessed need and assisted in offering information about possible nursing care homes.

8.4 The involvement of a social worker in continuing health care reviews irrespective of whether or not the Council had a funding interest in the person was good practice and an example of effective partnership working between NHS Continuing Health care Assessors and the Council.

8.5 The family stressed their gratitude for the quality of care from staff when she was admitted to hospital prior to her death.

8.6 Once professionals identified the problems at the time of Hilda's death they worked jointly and effectively to ensure all other residents were safe and well.

8.7 I am concerned that the health professionals at the nursing care home and possibly the GP service appeared not to know about the mandatory reporting arrangements for Grade 4 pressure ulcers. This raises a question as to whether Lincolnshire Safeguarding Adults Board is sufficiently assured that front line care nursing and primary care staff know of and apply this regulatory requirement. Also, front line professional nursing staff and their employers have a duty of care which includes a personal and organisational responsibility to escalate concerns that have not been taken sufficiently seriously. This seemed to be the case in this instance and begs the question whether the Board has sufficient assurance about the general awareness and application of this escalation requirement.

8.8 Although it has not been possible to obtain a direct contribution to this report from the nursing care home's representatives, I understand that the nurses employed at the nursing care home mainly had mental health nursing experience. Although all nurses should have a core set of competencies which would extend to the identification and management of pressure ulcers, a lack of recent experience in general nursing this group of people would not have assisted. The registered manager failed to recognise this point as they could have identified local support and training. The absence of a wider skill mix in the nursing care home's nurses may well reflect the general problems of recruitment nationally identified in Section 3 of this report.

9. Conclusions

9.1 My conclusions are linked to the specific questions raised in the Terms of Reference for this review. These are listed with my conclusions in the following paragraphs.

9.2 **Did Agencies discharge their functions in relation to Hilda in accordance with their own and with LSAB policies and procedures?**

Although most agencies did discharge their functions in accordance with their own and the Safeguarding Board's policies and procedures, some did not. The nursing care home should have ensured that their nursing care was effective in reducing chances of a pressure ulcer occurring and then ensuring additional external specialist help was secured at the point when Hilda's wound was determined to be Grade 3 or 4. Similarly representatives of the GP surgery ought to have made greater efforts to enquire about the specifics of Hilda's wound at that point ensure a physical examination rather rely on second-hand accounts.

9.3 **What information was or should have been shared in relation to Hilda within agencies and with other agencies?**

Information was not always shared effectively between and within agencies as evidenced in the previous section. The nursing care home recorded differing levels of severity for the pressure ulcer. Although the wound was photographed it was unclear why and what this evidence might be used for. They seemed unaware of their statutory reporting responsibilities and therefore did not pass on the information about the pressure ulcer to partners which would have elicited a response. The advice and intervention available through the Tissue Viability Nurse was not well utilised by the nursing care home or the GP.

9.4 **Was risk appropriately identified, analysed and addressed?**

In view of the evidence above it is clear that risk was not sufficiently identified by the nursing care home and GP regarding Hilda's pressure ulcer. Had appropriate risk analysis been in place, some of her discomfort and distress could have been avoided. The nursing care home failed to identify that its staff did not have sufficient understanding under Mental Capacity Act in relation to identifying quickly when an assessment concerning a possible deprivation of liberty needs to be made.

9.5 **Are systems and processes appropriately configured to assist agencies appropriately identify, manage and address risk?**

On the basis of one example it is not possible to be certain about the quality of systems and processes to identify, manage and address risk but there is cause to be concerned and for the LSAB Board to seek greater assurance that what Hilda experienced was a one-off. Discussions I had with partners represented on the Safeguarding Board indicate that there is uncertainty about how consistently nursing care homes and GP practices are aware of their wider safeguarding responsibilities. To address concerns about understanding of nursing care homes' responsibilities regarding pressure ulcers the CCG are introducing a flow chart that will guide them in making decisions on what action they should take. It will also be shared with GPs. Reporting of pressure ulcers has already been shared via GP safeguarding forums, newsletters, Safeguarding dashboard and KPIs.

Both agency recommendations to this Review and my recommendations to the partnership further address issues regarding systems and processes.

9.6 **Did Agencies have a clear understanding of their role and the role of other agencies during episodes of service delivery?**

It was not clear that all agencies had a clear understanding of their role and the role of other agencies. For example, it was unclear to me and to LSAB members assisting with this review why the GP sought community nursing support in preference to a Tissue Viability Nurse. I have made a recommendation about how the Safeguarding Board can obtain greater assurance about the prevalence or otherwise of this as an issue. Similarly, both the manager and nurses at the nursing care home should have sought external help more quickly as well as completing a statutory notification of a serious pressure ulcer.

9.7 **Did Agencies have the appropriate safeguarding policies and procedures in place and did they ensure effective safeguarding activity formed part of their service delivery?**

I did not see the safeguarding procedures in place at the time for the nursing care home therefore, I am unable to comment on their adequacy. However, had there been serious concerns they would have been picked up by the CQC in their inspections. Had safeguarding procedures at the nursing care home been significantly lacking at the time of inspection the CQC would have graded them 'inadequate'. However, the terms of reference rightly link any procedures in place to staff understanding and application which have to be questioned. The staff at the nursing care home should have been more aware of the significance of a serious pressure ulcer and acted more decisively and assertively to ensure Hilda received the right treatment. At the time the CQC had rated the GP surgery as 'good' in all domains. I have made a recommendation to assist the Board in knowing in future whether procedures and practice are fit for purpose.

9.8 **Did Agencies consider whether a multiagency approach to service delivery was required?**

Working in a multiagency way is critical to safeguarding individuals. More can be done to address some of the shortcomings that were evident in Hilda's situation. It is not clear precisely what the nursing care home expected when it discussed Hilda with the GP surgery. The GP was not willing to prescribe antibiotics without a consultation. However, if the nursing care home had concerns about the response from the surgery, or any other agency, it is important to be clear about how to escalate concerns if the requested response falls short of what was anticipated. An understanding and application of a shared policy on how to escalate concerns must be understood by all partners in reducing the likelihood of a similar event happening again. In a different context health and social care commissioners have identified they could do more to jointly monitor nursing care homes where both fund aspects of the care and have acted on this. More positively, once concerns about Hilda became apparent a combination of the CCG, CQC and the Council were quick to determine whether other residents were at risk.

9.9 **Did the regulatory framework work effectively in this case in relation to assessment, review and monitoring functions?**

There is no evidence that the regulatory framework failed to identify care issues in the nursing care home. At the time of the CQC's last inspection they identified that the nursing care home required improvement the level of concern was not sufficient for the nursing care home to be described as 'inadequate'. In the following seven months there were no concerns about care in the nursing care

home logged with the CQC either from the public or professional agencies and in those circumstances; they would not ordinarily go back into a nursing care home to re-inspect.

9.10 **Were there any resources or staffing implications in relation to service delivery in this case?**

Information from commissioners indicates that although they had previously had concerns about staffing levels this was less of an issue in early 2016. I have no direct information from the nursing care home itself. The CQC did not identify staffing levels directly in their report but mentioned that sometimes care staff had to assist with domestic tasks. Their report refers to an acting manager. Family members were clear in their criticisms of relatively frequent changes in staff management, but this had not been picked up as a concern by NHS or Council commissioners nor had there been any complaints about staffing to CQC. Maintaining levels of experienced and well-trained staff is a national issue in care and nursing homes. Without the direct involvement of the nursing care home in this review it's hard to be certain but regular changes in leadership and management does little for the continuity of care or staff support. No agencies identified significant staffing shortages that impeded them in their support and monitoring of the nursing care home. In fact, there are examples contained in this report where standard practice was beyond that which might be expected, particularly in relation to Continuing Healthcare reviews.

9.11 In summary, Hilda was elderly and frail and had a range of significant health problems. Even with the best care possible Hilda's physical and mental deterioration was inevitable but her health care and associated needs ought/had to be well-managed. There is sufficient evidence to conclude that in the nursing care home they were not. Additionally, there could have been greater professional curiosity from the GP practice as evidenced in sections 7.14 and 7.15 of this report. Safeguarding Adult Reviews are commissioned to support improved future practice and reduce the likelihood of a similar event recurring. Each agency concerned with Hilda 's care has reviewed their own practice and, where necessary, included internal recommendations and actions to support better practice. Some have already been implemented and already reduce the likelihood of a similar situation arising again. These include:

- The introduction of a pressure ulcers protocol across care and nursing homes. This will link to and sit alongside recently introduced Department of Health and Social Care Guidance.[12]
- The establishment of 125 Safeguarding Ambassadors in care homes and 110 more to follow.
- Commissioners have focussed on care homes rated by the CQC as requiring improvement leading to a 25% reduction in those in that category.
- Improved joint monitoring of private care home services between Adult Social Care and CCGs rather than it being two separate processes.

9.12 A complete list of these internal recommendations is included as Appendix 2 (p.19) to this report. The nursing care home concerned is no longer in business so there are no direct recommendations that can be proposed for them. Over and above individual agency recommendations there are recommendations arising out of this report for Lincolnshire Safeguarding Adults Board.

10. Recommendations

Lincolnshire Safeguarding Adults Board should:

10.1 Seek assurance from all agencies that they understand their professional responsibility to escalate serious concerns about care and, where necessary, initiate multiagency strategy discussions.

10.2 Undertake multiagency audits of case where there have been issues of category 3 or 4 Pressure Ulcers to seek assurance as to whether all relevant professionals understand and apply their mandatory reporting responsibilities. Depending on the outcome this may need to be a continuing process.

10.3 Seek assurance that there is consistent understanding among GP practices when they seek additional nursing help and advice to for a nursing care home whether this should come from a Tissue Viability Nurse or a Community Nurse.

[12] Safeguarding Adults Protocol – Pressure Ulcers and the Interface with a Safeguarding Enquiry – Dept. of Health and Social Care January 2018

10.4 Seek assurances from health and social care commissioners that staff in care and nursing homes knows how to apply safeguarding procedures and can demonstrate this.

10.5 As part of the Board's multiagency training programme ensure that the lessons from this SAR are understood and promoted.

10.6 Seek assurance from each partner agency that they have shared the findings of this review among relevant staff and can demonstrate they have understood how it might apply to their practice.

Alan Coe – Independent Social Care Consultant

Appendix 1

Agencies involved in the Safeguarding Adult Review:

- Lincolnshire Police
- Lincolnshire Council Adult Social Care Services
- Care Home – invited but did not respond
- United Lincolnshire Hospitals NHS Trust
- South West Lincolnshire Clinical Commissioning Group (CCG)
- Lincolnshire Community Health Services NHS Trust
- The Care Quality Commission
- East Midlands Ambulance Service
- The Glebe Medical Practice

Appendix 2

Individual Management Review report- Glebe Practice: Recommendations

The practice will continue to implement the protocol for assessment of pressure sores that has been embedded since the significant event review on the 1 November 2016.

Glebe Practice Protocol for Assessment and Management of Pressure Sores

October 2016

This protocol aims to support clinicians at the Glebe Practice to:

- Take a history and examine a patient with a pressure ulcer
- Grade the severity of pressure ulcers
- Manage a patient with a pressure ulcer
- Know when to refer a patient to a specialist

Any patient with suspected pressure sore should receive a full clinical assessment.

Pressure sores and the patient's general physical health condition are closely linked.

The whole patient must be assessed to identify causation and enable healing. Assessment of health status includes:

- ✓ Identification of risk factors/co-morbidities. E.g. Dementia, Diabetes, cardiovascular disease, Orthopaedic surgery, Chronic Neurological conditions.
- ✓ Continence
- ✓ Neurological
- ✓ Nutrition. BMI/diet – is referral to dietician needed
- ✓ Pain – consider stepping up the analgesic ladder
- ✓ Blood Supply
- ✓ Mobility
- ✓ Medication

Examinations – (Supported by photography calibrated with a ruler)

Ulcer assessment should include:

- Cause if ulcer
- Site/location
- Dimensions of ulcer
- Stage or grade (see 'Classification system', below)
- Exudate amount and type
- Local signs of infection
- Pain
- Wound appearance
- Surrounding skin
- Undermining/tracking (sinus or fistula)
- Odour

Classification system

European Pressure Ulcer Panel Grading System

- Grade 1: non-blanchable erythema of intact skin. Discoloration of the skin, warmth, oedema,

induration or hardness may also be used as indicators, particularly on individuals with darker skin – in whom it may appear blue or purple.

- Grade 2: partial-thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister. Surrounding skin may be red or purple.
- Grade 3: full-thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia.
- Grade 4: extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures, with or without full-thickness skin loss. Extremely difficult to heal and predispose to fatal infection.

Management

Patients with extensive superficial pressure ulcers, Grade 3 or 4 pressure ulcers or those that are deteriorating should be referred to a specialist service.

- Repositioning of the patient.
- Treatment of concurrent conditions which may delay healing.
- Pressure-relieving support surfaces such as beds, mattresses, overlays or cushions.
- Local wound management using modern or advanced wound dressings and other technologies.
- Patients with identified Grade 1 pressure ulcers are at a significant risk of developing more severe ulcers and should receive interventions to prevent deterioration.
- Pain relief
- Infection control:

Systemic antibiotics are required for patients with clinical evidence of infection. Offensive odour, systemic sepsis, spreading cellulitis or underlying osteomyelitis.

NB: do **NOT** offer systemic antibiotics to adults based only on positive wound cultures without clinical evidence of infection.

Pressure sores should be managed by a multidisciplinary team. Always ensure management plans are communicated fully (verbal and written documentation) so all members of the team are fully informed regarding management of patient. Recognise that poor communication between the interdisciplinary team can have negative implications for patient care. All members of the team need to be aware of their roles and responsibilities to the patient. Carers/GP's/Nurses/District Nurses/Specialist Tissue Viability Nurses all need to communicate well to ensure the best possible care of the patient.

PRESSURE RELIEVING EQUIPMENT - LEARNING POINT

Pressure relieving equipment redistributes the load or relieves the pressure at regular intervals (for example – alternating pressure systems).

Alternating pressure devices aim to produce low pressures at the skin interface by relying on the sequential inflation and deflation of cells within the system. This avoids high pressure at any one point, but specifically at bony prominences.

Pressure reducing equipment redistributes pressure by spreading the load (weight) over a larger surface area (for example – static overlays, mattresses and cushions, and dynamic air loss systems). Low air loss devices produce low interface pressures at cell inflation by conforming to the patient's weight and may offer an option for comfort in contrast to an alternating system.

Mobility and Movement of the patient remains important even when all the equipment is in place.

Individual Management Review report - Lincolnshire West Clinical Commissioning Group: Recommendations

LW CCG have identified no recommendations.

To note that since this incident Lincolnshire CCGs have signed up to the Lincolnshire Information Sharing

Agreement with Lincolnshire County Council, South West Lincolnshire CCG, South Lincolnshire CCG, Lincolnshire East CCG, Lincolnshire West CCG, East Midlands Continuing Health Care and the Care Quality Commission.

The purpose of this information sharing is to facilitate coordinated management, monitoring and improvement of high risk social and health care providers in Lincolnshire.

Individual Management Review report – Lincolnshire County Council: Recommendations

It is recommended that LCC and CCGs should explore the benefits of the Council acting as lead commissioner for FNC and CHC on behalf of Lincolnshire CCGs. This should include integrated contract management and market management of relevant care sector providers.

Individual Management Review report – United Lincolnshire Hospital Trust: Recommendations

ULHT have identified no recommendations.

Individual Management Review report – Lincolnshire Police: Recommendations

Lincolnshire Police have identified no recommendations.