Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review Summary Report in Respect of

Mrs Webster[1]
1931-2017

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[1] A pseudonym chosen by her family

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1. Executive Summary

1.1 This Safeguarding Adults Review relates to the circumstances surrounding the sad death of Mrs Webster, who died aged 86 in Kettering General Hospital, (KGH). Mrs Webster was the mother of 2 daughters, who described her as "a very independent person: a homemaker; creative in crafts like knitting; she spoke her mind - a Yorkshire woman"!

1.2 Mrs Webster was a widow for a number of years, living independently and generally in good health in Yorkshire until she was 80 when she had two burglaries, the second of which resulted in a hospital stay. Her daughters described her as losing confidence and in 2014 she moved to sheltered accommodation in Northampton to be nearer to her brother and elder daughter.

1.3 In September 2014 following a hospital admission to Kettering General Hospital (KGH), she received increasing support from commissioned home carers, interventions from Northamptonshire Health Foundation Trust (NHFT) falls prevention service, as well as family support.

1.4 On 11th September 2015, following an admission to KGH, she was assessed as requiring 24 hour care. She moved into Thorndale (Residential) Care Home. On admission to Thorndale her health concerns were noted as: vascular dementia, heart murmur, cataract in one right eye, poor mobility and a history of falls, and amongst other medications she was in receipt of regular vitamin B12 injections.

1.5 Her family, who visited regularly, described her as happy in the first year. She engaged in craft activities and importantly for her, had private space. Family members were very satisfied with her care and communication with the staff, though they felt this deteriorated in mid-2017.

1.6 Mrs Webster continued to fall in Thorndale, though without serious consequences. She was again assessed by the NHFT Falls Service and on advice, Thorndale provided some mobility aids.

1.7 However, on 10th November 2017 following an un-witnessed fall[2] it was identified that she had a wound to her back, which was initially thought by ambulance staff to be a stabbing wound. Safeguarding alerts were raised and Northamptonshire Police began an investigation but the wound was quickly identified as likely to have been caused from a splinter from a spinal fracture.

1.8 Mrs Webster was discharged back to Thorndale after a scan to her head but the next day she fell again badly cutting her face on her glasses and was taken to KGH where she underwent further scans to her spine. Before those scans were examined she was transferred to NGH for treatment of her facial injury and by mistake the scan taken of her head the previous day was sent rather than the new scans. Her spine fracture was not identified until the next day by her GP.

1.9 She was admitted again to KGH, where she died within two weeks of this 3rd admission.

[2] Mrs Webster had 34 recorded falls in Thorndale between 1st January 2017 and 11th November 2017 – 5 required A&E visits but only the 2 on 10th and 11th November required an overnight stay.

1.10 The findings from a post mortem on 15th December 2017 was that her death was from natural causes as a result of bronchopneumonia, likely exacerbated by lack of mobility due to the neck collar worn.

1.11 On 22nd December 2017, Northamptonshire County Council (NCC) Safeguarding Adults Team (SAT) submitted a referral for a Safeguarding Adult Review (SAR) to Northamptonshire Safeguarding Adults Board (NSAB) on the ground that Mrs Webster might have experienced "organisational abuse/neglect/acts of omission".

1.12 In Feb 2017, the Independent Chair of the NSAB agreed that the circumstances met the criteria for a SAR under section 44 of the Care Act.

1. KEY AREAS OF CONCERN

1. Was Thorndale (Residential) Care Home meeting Mrs Webster's needs and assessing her risks, particularly in relation to falls, appropriately and in a person-centred way over the period January 2017 to her death in November 2017?

2. Was there external oversight of Mrs Webster's direct care and of the quality and regulatory/contract compliance of Thorndale (Residential) Care Home.

3. Why were staff involved with Mrs Webster, including GPs, Community Nurses, KGH, NHFT, NGH, and Thorndale, not raising safeguarding concerns, given the number of falls she was experiencing?

4. Family involvement in multi-disciplinary discussions/ meetings.

   Why did no agency organise a multi-disciplinary professionals' meeting involving Mrs Webster's family following one of her attendances at A&E?

5. Mental Capacity Assessment (MCA) and Best Interest Assessment decision making

Given that there are a number of examples where Mrs Webster was distressed/non-compliant when health, care, and safety interventions were seen to be necessary, why is there such little recording of MCA assessments and BIA?

6. Why did the KGH staff not identify the significant injury to her spine[3] and why was the relevant scan not sent to NGH?

[3] "*The cervical **vertebrae** of the **spine** consist of seven bony rings that reside in the **neck** between the base of the skull and the thoracic **vertebrae** in the trunk. Among the **vertebrae** of the spinal column, the cervical **vertebrae** are the thinnest and most delicate bones*"

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Was Mrs Webster's death predictable and was it preventable?

Were there any actions that could have been taken that would have prevented her death or the physical and emotionally painful (for her, her family, and staff who knew her) circumstances in which she died?

3.1.1 Whilst Mrs Webster's family recognised that her health was deteriorating and she would die eventually, she came from a long-lived family. They were shocked that she died so quickly after the 10th November 2017 fall and subsequent events, and were extremely upset that she died in such circumstances.

3.1.2 Given her increasing number of falls and frequency of ill health incidents, research informs us that it was statistically predictable that Mrs Webster would die following a fall. As she grew older she accumulated an increasing number of risk factors for falls, including sensory deficits, mobility and balance issues, and cognitive decline. "Visual and hearing deficits are thought to impair balance control, increase cognitive load that reduces ability to multi-task distract attention from surroundings and contribute to inaccurate assessment of environmental obstacles. Because of age-related sensory and cognitive changes, older people have to allocate more attention, typically with reduced attentional capacity, to maintaining their balance during everyday activities."

3.1.3 Whilst the research evidence base is patchy, a current incomplete piece of research identifies that**, "**Falls are three times more frequent in care home residents than in older adults living in the community and outside long-term care: falls can lead to significant injury, with one in ten care home residents who fall sustaining a fracture: falls account for 40% of all injury deaths in care homes: this can lead to fear of falling in care home residents, with subsequent activity restriction and associated depressive symptoms, muscular atrophy and weakness."[4]

3.1.4 Unless people are going to be confined in a wheelchair or a bed it is very difficult to prevent falls in people with the range of health issues Mrs Webster had. Such confinement has its own health risks as well as human rights issues about least restrictive environments. More observation is unlikely to have prevented all her falls. Best practice consists of full and regular assessments of the person and the living environment; layout, furnishings and lighting of homes, and actions to prevent the impact of falls.

3.1.5 Whilst no one can humanely prevent all falls it is important that risk assessments fully explore with the person and/or relevant family members, particularly with those who have Power of Attorney responsibilities for Health and Welfare, their views on acceptable risk.

[4] "The Falls in Care Home study: a feasibility randomized controlled trial of the use of a risk assessment and decision support tool to prevent falls in care homes" Gemma M Walker, Sarah Armstrong, Adam L Gordon https://journals.sagepub.com/doi/full/10.1177/0269215515604672

4. Recommendations and Considerations

4.1 One of the key purposes of a SAR is to identify what lessons can be learnt so that an action plan can be put in place that will help prevent similar harm in future cases.

4.2 Mrs Webster's family have been actively involved in discussing what they would like to see changed following their experience in the last year of their mother's life, and also their involvement in this SAR.

4.3 They would like the following to be considered: If the resident has an increasing number of falls they should be able to change to a home where there is nursing care as clearly their safety needs are not being met in the residential home; Care Homes should communicate better with relatives, particularly Next of Kin; families should be informed of any inspections being carried out by the regulator, CQC; as both hospitals did not diagnose their mother's back injury correctly, there needs to be better communication between hospitals; safeguarding concerns could have been raised earlier by the care home, as they are failing other residents that have falls and as a result end up in hospital; there should be sufficient staff at all times in Care Homes – relatives should not be expected to step in; and the family noticed a positive difference in their mother when she had her regular vitamin B12 injection but they had difficulties getting this done on time by GP so there should not be delays in medication.

4.4 They also said in relation to their involvement in the SAR that they welcomed the opportunity and in the meetings they have felt listened to. However, they said, "As families have the opportunity to participate in a SAR and comment on the draft report, they also need the opportunity to view the report and consider the content before any meeting where comments are required to be made. Failure to do so gives the impression that their views are unimportant".

4.5 Recommendations

1. NCC senior managers should provide assurance to NSAB that their current actions to manage the identified shortages in assessment and review teams are having a positive impact in reducing waiting times for people as delayed reviews of care and support can have significant negative consequences for individuals whose needs and risks are likely to be change over time.

2. NCC Quality Team should provide assurance to NSAB that that the quality of all Residential Homes is being monitored and that action plans are in place to ensure people are receiving appropriate person centred support and risks to safety are assessed and managed.

3. NCC Commissioning Senior Managers should assure NSAB that measures are being taken to review the contractual relationship between NCC and all care providers to ensure that all residents using services are afforded the same level of scrutiny currently provided by the NCC Quality Team to some providers.

4. KGH should provide assurance to NSAB that it has implemented and is monitoring an action plan to prevent similar errors identified in this SAR.

5. All NSAB partner organisations should provide assurance to NSAB that the views (voice) in line with Making Safeguarding Personal (MSP) of the patient/service user is heard and recorded in treatment and care interventions.

6. All NSAB partner organisations should review their training (access to learning opportunities as well as formal training) and practice in relation to MCA assessments and Best Interest decision making.

7. NSAB should assure itself that it is promoting, supporting, and monitoring effective staff learning opportunities in the difficult area of mental capacity considerations within all organisations.

8. NSAB should arrange for the findings from this review to be widely disseminated, including through their standard post SAR learning event. Particular areas of learning that need to be shared include evidence based best practice in preventing and managing falls; effective use of the mental capacity assessments; and hearing the voice of the person and their family particularly in relation to shared risk taking.

9. Staff who have specific safeguarding responsibilities and who might be involved in, or supervise others involved in SARs, should have access to specific training/support and oversight including senior management sign off of the IMR report when an individual management review (IMR) is required.

10. NSAB should make its members aware of the Social Care Institute of Excellence (SCIE) draft SAR Quality markers and consider their use in commissioning SARs and the design of SAR documents/templates.

11. Where staff in Care Homes have concerns about being able to meet all the needs of a resident appropriately, they should refer them to NCC for an urgent care review, and NCC should respond in an agreed timescale as delays can have serious consequences for residents with increasing/changing needs.

12. In line with Regulation 9 of the Health and Social Care Act 2008, NSAB seek assurance that Northamptonshire County Council's Commissioning Team ensure providers are providing person centred care based on residents' needs and preferences and ensure that the communication with residents is heard and recorded.

13. Northamptonshire Partners should consider re-instating the Countywide Falls Ambulance Service given the evidence of good outcomes.[38]

[38] https://www.nice.org.uk/Media/Default/About/Who-we-are/Local%20Practice/13-0010-qpcs-crisis-falls.pdf

4. AGENCY AND FAMILY RELATIONSHIP DIAGRAM

The diagram illustrates that a number of agencies were involved with Mrs Webster but other than her family, Thorndale staff, and possibly her GP practice, most of her contacts with other agencies would have been of short duration, and individual staff were unlikely to have got to know her as a person.

Key:

Family
Health Agencies
Northamptonshire Police
Northamptonshire County Council Adult Social Care
Care Home