Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review Overview Report in respect of

Mrs Webster[1]
1931-2017

Report Author: Shirley Williams MSc. BA. RSW

[1] A pseudonym chosen by her family

Acknowledgements

I should like to thank all those who contributed to this Safeguarding Adults Review (SAR). These include Mrs Webster's two daughters and sons in law, SAR Panel members, and staff from a number of organisations who provided reports.

The management of SARs places significant responsibilities on what is often a small and very busy group of Safeguarding Board staff. I should like to thank those staff for their work and support throughout this Review.

Contents

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 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 a neurological examination and 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.

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.

2. The circumstances that led to a Safeguarding Adult Review (SAR)

2.1 86 year old Mrs Webster died in Kettering General Hospital (KGH) on 28th November 2017. Northamptonshire Police had become involved prior to her death due to a safeguarding concern being raised. The concern was that she had sustained an injury to her back that might have been as a result of a stabbing.

2.2 Following an admission to KGH on 10th November 2017 and subsequent investigation over the next 2 days, the reason for her injuries were assessed as due to a fall-related fracture to her spine, possibly resulting in a bone splint piercing her skin.

2.3 The findings from a post mortem on 15th December 2017 stated that the cause of death was bronchopneumonia which was likely exacerbated by lack of mobility due to the neck collar worn. The neck collar (cervical brace) was recommended as standard medical practice to stabilise the injured area following her receiving cervical and thoracic vertebral fractures as the result of an earlier fall. It was noted that Mrs Webster had vascular dementia and aortic stenosis, and that bronchopneumonia is a common cause of death in patients with substantial co-morbidity. There were no findings at post-mortem to indicate deliberate harm to her and all injuries were consistent with the information provided regarding multiple falls. Given this was deemed to be a death by natural causes there was no reason to hold an inquest.

2.4 However, information shared during the initial safeguarding enquiry indicated there might have been some issues with the quality of health and care interventions prior to this injury, which was as a result of a fall in Thorndale (Residential) Care Home[2], and subsequently during investigation and treatment of this injury, in Kettering General Hospital (KGH) and in Northampton General Hospital (NGH).

2.5 The Care Act 2014 states that a "Safeguarding Adults Board must arrange a SAR when an adult in its area dies as a result of abuse or neglect[3], whether known or suspected, ***and*** there is concern that partner agencies could have worked more effectively to protect the adult".

2.6 On 22nd December 2017, a Social Worker from the NCC's Safeguarding Adults Team submitted a referral form for consideration of a SAR to Northamptonshire Safeguarding Adults Board (NSAB) on the ground that Mrs Webster might have experienced "organisational abuse/neglect/acts of omission".

[2] Thorndale (Residential) Care Home, Kettering Northamptonshire, is part of Shaw Healthcare (De Montfort) Ltd. Thorndale is a 60 bedded residential service registered with the Care Quality Commission, providing personal (without nursing) care. Nursing care needs are met by local community healthcare professionals from Northamptonshire Health Foundation Trust.

[3] Neglect does not need to be intentional to be considered for a SAR.

2.7 On 6th Feb 2017, the SAR Sub Group of NSAB held an extraordinary meeting to consider the referral. On the basis of some initial information from partner agencies they agreed to recommend to the Independent Chair of the NSAB that the circumstances met the criteria for a SAR under section 44 of the Care Act.

2.8 The purpose of a SAR, as described in the Statutory Guidance to the Care Act 2014[4], is so "lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death".

2.9 The Guidance is very clear that the purpose of a SAR "is not to hold any individual or organisation to account*".*

2.10 The NSAB Independent Chair agreed and the process of commissioning an Independent Author and SAR Panel Chair, and the setting up of a Panel, was followed in line with the NSAB Inter-Agency Safeguarding Adults Procedure and SAR Protocol.

2.11 The reasons for NSAB commissioning a SAR were:

- Mrs Webster was an 'at risk' adult with care and support needs who was unable to protect herself from abuse and neglect;
- A number of health and social care agencies were involved with her and there might be lessons to be learnt about improvement in practice from what happened to her; and
- Some information suggested that she may not have received the most appropriate health and social care interventions prior to her death.

3. Methodology for this Safeguarding Adults Review (SAR)

3.1 There is no single prescribed method to conduct a SAR. The Statutory Guidance places emphasis on local decisions with a focus on "what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected".

3.2 The Guidance specifies that "families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively".

3.3 The Guidance also specifies that "professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith".

3.4 A Panel of relevant agency senior staff was drawn together to guide the SAR and take responsibility on behalf of the NSAB to ensure proper process was followed, including that a report with actionable recommendations was agreed.

3.5 I was appointed as the SAR Author/Panel Chair in April 2018. I have a Master's degree in Social Science and am a registered Social Worker.

[4] www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

3.6 **Panel members:**

Name	Role and Organisation
Shirley Williams	Independent Chair and Author
Business Manager	Northamptonshire Safeguarding Adults Board
Designated Nurse for Adult Safeguarding	NHS Nene and Corby Clinical Commissioning Groups
Director of Nursing and Quality	Kettering General Hospital NHS Foundation Trust
Lead for Adult Safeguarding and Dementia	Northampton General Hospital NHS Trust
Lead for Adult Safeguarding	Northamptonshire Healthcare Foundation Trust
Assistant Director	Adult Social Care Services, Northamptonshire County Council
Director of Compliance and Governance	Shaw Healthcare (De Montfort) Ltd.
Detective Chief inspector	Public Protection Command, Northamptonshire Police

The notes of meetings were taken by a member of the NSAB Business Office staff team.

3.7 **Individual Management Reports (IMRs) were provided by:**

East Midlands Ambulance Service (EMAS)
NHS Nene & Corby Clinical Commissioning Groups – GP Services
Kettering General Hospital (KGH)
Northampton General Hospital NHS Trust (NGH)
Northamptonshire Healthcare Foundation Trust (NHFT)
Northamptonshire County Council - Quality & Performance, Older Persons Team North - Care Management including Safeguarding
Shaw Healthcare (De Monfort) Ltd. – Thorndale Care Home

Statements of Information (SOI) were provided by:

Northamptonshire Police
Thames Ambulance Transport Service Limited (TASL)
Further information from Northamptonshire Healthcare Foundation Trust (NHFT) Mental Health Service was provided during course of the SAR process.
An inspection by the Care Quality Commission (CQC) of Thorndale Care Home had taken place on 4th April 2017 and I, SAR author, reviewed the public Report[5].

I also scanned the latest published CQC reports on the CQC website, for the health provider organisations, which had some involvement with Mrs Webster; NGH (November 2017); KGH (February 2018); NHFT (August 2018); and EMAS (June 2017).

[5] www.cqc.org.uk/sites/default/files/new_reports/INS2-2778389477.pdf

3.8 The methodology used for this SAR is a blended (sometimes described as a hybrid) approach. This has been done to build on Northamptonshire Safeguarding Adults Board's experience, including requirements for a chronology from each agency involved with Mrs Webster and for Individual Management Reviews (IMRs), containing analysis of practice as well as description of events.

3.9 Whilst it is good practice to hold 'share and learn' events for front line practitioners and clinicians in SARs it was agreed that the very brief involvement with Mrs Webster of some staff, particularly in hospital settings, would not necessarily result in key learning, and that their involvement in discussion for Individual Management Reports would be a proportionate contribution.

A multi-agency learning event post publication supported by a 6 step briefing is planned prior to this SAR Report publication.

3.10 On 30th April 2018, a SAR Scoping Panel was held of key SAR Sub Group partners.

3.11 On 18th May 2018, an initial planning meeting with the SAR Chair/Author was held. The timeline of events for the SAR was agreed to be from 1st January 2017 until the time of Mrs Webster's death on 28th November 2017.

However, IMR authors were asked to include brief relevant information for the period prior to January 2017.

3.12 On 21st June 2018, at the beginning of the SAR process, I (author) along with a note-taker (NSAB Business Support Officer) met with Mrs Webster's two daughters and the younger daughter's husband. Family members had been actively involved with her and were not in need of advocacy support.

3.13 The purpose of this meeting was to enable family members to share information about their mother/mother-in-law, that they felt was relevant to the Review; have their concerns and views taken into account; and identify any recommendations for improvements in systems and practice they would like to come out of this SAR to better assure that some of the negative things their relative experienced would not be repeated.

The family received and commented on notes from that meeting and made some recommendations they wanted included in the SAR Report. They also provided further information about their contact with Thorndale (Residential) Care Home, whilst Mrs Webster was a resident.

Additional information has been provided by Mrs Webster's elder daughter during the course of the SAR.

3.14 On 7th August and 5th September SAR Panel meetings were held to receive IMRs and discuss the emerging findings.

3.15 On 30th October a further SAR Panel meeting was held to receive updated IMRs and consider an early draft of the SAR report.

3.16 I met with family members in February and the beginning of March 2019 to share the findings of the draft Report. A small number of amendments/clarifications were requested and agreed. Areas of disagreement were expressed about some of the detail in section 4 of the Report but, acknowledging that the SAR's primary purpose was learning and improvement for the future, the family agreed that, as their concerns about these matters were already part of a complaint they were making relating to KGH, they would resolve their concerns through that process.

3.17 **Terms of Reference for SAR**

In addition to adherence to the general principles for all reviews, which includes that SARs should reflect the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability, SARs should both consider and reflect the 'making safeguarding personal' approach[6].

The Review Panel agreed that the following specific concerns needed to be addressed:

1. Mrs Webster had at least eleven falls[7] throughout 2017, with three happening in quick succession in November 2017. Some of these falls resulted in admissions to A&E. To review the quality of assessments, risk assessments and care plans relating to:
   ï) Mrs Webster's mental health to keep her safe from harm
   ii) Mrs Webster's physical health to keep her safe from harm
   iii) The interface between physical and mental health needs
2. To understand the extent to which the wishes of Mrs Webster and her family were taken into account about her care and treatment including compliance with the Mental Capacity Act 2005 and the accessibility and involvement of advocacy. Was consideration given by any agency, at any point, to making a referral to Adult Social Care and was action taken?
3. Did any family member express concerns to any agency regarding Mrs Webster's wellbeing or safety at the Care Home and if so, how was this dealt with?
4. What monitoring did Northamptonshire County Council have in place to review and monitor Mrs. Webster's needs?
5. Was there a delay in the identification of and/or reporting of the spinal fracture? If there was a delay: would earlier identification have resulted in any different decisions regarding the care and treatment of Mrs. Webster? What would the likely effects of the delay been for her?
6. The incident of the missed spinal fracture and the transfer from Kettering General Hospital to Northampton General Hospital for dressing a face/head injury was unclear. What information was shared between the Acute Trusts as Mrs Webster was discharged back to the residential home the following day?
7. Should the patient have been transferred with an unstable fracture?

[6] www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

[7] This was the information at the beginning of the SAR but it became evident that Mrs Webster had more than double that number of falls but very few needed hospital attention.

8. Who requested the spinal scan at Kettering General Hospital and what were their concerns that triggered the request. Who reviewed the scan and what is detailed on the patient's medical records.
9. The clear transfer of records is crucial between both acute trusts. How was the spinal fracture missed? What information did Kettering General Hospital provide and what was Northampton General Hospital's interpretation of the transfer records
10. To consider the quality of information sharing and multi-agency working between partner agencies and whether this had an impact on the care she received.
11. To examine any issues of diversity and discrimination, specifically in relation to her age, disability, and mental health.
12. To identify any organisational factors such as capacity or culture which may have impacted on Mrs Webster's care.
13. To review the effectiveness of procedures, both multi-agency and those of individual organisations.

4. Case summary, practice episodes, and interventions

4.1 Mrs Webster was a Caucasian woman born in North Yorkshire. She lived most of her life in Leeds. Her father worked as a tanner[8] and she was one of seven children. She worked in a mill when she was young woman. Her first husband died early when their daughter was a small child and she married again and had a second daughter. Sadly she was widowed again and she lived on her own in Leeds for many years.

4.2 Mrs Webster's daughters described her as a very independent person: a homemaker; creative in crafts like knitting; she spoke her mind - a Yorkshire woman! She could be sociable if encouraged but preferred her own company or that of people she knew well.

4.3 Aged 80, (2012) Mrs Webster was admitted to hospital following a serious burglary (the second in a short space of time). After this, her family describe her as losing her confidence and her health began to deteriorate[9].

4.4 Her daughters described her health up to the date of the burglary as exceptionally good; she always walked wherever she went and attended church regularly. She had a heart murmur from a young age, for which she had medication.

4.5 It was decided after the second burglary that she would grant Lasting Power of Attorney (LPA)[10] for finances and for health and welfare to both daughters, with her elder daughter having lead authority.

---

[8] Tanning is one of the world's oldest industries. Tanning is the process that turns raw animal hides into the soft, pliable, water resistant material called leather.

[9] http://webarchive.nationalarchives.gov.uk/20110218140642/http://rds.homeoffice.gov.uk/rds/pdfs2/r198.pdf Home Office research in early 2000 - The study was on a small scale but it does suggest that older victims of burglary decline in health faster than non-victims of similar age and the impact of burglary is typically great. Two years after the burglary, they were 2.4 times more likely to have died or to be in residential care than their non-burgled neighbours.

[10] For more information go to: www.gov.uk/power-of-attorney

4.6 She began to fall regularly at home in 2013/14 and after family discussions she moved from Leeds to St Andrews Court, Sheltered Accommodation in Broughton, Northampton to be near to one of her brothers and closer to her elder daughter.

4.7 In May 2014, KGH record their first contact with Mrs Webster. In September 2014, following a hospital admission, she received support from the Northamptonshire County Council Short Term and Re-ablement Team. From October 2014, she began to receive some domiciliary care support. Following a review of her needs in December 2014, her care hours were increased.

4.8 During 2014 and up to September 2015, NHFT had contact with Mrs Webster on a number of occasions following falls and hospital attendances. NHFT's Intermediate Care Team (ICT), Falls Service, and District/Community Nurses (DNs) were involved to provide discharge support, falls prevention interventions, and other community health interventions.

4.9 On 11th September 2015, following an admission to KGH, she was assessed as requiring 24 hour care. She moved into Thorndale (Residential) Care Home. She was 84 years old.

4.10 The Care Home Individual Management Review Report (IMR) recorded that her care assessment document from Northamptonshire County Council Adult Services, identified her health concerns as: vascular dementia, heart murmur, and cataract in her right eye. She had poor mobility and a history of falls, and was in receipt of regular vitamin B12 injections[11]. The assessment also documents that she was unable to follow instructions due to her dementia.

4.11 In December 2015, Mrs Webster fractured her femur (hip) whilst at Thorndale and was admitted to KGH. She spent several days in hospital and made a good recovery and returned to Thorndale.

4.12 From 16th December 2015 to 22nd September 2016, although Mrs Webster experienced some falls, her GP notes recorded nothing of significance. There were short admissions recorded by Thorndale, concerning dehydration and a safeguarding concern raised after she returned on one occasion from KGH with a grade 2 pressure ulcer.

4.13 On 22nd September 2016, Mrs Webster spent a few days in KGH after falling and suffering a head injury and later a chest infection.

4.14 Mrs Webster's family said that in that first year she enjoyed her stay at Thorndale, being involved in activities organised by a specialist staff member and also having privacy in her en-suite room.

4.15 Her family said that while they were told their mother had 'mixed'[12] dementia by clinicians, she still recognised them and followed her TV programmes. Their experience of her was that she was not noticeably confused most of the time even in the period just before she died.

[11] www.cks.nice.org.uk/anaemia-b12-and-folate-deficiency

[12] "Mixed dementia is a condition in which abnormalities characteristic of more than one type of dementia occur simultaneously. Physicians may also call mixed dementia "Dementia – multifactorial."
Reference: https://www.alz.org/alzheimers-dementia/what-is-dementia/types-of-dementia/mixed-dementia

4.16 Mrs Webster liked to walk about and in 2017 was having an increasing number of falls, though most still needed no hospital attendance. There were also concerns about her nutritional intake and weight loss.

4.17 During 2017 she was referred to the following NHFT services:

- Dietetics – for assessment and support with nutritional needs.
- District/Community Nursing – for holistic assessment of her physical health needs, including interventions from a Health Care Assistant who undertook the Phlebotomy (blood test).
- Falls Service – for assessment of falls risks and advice and intervention to reduce the risk of further falls.
- Community Mental Health Team (CMHT) – for assessment of her mental health.

The CMHT declined to carry out an assessment as Mrs Webster did not fit their criteria based on the information they were given.

4.18 In June 2017, NHFT district nurses reviewed Mrs Webster's risks related to her skin integrity and risk of pressure ulcers (Waterlow, SKIN assessment tools); risks related to poor nutritional intake (MUST tools); and risk of overall critical illness in the near future (NEWS). No specific concerns were identified for action at this point; though in July, a full nutritional assessment was undertaken and advice given to Thorndale about her diet.

4.19 On 11th September 2017, the GP visited Thorndale (Residential) Care Home for Mrs Webster's annual Dementia Review. She was seen with a Thorndale carer, and no new concerns were raised. Some recent problems of being tearful and constipated seemed resolved. The GP notes recorded that, 'The Care Home is able to meet all of Mrs Webster's needs'.

4.20 During July 2017, there were some staff changes at Thorndale. These included the registered manager who left on 27th June with a replacement commencing on 3rd July 2017, and the activities worker, who left on 8th May after nearly 7 years in post. A replacement was in post by 31st July. Her family believed these changes upset her. Her daughter also said when meeting with me (the author) that she felt standards began to slip in Thorndale and sometimes there were not enough staff, to the point where on one occasion she found herself having to help other residents as well as her mother.

4.21 Between 2nd October and 10th November 2017, Thorndale Care Home recorded 7 falls by Mrs Webster with 2 of them occurring on 8th November. Only one on 13th October resulted in admission to KGH. The hospital recorded that she remembered having a fall as she got out of bed, and there seemed to be no increased levels of confusion, routine tests were normal and she returned to Thorndale on the same day.

4.22 On 9th October 2017, the NCC Quality Team that had some responsibility to monitor care homes, received an anonymous Notification of Concern[13] that said there was not enough staff to meet the needs of the Thorndale residents and the manager was not approachable.[14]

[13] www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-notification-other-incidents#full-regulation

[14] Mrs Webster's family asked for it to be noted that it was not them who raised these concerns

4.23 These issues of concern were shared with the Area Manager for Shaw Healthcare (De Montfort) Ltd., Thorndale's parent company, and they were asked to provide dependency information and staffing levels for a two-month period. The information was supplied and was signed off as acceptable from the NCC Quality Team on the 19th October 2017. No visits were undertaken to Thorndale.

4.24 On 10th November 2017 at approximately 17:30, Mrs Webster was found by staff crying out on her bedroom floor. Staff checked her over and took her to the lounge to observe her as they believed she had fallen but they didn't notice any injuries.

4.25 At around 20:30, evening staff took Mrs Webster to her bedroom for personal care and identified a large blood stain on her clothing with a hole in both outer and under garments. A District Nurse was visiting another resident and was asked by care staff to review Mrs Webster who had a puncture wound to her back, close to the top of her spine. The wound continued to bleed despite remedial first aid.

4.26 East Midlands Ambulance Service (EMAS) was called and took Mrs Webster to KGH where she was admitted at 22:49. Her daughter was informed. The EMAS IMR notes that staff reported she appeared to have no pain on palpation of neck or back, but there was postural drop (hypotension) to blood pressure.[15] It was also recorded that she was orientated to time, place and person. Her elder daughter said she had been notified earlier in the day of the fall but told all seemed 'okay'. She was notified again in the evening to say staff were taking her mother to hospital to have the wound checked out.

4.27 Because of the unexplained puncture wound to her back, including piercing of her clothing, EMAS sent a safeguarding notification to NCC, but did not report the incident to the Police until 3 days after having concerns about the nature of the wound.

4.28 On admission to KGH it was noted that Mrs Webster was taking Clopidogrel, which would have provided some explanation to the bleeding as this is blood-thinning medication. On examination no other injuries were found.

4.29 The KGH Emergency Department Paramedic and a Nurse in charge reviewed the wound and felt that there was no cause to raise a safeguarding concern in addition to the one that EMAS indicated they would raise.

4.30 A CT scan of Mrs Webster's head was carried out and no abnormalities were detected. The hospital has no evidence that any other scans were undertaken at this time. A Best Interest Assessment recorded a decision regarding basic nursing care, assessments and all necessary procedures and observations; however there was no evidence of a mental capacity assessment to indicate whether she lacked capacity to make these decisions herself.

4.31 On 11th of November, her elder daughter phoned Thorndale for an update and was told she was on her way back from KGH. Mrs Webster was discharged back to Thorndale at midday with a dressing to the injury but no other concerns were raised.

[15] Postural drop/hypotension occurs when blood pressure drops when moving from seated/lying position to upright position. www.nhs.uk/conditions/low-blood-pressure-hypotension/

4.32 Later the same day (11th November), Mrs Webster had another un-witnessed fall when she was found outside the team leader's room. Her daughter told me (the author) that she understood from a Thorndale staff member that the wound was the result of Mrs Webster hitting her head while wearing glasses, which had broken and a piece of metal frame had cut her face. Mrs Webster suffered swelling and bruising to her left eye and zygomatic (cheek) bone with laceration (a deep cut) approximately 2cm long, which bled continuously. It took some time with calls at 16:04, 16:40 and 17:07 before an ambulance was available. Her daughter was called and went in the ambulance to KGH with her mother, who she described as bleeding continuously from the face wound. An adverse incident statutory notification to CQC was completed and sent by Thorndale.

4.33 Mrs Webster was taken to KGH by EMAS, who noted that she had no nausea or vomiting. The crew did not consider there were any safeguarding concerns, and described her as alert but confused on attendance.

4.34 She was reviewed by the KGH Emergency Department Associate Specialist Doctor[16] and the plan was to have a CT scan of her head, cervical spine and facial bones. The KGH IMR states that, "Doctor unable to assess eye due to swelling or carry out a full neurological examination due to dementia, however a grossly normal[17] neurological examination is documented". Her daughter said they waited some time for the scans to be carried out. She accompanied her mother to have the scans and was told by staff at the scan unit that they had done the scan when she was admitted the previous day. The plan was to transfer her as a matter of urgency to NGH to have the facial wound treated if the scans were clear (NGH was the specialist 'point of contact' for all referrals relating to Maxillofacial injuries across Northamptonshire). Analgesia, intravenous fluids and anti-emetic medication were given and the planned scans undertaken by 4ways Healthcare staff at 21:46[18].

4.35 There is no evidence that the scans taken that day were reviewed by any KGH staff before Mrs Webster was transferred to NGH.

4.36 There is documentation that the KGH doctor reviewed a CT scan of her head and attached that to her notes for the transfer to NGH. In fact, that CT attached report is dated 11.11.17 at 04:35 and was the scan result from the CT performed following Mrs Webster's admission the previous day (10.11.17).

4.37 She was transferred and arrived at NGH at 22:22 on 11th November. All the notes from the current (11.11.17) KGH Emergency Department attendance were copied and sent to NGH. Her daughter did not accompany her because the time for transfer was uncertain, she lived some distance from Northampton, and she needed to attend to her own health needs.

[16] A senior middle-grade doctor working in the UK, who has trained and gained experience in a medical or surgical specialty but has not gone on to become a consultant. These doctors usually work independently but are attached to a clinical team led by a consultant in their **specialty**.

[17] **Grossly** normal **means** that the larger picture is normal. In **medical terminology** there is fine and gross. Gross is the larger picture which fine tends to be smaller. It has nothing to **do** with the **term** as we know it 'gross'.

[18] Family members have a number of issues with how many scans were carried out, and which areas of their mother's back was viewed and will pursue these concerns during their complaint with KGH.

4.38 Mrs Webster was initially seen for the specialist assessment and treatment in the NGH Emergency Department (ED) at 22.57. The Maxillofacial Doctor undertook an examination and assessment of her at 00:30 following review of all clinical documentation which was made available by KGH on transfer. This included an initial assessment and identification of a large facial wound which required suturing. The CT scan of the head was also made available which noted there were no fractures identified, though, as noted in paragraph 4.36, this was sent by mistake as it was not the most up to date scan.

4.39 No further information was received that there were concerns by KGH regarding a cervical back injury or that further CT scans had been undertaken.

4.40 After treatment, which in the event did not involve suturing, and a period of observation, there was a discussion with Thorndale Care Home staff about Mrs Webster being discharged back to the residential home.

4.41 The hospital discharge plan was for her to return to Thorndale (Residential) Care Home that day, and the notes recorded that her daughter voiced concerns that Thorndale would not be able to cope with her mother's needs. The Discharge Nurse advised that the family should have a discussion with Thorndale as they had confirmed to another member of NGH staff that they would be able to meet Mrs Webster's presenting needs.

Mrs Webster was discharged back to Thorndale (Residential) Care Home at 13:30 on 12th November.

4.42 On 11th November, the NCC Safeguarding Adults Team were made aware of concerns in relation to Mrs Webster following the EMAS notification and Police involvement because of the unexplained puncture wound.

4.43 Detectives from Northampton Police attended Thorndale (Residential) Care Home to ascertain whether the puncture wound Mrs Webster sustained on 11th November had been caused by an assault.

They found no evidence of this and attributed the injury to an accidental fall.

4.44 On 13th November, Thorndale staff contacted the GP practice at 14:07 to inform them that they were concerned about Mrs Webster, who had been discharged the previous day. She appeared to be in pain and was unable to swallow her routine medication.

4.45 The GP called Thorndale after reviewing her recent medical records and hospital scans and noted the results of the investigations of the head, face and spine carried out at KGH on 11th November 2017. The CT scan had been recorded as reported at 21.41 on 11th November 2017, and noted an unstable fracture of the spine (neck) C1-C2. Given the nature of this serious injury the report recommended an emergency review by the KGH spinal and orthopaedic team[19].

[19] Injuries to the spinal cord at the C1 & C2 vertebral levels are considered to be the most severe of all spinal cord injuries as they can lead to full paralysis but are most often fatal. www.spinalcord.com/c1-c2-vertebrae-spinal-cord-injury

4.46 The GP advised the Thorndale staff member not to move Mrs Webster and called 999 requesting an emergency ambulance for her. The GP travelled to Thorndale and at 15.59 recorded that the ambulance had already arrived when they reached the Care Home. The GP noted Mrs Webster appeared to be in a lot of pain and was mouth breathing.

4.47 KGH staff had a telephone discussion with the Coventry University Hospital, Major Trauma Unit who advised EMAS to take Mrs Webster to KGH in the first instance. EMAS record immobilisation during the transfer and that she was difficult to assess due to her dementia. Her daughter was called by the GP and went to Thorndale (Residential) Care Home and followed the ambulance to the hospital.

4.48 A Mental Capacity Assessment was carried out in the KGH Emergency Department in relation to basic nursing care, observations and assessments as well as necessary procedures. Mrs Webster was deemed not to have capacity to consent to these interventions. There was no evidence of Best Interest decision-making, nor is it recorded that any discussion with her daughter took place in relation to Best Interests.

4.49 The KGH Serious Incident Report stated that on 13th November 2017, Mrs Webster had a "thoracic spine that identifies fractures of the spinous processes from t5 to t9."

4.50 KGH nursing notes indicated that a small foreign body described as a small bone fragment was expelled from the puncture wound to Mrs Webster's back.[20]

4.51 In seeking more clarification for this Review, particularly as the family said they had been told that old healed fractures had shown up on the CT scan, the KGH consultant responded with the following, "The conclusion was osteoporotic collapse at multiple levels, multiple spinous process fractures: the age of these are unclear. Detachment of anterior body spurring at one or more levels cannot be excluded".

4.52 There is some evidence that a Mental Capacity Assessment was carried out regarding treatment for the cervical spine fracture, a Best Interest decision was partially completed regarding this decision and LPA to Mrs Webster's elder daughter was noted.

On the 21st November family members noticed Mrs Webster no longer had a cannula attached. Her daughter was concerned that this meant there was no way to offer pain relief at this time. The IMR for KGH states, "Patient appeared at times to be distressed; this manifests itself in her attempts to pull off the Aspen collar and remove the intravenous cannula and to call out".

4.53 As Mrs Webster was still deemed to be unable to consent to her care and treatment, a Deprivation of Liberty Authorisation (DoL)[21] was appropriately made on 15.11.17.

[20] The family believe this was never confirmed and they will try to clarify in their Complaint with KGH

[21] www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards

4.54 On 23rd November, as Mrs Webster's health deteriorated and she was distressed by the collar, the consultant discussed the poor prognosis with her daughter. Her daughter told me that she talked to her mother, and asked, as she had done before when completing a DNAR[22] form, whether she wanted to have active treatment or not have interventions. She said her mother confirmed that she stood by her previous decision, even when asked a second time later that day. It was agreed to move to adopt a palliative care regime and that there should be no nasogastric tube for nutrition.

4.55 Moving Mrs Webster to a hospice was discussed on 27th November but she became too unwell and died on 28th November 2017.

4.56 On 29th November, the NCC Strategic Lead for Adult Safeguarding and Quality Team called a safeguarding meeting involving staff with safeguarding and/or care quality assurance responsibilities in NCC, KGH, CCG, CQC, and Thorndale (Residential) Care Home (NGH was unable to attend). It was agreed NCC Care Quality and Monitoring would undertake a quality assurance visit to Thorndale. It was agreed that plans for other actions would be delayed until there was more information from the coroner on cause of death

4.57 On 12th December, a second safeguarding meeting was held with a similar attendance plus NGH and a Detective Constable (DC) from Northamptonshire Police, but without representation from Thorndale (Residential) Care Home. The outcomes from this meeting were to: request more information on the reporting of falls from Thorndale (Residential) Care Home to the NHFT Falls team: issue an interim safeguarding plan to KGH and NGH on information sharing: and an interim safeguarding plan to Thorndale in relation to falls prevention.

4.58 Feedback from the Falls Team was that following the Falls assessment and action plan on 14th and 20th April, and 10th May 2017, when she was discharged, she did not receive any further requests for further assessment. Contact was made with community nursing staff who confirmed that they did not have concerns about falls at Thorndale.

4.59 NCC staff from Safeguarding and Care Quality visited Thorndale on 14 occasions following Mrs Webster's death and identified 13 residents, because of their high needs, who needed care reviews, including 4 who needed referral to the Falls Team. These were all completed.

[22] Do Not Attempt Resuscitation

5. Pictorial of family and agency relationships document

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

6. Findings and Analysis

6.1 The Practice Guidance developed by the Social Care Institute for Excellence (SCIE) to assist agencies carrying out Safeguarding Adult Reviews (SARs) as required by the Care Act 2014, suggests that a SAR is needed to achieve understanding of the following[23]:

1. What happened?
2. Were there any errors or problematic practice and/or what could have been done differently?
3. Why did those errors or problematic practice occur and/or why weren't things done differently?
5. Which of those explanations are unique to this case and context, and what can be extrapolated for future cases so become findings?
6. What remedial action needs to be taken in relation to the findings to help prevent similar harm in future cases?

6.2 Section 5 of this report sets out 'What happened'. Section 6 looks at the areas of errors/problematic practice and what could have been done differently and considers why it didn't happen and makes suggestions about how the findings could help to prevent similar harm in future.

Section 7 draws out conclusions and identifies recommendations for remedial action.

6.3 With the benefit of hindsight, this SAR can identify five key areas of potential concern about health and care practice that could have been done differently, and comments on the systems in which the practice occurred. There is a sixth area where an acknowledged error occurred. These areas cover the questions posed in the Terms of Reference at the beginning of the SAR.

6.4 The question "Would different practice have prevented Mrs Webster's death or the physical and emotionally painful (for her, her family, and staff who knew her) circumstances in which she died" will be considered at the beginning of Section 7.

6.4.1 First Key area of Concern

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?

If not, what would better practice look like and were there missed opportunities to improve practice?

[23] www.scie.org.uk/safeguarding/adults/reviews/care-act

6.4.2 The Thorndale IMR states that the number of falls recorded by staff in the last eleven months of Mrs Webster's life was 34; 24 resulted in no injuries; 3 required minor first aid on-site: and there were 5 where hospital treatment was sought for minor injuries and observation due to need for medication oversight. Mrs Webster did not require overnight hospital stays for falls until the 2 falls on 10th and 11th November 2017.

6.4.3 In the analysis section of the Thorndale IMR, a review of the timeline of the chronology put together for this SAR highlighted that the risk of falling was recognised. Assessment and support were sought from the GP practice and referrals were made to the NHFT Falls Service. Improvements, like the replacement of a wheeled Zimmer frame in mid-2017, and then, in October 2017, the purchase of a reverse-pressure alarm mat was made[24]. The purpose of the latter was to alert staff to enable a quicker response when Mrs Webster fell getting out of bed to go to the toilet or after becoming anxious and looking for company, however this did not prove helpful.

6.4.4 The Thorndale IMR also recognised that some things could have been done differently: internal care reviews were needed more regularly to highlight changes in Mrs Webster's needs, and introducing more assistive equipment earlier might have helped to manage the impact of her falls.

6.4.5 Review of the timeline also highlighted that Thorndale staff were not requesting Northamptonshire County Council (NCC), who commissioned and funded Mrs Webster's residence and care at Thorndale, to review/reassess her needs particularly in relation to the impact of her dementia, even though it was likely to be becoming more significant, nor were they evaluating the reasons for her frequent falls.

6.4.6 Thorndale sought GP advice regularly and specialist health referrals were made in discussion with her family and some assessments were being undertaken but no one arranged any all agency/multi-disciplinary review meetings.

6.4.7 Thorndale staff identified that 1:1 staffing for Mrs Webster might have gone some way to reduce/prevent her falls, but they said from experience they had no faith in getting a positive response from NCC to agree to that. It is of note that a referral for a review by NCC was identified as seeking more resources or a potential placement move rather than adopting a multi-disciplinary thinking/problem-solving approach. It was acknowledged that NCC was struggling to staff regular yearly care reviews and the one that was scheduled for Mrs Webster in April 2017 did not take place, though there is also no evidence that Thorndale staff contacted NCC about this.

[24] Use of technology to enhance safety in care homes https://www.sciencedirect.com/science/article/pii/S0020748917300949

6.4.8 It is clear that some good practice was taking place in mid-2017 to assess a number of Mrs Webster's specific health needs, but there was no holistic assessment. The referral to the Community Mental Health Team (CMHT) did not result in an assessment, seemingly because it was asking for specific advice relating to a potential prescription of a "mild sedative to help her sleep at night and therefore avoid falling". There was no mention in the referral of her having behavioural or psychological symptoms, though, from Thorndale records and from some of her hospital records, it would seem that there were other issues that could have benefitted from assessment by the Mental Health Team, such as agitation and distress on occasion and refusal to accept certain treatments.

6.4.9 There was no re-referral to the Mental Health Team, which may have been a missed opportunity, as assessment might have indicated the need for a more holistic review and greater consideration of her mental capacity, including the sort of decision-making areas where practitioners needed to be more aware that Best Interest decision-making might follow assessment of capacity.

6.4.10 Using a 'making safeguarding personal'[25] approach to Mrs Webster might have resulted in a more balanced assessment of her needs, risks *and* her wishes. Her family said she liked to walk; had walked everywhere until she was 80 years old; she liked privacy but also sought company/reassurance on occasion; she liked to do craft activities. Given that her daughters also had Lasting Power of Attorney for her Health and Welfare, it would also have provided an opportunity to discuss how she could be enabled to do things that she enjoyed but which might be risky, for example, walking regularly with planned support, while at the same time taking her safety needs into account.

6.4.11 One of Mrs Webster's family's key concerns on reading the draft of this Report was the consistent references to their mother's dementia. They believed she was sometimes forgetful, and, if unwell, could have periods of confusion, particularly if her vitamin B12 injections were delayed, but they would not describe her dementia as severe, and certainly not advanced as seen in some health reports. Their view was that her behaviour when in pain was put down to dementia when it was a normal reaction to pain. They described her as stubborn; had always been reluctant to take medicine, but she knew how many tablets she was taking and would always ask what they were for.

6.4.12 It is clear from Thorndale staff who attended the first Panel meeting that Mrs Webster was known by staff and they were concerned about her. Her daughter also spoke positively of some staff and that Mrs Webster liked them.

What is of concern is that Mrs Webster's voice does not come through in any of the IMRs. It is difficult to get a sense of her likes and dislikes even within the Thorndale IMR; how she wanted her care to be provided; what she thought about her frequent falls; how she liked to dress; what she liked to do; and what she liked to eat. It is probable that this is because the requirements of completion of IMRs tend to be problem-focused, where good practice is identified with compliance to policies and procedures, sometimes to the loss of hearing and recording the voice of the person. It is also acknowledged that staff in the hospitals would have had very little ongoing contact with Mrs Webster, and most contact would have been difficult as she was in pain.

[25] Making Safeguarding Personal (MSP) Briefing on working with risk for Safeguarding Adults Boards www.local.gov.uk/briefing-working-risk-safeguarding-adults-boards

6.4.13 It is also clear that risks to Mrs Webster's safety, such as fluctuating cognition, deteriorating eyesight, poor hearing, blood-pressure drops, as well as reduced mobility and frailty, warranted regular multi-practitioner assessment and interventions to mitigate the impact of those risks.

6.4.14 As the author of the IMR from NHFT Falls Service notes, "Falls are a symptom not a diagnosis and it is very difficult to mitigate all falls risks". Good personalised care needs to focus on enabling the person to undertake activities that are important to them in the least restrictive manner/environment. Such an approach needed a realistic and shared understanding of the potential risks, including involvement of her relatives and, where possible with Mrs Webster herself, to reach decisions that prioritised her emotional as well as physical wellbeing.

6.4.15 Mrs Webster's family were regular and attentive visitors. Her brother visited her frequently, sometimes daily. The family were involved with her medical oversight, and attended medical appointments with her, including the Falls Assessment appointment.

6.4.16 In April 2016, whilst there were some concerns raised in a letter to Thorndale (Residential) Care Home from Mrs Webster's elder daughter about staffing and cleanliness, the letter concluded that, "*The quality of the food, entertainment and staff personnel are very good and we couldn't have wished for a nicer place for her to live in her later years. I know and my uncle does that mum is very happy at Thorndale*". The tone of this letter and the discussion I (author of this SAR report) had with family members demonstrates their focus was on their mother's happiness, whilst appropriately raising issues of care standards.

6.4.17 In the Spring/Summer of 2017, there is evidence from Mrs Webster's family that they had raised some concerns with Thorndale, again relating to cleanliness and staffing levels (however there is no record of this at Thorndale or within the corporate data base system). Internal audits also did not raise cleanliness and staffing levels as an issue.

6.4.18 The family's concerns would have been an opportunity for all to share views on risk-taking and maintaining her general wellbeing. It would have been good practice and might have led to different outcomes for their mother in that other supports, technological and human, could have been considered.

6.4.19 On 19th September 2017, Mrs Webster's elder daughter did attend one of the regular relatives' meetings organised by Thorndale and raised issues about staffing/laundry/cleaning and entertainment. She said she had asked for minutes from the meeting but never received them. She had not been able to attend many of those meetings due to her work commitments but said she asked for but never received any minutes.

6.4.20 On 30th September 2017, Mrs Webster's daughter visited Thorndale at 11.30. She described, "staffing at its worst...mum dressed but no breakfast...I helped give dinners out to other residents...only 2 staff on floor/care bells ringing". She described the senior staff member on duty as making phone calls to try to get a more senior staff member to attend.

6.4.21 Mrs Webster's daughter followed up the concerns she had from the 30th by visiting Thorndale on 2nd October. She said that she spoke to the Assistant Care Manager about a number of matters, including appropriate menus and cleaning, and also asking whether her mother had been given her vitamin B12 injection[26] and being concerned that no one could answer her question. The family experienced their mother being less confused following her injections, and had shared concerns with the GP that they were not being given frequently enough. She also raised concerns that they were not contacted about her mother's falls, and began to have increasing concerns about how her needs were being met.

6.4.22 This was another opportunity where there could have been a broader discussion and arrangements made for a review of Mrs Webster's overall increasing needs, and whether Thorndale could still safely meet those needs.

6.5 Second Key area of Concern: External oversight of Mrs Webster's direct care and of the quality and regulatory/contract compliance of Thorndale (Residential) Care Home

6.5.1 Why was NCC not fulfilling its own requirement to carry out person-centred case reviews of Mrs Webster in her residential placement? A scheduled review in July 2017 hadn't been carried out. Why was there no direct contractual oversight of Thorndale? What would better practice look like and were there missed opportunities to improve practice?

6.5.2 There was some good practice in external oversight of Mrs Webster's health needs through her GP Practice/GPs and Practice Nurse and other health professionals involved in assessments and health interventions, including from KGH staff. She was monitored by the Practice on a 'Review of admission avoidance plan' (RAAP) in which the practice safeguarding administrator and GP reviewed her records regularly and updated their understanding of her condition, noting any changes needed to avoid hospital admission.

6.5.3 However, there was only one contact from NCC Adult Social Care service during the 2 years Mrs Webster lived at Thorndale. NCC's Older People's Team provided the IMR for this SAR in relation to reviewing her needs and the appropriateness of her care at Thorndale. However, neither that team, nor any other NCC social care team, had any contact with her or her family from April 2016.

6.5.4 Mrs Webster had moved to Thorndale on 11th September 2015. This followed a reassessment of her needs after a fall at home that led to a hospital admission. She had been receiving support from her family and contracted domiciliary care staff. Her care/placement at Thorndale was reviewed by NCC on 6th April 2016. Her daughter was involved in the review and reported that her mother was happy and Thorndale was meeting her needs.

---

[26] Information on B12 deficiency can be found at: www.nice.org.uk/advice/mib40/chapter/introduction
One of the symptoms of deficiency is memory loss and some studies have identified 20% of people over 80 may have vitamin B12 deficiency.

6.5.5 NCC Adult Social Care policy is to review commissioned/funded care placements annually and records indicate that the Central Review Team had responsibility to undertake the annual review on 25th April 2017, but this did not take place. NCC had reorganised teams and responsibilities to cope with increasing demand, and a large number of cases for review were unallocated. The SAR Panel was informed that this situation remained the same at the time of the SAR although temporary staff had been/were being recruited to deal with the backlog of reviews.

6.5.6 It is of note that Mrs Webster's daughter was expressing concern in April 2017 about 'slipping' standards at Thorndale. NCC's Older People's Team IMR author rightly identifies that, if the scheduled review had taken place, these concerns could have been considered by a multi-disciplinary team at the same time as looking at the number and significance of Mrs Webster's falls.

6.5.7 Care Homes themselves are subject to scrutiny from a number of organisations, some on a planned basis, for example, commissioning/contract monitoring/quality departments of local authorities and from the Care Quality Commission; and from others like the Health and Safety Executive (HSE), on a more incident notification basis.

6.5.8 The SAR Panel were made aware from an early draft IMR by the NCC Quality Team that scrutiny, by way of direct contract monitoring of the quality of care at Thorndale, was not being carried out by NCC. The last monitoring visit by that team to Thorndale had been undertaken on the 19th of June 2015 following a Notification of Concern. The SAR Panel expressed some concerns about this and asked for further information.

6.5.9 A final version of the IMR of the Quality Team stated that, "NCC has a number of different contracts with Providers for the delivery of care and support. All of the contracts have terms and conditions that specify the requirement for quality monitoring. Quality Monitoring for all Providers is completed using the same process with the exception of the Shaw Private Finance Initiative (PFI) and Public-Private Partnerships (PPP) contract. Thorndale (Residential) Care Home comes under the Shaw Healthcare (De Montfort Ltd.) PPP contract".

6.5.10 On 9th October 2017, (see section 4.22/4.23 for more detail) a Notification of Concern was received anonymously by the Quality Team about staffing levels at Thorndale but no visit was made to check out concerns.

6.5.11 On 15th November 2017, however, the Quality Team did visit Thorndale in response to a concern raised by a detective constable, who had visited Thorndale as part of the police investigation carried out following Mrs Webster's injuries and hospital admissions from 10th to 13th of November. By 15th November the nature of her puncture wound, originally reported as a potential 'stabbing' injury, had been clarified as resulting from a fall, but Thorndale's quality of safe care was still under scrutiny. Mrs Webster had been re-admitted to KGH at this date and the Quality Team had no contact with her or her family.

6.5.12 The areas the Quality Team's Contract Monitoring Officer (CMO) looked at during their November visit were to identify if Thorndale was able to meet the needs of residents, and to identify if there was adequate staffing levels. During this visit, Thorndale managers identified five residents whose needs had changed/increased and for whom they could no longer meet all their needs, and alternative placements needed to be sourced. Referrals had been made to NCC Care Management and Brokerage staff and alternative placements were being sought. The Registered Manager advised that no residents were at immediate risk and that they were working with other professionals to ensure that needs were being met in the interim. No concerns about staffing levels were noted.

6.5.13 It is difficult to judge what impact the lack of direct contract monitoring by NCC's Quality Team might have had on any care quality issues, particularly in relation to staffing levels at Thorndale. Shaw Healthcare (De Montfort Ltd.), the parent company for Thorndale, reported to the SAR Panel that staff vacancy rates were around 5%; which is less than the average of 8% found in a 2018 survey of residential care homes by the organisation, 'Skills for Care".[27]

6.5.14 As part of the Shaw Healthcare (De Montfort Ltd.) contract with NCC, Thorndale was subject to internal monitoring by the parent company, which was required to submit regular monitoring information to NCC. However, the Quality Team IMR author identified that, "The standards, which we are expected to monitor against (with Shaw Healthcare), have not changed throughout the terms of the (NCC) contract in line with changes to associated regulations and standards."

6.5.15 As well as issues of potential unequal treatment of providers, the Quality Team were concerned that the absence of on-site monitoring by NCC Quality staff was a potential risk. An earlier scheduled visit to Thorndale might have identified risks in relation to falls and growing concerns amongst Thorndale staff themselves about their capacity to meet some residents' needs, particularly at a time when other safeguards like regular social care reviews of individuals were not being routinely undertaken.

6.5.16 The regulatory body for care homes for adults, Care Quality Commission (CQC), did carry out an unannounced inspection at Thorndale on 4th April 2017. The findings were that Thorndale was rated as 'Good' overall and within the 5 key domains inspected: Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well-led?

6.5.17 The April CQC report notes that, "People received care from staff that knew them well and were kind, compassionate and respectful...needs were assessed prior to coming to the home and individual care plans were in place and reviewed regularly...staff understood the need to undertake specific assessments where people lacked capacity to consent to their care and/or their day to day routines…people's health care and nutritional needs were carefully considered and relevant health care professionals were appropriately involved...staff understood their responsibilities to safeguard people and knew how to respond if they had any concerns...there were sufficient staff to meet the needs of the people...staffing levels were kept under review to ensure that people's needs were met in timely way...people had access to a healthy balanced diet...staff knew people well and there was an activities programme which took into account people's individual and group interests"(extracts from CQC Report – see footnote 4 to access full CQC Report under section 3 of this report).

[27] www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/publications/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

Nothing is noted as being raised about concerns over levels of dependency of some residents.

6.5.18 Whilst there is some public scepticism that findings from CQC inspections are only valid on the day(s) of the inspection, there is substantial routine monitoring of data provided by residential homes and also from other organisations and particularly prior to inspections. This was an unannounced inspection, which meant any findings would be more authentic than a notified inspection, which is the practice for CQC's NHS inspections, but it also meant that Thorndale was unable to give notice to relatives and arrange for them to meet with the inspectors unless the relative was in the home on that day.

6.5.19 It is of note, from information provided by Thorndale, that 1 manager left in July 2017 after 4 years in post but a new service manager was appointed immediately and was still in post at the time of Mrs Webster's death. The activity-organiser member of staff left in May 2017 after 6+ years in post and a new person was appointed just two months later on 31st July 2017, though the family said he could not take up his post for another two months. Whilst this demonstrates that Thorndale was taking appropriate measures to recruit staff, the experience of Mrs Webster's elder daughter was that there were significant gaps during Spring/Summer of 2017. More significantly for her mother and her family, was that people known and generally trusted by them were no longer in post and new relationships can take time to build up.

6.5.20 The Shaw Healthcare (De Montfort Ltd.) website identifies 6 other residential homes in the Northamptonshire and adjacent areas. All those homes, except for 1, where there is a very recent CQC judgement of 'Requires Improvement', have 'Good' judgements, though inspections of 3 of those homes took place more than 2 years ago.

6.5.21 There are some areas described in this second Key Area of Concern where different practice could have made a difference to the quality of Mrs Webster's and her family's experience in the last months of her life. The lack of a person-centred holistic review, and placement monitoring and scrutiny are concerning. If a NCC social care led review had taken place, there might have been an opportunity to take multi-agency stock of the impact of frequent falls on Mrs Webster, identify a lead professional to bring others together to look in depth at her capacity with others including her family (the structure for this already seemed to exist in the GP Practice), give greater attention to what Mrs Webster's daughter was observing, and to consider the advantages and risks of different care or moving to a dementia-specific care home. National evidence, however, would suggest that moving placements wouldn't prevent or reduce falling and would be likely to cause distress for someone already experiencing general disorientation.

6.5.22 No regulatory evidence has been provided that would suggest Thorndale wasn't regarded as a 'Good' residential home, and, until the events in November 2017, Thorndale wasn't on any agency's concern 'radar'. There are some concerns highlighted during this SAR process that it was trying to support some residents beyond its capacity to do so safely. This was partly influenced by the publicly acknowledged difficulties being experienced by NCC to meet demand/afford to provide quality assessment, review and monitoring services.

6.6 Third Key Area of Concern: Safeguarding

6.6.1 Why were staff involved with Mrs Webster, including GPs, - KGH, NHFT, NGH, and Thorndale, not raising safeguarding concerns, given the number of falls she was experiencing? What would better practice look like and were there missed opportunities to improve practice?

6.6.2 NCC's Safeguarding Adult Team had no direct involvement with Mrs Webster prior to events following her hospital admission on 10th November 2017. There was a Safeguarding Section 42 Enquiry following a Safeguarding Notification in 29.12.16. This was made by Thorndale staff stating Mrs Webster had returned to Thorndale from KGH with a grade **2** pressure ulcer[28] to her right heel. This was treated as an alert by the Safeguarding Team due to the low level grade of pressure sore, and no investigation was carried out. The Safeguarding Team IMR author had concerns that her mental capacity had not been appropriately considered during this Section 42 Enquiry.

6.6.3 During the period 1st January 2017 to 10th November 2017, there were no referrals to the NCC Safeguarding Team in relation to Mrs Webster from any organisation. Thorndale report that she had 34 falls during that period; 5 required an A&E hospital visit, but only 2 during 10-12th November required an overnight hospital stay. None of the falls up to 10th November led to a safeguarding referral.

6.6.4 The key questions are, what sort of falls should be reported to safeguarding and how many falls should provide a trigger that prompts an organisation, not only to reflect that "We need to do something different as we are not keeping this resident safe", but also to decide that, "We need to report these falls/frequency of falls to NCC Safeguarding Team"?

6.6.5 Thorndale staff referred Mrs Webster to the NHFT Falls Clinic. Assessments were carried out, advice was given to the Care Home, and assistive equipment was recommended and was provided by the Care Home. She continued to fall, but as before, most of her falls did not result in injury. Given that was the case, it is possible to speculate that Thorndale staff and health staff regarded her falling as 'normal' for her but not dangerous, and developed a level of tolerance.

6.6.6 Her family were raising general standards of care concerns in April 2017 and September/October 2017, though this did not specifically include concerns about particular falls. Her elder daughter did, however, express concerns that the family were not being informed each time a fall took place unless there was a visit to hospital needed.

6.6.7 Between 10th and 15th November, a number of safeguarding notifications were made, initially by EMAS who were concerned about the 'stabbing' wound to Mrs Webster's back, and then from Thorndale because of her unsafe discharge from NGH. NGH also sent a notification because they became aware that they had not received correct scans from KGH so they were not aware of the risks to Mrs Webster, when she was sent to them, and when they discharged her to Thorndale.

[28] At **stage 2 pressure ulcer**, the skin breaks open, wears away, or forms an **ulcer**, which is usually tender and painful.

6.6.8 Whilst Thorndale was notifying adverse incident reports about Mrs Webster's falls to CQC, these were not identified as being of a level of injury/harm to require a Section 42 enquiry until mid-November 2017. It is not entirely clear what an earlier investigation might have achieved but better practice would have been to involve an external professional, like a member of the NCC Safeguarding Team, who might have identified that her need for safety was not being fully met and made a direct referral for the delayed care-management review to be undertaken.

6.7 Fourth Key Area of Concern: Family involvement in multi-disciplinary discussions/ meetings

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

6.7.2 Some of the responses to previous areas of concern in this Report cover the apparent missed opportunities of more formal family involvement. Thorndale described their relationship with Mrs Webster's family as positive and mutually supportive, and expressed some surprise that her elder daughter expressed concerns about what she saw as deteriorating practice.

6.7.3 Mrs Webster's daughter attended KGH hospital with her mother on a number of occasions over the years, including on 11th November following the fall that resulted in the facial injury. She was unable to accompany her to NGH but had contact with a member of staff on 12th November when NGH were planning to discharge her mother. She expressed her concerns about Thorndale's ability to care for her, particularly given the events of 10th and 11th, but was advised to discuss them with Thorndale staff, who had previously agreed Mrs Webster could return there. Given that she had experienced 1 fall that resulted in an unexplained injury (puncture wound to her spine) and 1 fall resulting in a serious injury to her face in less than 36 hours, it might have been prudent for discussions to take place about whether Thorndale was the right place for her. It would have also saved her another ambulance journey without the safety equipment for her (at that point) undiagnosed spinal injury.

6.7.4 Frequent falling of older people in their own homes is one of the key reasons why concerned relatives consider residential care. What isn't always recognised is that the move to unfamiliar surroundings and often longish corridors and shared eating areas can increase incidences of falling, particularly for people who have dementia and/or sensory impairments. Whilst the lower risk of not being found quickly after a fall is one of the positive features of care home living, serious injuries from falls still occur. The person and relatives need to be made aware of this and that more staff might mitigate but can't eliminate the risk.

6.7.5 On the basis of evidence from this single Review, it is difficult to conclude how unusual Mrs Webster was in terms of the number of her falls, but she was identified by her GP practice as being at high risk of hospital admissions (not just from falls). Her admissions to hospital following falls were comparatively few compared to the number of falls recorded by Thorndale, but it was clear that records identified her as a patient 'at risk' of falls' and greater professional curiosity resulting in an alert to NCC Safeguarding team, would have provided a multi-disciplinary arena to share and weigh information. It is to be noted that Thorndale were not raising issues about receiving Mrs Webster back from hospital, except on one occasion when there was an infection outbreak in the Home.

6.7.6 Following Mrs Webster's return to KGH and discovery of the seriousness of her spinal injury, her family were more involved in meetings and were party to end-of-life/palliative care discussions, but they expressed concerns to me (the author) over the lack of communication about the reasons the spinal injury wasn't detected and also that they felt 'not listened to'.

6.8 Fifth Key Area of Concern: Mental Capacity Assessment (MCA) and Best Interest Assessment decision making

6.8.1 There is very little evidence collated by IMR authors that any agency *recorded* Mental Capacity Assessments (MCA) and subsequent Best Interest Assessments to support Mrs Webster's decision-making and that of professionals involved with her. Given that there are a number of examples where she was distressed/non-compliant when health, care, and safety interventions were seen to be necessary, why is there such little recording?

6.8.2 It is of note that Mrs Webster's elder daughter had lead responsibility for Lasting Power of Attorney (LPA)[29] for her mother's Health and Welfare and should have been involved in any Best Interest Decision making on occasions when she mother was assessed as lacking capacity to make her own decision.

6.8.3 The IMR from NHFT reviewed their contacts with Mrs Webster across a number of services and noted that, "assessment previous to the time boundaries of this (SAR) report she appeared to have mental capacity with regards to various areas of her care".

As her mental health deteriorated, it was documented that she did not have mental capacity to consent to skin assessments and provision of equipment. However, there was no evidence of a formal mental capacity assessment to be found in her clinical records to support this conclusion. Similarly, no Best Interest discussions were documented relating to how her care and risks should be managed.

6.8.4 There appear to be no recorded mental capacity assessments in the IMR of the GP Practice, though there was very regular contact with/about her, and knowledge that she sometimes refused treatment.

6.8.5 The KGH IMR describes the issue of mental capacity to have "been a challenging area to gain clarity on". The IMR author concluded that, "whilst issues of consent to treatment were considered and attempts made to assess Mrs Webster's capacity to make decisions and consent in almost all cases these assessments lacked rigour and were not transparent. There is inadequate consideration of best interests or acknowledgement that there was a registered Lasting Power of Attorney (LPA) for Health and Welfare and what role they have in decisions regarding care and treatment. Whilst there is evidence of family involvement it is not acknowledged that this was as a LPA".

[29] www.gov.uk/government/publications/make-a-lasting-power-of-attorney

6.8.6 Although mental capacity is considered within the District Nurse treatment plans for Mrs Webster, there is no record of formal Mental Capacity Assessments being undertaken. It was, however, noted within the care plans which the District Nurses used to document their actions, following interventions with her, that, she was not considered to have mental capacity. Given that the assumption of capacity should be a guiding principle and testing of capacity should be 'decision specific' and carried out by the staff member making the decision, the use of global assumptions would not be considered good practice. "The statement 'Person lacks capacity' is, in law, meaningless".[30]

6.8.7 The NHFT IMR reports that evidence in the medical records is that practitioners involved Mrs Webster's LPA when needed and also that the LPA's views on her mother's treatment was heard and acknowledged when reviewing treatment regimes.

6.8.8 Some agencies recorded that Mrs Webster had fluctuating capacity and that capacity was considered on a number of occasions including by East Midlands Ambulance Service (EMAS) when attending and transporting her. EMAS noted occasions when she seemed to be able to express her views. In relation to accepting medication/medical interventions like taking blood in Thorndale and in hospital, she was sometimes described as non-compliant or refusing intervention. However, it is not always clear whether she didn't have capacity to make an informed decision to refuse treatment or whether she did have an understanding and made a decision that she didn't want the treatment.

6.8.9 Whilst there is evidence that there has been substantial training on using the MCA, there is evidence from research, including findings from SARs[31], that the guidance, particularly the *recording* of reasons for mental capacity decisions, has not been followed. There is also a growing body of evidence that faced with the same information, staff from the same professional backgrounds, as well as from different professional backgrounds, will reach divergent conclusions about the capacity of an individual.[32]

6.8.10 The Mental Capacity Act and Statutory Guidance is widely regarded as bringing some clarity and a person-centred/enabling approach to decision-making about mental capacity, but its requirement for capacity considerations and recording for each action a person needs to make decisions about can be cumbersome and probably not proportionate in a busy hospital emergency department environment. It is not evident that the information about lack of recorded assessments of Mrs Webster, contributed in any way to her death, but professional discussions amongst professionals and with her family about the impact of her dementia on her decision-making may have led to different decisions about how her falling risk was viewed and how some aspects of her care were provided. This was done when it was identified that she was nearing the end of her life.

---

30 http://www.39essex.com/wp-content/uploads/2016/08/Capacity-Assessments-Guide-August-2016.pdf

31 3.Learning from SARs – A Report for London SAB http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf

32 "Participants did not respond consistently to the scenarios, but disagreed most significantly when patient decisions conflicted with clinical advice, and when to conduct a capacity assessment. These responses suggest that clinical responses vary significantly between individuals (even within settings or professions), and that the application of Mental Capacity Act (MCA) is complicated and nuanced". George Clerk, Jason Schaub, David Hancock, Colin Martin, (2018) "A Delphi survey of practitioner's understanding of mental capacity", The Journal of Adult Protection, Vol. 20 Issue: 5/6, pp.174-186, https://doi.org/10.1108/JAP-05-2018-0009

6.9 Sixth Key Area of Concern

6.9.1 Why did the KGH staff not identify the significant injury to her spine[33] and why was the relevant scan not sent to NGH?

6.9.2 KGH's acknowledged error in relation to viewing the 3 scans on Mrs Webster's return to hospital on 11th November and transferring the correct scans to NGH that evening, meant that Mrs Webster was moved without a fully informed risk assessment, and subsequently NGH made decisions about treatment and transport back to Thorndale without crucial information.

The 3 scans were taken after the second fall that caused the serious facial injury: one of these was identified the next day by the GP as containing evidence of the spinal fracture. The scan that was sent to NGH was taken following the first fall that resulted in the puncture wound in the early hours of the morning of 11th November and showed no spinal injury.

The KGH IMR author indicates that the evidence pointed to, "individual error with regard to reviewing the correct images and not a systemic issue within the Emergency Department".

6.9.3 It seems likely, given the nature of both falls, that, even if the scan information had been immediately reviewed at KGH and scan evidence communicated to NGH, the treatment would have been the same. Any treatment would have posed risks, given her general frailty and difficulty in complying with wearing the neck collar and bed rest. It is not certain that different practice would have prevented her death, but it is possible that the physical and emotionally painful (for her, her family, and staff who knew her) circumstances in which she died, might have been alleviated.

6.9.4 KGH undertook a Serious Incident investigation following Mrs Webster's death and produced a report dated 30th April 2018[34]. Discussions continue between the family and KGH about some areas of continuing concern.

7. Conclusions and Recommendations

7.1 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?

7.1.1 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.

---

[33] "*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*"

[34] This SI was requested by the SAR author and was made available after the penultimate report was written. The family believe they have seen this document but were not absolutely sure.

7.1.2 Given the initial concerns about the circumstances of her falls and subsequent hospital care they had to wait several weeks before they could hold a funeral. Both daughters said they had not been able to grieve properly due to poor and often confusing communication in those few days before she died, and subsequent concerns about the treatment she received following her two November falls. Other family members, particularly her brother living locally who visited her several times a week in Thorndale (Residential) Care Home have also been deeply affected.

7.1.3 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."[35]

7.1.4 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."[36]

7.1.5 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.

7.1.6 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.

[35] Hearing and vision impairment and the 5-year incidence of falls in older adults Bamini Gopinath Catherine M. McMahon George Burlutsky Paul Mitchell
Age and Ageing, Volume 45, Issue 3, 1 May 2016 https://academic.oup.com/ageing/article/45/3/409/1739739

[36] "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

8. Recommendations and Considerations

8.1 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.

The recommendations and considerations in this section are directed at the NSAB and its partners. Other recommendations are relevant to particular organisations/service areas and have been identified by authors in IMR reports.

8.2 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.

8.3 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.

8.4 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".

8.5 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)[37] 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]

[37] www.scie.org.uk/safeguarding/adults/reviews/library/project - in order to access the Quality Markers you may need to register (free) with SCIE

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

Appendix A - Recommendations from Individual Agency Reviews

KGH Internal Recommendations from IMR

1. To develop a six step briefing related to the findings and disseminate through internal communication, and utilise as a learning tool across multiple formats such as Academic Education and Matrons forum.
2. Raise awareness through training the importance of considering cumulative history and considering appropriate action, and incorporate findings into a scenario that can be used within existing safeguarding training.
3. Develop an emergency transfer document for use in the Emergency Department, and disseminate document in conjunction with acute partner(s).
4. Establish local process to utilise the patient electronic system frequent attender flag as a trigger to review those from known at risk groups. Develop a process with data team and communicate changes.
5. Increase awareness and confidence in using the mental capacity act to support patients, and develop and provide additional practical scenario based training in addition to the current existing training available.
6. Re-circulate Trust policy regarding Lasting Power of Attorney processes and information, and incorporate into the six step briefing.

NGH Internal - Recommendations from IMR

1. **Mental Capacity Act**
   The Trust will revise the NGH Mental Capacity Act training to ensure that training content is fit for purpose, introduce simulation training and undertake 'spot checks' and quarterly audits to ensure the Act is embedded into practice and compliance is sustained. An escalation plan will be instigated with the agreement of the Medical Director.

2. **Involvement of Family Members**
   The Trust will revise the NGH Mental Capacity Act training and safeguarding adults training to ensure that the involvement of family members is documented within clinical records. This will be reinforced by screensavers and spot checks by the Quality Matrons as part of ward accreditation.

3. **Safeguarding**
   The Trust will revise the NGH safeguarding adults training to ensure that staff are made aware of the relevance of a ensuring a safeguarding referral is completed for patients who are transferred from other providers and an adult at risk is identified.

4. **Transfer of Patients Requiring Specific Maxilla Facial Treatment**
   The Trust should work in partnership with KGH to develop a written departmental policy for accepting patients from other units. A bi-annual audit should be undertaken to ensure that the policy is being embedded into practice and compliance is sustained.

Thorndale (Residential) Care Home - Internal Recommendations from IMR

1. A Northamptonshire National Health Service Falls Risk/Action Plan support service to be contacted after 2 falls and the Falls Risk Assessment Action Plan to be completed alongside Shaw healthcare's policies on Falls/Risk Assessment.
2. A more robust identification for the use of assistive technology is to be made available for the individuals identified who are at high risk of falls. Assistive technology does not prevent falls but is used as an alert for a quicker response.
3. Care Reviews to be requested on a yearly basis for all service users placed by Northamptonshire County Council.
4. In addition, with the co-operation of Northamptonshire County Council, Urgent Care Reviews to be carried out in a timely manner when the service feels it can no longer meet the needs of the individual.
5. Thorndale staff will be more pro-active in requesting documentation from external services; this will be reviewed on an on-going basis by the Service Manager during their business meetings with their Operations Manager.

NCC Safeguarding Adult Team - Internal Recommendations from IMR

1. When arranging safeguarding meetings the SAT will ensure all relevant Agencies, including Residential Homes, are invited to attend and provided with the opportunity to share their thoughts and/or concerns.

NCC Quality Team - Internal Recommendations from IMR

1. The same rigor and approach to monitoring of contracts should be completed regardless of the type of contract to ensure consistency. The Performance Standards required reviewing under the Shaw contract for Care Home to make sure that it met the requirements of changing standards and regulations.

NCC Older Persons Team

No recommendations.

GP Practice - Internal Recommendations from IMR

1. Practices should utilise the IT safeguarding tools available on their medical records system so that any risks or concerns identified by individual clinicians, or contained within incoming correspondence can be coded on the medical records. This will facilitate recognition of increasing risk and timely appropriate action taken to safeguard.

Appendix B – Glossary of acronyms used in this report

CMHT	Community Mental Health Team
CMO	Contract Monitoring Officer
CQC	Care Quality Commission
DC	Detective Constable
DoLS	Deprivation of Liberty Safeguards
ED	Emergency Department
GP	General Practitioner
KGH	Kettering General Hospital
ICT	Intermediate Care Team
IMR	Independent Management Report
LPA	Lasting Power of Attorney
MCA	Mental Capacity Assessment
NGH	Northampton General Hospital NHS Trust
NHFT	Northamptonshire Healthcare Foundation Trust
NCC	Northamptonshire County Council
NSAB	Northamptonshire Safeguarding Adults Board
PFI	Private Finance Initiative
PPP	Public-Private Partnerships
SAR	Safeguarding Adult Review
SCIE	Social Care Institute for Excellence
TASL	Thames Ambulance Service Limited