Salford Safeguarding Adults Board

Safeguarding Adults Review (SAR) in respect of Stanley

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1.0 Introduction

1.1 Stanley died in hospital in May 2021 after being admitted from a nursing home where he had recently commenced a six-week respite placement whilst his civil partner and carer Matthew underwent and recovered from a double hernia operation. Matthew had cared for Stanley in the home they shared for over a decade. Stanley had a diagnosis of vascular dementia and dysphagia and was unable to communicate verbally. Matthew became concerned about the care Stanley was receiving in the respite placement when Stanley developed a moisture lesion and potential indications of unsatisfactory care began to emerge. He worked with agencies to try and curtail the respite placement in the nursing home and secure Stanley's return home. This proved challenging for Matthew for a number of reasons which are explored in this report.

1.2 Following Stanley's hospital admission a Section 42 Safeguarding Enquiry was initiated which was completed after Stanley's death. The outcome of the Safeguarding Enquiry was that 'abuse by neglect omission of care' was substantiated. Salford Safeguarding Adults Board initially decided that the criteria for a Safeguarding Adult Review (SAR) had not been met as the circumstances appeared to strongly suggest that learning was limited to a single agency (Nursing Home A which was the provider of Stanley's respite placement). When further information was obtained Salford Safeguarding Adults Board decided that the criteria for commissioning a SAR had been met on the grounds that there appeared to be wider multi-agency learning to be gained.

1.3 David Mellor was appointed as independent reviewer for the SAR. He is a retired chief officer of police and has eleven years' experience of conducting statutory reviews. He has no connection to any agency in Salford. The process by which the SAR was conducted is shown in Appendix A.

1.4 Stanley's death was reported to the Coroner and no inquest is to be held.

1.5 Salford Safeguarding Adults Board wishes to express sincere condolences to the family and friends of Stanley.

2.0 Terms of Reference

2.1 The SAR primarily focusses on the period from when Stanley's respite placement was agreed in December 2020 until his death in May 2021.

2.2 The following general terms of reference questions have been addressed:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support people with complex health needs.
- Identify what went well and examples of good practice.
- Identify clearly what those lessons are, both within and between agencies; how those lessons will be acted on, within what timescales and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Determine what agencies could have done differently that could have prevented harm or death and that might prevent similar harm in future.

2.3 The following case-specific themes have also been explored:

- Voice of the adult to ensure personalised approach to care and support – if there was no alternative to 24-hour care, was there person-centred discussions regarding how care would be provided to Stanley – was care service led or person centred led?
- Continuity of care and care needs (engaging with the carer)
- Capacity and Market Management – Stanley had support prior to the respite stay which then wasn't available shortly after which may have delayed a return home.
- Voice of the carer – was he listened to prior to the admission/when expressed concerns what action was taken?
- Impact of covid – was Stanley seen by professionals? Did Matthew have the ability to visit?
- Working together – once Matthew expressed concerns regarding the care and support Stanley was receiving, what action was taken to address those concerns?
- Escalation pathways
- Implementation of safeguarding Policy and Procedures
- Holistic strength-based assessments and supporting planning
- Was there a co-ordinated approach and a clear and effective communication between professionals.

- Application of legal framework and statutory duties
- Assurance around standards of care within the care home
- Review to explore the personalised offer for respite in Salford i.e. using direct payment, flexibility of care and personal and health budgets
- Deprivation of Liberty Safeguards

3.0 Chronology of key events

3.1 Stanley was 82 years of age at the time of his death. He lived with his civil partner Matthew who was ten years his junior. Matthew has contributed to this SAR and he said that he and Stanley had been together as a couple for 45 years, having met in Manchester and 'instantly connected' and been devoted to each other from that time onwards. He described Stanley as an easy going person who loved music and, in addition to his employment as a mechanical engineer, had been a musician and an entertainer. Prior to their retirements both Stanley and Matthew had been employed as mechanical engineers. They were both White British men.

3.2 Matthew said that Stanley's cognitive decline began when he was around 70 years of age and he had subsequently been diagnosed with vascular dementia[1], hyperthyroidism[2], aortic aneurism[3], Eczema and dysphagia[4]. Matthew said that

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[1] **Vascular dementia is a common type of dementia caused by reduced blood flow to the brain. It's estimated to affect around 150,000 people in the UK.**

Dementia is the name for problems with mental abilities caused by gradual changes and damage in the brain. It's rare in people under 65.

Vascular dementia tends to get worse over time, although it's sometimes possible to slow it down.

[2] **An overactive thyroid, also known as hyperthyroidism or thyrotoxicosis, is where the thyroid gland produces too much of the thyroid hormones.**

The thyroid is a small butterfly-shaped gland in the neck, just in front of the windpipe (trachea). It produces hormones that affect things such as your heart rate and body temperature.

Having too much of these hormones can cause unpleasant and potentially serious problems that may need treatment.

[3] **An abdominal aortic aneurysm (AAA) is a bulge or swelling in the aorta, the main blood vessel that runs from the heart down through the chest and tummy.**

An AAA can be dangerous if it is not spotted early on.

It can get bigger over time and could burst (rupture), causing life-threatening bleeding.

[4] **Dysphagia is the medical term for swallowing difficulties.**

Some people with dysphagia have problems swallowing certain foods or liquids, while others can't swallow at all.

Other signs of dysphagia include:

- coughing or choking when eating or drinking
- bringing food back up, sometimes through the nose
- a sensation that food is stuck in your throat or chest
- persistent drooling of saliva

he had become his partner's carer, a role he increasingly fulfilled '24/7' over the final 12 years of Stanley's life. Stanley became unable to communicate verbally apart from the 'odd word' and his mobility diminished until he was unable to weight bear. Gantries had been fitted in the lounge and bedroom of the home they shared in order to hoist Stanley. Matthew said that Stanley had been on a pureed diet for around a year prior to his death. He added that although his carer role was demanding, Stanley was 'easy to look after' as he was very placid and did everything asked of him. Matthew said that he received excellent support from the Day Centre 1 which Stanley visited three times weekly from 10am to 3.30pm which allowed Matthew 'a bit of respite' to go swimming for example. He added that Stanley enjoyed the Day Centre and the staff there 'adored' him. He said that during the pandemic the support provided by the Day Centre switched to home visits. He said that dementia home care provider 1 carers visited three times each day to support him to care for Stanley but he had reduced this to two visits daily as he found three visits to be 'too much'.

3.3 On 23rd March 2020 the UK Government announced the first Covid-19 lockdown. As a result of the lockdown, Stanley was unable to access the Day Centre but staff from the Centre began to support Stanley in the home he shared with Matthew for 2-4 hours on a twice weekly basis. On 4th July 2020 the restrictions introduced to address the pandemic begin to ease in England.

3.4 On 15th October 2020 Stanley's needs and capacity were assessed by Adult Social Care. Protective measures needed to prevent infection from Covid-19 to enable Stanley to return to the Day Centre were amongst the issues discussed.

3.5 On 5th November 2020 the second England Covid-19 lockdown began.

3.6 On 23rd December 2020 Adult Social Care first became aware that Matthew would be attending hospital 'soon' for a hernia operation and that he felt that a respite placement would be the 'best option' for Stanley as he felt that he would be unable to manage in between home care calls in view of Stanley's high level of needs. It is assumed that it was determined that Stanley lacked the capacity to make a decision in respect of respite care as a best interests meeting was held on 29th December 2020 at which it was decided that it would be in Stanley's best interests to be placed in respite whilst Matthew underwent and recovered from

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- being unable to chew food properly
- a gurgly, wet-sounding voice when eating or drinking

Over time, dysphagia can also cause symptoms such as weight loss and repeated chest infections.

his hernia operation. Adult Social Care began searching for a respite placement and contacted a number of local nursing homes without success.

3.7 On 6th January 2021 Matthew was advised that the waiting time for his operation could be from three to six months. Adult Social Care concluded that there was therefore no urgent need to identify a respite placement for Stanley. Also on 6th January 2021 the third England Covid-19 lockdown began. During the early months of 2021 Stanley received his first and second Covid-19 vaccinations.

3.8 Later in January 2021 Stanley's eligibility for NHS Continuing Healthcare (CHC)[5] was (further) assessed. After reports from relevant services had been gathered a multidisciplinary team meeting was held on 10th February 2021 at which it was decided that Stanley was not eligible, meaning that Adult Social Care would retain responsibility for lawfully commissioning and overseeing Stanley's care.

3.9 During February and March 2021 Matthew had three telephone consultations in respect of Stanley with their GP practice relating to a chest infection and night sweats.

3.10 From 8th March 2021 a stepped approach to easing Covid-19 restrictions began. Under 'Step 1', schools re-opened but the general stay at home order remained in place.

3.11 On 11th March 2021 Adult Social Care reviewed Stanley's home care package after Matthew expressed concern about the age and experience of the carers which was documented to be causing him carer stress. Dementia home care provider 1 – was also consulted and suggested doubling up carers for hoisting Stanley. Ultimately Matthew decided to retain the same home care provider but the number of visits was reduced from three to two per day.

3.12 From 11th March 2021 Stanley was supported in the Day Centre on 'reduced hours' of 9.45am to 1.45pm on three days each week due to Covid-19 restrictions although the Centre closed for a Covid-19 related 'deep clean' on 20th March 2021 – re-opening 31st March 2021.

3.13 On 29th March 2021, the stepped approach to easing Covid-19 restrictions continued. 'Step 2' included the ending of the stay at home order.

[5] Some people with long-term complex health needs qualify for free social care arranged and funded solely by the NHS. This is known as NHS continuing healthcare which can be provided in a variety of settings outside hospital, such as the person's own home or in a care home.

3.14 On 1st April 2021 Matthew advised Adult Social Care that he had been given a provisional date of 30th April 2021 for his hernia operation.

3.15 On 8th April 2021 the District Nurse Service was requested to carry out a Specialist Health Needs Assessment of Stanley to inform the type of respite placement he would require. Also on 8th April 2021 the Bladder and Bowel Service completed an assessment which recommended more absorbent pads overnight.

3.16 The outcome of the Specialist Health Needs Assessment was that 'due to Stanley's current condition, requiring all needs to be anticipated, his non-weight bearing status and needing feeding', respite in nursing care was recommended. Adult Social Care documented that Matthew was 'not happy' with this outcome. He said that he would like Stanley to be cared for by a Respite service - which was a service linked to the Day Centre - and had four rooms with which to provide respite care. However, the Respite service was not registered for nursing care and the SAR has been advised that at that time the Respite service had been closed for some time as a result of the pandemic and had yet to re-open.

3.17 It was subsequently agreed that Stanley would be placed in Nursing Home A – which was registered for both residential and nursing care – from 28th April 2021 for a period of five weeks. Funding was approved by the NHS Funded Care Team.

3.18 On Monday 26th April 2021 Matthew phoned Adult Social Care (ASC) to say that he did not want Stanley to go into respite care anymore and was also 'upset' about the standard of care provided by Stanley's home care provider. After Matthew had a 'long talk' with the ASC social worker, Matthew agreed that Stanley's placement at Nursing Home A would go ahead 'even for just a short period of time to allow Matthew time to recover and then we would take things from there'.

3.19 Also on Monday 26th April 2021 Matthew had a telephone consultation about Stanley with the GP practice. Matthew was concerned about a night sweat the previous night and that his continence pad had been wetter than normal. The GP documented that there was no fever or temperature. The GP advised Matthew to monitor Stanley's symptoms over the next week and it was agreed that a urine sample would be obtained from Stanley. During the consultation Matthew sought the GP's opinion on whether he would be physically able to care for Stanley following his forthcoming hernia operation or whether the GP would advise respite care. The GP advised Matthew to speak to the home care provider to ascertain whether they could offer additional support. If not, the GP advised that respite may be a better option as Matthew was likely to experience some post-

operative discomfort and may not be able to safely assist with moving and handling.

Wednesday 28th April 2021

3.20 At around 4pm on Wednesday 28th April 2021 Matthew took Stanley to Nursing Home A for what they understood to be a six week placement. (The NHS Funded Care Team had approved funding for only 5 weeks). In their chronology submitted to the SAR, Nursing Home A state that Stanley 'came to the Nursing Home poorly and was on a course of antibiotics' (Matthew actually consulted the GP about Stanley's chest cough the following day when antibiotics were prescribed). Nursing Home A provides nursing care as well as care for people living with dementia. The home provides single occupancy rooms, across two units, and is registered to support up to 68 people. Stanley's ASC social worker had prepared a support plan for his respite placement which the SAR has been advised clearly indicated that Stanley needed support in respect of eating and drinking, specifically 'Stanley has a soft diet and thickened fluids. Fortified diet is required and lots of time and encouragement to eat.' 'Stanley requires thickened fluid but is able to sip from a normal glass as long as carers hold this to his lips'. 'He is at risk of choking and a diligent approach and upright position is required during eating'. (ASC Care Plan not shared with SAR). Nursing Home A had completed a pre-admission and admission assessment (Pre-admission and admission assessment shared with the SAR). The pre-admission document had not been fully completed and there were a number of errors and omissions. The document contained no signature or completed statement to say whether Stanley's needs could be met by the nursing home or not. The following 'preparation for admission' section of the assessment was blank as was the 'details on admission' section. The latter section required the completion of a body map and details of height, Waterlow score[6], temperature, pulse, respirations and oxygen saturation to be completed. (When Matthew read this SAR report he commented that the ASC Care Plan was not discussed or shared with him (Matthew)).

Thursday 29th April 2021

3.21 On Thursday 29th April 2021 Matthew had a telephone consultation with the GP in respect of Stanley – who he said had had a chesty cough for a few days. The

[6] The Waterlow assessment calculates the risk of pressure ulcers developing on an individual basis through a simple points-based system.

GP prescribed amoxicillin[7], the first dose of which was administered by Nursing Home A care staff the same afternoon.

Friday 30th April 2021

3.22 On Friday 30th April 2021 the GP reviewed the results of Stanley's urine analysis and decided to prescribe ciprofloxacin[8] instead of amoxicillin as, in addition to the possible chest infection, Stanley may have had a urine infection. On the same day Matthew attended hospital for his hernia operation.

Monday 3rd May 2021 (Public Holiday)

3.23 On Monday 3rd May 2021 Matthew phoned the Nursing Home A manager to say that he 'felt better' after his operation and said he wanted Stanley to return home. The nursing home manager advised that she needed to discuss the matter with Stanley's ASC social worker as she understood Stanley's home care package to have been suspended for the duration of his respite placement in Nursing Home A. The manager phoned the social worker who confirmed that this was the case. The social worker later called the nursing home manager back to advise that he had spoken to Matthew who understood that a home care package would need to be in place to enable Stanley to return home.

Wednesday 5th May 2021

3.24 On Wednesday 5th May 2021 Stanley's ASC social worker documented that Matthew had phoned him to say that he wanted Stanley home, wanted to 'increase care' (presumably to ease the carer burden on Matthew whilst he fully recovered from his operation) and change the current provider of the home care package. Following discussion, it was agreed that Matthew would continue with the current home care provider until a new provider could be identified. The social worker planned to speak to dementia home care provider 1 and the Day Centre to ascertain whether they could reinstate the care and support provided to Stanley to allow him to return home.

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[7] Amoxicillin is a penicillin antibiotic. It is used to treat bacterial infections, such as chest infections (including pneumonia) and dental abscesses.

[8] Ciprofloxacin is a broad-spectrum antibiotic which means that it's used to treat a number of bacterial infections, such as:

- uncomplicated urinary tract infections (UTIs) where other antibiotics are not suitable and complicated UTIs
- chest infections (including pneumonia)

Friday 7th May 2021

3.25 On Friday 7th May 2021 the ASC social worker advised Matthew that the Day Centre was unable to resume support for Stanley at that time as his place had been allocated to someone else on an interim basis. Nor were they able to provide a home sitting service. The dementia home care provider advised that they had no availability to increase the care they normally provided.

3.26 On the same date the Nursing Home A staff nurse was informed that redness to Stanley's sacrum had been observed. After assessing the affected area the staff nurse felt that barrier cream was required and Matthew was requested to obtain the barrier cream from the duty pharmacy, which he did and brought it to Nursing Home A. The nursing home noted that Matthew appeared 'upset' by this request. They explained that the cream they had on site was prescribed to other residents and asking Matthew to obtain the cream that evening would be quicker than requesting it via the GP. During the day Matthew had phoned the GP to express concern that Stanley had developed a 'pressure sore'. The GP liaised with Nursing Home A staff who advised that they had placed Stanley on bed rest on an airflow mattress with two hourly repositioning.

Monday 10th May 2021

3.27 On Monday 10th May 2021 Nursing Home A referred Stanley to the Tissue Viability Nurse service as there had been no improvement to his moisture lesion. The GP practice referred Stanley to the District Nurse service in respect of the same moisture lesion but as Stanley was already receiving nursing care at Nursing Home A, expected practice would be a referral to Tissue Viability.

3.28 On the same date Matthew had further contact with the ASC social worker in an effort to arrange Stanley's return home. He was particularly keen for Stanley to return home given the development of the moisture lesion whilst Stanley was in the care of Nursing Home A. Matthew said that he could manage with the usual level of home care support provided by the dementia home care provider rather than the additional support which had been under discussion at the end of the previous week but appeared to be under the impression that district nurses would visit Stanley at home three times each day. The ASC social worker subsequently spoke to the district nurses who said that they could not offer that level of support. Nursing Home A expressed concern to the social worker over whether Matthew would be able to cope with caring for Stanley at home given the fact that he required repositioning every two hours and it was understood that Matthew was having the staples removed that day following his recent hernia operation. The possibility of holding a best interests meeting was discussed but not actioned at that time.

Tuesday 11th May 2021

3.29 On Tuesday 11th May 2021 Stanley was seen by the Tissue Viability Nurse at Nursing Home A. She found that Stanley had been incontinent of faeces and so it was necessary to provide him with personal care before she could assess Stanley. Both of his inner buttocks were noted to be excoriated and sore. The Tissue Viability Nurse noted that Medi Derma-S barrier cream and Telfa dressings were currently being applied and advised that Medi Derma-S was not appropriate for excoriated skin and applied Flamigel RT, which supports the fast healing of skin by covering the wound. It absorbs excess moisture from wet wounds and can also make dry wounds moist. It builds a protective barrier, soothes pain and prevents skin breakdown. Flamigel RT was left at the side of Stanley's bed for use by nursing home staff. The Tissue Viability Nurse advised the Nursing Home A nurse on duty to apply the Flamigel RT 6 times a day and cover with the secondary Telfa dressing. (When Matthew read a late draft of this report he questioned whether Nursing Home A consistently applied the Flamigel RT6 as on two subsequent dates, their records of the care provided to Stanley documented that the inappropriate Medi-Derma-S was applied). The Tissue Viability Nurse also advised staff to check regularly for episodes of incontinence to prevent wound breakdown and ensure regular repositioning – at a minimum three hourly - and to encourage diet and fluids to aid wound healing. The Tissue Viability Nurse also referred Stanley for a District Nursing assessment when he returned home. The Tissue Viability Nurse carried out a MUST (malnutrition universal screening tool)[9] assessment which disclosed a 'low' risk and a Waterlow assessment which disclosed a 'high' risk of pressure sores developing which was currently being addressed by the use of an air mattress/cushion. (When Matthew read a late draft of this report he questioned the reliability of the MUST assessment, given that the Tissue Viability Nurse estimated Stanley's height and weight. The Tissue Viability Nurse Service has responded by advising that Stanley's height and weight were obtained from the Nursing Home records).

3.30 During the day the dementia home care provider advised the ASC social worker that they were able to reinstate the home care visits (ASC chronology states 4 daily visits were to be reinstated instead of the 2 daily visits which were being made prior to Stanley's respite placement). The plan at that stage was for Stanley to return home the following day.

[9] 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Wednesday 12th May 2021

3.31 On Wednesday 12th May 2021 the dementia home care provider advised Adult Social Care that they were unable to resume homecare for Stanley until the morning call (later stated to be the tea time call) on Monday 17th May 2021. The prior home care package of two calls per day would need to be increased to four visits per day to support Matthew whilst he continued to fully recover from his operation. The ASC social worker and his manager unsuccessfully attempted to source an alternative homecare provider who could provide bridging care until the dementia home care provider was able to resume the provision of home care. The ASC manager also contacted a provider of a bridging service when people are discharged home from hospital but this provider was unable to assist. Matthew was documented to be 'unhappy' with the situation.

Thursday 13th May 2021

3.32 On Thursday 13th May 2021 Matthew contacted the ASC duty social worker to propose that Matthew's sister assist him to care for Stanley at home until the dementia home care provider was able to reinstate care. Following discussion, Adult Social Care documented that Matthew decided to wait until Monday 17th May 2021 for Stanley to return home.

3.33 On the same day Matthew contacted the GP practice to advise that Stanley was 'chesty', that Nursing Home A 'were not looking after him' and because there had been an outbreak of diarrhoea and vomiting (D&V) at the nursing home, Matthew was unable to visit Stanley. The GP visited Stanley in Nursing Home A and on examination, found him to be alert and well. The GP had changed Stanley's medication from ciprofloxacin to amoxicillin on Monday 10th May 2021 and it was decided that Stanley should complete the course. Nursing Home A's chronology states that their staff nurse documented that Stanley's chest was clear.

Friday 14th May 2021

3.34 On Friday 14th May 2021 Matthew contacted the Care Quality Commission (CQC) to make a complaint about the care Stanley was receiving from Nursing Home A, specifically that Stanley had developed a pressure lesion whilst on respite care there and that he wanted Stanley to return home but Nursing Home A 'won't let him'. Matthew added that he was currently unable to visit Stanley as the nursing home was closed due to a D&V outbreak. Matthew was advised that the CQC's remit was not to investigate individual complaints as this was initially the provider's responsibility via their complaints process. Matthew was advised to raise a formal complaint with Nursing Home A and was also 'signposted' to the

Local Government and Social Care Ombudsman[10]. The CQC contacted the nursing home manager who advised them that Stanley had developed a moisture lesion which had been referred to the Tissue Viability Nurse, that whilst Matthew wanted Stanley to return home, there needed to be a home care package in place to enable this to happen. The nursing home manager confirmed that she was liaising with Adult Social Care. The CQC decided that no further action was required by them.

Saturday 15th May 2021

3.35 On Saturday 15th May 2021 Matthew went to Nursing Home A but was unable to visit Stanley as the nursing home remained closed to visitors as a result of the D&V outbreak. A member of the care staff used Matthew's smartphone to take photos and a video of Stanley which Matthew subsequently viewed. Matthew has advised this SAR that he was 'horrified' by what he saw of Stanley's presentation in the images. He noted that Stanley was unshaven, had what appeared to be food stains around his mouth and on his pillow and did not appear alert. Matthew telephoned the nursing home manager to express his concerns and was advised about the nursing home's complaints process.

3.36 At around 4pm that day a member of care staff at Nursing Home A felt that Stanley appeared unwell and was experiencing difficulty breathing and after consulting the staff nurse an ambulance was called. Matthew was contacted and had attended the nursing home by the time the ambulance service paramedics arrived and conducted a clinical examination. The paramedics followed the pathway for Red Flag Sepsis and conveyed Stanley to Hospital 1 ED (emergency department) – which was pre-alerted – using blue lights and sirens.

3.37 Stanley was triaged in ED where the presenting complaints were documented as 'possible sepsis' and 'shortness of breath'. The ED clinical review documented that Stanley had become lethargic and confused over the past 3 days, had been visited by his GP and prescribed co-amoxiclav[11] and had not eaten or drunk much for the past two days. Stanley had become more unwell that day (15th May 2021). The clinical review noted that Stanley was a 'very frail man' who was

[10] The Local Government and Social Care Ombudsman can investigate individual complaints about councils, all adult social care providers (including care homes and home care agencies) and some other public service organisations.

[11] Co-amoxiclav is an antibiotic used for bacterial infections which contains amoxicillin (an antibiotic from the penicillin group of medicines) mixed with clavulanic acid. The clavulanic acid stops bacteria from breaking down amoxicillin, allowing the antibiotic to work better.

'severely dehydrated'. The diagnosis was sepsis -of unknown origin – secondary to pneumonia with fast atrial fibrillation and acute kidney failure. Stanley was admitted to hospital and transferred to a ward the following day when he was documented to have a category 1 pressure ulcer on his sacrum which had developed in the nursing home. A MUST assessment disclosed a 'medium' risk which required encouragement of eating, drinking and snacks between meals and a Waterlow assessment disclosed a very high risk of developing pressure sores.

Monday 17th May 2021

3.38 On Monday 17th May 2021 Adult Social Care were advised of the circumstances of Stanley's hospital admission and decided to commence a Section 42 Safeguarding Enquiry although the continuing D&V outbreak at Nursing Home A prevented the ASC social worker from obtaining Stanley's case notes for several days.

Tuesday 18th May 2021

3.39 On Tuesday 18th May 2021 Matthew was advised by the hospital that there had been no clinical improvement in Stanley's condition and if this continued or any deterioration occurred over the next 24 hours, end of life management would be considered.

Friday 21st May 2021

3.40 On Friday 21st May 2021 Stanley experienced further significant respiratory deterioration and gastrointestinal bleeding and it was recognised that he was approaching the end of his life. A plan for end of life care was formulated and support provided to Matthew.

Monday 24th May 2021

3.41 Stanley died in hospital on Monday 24th May 2021. His provisional cause of death was recorded as 1 (a) Sepsis and gastrointestinal bleed (b) pneumonia and 2 chronic kidney disease. Stanley's death was reported to the Coroner on the grounds that he had been admitted to hospital from respite care and a safeguarding concern had been submitted regarding the care Stanley received in respite care. Following an examination by a pathologist a death certificate was issued which recorded the cause of death to be 1(a) Pneumonia (b) Chronic Obstructive Airway disease. The Pathologist concluded that the contribution of dehydration and kidney malfunction to Stanley's cause of death was 'not more than minimal'.

3.42 The Section 42 Safeguarding Enquiry concluded on 3rd August 2021 and the outcome was that 'abuse by neglect omission of care' was substantiated.

4.0 Contribution of Stanley's partner

4.1 Matthew met the independent reviewer and the Salford Safeguarding Adults Board Business Manager at his home address and was supported by an advocate. Matthew was keen to contribute to the SAR. Additionally he had made complaints about Stanley's care - and the manner in which his concerns about Stanley's care had been looked into - to a number of bodies and shared all correspondence relating to the complaints with the independent reviewer.

4.2 As previously stated, Matthew said that he and Stanley had been together as a couple for 45 years, having met in Manchester and 'instantly connected' and had been devoted to each other from that time onwards. He described Stanley as an easy going person who loved music and, in addition to his employment as a mechanical engineer, had been a musician and an entertainer.

4.3 Matthew said that Stanley's cognitive decline had begun when he was around 70 years of age and he had developed dementia. He said that he had become his carer, a role he increasingly fulfilled '24/7' over the final 12 years of Stanley's life. Stanley became unable to communicate verbally apart from the 'odd word' and his mobility diminished until he was unable to weight bear. Gantry's had been fitted in the lounge and bedroom of the home they shared in order to hoist Stanley. Matthew said that he had been on a pureed diet for around a year prior to his death. He added that although his carer role was demanding, Stanley was 'easy to look after' as he was very placid and did everything asked of him.

4.4 Matthew said that Stanley maintained contact with his family, particularly a sister and a niece and he would take Stanley out in their car to visit them.

4.5 Matthew said that he received excellent support from the Day Centre which Stanley visited twice weekly from 10am to 3.30pm which allowed Matthew 'a bit of respite' to go swimming for example. He added that Stanley enjoyed the Day Centre and the staff there 'adored' him. He said that during the pandemic the support provided by the Day Centre switched to home visits. He said that the dementia home care carers visited three times each day to support him to care for Stanley but he had reduced this to two visits daily as he found three visits to be 'too much'.

4.6 Turning to his operation, he said that hernia problems may have been brought on by 'heavy lifting' of Stanley and he was keen to have the operation – for which he said he had waited for a long time. He said that he had been worried about the operation and how he would feel afterwards but he said it was 'fine' and that he had been 'in and out' of hospital in a couple of hours.

4.7 Prior to the operation he recalled dropping Stanley off at Nursing Home A. He said he had chosen Nursing Home A because it was not far away from his home and he had heard that the manager had a good reputation. He also understood her to have moved to Nursing Home A from a linked care home where Stanley had been satisfactorily placed for respite purposes on a previous occasion. He said that Stanley's room was upstairs next to the nurse's office. He thought that this arrangement meant that Stanley was a little detached from other residents but assumed that this room may have been provided because Stanley was there for a short period of respite.

4.8 Matthew said that visits to Nursing Home A were limited because of Covid-19 restrictions and so it was necessary to book appointments so that the nursing home did not have too many visitors on the premises at one time and he said that he was not allowed to visit Stanley on a daily basis. He said that Stanley was visited by family members (sister and niece) on days on which he was not permitted to visit. Matthew said that he tried to visit at dinner time to make sure that Stanley was getting adequate food and fluid and – as he was unshaven in the nursing home - he would shave Stanley, feed him and clean his teeth afterwards. He went onto say that Stanley's bed was 'old style' and his recliner chair had a hard, plastic surface. He added that he brought a pressure cushion in from home to help make Stanley more comfortable.

4.9 Matthew said that he was told about Stanley's moisture lesion on either 6th or 7th May 2021 and that this would necessitate bed rest for a few days. He said he was concerned about this as he had never had any problems of this nature whilst being cared for at home or at the Day Centre. He says that he subsequently understood that Stanley had been left for hours in urine and faeces (This was an assumption by Matthew based on the Tissue Viability Nurse finding that Stanley was incontinent of faeces when she visited him in Nursing Home A (Paragraph 3.29). He said that Stanley used a commode at home.

4.10 Matthew said that he became increasingly concerned about the care that Stanley was receiving at Nursing Home A and said he was 'trying to get anybody' to go in and check on him. He said that he arranged for the GP and the District Nurse to visit Stanley which gave him some reassurance (The GP made a referral for the District Nurse to visit but Stanley was actually seen by the Tissue Viability Nurse).

4.11 He recalled that on 15th May 2021 he was unable to visit Stanley because the nursing home was closed because of a D&V outbreak and so he asked one of the care staff to take photos/video of Stanley on Matthew's smartphone to enable him to see that Stanley was 'OK'. He said that when he went home and looked at the images and felt 'heart-broken' as Stanley looked gaunt, was unshaven, and

had food stains around his mouth and in his beard. He said he felt 'disgusted' at how Stanley looked and rang the nursing home manager who asked him to submit a complaint to her by email. Matthew said that the manager was not present in the nursing home on that day (a Saturday) but he said that he would have expected her or her assistant to have visited the nursing home in response to his complaint but this did not happen. He said that he received a phone call from the nursing home around 4pm advising him to visit as Stanley was unwell and the ambulance arrived at 4.48pm and Stanley was taken to hospital.

4.12 Matthew was clearly very unhappy with the care that Stanley received in Nursing Home A. He said that the staff were largely 'inexperienced kids' rather than qualified nursing staff who didn't give Stanley enough time to eat and to drink. He said that Stanley was a 'slow eater' and that at home, he allowed an hour to an hour and a half for meals. He added that Stanley had had no problems with moisture lesions at home and had never needed repositioning as a result. By the time of his admission to hospital he felt that Stanley was looking 'emaciated'. He was also unhappy that he had been asked to obtain the gel for Stanley's moisture lesion from the out of hours pharmacy. He said that this had necessitated a drive to a pharmacy some distance from his home during the evening at a time when he still had stitches in place from his hernia operation.

4.13 The records relating to Stanley's respite stay at Nursing Home A had subsequently been shared with Matthew. After reading these records he made the following observations:

- Stanley was offered sandwiches despite being on a pureed diet.
- He was given coffee on occasions despite his preference for tea.
- When he was asleep he didn't get any food or drink
- Offered but refused (OBR) in the food and fluid charts indicated to Matthew that staff had not tried hard enough to encourage Stanley to eat and drink.
- The charge nurse was supposed to sign the food and fluid charts daily but never did so.
- The Tissue Viability Nurse had to 'clean up' Stanley and so he could have been left in his own urine and faeces for hours.
- The GP could have been more proactive when visiting Stanley on 13th May 2021 and asked to see the food and fluid charts.
- He believes nursing home records to have been falsified – to show Stanley had lunch on the day he was admitted to hospital and that entries on the Daily Records had been filled in in advance and then crossed out following Stanley's admission to hospital

- The amount of urine Stanley was passing diminished and this was not picked up on.

4.14 Matthew also questioned why the Tissue Viability Nurse did not visit Stanley until 11th May 2021 when the moisture lesion had first been seen on either 6th or 7th May 2021. Matthew's advocate said that the nursing home records prove that Stanley was taking insufficient liquids, why was there not a prompt investigation and staff suspended? (Issues relating to investigations, suspension of staff and disciplinary proceedings generally are beyond the scope of a Safeguarding Adults Review).

4.15 When the SAR was drawing to a conclusion the Board Business Manager and the independent reviewer visited Matthew and his advocate and provided them with copies of a late draft of the report to read and comment on. Matthew made a number of comments which have been incorporated into the report. He said that the SAR report was 'exceptional' and that reading the report had 'lifted a weight off him'. He added that he felt he had been listened to.

5.0 Analysis

5.1 In this section of the report each of the SAR themes will be addressed in turn.

Holistic strength-based assessments and supporting planning

5.2 The Specialist Health Needs Assessment was of critical importance to what followed as the decision that Stanley required nursing care precluded the consideration of residential care homes which did not provide nursing care and also ruled out what emerged as Matthew's preferred option which was the four bedded respite service run by the same organisation which had become very familiar with Stanley's needs whilst he was accessing the associated Day Centre. However, as discussed this Respite service had closed during the pandemic and had not yet reopened.

5.3 At the reflective event for practitioners arranged to inform this SAR, the question of the rationale for Stanley being assessed as needing nursing care was raised – given that he was supported at home by his informal carer, with two visits per day by home care providers, through attendance at the Day Centre and minimal District Nurse involvement. The District Nurse present at the reflective event (who did not personally complete the Specialist Health Needs Assessment) felt that the high level of support Stanley required to meet his daily needs - including full personal hygiene, feeding and drinking support - including managing the risk of aspiration associated with dysphagia and continence care was likely to have 'tipped' him into nursing care.

5.4 The Specialist Health Needs Assessment has been shared with this SAR. The template consists of a list of headings namely 'personal hygiene', 'moving and handling', 'eating and drinking', 'maintaining a safe environment', 'elimination' (which relates to continence), 'communication', 'sleeping', 'social and cultural needs', 'sexuality', 'skin integrity', 'medications', 'mental health status', 'friendship/relationships/family', 'medical/surgery history and current medical condition' and 'breathing' followed by a summary, where in this case, the district nurse who completed the assessment made her recommendation. The template states that the headings are not intended to be prescriptive or exhaustive.

5.5 The introduction at the beginning of the template appears to envisage the Specialist Health Needs Assessment being part of a 'comprehensive assessment from all health and social care professionals'. In Stanley's case the Specialist Health Needs Assessment appeared to be regarded as solely determining the type of respite care Stanley would need as well as being part of a wider assessment.

5.6 The aim of the assessment is stated to be to facilitate an appropriate package of care/placement that is client focused. In the guidance notes for completing the aforementioned 'summary' of the assessment – the professional completing the assessment is advised to give a brief summary of information detailed previously, including the person's own thoughts, perceptions and wishes in respect of their care needs and how they may be addressed. The assessment contains no information about Stanley's 'thoughts, perceptions or wishes'. The guidance notes are silent on what action to take if a person lacks capacity to share their 'thoughts, perceptions or wishes', although towards the end of the template there is a check list - primarily of care options - for which a 'yes' or 'no' response is required. This list includes the question 'Has 'Best Interests' been considered (if applicable)' which in Stanley's case is answered 'yes' although no further details are given.

5.7 In the assessment, there is no reference to the views of the person's family or carer although the template asks for 'name', 'relationship' and 'contact details if they are not NOK' of any representative nominated by the person. This section of the template has not been completed.

5.8 Towards the end of the template, the following question is asked: 'If possible indicate what health/social care professional could (be the) best person to deliver the care e.g. registered nurse required or carer. Also include District Nurses input, and expected plan of care, frequency of visits etc and if possible how care needs may change in the next 4-6 weeks'. This question seems to be an opportunity for the person completing the assessment to think a little creatively about the way in which the person's assessed needs could be met and may also be an opportunity to collaborate with any family carer. However, in this case this question is responded to only by answering 'yes' to the 'nursing home care' and 'no' to the other options such as 'residential care', 'home package' etc. (It is worth pointing out that the template contains several references to 'service users' which it may be advisable to change to a more person-centred term).

5.9 It is known that Matthew advised Adult Social Care that he was unhappy with the outcome of the Specialist Health Needs assessment (Paragraph 3.16) but, assuming the district nurse completing the assessment was aware of Matthew's views, they are not recorded on the template.

5.10 As stated the outcome of the assessment was a recommendation that 'due to Stanley's current condition, requiring all needs to be anticipated, his non-weight bearing status and needing feeding', respite in nursing care was recommended.

Finding 1

The Specialist Health Needs Assessment completed in respect of Stanley recommended respite in nursing care. Given the level of his needs this was a justifiable decision. However there is little indication that the 'thoughts, perceptions or wishes' of Stanley or his partner and carer Matthew were taken into account or any reference to Matthew disagreeing with the assessment. Additionally, the assessment did not appear to consider more creative options for meeting Stanley's needs, although the reflective event explored whether the 'nursing' component of Stanley's care could have been met in any other way at that time and concluded that, other than the development of night carer support as an alternative to respite (see later), it could not. Additionally, it should be noted that the assessment was completed as the third England Covid-19 lockdown restrictions were being eased, at a time when the health economy, including the nursing home sector, was under extreme pressure from sickness absence through self-isolation by staff amongst other impacts of the pandemic.

Questions for the Safeguarding Adults Board

- What are the barriers to professionals adopting a more flexible, creative and collaborative approach to considering how a person's assessed health and social care needs could be met, and how might any barriers be overcome and what might be enablers of a less rigid approach?
- How might personal choice of the person be promoted in decision making in respect of how assessed health and social care needs may be met?

Continuity of care and care needs (engaging with the carer)

Hydration

5.11 When admitted to hospital from the Nursing Home, Stanley was noted to be 'severely dehydrated' (Paragraph 3.37), although as previously stated the Pathologist who completed the post mortem on Stanley concluded that the contribution of dehydration and kidney malfunction to his cause of death was 'not more than minimal'. As stated, the Section 42 Safeguarding Enquiry concluded following Stanley's death found that 'abuse by neglect omission of care' was substantiated.

5.12 The Daily Progress Notes completed by Nursing Home A staff have been shared with the independent reviewer. After examining the Daily Progress Notes, the following observations are made:

5.13 There were significant concerns about the management of Stanley's fluid intake whilst a resident of Nursing Home A. During the 16 full days of Stanley's

placement he was generally recorded as being offered no more than 1200 millilitres of fluid per day. It is understood that 1500 to 2000 millilitres of fluids per day is generally recommended for care/nursing home residents. Stanley was frequently recorded as consuming less fluid than he was offered. On average he is recorded as consuming 880 millilitres per day. Whether fluids were thickened - as Stanley's support plan for the respite stay specified (Paragraph 3.20) was never recorded. On the daily record of dietary and fluid intake there is a space to record the target intake in millilitres. This was never completed.

5.14 On 7 of the 16 full days of Stanley's placement he is recorded as having no food or fluids for between 16 and 17 hours. This appeared to be a consequence of the tea time meal being offered between 4pm and 5pm daily and supper not being offered until after 8pm when the night staff would be on duty. If a drink was refused at supper time or Stanley was asleep at that time, the 16 or 17 gap without food or fluid appeared to be an inevitable consequence which generated no documented concerns in the nursing home. It appears that the way in which the nursing home was organised meant that all, or nearly all of the fluids offered to Stanley were offered during the daily window of 8.30am to 5pm. This appeared to be a function of the division of responsibilities of 'day' and 'night' staff, although it has been suggested in research reports that restricting fluid intake in the evenings may help carers to manage nocturia (waking in the night to urinate) although in Stanley's case he would urinate into his pads during the night. However, this may not have been the case with other residents of the nursing home.

5.15 It is accepted that it is possible that the recording of Stanley's fluid intake may not have captured every drink he was offered or consumed. Recording what is offered, what is consumed, and the efforts made to encourage the person to take fluids is one task amongst many for care workers, although it is of vital importance. However, the Daily Progress Notes for Stanley demonstrate that his apparently low fluid intake was never picked up on in those Notes or through any other form of monitoring or apparently escalated.

5.16 For example on 29th April 2021 Stanley's fluid intake was 675 millilitres of the 1125 offered and he ate half his breakfast and three quarters of his teatime meal. On the Daily Progress Notes for that date dietary intake was described as 'good' and there was no mention made of his very low fluid intake. The instructions for completing the Daily Progress Notes state that the resident's 'intake and output' should be reviewed each night by the person in charge of the shift. There is no indication that this was ever done, or if done, ever documented. The Daily Progress Notes allow a running total of fluid consumed and a total for each 24 hour period to be recorded. The total fluid consumed over

a 24 hour period was added up and filled in on only one occasion and on that occasion was incorrect as the running totals were added together to arrive at an inflated figure.

5.17 Dehydration is a potential underlying cause of pressure ulcers and from 6th or 7th May 2021 Stanley had been receiving care for a moisture lesion which could develop into a pressure sore and the Tissue Viability Nurse recommended that food and fluids should be encouraged. When admitted to hospital from Nursing Home A the moisture lesion was noted to have developed into a category 1 pressure ulcer (Paragraph 3.37).

5.18 When admitted to hospital the ED clinical review noted that Stanley 'had not eaten or drunk much for the past two days' (Paragraph 3.37). It is assumed that this information was obtained from the nursing home via the ambulance crew. Whilst the Daily Progress Notes for 14th May 2021 (the day before Stanley's hospital admission) documented a fluid intake of 700 millilitres and that he had refused his breakfast, eaten a few mouthfuls of his lunch and refused his teatime meal and had no food or fluid after 4pm, no concern about this was documented in the Daily Progress Notes which noted only that he had been fully assisted with diet and fluid intake.

5.19 Concerns about lack of hydration in residential and hospital settings are not new. The Francis report into the care of patients in Mid-Staffs Hospital noted that about half the patients and their families who gave oral evidence to the Inquiry provided accounts of issues with obtaining appropriate food and drink (1). A 2014 University of Oxford, Barnet and Chase Farm Hospitals NHS Trust, and the London School of Hygiene & Tropical Medicine study entitled *Are patients admitted to hospitals from care homes dehydrated? A retrospective analysis of hypernatremia*[12] *and in-hospital mortality* (2) found that 1% of patients admitted to hospital from their own home were found to have high sodium levels whilst the figure for patients admitted from care homes was 12%. Dehydration leads to high sodium levels.

5.20 Additionally, the fact that the admission documentation for Stanley was not completed meant that apart from his weight – residents of Nursing Home A are weighed weekly – there was an absence of baseline data which would have been helpful in monitoring any deterioration in Stanley's condition.

[12] A deficiency of water relative to sodium.

Nutrition

5.21 For supper on one evening Stanley was offered sandwiches which he refused. The support plan for his respite placement highlighted Stanley's risk of choking and stated that he required a soft diet (Paragraph 3.20). The error in offering Stanley sandwiches was not picked up on in the Daily Progress Notes.

5.22 The support plan for Stanley's respite placement also stated that he required lots of time and encouragement to eat (Paragraph 3.20). No information about the efforts made to encourage Stanley to eat was recorded on the Daily Progress notes which documented that he 'refused' a meal or a drink on eight occasions during his respite placement. There is a requirement to complete a box to state whether food was 'pureed', 'pre-mashed' or 'fork-mashable' which was completed on one day only. The amount offered and the amount eaten was rarely recorded.

5.23 There is no indication that either the Tissue Viability Nurse (on 11th May 2021) or the GP (on 13th May 2021) checked the fluid charts for Stanley. The SAR has been advised that if the person is presenting reasonably well then it would not be expected practice to check the fluid charts.

Finding 2

During his respite placement Stanley's documented fluid intake was consistently low and remained consistently low even after the Tissue Viability Nurse had recommended that food and fluids should be encouraged. Whether or not the fluid offered Stanley was thickened also went unrecorded. There is no indication that Stanley's low documented fluid intake was monitored by nursing staff or management, or any concerns escalated. During his respite placement Stanley was offered food on one occasion which, had he not refused it, would have exposed him to the risk of choking.

Questions for the Safeguarding Adults Board

- The SAR Panel felt that the problems with recording, providing, encouraging and monitoring hydration of residents observed in this case is not an isolated occurrence. How might the Board and partners further engage with the providers of Care/Nursing Homes to emphasise the importance of hydration?
- Could there be any creative solutions to the challenges of hydrating residents of Care/Nursing Homes which could be explored such as the use of assistive technology and more flexible shift systems?
- Could visiting professionals have a role to play in monitoring hydration and nutrition in Care/Nursing Homes. The SAR has been advised that the paper records used at the time of Stanley's placement have been replaced by

electronic records which, the SAR has been advised, remain readily accessible to visiting professionals?

- Have all training offers in respect of nutrition and hydration been explored. (The SAR was advised of an Age UK training offer aimed at Care and Nursing Homes).

Skin integrity

5.24 Assuming Stanley's moisture lesion was first noticed on 7th May 2021 (a Friday) – although Matthew has suggested that he was told about the moisture lesion a day earlier – no referral was made to the Tissue Viability Nurse until 10th May 2021 (the following Monday) and Stanley was not assessed until the following day – Tuesday 11th May 2021. When the Tissue Viability Nurse assessed Stanley, she found the barrier cream which the Nursing Home had been using to be inappropriate (Paragraph 3.29). The SAR Panel noted that whilst nursing homes employ registered nurses who are expected to be able to respond to skin integrity concerns, delays in making referrals to the Tissue Viability Nurse are not uncommon and may reflect a perception on the part of nursing home providers/managers that referrals for Tissue Viability Nurse support do not reflect well on the standard of care provided in the nursing home. The SAR has been advised that Salford Integrated Care Partnership chair a weekly meeting of Tissue Viability Nurses at which, amongst other things, any concerns about skin integrity care in Care/Nursing Homes are discussed.

5.25 The SAR has been advised of two relevant developments in skin integrity care since the period on which this SAR focusses. Firstly, the Tissue Viability Nurse would now be expected to create a DATIX incident report which would be shared with the commissioners of the Tissue Viability Nurse service. Secondly, Tissue Viability Nurses are able to personally prescribe treatments which the Care/Nursing Home fax or email to the pharmacy.

Finding 3

There was a three or four day delay in Nursing Home A referring Stanley to the Tissue Viability Nurse and during that period the Nursing Home treated Stanley with barrier cream the Tissue Viability Nurse considered inappropriate.

Question for the Safeguarding Adults Board

- What further steps are needed to encourage Nursing Homes to make prompt referrals to the Tissue Viability Service?
- What further steps are needed to encourage take-up of skin integrity training by Care/Nursing Homes.

Assurance around standards of care within the Nursing Home

5.26 The Care Quality Commission (CQC) is the independent regulator of all health and social care services in England. The CQC monitors, inspects and regulates services and publishes what they find. The last CQC inspection of Nursing Home A which took place prior to Stanley's death occurred on 13th March 2019 (published on 15th May 2019) and assessed the service as 'good' with one area – 'safe' – requiring improvement.

5.27 No further CQC inspection took place until 25th and 26th October 2022 (published on 21st December 2022). The pandemic is a major contributing factor to the gap of three and a half years between CQC inspections, but it is worthy of note that the 25th/26th October 2022 CQC inspection report refers to Nursing Home A as a 'newly registered service'. The only respect in which the service could be described as 'new' is that it is under new ownership. Nursing Home A was purchased by SPV4 Limited in January 2021. The CQC do not inspect newly registered services for 12 months as a general rule – which may have contributed to the gap between CQC inspections – and the new provider no longer maintains the previous provider's regulatory history.

5.28 The most recent 25th/26th October 2022 CQC inspection of Nursing Home A assessed the service as requiring improvement overall, and specifically requiring improvement in the areas of 'safe', 'effective' and 'well-led'. Whilst this CQC inspection took place 17 months after the death of Stanley, some of the detailed findings give cause for concern. Under the 'safe' heading reference was made to the fact that record keeping in respect of thickening powder used in people's drinks when they are at risk of choking, was not consistent. Staff did not always record they had used thickener when making people's drinks or what they recorded was not always accurate. Under the 'effective' heading reference was made to food charts lacking detail about what people had actually eaten and fluid intake not being recorded accurately. After the provider had previously identified issues with the quality of food and fluid records, nursing staff had been tasked with checking daily intake records. Despite this, during the inspection the CQC found food charts still lacked sufficient detail of what people had eaten and fluid charts did not accurately reflect people's intake. Fluid charts indicated people were not consistently offered their daily recommended intake.

5.29 The SAR has been advised that following the finalisation of the Section 42 Safeguarding Enquiry, Salford Adult Social care worked with Nursing Home A in an effort to ensure that standards had improved in relation to record keeping and they met with the Nursing Home A registered manager to review the changes made to recording systems. Adult Social Care noted that all records regarding food and fluid intake were now electronic and the electronic document does not

allow the user to move on until it has been completed and the necessary information inputted. Adult Social Care were advised that the registered manager checked this daily herself to ensure oversight. The progress achieved was deemed sufficient at the time to move to general system-wide Market Management and Care Home oversight. Obviously, some time has elapsed between the point at which Adult Social Care ceased their focussed involvement with Nursing Home A and the 25th/26th October 2022 inspection.

5.30 Turning to the system-wide Market Management and Care Home oversight, the SAR has been advised that the key elements of this oversight process are as follows:

- A Care Home Quality Improvement Network (QIN) on which Salford Adult Social Care, NHS Greater Manchester (GM) Integrated Care (Salford Locality), Salford Royal Hospital, Greater Manchester Mental Health NHS Trust, Public Health and the CQC are represented. This Network meets monthly and highlights areas of need, areas of growth, areas for improvement and 'pressure points' across the system. The SAR has also been advised that it is intended to form a QIN operational group – also known as the Care Home Excellence Programme - to complement the broadly strategic focus of the existing QIN group. Additionally, the SAR has been advised that, going forward, nutrition and hydration will be one of three strategic priorities alongside dementia care and medication management.
- A Care Homes Safeguarding/Quality/Medicines/IPC operational meeting held weekly and hosted by NHS GM Integrated Care (Salford Locality) - which deals with care home safeguarding and quality concerns and is attended by ICP quality and safeguarding leads, Funded Nursing Care (FNC)/NHS Continuing Healthcare (CHC) leads. All active safeguarding enquiries and concerns, any intelligence from review activity and 'soft intelligence' are discussed.
- The PAMMS (Provider Assessment and Market Management Solution) has been taken into use in Salford which 'aims to deliver dynamic data collection, analysis and reporting to increase care quality and mitigate the risk of provider failure'. PAMMS contains a quality framework which is broadly similar to the CQC inspection framework. The six domains of the PAMMS system involves staff interviews, service user engagement, care delivery observations as well as examining policies and procedures. The assessment results in a Provider rating which ranges from 'poor' to 'excellent'. All of Salford's Supported Living providers have been assessed using PAMMS and at the time of writing 12% of care homes and 14% of home care providers have been assessed.

- The ICP Salford Quality Assurance Team conduct quarterly quality assurance visits to all care homes which provide funded nursing care to Salford residents (14 establishments at present, including Nursing Home A). These visits were disrupted by the pandemic – when the visits were conducted by telephone - and so were not physically taking place during Stanley's respite placement. The visits resumed in quarter 4 (January – March) 2022, have continued thereafter and the practitioner has regular contact with the nursing home. The record of the quality assurance visit undertaken during quarter 3 (October, November, December) of 2022/23 has been shared with the SAR. The record consists of a number of domains – 'staffing', 'residents', 'infection control/Covid', 'winter planning', 'safeguarding', 'home improvements' and 'CQC'. Each domain consists of a number of questions for which a 'Y' or 'N' answer is anticipated followed by an expandable space for comments. Under 'safeguarding' there is a question 'Any SG1 outstanding?' which was answered 'Y' and appropriate detail was included in the 'comments' section. Under 'CQC' there are two questions 'Audits/policies up to date? – Y' and 'Action plan from the most recent visit complete? Do you need support – Y'. However this latter question consists of two questions and it is therefore unclear to which of the two questions 'Y' is the answer.

5.31 The SAR has been advised that all relevant elements of the system-wide Market Management and Care Home Oversight are aware of the outcome of the 25th/26th October 2022 CQC inspection of Nursing Home A.

Finding 4

It is deeply concerning that hard lessons learned from the Section 42 Safeguarding Enquiry completed following the death of Stanley and the ongoing Safeguarding Adults Review do not appear to have led to all of the issues which adversely affected the care of Stanley during his respite placement being addressed or improvements made being sustained.

Questions for Safeguarding Adults Board

- Are the elements of the system-wide Market Management and Care Home oversight sufficiently sensitive to concerns relating to hydration, given the centrality of hydration to overall patient care?
- Are teams with responsibility for Market Quality and Care Home oversight made aware of the outcomes of Section 42 Safeguarding Enquiries and the learning from Safeguarding Adult Reviews to allow for increased monitoring of provider services and to ensure action plans/improvement plans are being completed and improvements sustained?

Capacity and Market Management – Stanley had support prior to the respite stay which then wasn't available shortly afterwards which delayed a return home?

5.32 At the reflective event arranged to inform this SAR, professionals discussed the difficulties in sourcing a care package at short notice at the time that Matthew was attempting to bring Stanley home from respite. It was stated that the care market was under significant pressure from Covid-19 related issues, particularly the requirement that employees who tested positive for Covid-19 isolate at home for 14 days. However, professionals felt that the care market continued to lack the capacity to respond to short notice requests. The manager of the dementia home care provider who attended said that their particular service had limited capacity to support tea and bed time cover in Salford.

5.33 However, the SAR has been advised of a number of important developments which have been, or are being, implemented which are intended to increase the flexibility and responsiveness to the needs of people with care and support needs and their informal/family carers.

5.34 An overnight support offer is now in place involving nine providers with a Salford footprint. The overnight support offer could be a full nights support or a shorter period depending on the person's needs and wishes. The SAR has been advised that this offer has helped to facilitate more timely hospital discharges, assisted in 'stepping-up' and 'stepping-down' care and support and helped people to access care and support in their own homes. The overnight support offer is currently an interim solution and it is assumed it will ultimately become a fully commissioned service.

5.35 The Salford Carers Strategy is being revised and a key element of the Carers Strategy action plan is developing and improving the respite offer to carers. This work began in the summer of 2022 and the professional leading the work initiated a mapping exercise of current provision such as day care services, Direct Payments etc. Unfortunately the professional leading the respite offer work has left their post and a replacement has not yet been appointed and so the work is currently on hold. When re-commenced the work will consult with people with lived experience of the various current methods of obtaining respite care.

5.36 Additionally work continues to improve the home care market offer generally including:

- enhancing the resilience of providers and raise the status of home carers by mandating the payment of the 'real living wage' which is a voluntary wage level which exceeds the 'statutory minimum wage' and 'national living wage'.

To achieve this an enhanced rate is paid to providers commissioned to provide home care.

- strength based assessments and an enhanced reablement offer to support people to stay in their own homes longer and reduce demand for residential care and prevent hospital admissions.
- work with providers to enhance relationships, understand the risks and dilemmas they are managing and try to prevent them from withdrawing from the market.
- introduction of a hospital retainer payment on a trial basis under which homecare providers continue to receive payment for homecare in respect of people they support who are admitted to hospital. Payment is for two weeks and enables packages of care to be kept open rather than stopped and then difficulty and delays being experienced in re-starting the care package when the person is medically fit for discharge.

5.37 The SAR has also been advised that sourcing timely home care packages remains challenging and there has been a significant reduction in the number of people waiting for a care package although demand and the capacity of the market to meet demand can fluctuate on a daily basis.

Finding 5

It must be a better option for people such as Stanley with high needs who is being very effectively cared for at home to be provided with additional care in the familiarity of his home to remain at home rather than facing the disruption, anxiety and risk of being placed in respite care where, as has been seen in this case, their presentation may deteriorate very quickly. It may also be a better option for family carers such as Matthew, in order to prevent the feelings of anxiety about the quality of care provided in the respite placement and the difficulties involved in challenging the provider.

Questions for Safeguarding Adults Board

- To what extent is the overnight support offer making a difference to the need for respite care placements of the kind which was considered necessary for Stanley?
- How might the nursing needs of people who could benefit from the overnight support offer be met?
- To what extent will the learning from this SAR be used to inform the further development of the overnight support offer and the respite offer to carers as part of the Carers Strategy?

- To what extent will the voice of carers feed into the improvements underway and could Matthew be offered the opportunity to influence changes being made?

5.38 The SAR Panel questioned whether having a personal budget for Stanley's care may have given Matthew more control over the situation. Professionals who attended the reflective session observed that Matthew appeared quite disempowered with little choice over the arrangements for Stanley's respite care. (Direct Payments had previously been discussed by Adult Social care with Matthew but not progressed at that time). According to a November 2022 Age UK Factsheet, whilst Direct Payments cannot generally be used to pay for long term residential care, it is possible to purchase short-term respite or replacement care in a care home using a direct payment. The direct payment regulations limit this to four consecutive weeks in a year. If residential care for less than four weeks at a time is purchased, the amounts are added together. This does not apply if the gap in between is at least four weeks (3).

5.39 It would therefore appear that Matthew could not have used a Direct Payment to purchase a five or six week respite placement but could have used it to purchase a four week respite placement. But it is assumed that Matthew would have come up against the same market capacity issues experienced by Adult Social Care. However, Direct Payments would have allowed Matthew to employ a personal assistant to support him in caring for Stanley whilst recuperating from his operation. However, recruitment of personal assistants is not normally a quick process although it is much speedier when recruiting a family member although rules apply which may preclude employment of a family member who is normally resident with the person with care and support needs, but in Matthew's case employment of the sister or the niece – who lived elsewhere - may have been a viable option.

5.40 However, the SAR has been advised that the direct payment process is further complicated if the person has nursing needs as the direct payment system cannot duplicate funded health care such as district nurse care. The SAR Panel felt that this issue should form a question for the Safeguarding Adults Board.

Question for Safeguarding Adults Board (Direct Payments)

- How might barriers to using the direct payment system for people with nursing needs be overcome?

Working together – once Matthew expressed concerns regarding the care and support Stanley was receiving, what action was taken to address those concerns?

5.41 Matthew began requesting that Stanley return home early from his respite placement on Monday 3rd May 2021 (Paragraph 3.23). He had undergone a double hernia operation only three days earlier and legitimate concerns were expressed by Adult Social Care, Nursing Home A and the GP about Matthew's ability to care for Stanley at home so soon after his operation. NHS guidance states that 'normal activities can gradually be resumed over time when they can be carried out without feeling any pain. The latest hernia repair techniques usually allow you to return to normal activities within two weeks. Gentle exercise, such as walking, can help the healing process. Heavy lifting and strenuous activities should be avoided for about 4 to 6 weeks (4). The length of the period of respite care arranged for Stanley – five or six weeks – therefore appears consistent with the NHS guidance. Caring for Stanley at home would have been strenuous at times. Additionally, Matthew was concerned about the impact of driving to the out of hours pharmacy on Friday 7th May 2021 on the stiches from the operation (Paragraph 4.12) and felt that the need for the hernia operation may been the 'heavy lifting' involved in caring for Stanley (Paragraph 4.16).

5.42 Professionals also had legitimate concerns for the welfare and safety of Stanley if he was cared for at home before Matthew had recovered sufficiently to provide the level of care required. There was also the risk of carer breakdown if Stanley was returned home too soon, which may have necessitated an unplanned return to respite care.

5.43 Following the development of a moisture lesion on Stanley's sacrum on either 6th or 7th May 2021, this presented an additional obstacle to Matthew being able to safely care for Stanley at home as Nursing Home A decided that it was necessary to reposition Stanley every two hours and the Tissue Viability Nurse recommended that he needed repositioning at a minimum of three hourly when she assessed Stanley on 11th May 2021. It would not have been conducive to Matthew's recovery to be responsible for repositioning Stanley every two or three hours and it would have been difficult to arrange for home carers to visit sufficiently frequently and during the night to support the frequency of repositioning required.

Voice of the carer – was he listened to prior to the admission/when expressed concerns what action was taken?

5.44 Matthew as carer was listened to by professionals who appeared to regard him as a very committed and assiduous carer and advocate for Stanley. The GP in particular appeared to be very responsive to concerns raised by Matthew on Stanley's behalf.

5.45 When Matthew began to have 'second thoughts' about Stanley going into respite care shortly before the Nursing Home A placement began, the ASC had a 'long talk' with Matthew (Paragraph 3.18). There was documented to have been an agreement reached that Stanley's placement at Nursing Home A would go ahead 'even for just a short period of time to allow Matthew time to recover and then we would take things from there'. If this is an accurate summary of the outcome of the lengthy discussion, then Matthew may have been given an overly optimistic view of the possibility of ending Stanley's respite placement prematurely. As we have seen once the placement began, it proved very challenging to end it early. Adult Social Care were able to achieve the reinstatement of the dementia home care provider from Monday 17th May 2021. Had Stanley been well enough to return home on that day Matthew would have received additional support from dementia home care provider in terms of 4 visits daily increased from the previous 2, but would have lacked any support from the Day Centre until the anticipated five or six week placement period had elapsed.

5.46 An adversarial relationship between the nursing home and Matthew developed. This came across very clearly from the conversation between the independent reviewer and the Nursing Home manager. The animosity which developed may also have sprung from the subsequent Safeguarding Enquiry and complaints investigation. Matthew was clearly very anxious about Stanley going into a respite placement. Stanley had been his partner for 45 years and he had cared for him for over a decade and was very attuned to his needs provided loving, personalised and effective care. Matthew's experience of what he sometimes felt were variable standards of homecare provided by the dementia home care provider appears to have fuelled his anxiety. There are some indications that professionals may not always have responded empathetically to the manifestations of Matthew's anxiety about Stanley. Matthew was clearly anxious about Stanley going into a respite placement and his anxiety increased when concerns about the care which Stanley was being provided began to arise.

5.47 The SAR Panel raised the issue of whether Matthew's expectations of the type of care Stanley would receive in a nursing care home were appropriately managed. Whilst it is not suggested that anyone should accept a lower standard of care than they receive in their own home, the process by which care is provided in residential and nursing care has a different profile and it is extremely difficult to mirror the care routine which is possible within the home environment. In residential care and nursing homes it inevitably takes care staff some time to fully understand the person's needs and how they express those needs.

Voice of the adult to ensure personalised approach to care and support – if there was no alternative to 24-hour care, was there person-centred discussions regarding how care would be provided to Stanley – was care service led or person centred led?

5.48 Stanley was unable to communicate verbally other than the odd word and was described as 'easy to look after' by Matthew, who added that Stanley was 'very placid' and did everything asked of him. He did require time and encouragement to eat and drink. Stanley is likely to have felt the emotional impact from being separated from Matthew. Although the nursing home has advised that Matthew was allowed greater access to Stanley than was normally the case, his visits to Stanley were limited as a result of Covid-19 related restrictions. Government guidance on care home visiting (5) stated that every care home resident should have an identified essential care giver who would be allowed to visit the home to offer companionship or help with care needs even during periods of isolation or outbreak. The registered manager of Nursing Home A has advised that Stanley's respite care placement took place before the 'essential care giver' guidance was published.

5.49 Looking back on events, the combination of Stanley's placid demeanour, his verbal communication challenges, the time and effort required to encourage him to eat and drink and the limitation on the time Matthew was allowed to spend with him, may have combined to inadvertently increase the risk of dehydration.

Application of legal framework and statutory duties

5.50 Stanley was assessed as lacking capacity to make decisions relating to his respite care for Matthew's operation and post-operative recovery and a best interests meeting took place on 29th December 2020 at which it was decided that it would be in Stanley's best interests to go on the respite placement. Given that capacity assessments are time specific, it would have been good practice to arrange a further best interests discussion when Matthew was notified of his operation date, which was four months after the 29th December 2020 best interests meeting.

5.51 When Matthew began requesting that the respite placement should be curtailed early and Stanley returned to his care at home, the potential need to hold a best interests meeting was discussed but not actioned. With hindsight, this appears to have been a significant missed opportunity as the arguments against Stanley's respite placement ending prematurely were quite strong and it would have been a good opportunity for the arguments for and against Stanley returning home early to be presented and tested out, allowed efforts to be made

to ascertain Stanley's views and for his partner Matthew's views to be heard and the eventual outcome documented.

5.52 The Nursing Home manager advised the SAR that a Deprivation of Liberty Safeguards (DOLS)[13]referral was made in respect of Stanley although there is no record of a DOLS referral being received by the Salford DOLS team. However, the SAR has been advised that if a DOLS application had been submitted by Nursing Home A, the DOLS team would have reviewed it to see if there were any factors that required a priority assessment, such as any objections being raised by Stanley or others to his care. The team would have taken into account that Stanley's placement was temporary and there was no intention to permanently deprive him of his liberty at Nursing Home A. However, once Matthew began to request and then more urgently press for Stanley to return home, this changed the dynamic and had the DOLS team been notified of this, the priority afforded to any DOLS application may have altered. Otherwise there may have been a risk that Matthew and Stanley's Article 8 rights to a family life may have been breached.

Escalation pathways

5.53 As previously stated there is no indication that concerns about Stanley's care were ever escalated within Nursing Home A. Whilst much valid information went unrecorded – such as whether the fluid offered to Stanley was thickened as required because his dysphagia meant that he was at risk of choking if his fluids were not thickened – there was a wealth of information recorded which should have indicated to any professional checking, signing off or monitoring Stanley's notes that he was at serious risk of dehydration which increased the risk of his moisture lesion not healing or developing into a pressure sore – which it was noted to have done when he was admitted to hospital.

5.54 Matthew began expressing concern about Stanley's care from Friday 7th May 2021, initially to his GP (Paragraph 3.26), then to Adult Social Care (Paragraph 3.28), the GP again (Paragraph 3.33) and the CQC (Paragraph 3.34). The CQC advised Matthew that the initial step if he wished to formally register concern about Stanley's care was to complain to the nursing home, which he did the following day after viewing the images of Stanley taken by a member of the Nursing Home A staff. The CQC also signposted Matthew to the Local Government and Social Care Ombudsman. However, this advice was principally

[13] The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

about how to make a complaint and obviously it takes time to investigate a complaint. In his contribution to this SAR, Matthew said that he was 'trying to get anybody' to go in and check on Stanley (Paragraph 4.10). The GP visited Stanley in the nursing home (Paragraph 3.33) although this visit was prompted primarily by Matthew's reporting of Stanley experiencing a chesty cough. After viewing the daily care records completed by Nursing Home A, Matthew feels that the GP could have been more 'proactive' by viewing the fluid and food charts (Paragraph 4.13). Additionally, Matthew was under the mistaken impression that the District Nurse would be visiting Stanley following the GP referral to that service. The impression gained is of Matthew increasingly coming to the conclusion that Stanley was not being well cared for in Nursing Home A but struggling to find the most appropriate avenue to escalate those concerns. His personal access to Stanley had been restricted as a result of the third Covid-19 lockdown (although the Nursing Home manager has advised this SAR that the usual rules were relaxed to a degree to allow Matthew greater access to Stanley) and then the D&V outbreak. No-one appeared to suggest that Matthew's concerns could be escalated to the NHS Funded Care team which had approved funding for the respite placement (Paragraph 3.17). The latter team has advised that they do not routinely complete reviews of individuals in short term placements. The review process would only be prompted if an individual remained in the care home longer than anticipated *or if concerns were raised about the care they were receiving.* Nursing Home A has been unable to confirm that Matthew received a 'welcome pack' when Stanley's placement began – due to the change in ownership referred to earlier which means that some records have been lost. However, they do confirm that information about the Home's complaints procedure is visible throughout the establishment (When Matthew read a late draft of this SAR report he said that he was not provided with a 'welcome pack' and felt that, in addition to information about the complaints process being displayed for family members to read, this information should also be personally explained to family members).

5.55 It is worthy of note that families of residents of residential and nursing homes represent an informal but important form of surveillance of standards within residential and nursing homes which has been seriously disrupted by visitor restrictions arising from the management of the Coivid-19 pandemic. One wonders whether this has received sufficient weighting in the assessment of risks to residents in residential and nursing homes about which there are concerns.

Questions for Safeguarding Adult Board

- Is the Board satisfied that information on how to make a complaint and/or escalate concerns is sufficiently clear and sufficiently available to family members supporting people in residential care?

- Are there any barriers to family members making complaints and/or escalating concerns which need to be addressed as a result of the learning from this case?

Implementation of Safeguarding Policy and Procedures

5.56 Safeguarding procedures were not implemented until two days after Stanley was hospitalised. There appears to be some learning from conduct of the Section 42 Safeguarding Enquiry but this is currently not included within the scope of the SAR.

Was there a co-ordinated approach, clear and effective communication between professionals.

5.57 There was much effective partnership working to arrange Stanley's placement and professionals worked together conscientiously in an effort to safely meet Matthew's request for Stanley to return home early from his placement.

5.58 The GP referred Stanley to the District Nurse service when advised by Matthew that Stanley had developed a moisture lesion during his respite placement at Nursing Home A (Paragraph 3.27) which suggested either a lack of clarity over the level of care Stanley was receiving in Nursing Home A (i.e 'nursing' as opposed to 'residential') or that there may be a lack of clarity about the role of District Nurses in supporting residents receiving 'nursing' care.

Impact of Covid – was Stanley seen by professionals? Did Matthew have the ability to visit?

5.59 The third Covid-19 lockdown was gradually being eased at the time that Stanley's respite placement at Nursing Home A commenced. At that time Nursing Home A were trying to maintain the safety of residents, staff and visitors through an appointment system for visits by family members. The nursing home manager has advised this SAR that individual family members were limited to weekly visits at that time but that this was relaxed for Matthew. However, he was unable to visit as frequently as he would have preferred which reduced the extent to which he could liaise with care staff in relation to Stanley's ongoing needs given that Stanley was largely unable to communicate verbally and he was less able to monitor Stanley's presentation and the care he was receiving.

Equalities issues

5.60 Stanley and Matthew were a gay couple who entered into a civil partnership when it became legal for them to do so. There is no suggestion that either

Matthew or Stanley were discriminated against or treated insensitively because of their sexuality.

5.61 It should be borne in mind that gay men of the age of Stanley and Matthew are likely to have experienced adversity in their earlier lives.

5.62 Whilst attitudes to sexuality have been transformed over the years, it shouldn't be assumed that because Stanley and Matthew were an 'out' gay couple living peacefully together in Salford in the 2020s that perceptions and attitudes to their sexuality would not be of relevance. It is of interest that the professional completing the Specialist Health Needs Assessment recorded 'no issues' under the heading of sexuality. Absolutely no criticism is intended for this response but research into older LGBT people's experiences has indicates that they can be an 'invisible' and 'marginalised' population in later life and that their life stories and relationships are frequently overlooked by care providers and staff and managers employed in care homes (6).

Question for the Safeguarding Adults Board

- How content does the Board feel that the care needs of older LGBT people are being met in manner which is sensitive to their needs. Equity is an important issue in the provision of health and social care and so there could be value in reflecting on the life histories of Stanley and Matthew and thinking about how well equipped local health and social care services are to respond appropriately to the needs of older LGBT people.

Good practice

5.63 The ASC manager adopted a creative approach in asking a bridging care provider to assist. Strictly speaking Stanley was not eligible for support from this agency as they provide bridging care for people discharged from hospital but the ASC manager was prepared to adopt a flexible approach in an effort to support Stanley's return home.

Dealing with complaints

5.64 Matthew's life has been consumed by the Safeguarding Enquiry and multiple complaints processes which did not appear to have given him a great deal of satisfaction. It appears that SAR process has met his needs, perhaps because it has a strong element of independence, is less defensive than complaints processes can appear to be and enabled the Board Manager and independent reviewer to develop a constructive relationship with Matthew over time. What came across very strongly was that Matthew felt a degree of guilt for Stanley's death. This is a far from unusual feeling for people trying to come to terms with the loss of a loved one. Matthew appeared to feel that the SAR process with its

focus on learning from professional contact with Stanley and Matthew somehow helped to ease the burden of guilt he felt.

Question for Safeguarding Adults Board

- Could there be more effective ways of responding to complaints from family members relating to the care provided to a loved one?

6.0 Findings and Questions for the Safeguarding Adults Board

Finding 1

The Specialist Health Needs Assessment completed in respect of Stanley recommended respite in nursing care. Given the level of his needs this was a justifiable decision. However there is little indication that the 'thoughts, perceptions or wishes' of Stanley or his partner and carer Matthew were taken into account or any reference to Matthew disagreeing with the assessment. Additionally, the assessment did not appear to consider more creative options for meeting Stanley's needs, although the reflective event explored whether the 'nursing' component of Stanley's care could have been met in any other way at that time and concluded that, other than the development of night carer support as an alternative to respite (see later), it could not. Additionally, it should be noted that the assessment was completed as the third England Covid-19 lockdown restrictions were being eased, at a time when the health economy, including the nursing home sector, was under extreme pressure from sickness absence through self-isolation by staff amongst other impacts of the pandemic.

Questions for the Safeguarding Adults Board

- What are the barriers to professionals adopting a more flexible, creative and collaborative approach to considering how a person's assessed health and social care needs could be met, and how might any barriers be overcome and what might be enablers of a less rigid approach?
- How might personal choice of the person be promoted in decision making in respect of how assessed health and social care needs may be met?

Finding 2

During his respite placement Stanley's documented fluid intake was consistently low and remained consistently low even after the Tissue Viability Nurse had recommended that food and fluids should be encouraged. Whether or not the fluid offered Stanley was thickened also went unrecorded. There is no indication that Stanley's low documented fluid intake was monitored by nursing staff or management, or any concerns escalated. During his respite placement Stanley was offered food on one occasion which, had he not refused it, would have exposed him to the risk of choking.

Questions for the Safeguarding Adults Board

- The SAR Panel felt that the problems with recording, providing, encouraging and monitoring hydration of residents observed in this case is not an isolated

occurrence. How might the Board and partners further engage with the providers of Care/Nursing Homes to emphasise the importance of hydration?

- Could there be any creative solutions to the challenges of hydrating residents of Care/Nursing Homes which could be explored such as the use of assistive technology and more flexible shift systems?
- Could visiting professionals have a role to play in monitoring hydration and nutrition in Care/Nursing Homes. The SAR has been advised that the paper records used at the time of Stanley's placement have been replaced by electronic records which, the SAR has been advised, remain readily accessible to visiting professionals?
- Have all training offers in respect of nutrition and hydration been explored. (The SAR was advised of an Age UK training offer aimed at Care and Nursing Homes).

Finding 3

There was a three or four day delay in Nursing Home A referring Stanley to the Tissue Viability Nurse and during that period the Nursing Home treated Stanley with barrier cream the Tissue Viability Nurse considered inappropriate.

Question for the Safeguarding Adults Board

- What further steps are needed to encourage Nursing Homes to make prompt referrals to the Tissue Viability Service?
- What further steps are needed to encourage take-up of skin integrity training by Care/Nursing Homes.

Finding 4

It is deeply concerning that hard lessons learned from the Section 42 Safeguarding Enquiry completed following the death of Stanley and the ongoing Safeguarding Adults Review do not appear to have led to all of the issues which adversely affected the care of Stanley during his respite placement being addressed or improvements made being sustained.

Questions for Safeguarding Adults Board

- Are the elements of the system-wide Market Management and Care Home oversight sufficiently sensitive to concerns relating to hydration, given the centrality of hydration to overall patient care?
- Are teams with responsibility for Market Quality and Care Home oversight made aware of the outcomes of Section 42 Safeguarding Enquiries and the learning from Safeguarding Adult Reviews to allow for increased monitoring of

provider services and to ensure action plans/improvement plans are being completed and improvements sustained?

Finding 5

It must be a better option for people such as Stanley with high needs who is being very effectively cared for at home to be provided with additional care in the familiarity of his home to remain at home rather than facing the disruption, anxiety and risk of being placed in respite care where, as has been seen in this case, their presentation may deteriorate very quickly. It may also be a better option for family carers such as Matthew, in order to prevent the feelings of anxiety about the quality of care provided in the respite placement and the challenges involved in challenging the provider.

Questions for Safeguarding Adults Board

- To what extent is the overnight support offer making a difference to the need for respite care placements of the kind which was considered necessary for Stanley?
- How might the nursing needs of people who could benefit from the overnight support offer be met?
- To what extent will the learning from this SAR be used to inform the further development of the overnight support offer and the respite offer to carers as part of the Carers Strategy?
- To what extent will the voice of carers feed into the improvements underway and could Matthew be offered the opportunity to influence changes being made.

Question for Safeguarding Adult Board (Direct Payments)

- How might barriers to using the direct payment system for people with nursing needs be overcome?

Question for Safeguarding Adult Board

- Is the Board satisfied that information on how to make a complaint and/or escalate concerns is sufficiently clear and sufficiently available to family members supporting people in residential care?
- Are there any barriers to family members making complaints and/or escalating concerns which need to be addressed as a result of the learning from this case?

Question for the Safeguarding Adults Board

- How content does the Board feel that the care needs of older LGBT people are being met in manner which is sensitive to their needs. Equity is an important issue in the provision of health and social care and so there could be value in reflecting on the life histories of Stanley and Matthew and thinking about how well equipped local health and social care services are to respond appropriately to the needs of older LGBT people.

Question for the Safeguarding Adults Board

- Could there be more effective ways of responding to complaints from family members relating to the care provided to a loved one?

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Appendix

Process by which the SAR completed and membership of the SAR Panel

It was decided to adopt a broadly systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Membership of the SAR Panel:

Judd Skelton (Chair) Assistant Director – Integrated Commissioning, Salford City Council/NHS Salford Clinical Commissioning Group (CCG) (The CCG's functions have now been taken over by NHS Greater Manchester Integrated Care)
Jane Bowmer - Salford Safeguarding Adults Board Business Manager.
Ann Brooking – Head of Service/ Principal Social Worker, Adult Social Care/Salford Royal NHS Foundation Trust
Eileen Conneely – Principal Manager for Safeguarding, Salford Royal NHS Foundation Trust /Adult Social Care
John Fenby – Professional Lead for Social Care, Greater Manchester Mental Health NHS Trust.
Michelle Hulme – Salford Safeguarding Adults Board Training and Development Officer.
Dr. Rebecca Marchmont – Named GP for Adult Safeguarding, NHS Salford Clinical Commissioning Group (The CCG's functions have now been taken over by NHS Greater Manchester Integrated Care)
David Mellor - Independent Reviewer
Victoria O'Neill – Specialist Nurse Safeguarding Families, NHS Salford Clinical Commissioning Group. (The CCG's functions have now been taken over by NHS Greater Manchester Integrated Care)
Martin Sexton Mental Capacity Act/Deprivation of Liberty Safeguards Lead, Salford City Council
Kerry Thornley, Head of Service Market Management, Salford City Council

Eileen Tighe, Named Nurse, Salford Care Organisation
Guy Twemlow – Solicitor, Salford City Council Legal Services
Elizabeth Walton, Designated Nurse Safeguarding Adults, NHS Salford Clinical Commissioning Group. (The CCG's functions have now been taken over by NHS Greater Manchester Integrated Care)
Gail Winder – Assistant Director, Adult Safeguarding, Northern Care Alliance.

Chronologies which described and analysed relevant contacts with Stanley and Matthew were completed by the following agencies:

- Day Centre Provider
- Greater Manchester Police
- Home Care Provider
- NHS Salford Clinical Commissioning Group (The CCG's functions have now been taken over by NHS Greater Manchester Integrated Care)
- Northern Care Alliance
- North West Ambulance Service
- Nursing Home A Provider
- Salford City Council Adult Social Care

The chronologies were analysed and issues were identified to explore with practitioners at a reflective event facilitated by the lead reviewer. Additionally, the lead reviewer had separate conversations with a range of professionals.

Stanley's partner and carer Matthew contributed to the SAR. He provided his account to the review and later read and commented on a late draft of the SAR report. He also shared copies of correspondence relating to complaints he made about the care and treatment Stanley received and copies of documents he accessed from the agencies which provided care, support and treatment to Stanley with the independent reviewer.

The independent reviewer developed a draft report which reflected the chronologies, the contributions of practitioners and the information provided by Matthew.

The report was further developed into a final version and will be presented to Salford Safeguarding Adults Board.