STOCKPORT SAFEGUARDING ADULT BOARD

SAFEGUARDING ADULT REVIEW CONCERNING

'MRS ROGERS'

OVERVIEW REPORT

Final

11 May 2017

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Supported by Paul Cheeseman

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1. INTRODUCTION

1.1 The main people referred to in this report are anonimised, and for the purpose of the report, the deceased woman, is referred to as Mrs Rogers:

Mrs Rogers 82 years of age at the time of death: White British

Louise	Daughter of Mrs Rogers
Ann	Daughter of Mrs Rogers
Jane	Daughter of Mrs Rogers

1.2 This review is about Mrs Rogers who until 16 July 2015 was living independently in her own property with support from her family. She was admitted to Stepping Hill Hospital the 16 July 2015 having fallen[1] at home. Mrs Rogers was diagnosed with a fractured pelvis and discharged home the same day.

1.3 On 23 July 2015 Louise, contacted Stockport Adult Social Care reporting that Mrs Rogers had fallen in the bathroom. The following day a home visit was completed by a physiotherapist and a nurse. No additional needs were identified.

1.4 On 27 July 2015 Louise re-contacted Adult Social Care saying her mother was unable to cope. Mrs Rogers was provided with two morning calls from carers. This fell short of her assessed needs because there was no service provision for the additional care she needed. The next day Mrs Rogers was admitted to a Rapid Response bed [often referred to as a Hub Bed] [2] at the care home.

1.5 During the next twelve days Mrs Rogers' health deteriorated and on 7 August 2015 she was taken by ambulance from the care home to Stepping Hill Hospital where she died the same day. The family raised a safeguarding alert with the hospital.

1.6 Her Majesty's Coroner was informed of Mrs Rogers' death and authorised a post mortem which established the cause of death as:

1a) peritonitis

1b) Perforated sigmoid colon diverticulitis

1.7 After the post mortem HM Coroner decided not to hold an inquest.

1.8 Peritonitis[3] is inflammation of the peritoneum, the thin layer of tissue that lines the inside of the abdomen. It is caused by an infection, which can

[1] Among community-dwelling older people over 64 years of age, 28-35% fall each year. Of those who are 70 years and older, approximately 32%-42% fall each year. The frequency of falls increases with age and frailty level. A Global Report on Falls Prevention Epidemiology of Falls by Sachiyo, Ageing and Life Course Family and Community Health World Health Organization

[2] See paragraph 5.5.3 for a description of hub beds.

rapidly spread around the body. Peritonitis requires immediate treatment and is a medical emergency. Signs of peritonitis often develop quickly and include:

- sudden abdominal pain that becomes more severe
- feeling sick (nausea)
- a lack of appetite
- a high temperature (fever) of 38C (100.4F) or above
- not passing any urine or passing less than normal

1.9 The sigmoid colon [pelvic colon] is the part of the large intestine that is closest to the rectum and anus.

1.10 Diverticular disease and diverticulitis are related digestive conditions that affect the large intestine [colon].

1.11 In diverticular disease, small bulges or pockets [diverticula] develop in the lining of the intestine. Diverticulitis is when these pockets become inflamed or infected.

Symptoms of diverticular disease include:

- lower abdominal pain
- feeling bloated

1.12 The majority of people with diverticula will not have any symptoms; this is known as diverticulosis.

Symptoms of diverticulitis tend to be more serious and include:

- more severe abdominal pain, especially on the left side
- high temperature (fever) of 38C (100.4F) or above
- diarrhoea or frequent bowel movements [3]

[3] www.nhs.uk/conditions/Peritonitis

2. ESTABLISHING THE ADULT SAFEGUARDING REVIEW

2.1 Decision Making

2.1.1 The Care Act 2014[4] gave new responsibilities to local authorities and Safeguarding Adult Boards [SAB]. Section 44 of that Act[5] requires SAB's to arrange for a review of a case when certain criteria are met. These criteria appear in Appendix A.

2.1.2 The case was assessed as eligible for a SAR following the case conference on 28 April 2016. The SAR referral was completed once the family had been consulted. SAR panel meetings were held quarterly.

2.1.3 On 18 August 2016 Stockport Safeguarding Adult Review Panel screened Mrs Rogers' case and recommended to the chair of the Stockport Safeguarding Adult Board that the criteria had been met and that a Safeguarding Adult Review [SAR] should be undertaken. The Chair of Stockport Safeguarding Adult Board [SSAB] agreed and arrangements were made to appoint an independent chair.

2.2 Safeguarding Adult Review Panel

2.2.1 David Hunter was verbally appointed as the Independent Chair and author on 28 September 2016 and had the position confirmed in writing on 21 October 2016. He is an independent practitioner who has chaired and written previous adult and child serious case reviews, domestic homicide reviews and multi-agency public protection arrangement reviews. He has never been employed by any of the agencies involved with this adult serious case review and was judged to have the necessary experience and skills. He was supported in the task by Paul Cheeseman also an independent practitioner who brings the same experience.

2.2.2 The first of four panel meetings was held on 27 October 2016. The panel established key lines of enquiry and asked agencies for a chronology of contacts. These were discussed at subsequent meetings at which the learning was refined and recommendations developed. Attendance at the meetings was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone.

[4] Enacted 1st April 2015

[5] The specific requirements placed upon a Safeguarding Board by S44 of the Care Act 2014 are set out in Appendix A.

2.3 Panel Membership

2.2.3 The panel comprised of representatives from agencies involved in the care of Mrs Rogers and the investigation of the safeguarding alerts. A full list of panel members is provided at Appendix B.

2.4 Agencies Submitting Information to the Review

2.4.1 The following agencies provided written material to the review panel.

- Greater Manchester Police
- Stockport Adult Social Care
- Stockport NHS Foundation Trust [Stepping Hill Hospital]
- The care home
- Stockport Clinical Commissioning Group[6]

2.4.2 Written statements made to Stockport Adult Social Care by the family and interviews with care staff from the care home, were seen. The post mortem report was viewed.

2.4.3 The following people were seen by the SAR chair and Paul Cheeseman.

- Julie Fardon [current manager of the care home]

2.5 Notifications and Involvement of Families

2.5.1 The Chair of the SAR saw Mrs Rogers' three daughters on 2 April 2017 and heard first-hand what their concerns were.[7]

2.6 Purpose of a Safeguarding Adult Review

2.6.1 Section 44 (5) of the Care Act 2014 specifies:

Each member of the Safeguarding Adult Board must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) Identifying the lessons to be learnt from the adult's case, and

(b) Applying those lessons to future cases.

2.6.2 SSAB added the following requirement:

'The review will focus on identifying how partner agencies could have worked together more effectively to prevent harm or abuse occurring. The

[6] Stockport CCG facilitated the information on behalf of the general practitioner.
[7] See 2.10.1

emphasis should be on learning lessons from SAR and not to apportioning blame'.

2.6.3 The SAR was undertaken from that perspective.

2.7 Key Lines of Enquiry

2.7.1 An analysis of the screening papers by the SAR panel identified the following Key Lines of Enquiry. The analysis of these lines will be addressed in Section 5 of the report.

1. Establishing what Mrs Rogers' wellbeing was before admittance to hospital on 16 July 2015.

2. Determine what discharge planning was done and whether it complied with contemporary policies and practice and met Mrs Rogers' needs.

3. Explore what services were provided to Mrs Rogers in the weeks after her discharge from hospital and before she was admitted to a Hub Bed.

4. Identify the reasons Mrs Rogers was admitted to a Hub Bed in the care home.

5. Examine the admittance procedure and in particular whether Mrs Rogers' full medical history was ascertained and recorded.

6. Look at Mrs Rogers' care during her residency in the care home.

7. To understand the reasons for Mrs Rogers' subsequent admission to hospital and whether the timing was appropriate.

8. Involve Mrs Rogers' family in the SAR.

9. Meet with staff involved with the care of Mrs Rogers.

2.8 Period under Review

2.8.1 16 July 2015 to 7 August 2016.

2.9 Other Processes

2.9.1 Greater Manchester Police attended at the care home the day after Mrs Rogers' death. They concluded it was not necessary to begin an investigation into criminal neglect.

2.9.2 Following the post mortem HM Coroner decided it was unnecessary to hold an inquest.

2.9.3 Stockport Adult Social Care completed two reviews of the family's complaints. The first in October 2015 found the complaints unsubstantiated.

The second in April 2016 concluded that there were 'acts of omissions' made with regards to how the care staff interacted with Mrs Rogers and her family. The case conference did not conclude that there was any wilful neglect or that the actions of the staffing team contributed to Mrs Rogers' admission to hospital.

2.10 Family's Concerns

2.10.1 The family of Mrs Rogers shared their concerns with Stockport Adult Social Care immediately following her death.

1. In the week before Mrs Rogers' death on 7 August 2015 the family shared their concerns with care staff at the care home that her health deteriorated. The family's concerns were ignored.

2. On 7 August 2015 the family told care staff at the care home that Mrs Rogers' was unwell. The family's concerns were ignored.

3. On 7 August 2015 care staff at the care home did not call an ambulance until it was too late.

4. The family said that on several occasions when they visited Mrs Rogers in the care home that they found her in her own faeces and that there were faeces in the sink in her room.

5. The family reported that no rehabilitation had been undertaken with Mrs Rogers during her residency at the care home.

6. The family said that Mrs Rogers had requested that only female staff provide care but that after two days male staff were providing care to Mrs Rogers.

2.10.2 The family's concerns are addressed in the analysis at Section 5 [beginning 5.7.4] along with the key lines of enquiry.

3. BACKGROUND OF MRS ROGERS

3.1 Mrs Rogers was one of four children who was born, brought up and educated in Stockport. She married at eighteen years of age and had four children of her own. She worked in local manufacturing and for many years was the cleaner at a local takeaway. Mrs Rogers' husband died in 1997 and she lived alone in a ground floor maisonette with support by her family.

3.2 Mrs Rogers had a stroke in 2009 from which she soon recovered and regained full independence. It was the family's expectation that she would repeat this pattern when admitted to the care home in 2015.

3.3 Mrs Rogers was described as the matriarch of the family who was a grandmother, great grandmother and a great great grandmother. She was a very private person who liked her routine, did not want to put pressure on her family and was stoical in her attitude. The family said she was not a 'moaner'

3.4 She was a very caring and supportive person whose life centred on her family.

3.5 Stockport Safeguarding Adult Board would like to thank Mrs Rogers' three daughters for contributing to the review and acknowledge it was difficult for them to talk about what were painful memories.

4. TIMELINE OF SIGNIFICANT EVENTS

4.1 The following table sets out the significant events prior to Mrs Rogers' residency at the care home and after her arrival. The source of the information is from records held by: Mrs Rogers' GP, North West Ambulance Service, The care home's records and statements made by Jane, three carers and Nurse 1. The events are listed without commentary. These appear in section 5 of the report.

TIMELINE OF SIGNIFICANT EVENTS

Date	Events Prior to The Care Home
05.05.2015	Mrs Rogers hurt herself at home by turning suddenly while taking washing in from line. She felt pain in hip/groin and continued to mobilise since, but has pain on moving. Source: Ambulance service
15.07.2015	Seen by GP, pulled muscle, given analgesia. That night [16.07.2015] whilst walking in her flat with a stick, stumbled and hit her left arm on wall, and fell. Mrs Rogers summoned an ambulance which took her to Hospital.
16.07.2015 0407 hours	Arrived at Stepping Hill Hospital. An X-ray revealed a fracture to pubic rami [a bone in the pelvis] discharged home the same day from the Clinical Decision Unit.[8]
16.07.2015	Seen by Community Assertive in Reach Team Stockport ASC prior to discharge. The assessment was completed by a physiotherapist and a nurse to determine if Mrs Rogers could manage at home and/or if extra support was required. Patient and daughter happy with the plan.
16.07.2015	Louise called Adult Social Care requesting a bathing assessment for Mrs Rogers. The referral was prioritised by the Duty Occupational Therapist as a low priority for the Equipment and Adaptation Officer. The referral was put on a waiting list for allocation.
17.07.2015	A home visit was completed by a physiotherapist and a nurse from the Community Assertive in Reach Team. No additional needs were identified and Mrs Rogers was discharged from the service.
23.07.2016 Thursday	Louise told ASC that her mother had fallen in her bathroom while getting off the lavatory. ASC arranged a Rapid Response and a GP visited Mrs Rogers.

[8] The CDU is a facility where patient waits while a decision is made on whether to admit them to hospital

Date	**Events Prior to The Care Home**
24.07.2015 Friday	Social Worker 1 [SW1] visited Mrs Rogers and completed a Rapid Response assessment and made a referral to the Equipment and Adaptation Team for a lavatory raiser.
25.07.2015	Seen by Mastercall[9]: reduced mobility and worsening pain.
25.07.2015	Reablement assessment completed
26.07.2015	Mrs Rogers received a support visit in the morning and one in the afternoon.
27.07.2015	Mrs Rogers received a support visit in the morning and one in the afternoon.
27.07.2015 Monday	Equipment and Adaption Officer [EAO] visited Mrs Rogers at home and recommended the provision of a bed lever, raised lavatory seat with frame and a standard commode.
27.07.2015	Louise telephoned ASC saying her mother was unable to cope and felt Mrs Rogers needed four house calls each day.
28.07.2015 Tuesday	Mrs Rogers' mobility deteriorated and she was unable to transfer to the lavatory without assistance.
28.07.2015	No availability to provide morning support visit, but one took place in the afternoon.
28.07.2015	ASC approved Mrs Rogers' occupation of a hub bed at the care home.
28.07.2015 9.55 pm	A nurse at the care home noted that Mrs Rogers was accepted for short term residential respite.
29.07.2015	Ann visited Mrs Rogers in the morning and felt her mother was fine. Staff told Ann that a GP would visit her mother that afternoon.
29.07.2015 1600 hours	Body Map bruise on right hand finger
29.07.2015	Louise visited Mrs Rogers in the evening; GP had been but it is not known if he knew of the family's concerns about Mrs Rogers' stomach. The GP visit is not recorded in the 'Daily Statement of Well Being'.

[9] Mastercall Healthcare provides Out of Hours care to patients registered with practices in the Stockport and Trafford areas. The service is available between the hours of 1830-0800 hours Monday to Friday and 24/7 Saturday/Sunday and Bank Holidays.

30.07.2015 Wednesday	The 'Daily statement of Care and Well Being' has an entry saying Mrs Rogers was visited by the Rapid Response nurse who would make a referral to physiotherapy.
Date	**Events at The Care Home**
30.07.2015	Ann visited Mrs Rogers in the morning. She thought her mother was depressed but otherwise well cared for.
30.07.2015	Louise visited in the evening, Mrs Rogers told Louise that a nurse had seen her the previous night and she was fine.
30.07.2015 Friday	GP Summary for Mrs Rogers faxed to new GP
02.08.2015 0515 hours Sunday	Body map bruise on back of right knee and right buttock
02.08.2015	Ann told care staff that Mrs Rogers' room smelled of urine and faeces.
03.08.2015 Monday	Louise visited Mrs Rogers and found she was unable to get out of her chair and was soiled. The bed's functionality was compromised. Later that day Louise found her happy and chatty.
04.08.2015 Tuesday	Mrs Rogers visited by physiotherapist.
05.08.2015 Wednesday	Louise visited Mrs Rogers in the morning. She had soiled herself, faeces in the sink. Ann visited in the afternoon and noted a horrendous stench in Mrs Rogers' room. Cleaning cloths were not available. Ann discussed Mrs Rogers' continuing deterioration with a nurse but there was no offer to have Mrs Rogers reassessed by a GP.
06.08.2015 1000 hours Thursday	A GP saw Mrs Rogers and said that apart from recovering from a fractured hip there were no concerns that she was unwell. Her medication was not altered. Mrs Rogers' cousins visited in the afternoon and believed she had deteriorated since Tuesday [04.08.2015] and had to clean her because of faecal incontinence.
07.08.2015 Friday	This is the day Mrs Rogers died.
Morning	Staff noted Mrs Rogers had a settled night and slept well.
1015 hours	Jane felt Mrs Rogers seemed distressed. The call button and her breakfast were out of Mrs Rogers' reach. Jane recalls a carer saying that Mrs Rogers had a bowel explosion in the night.

1100 hours	A carer noted that Mrs Rogers had eaten her breakfast. No concerns were noted.
Date	**Events at The Care Home**
Lunch Time	Jane assisted Mrs Rogers to eat her lunch. However Mrs Rogers vomited. Care staff do not recall this. Jane noted that Mrs Rogers was lethargic, her speech was slurred to the extent that Jane could not understand her.
1500 hours	Jane told carers she was worried about her mum. The carers fetched the nurse who asked Mrs Rogers if she was alright. The carers said, 'don't worry we'll get her to come back and keep a close eye of her'.
1630 hours	Nurse 1 was called to Mrs Rogers by the carers who had been alerted by Jane that her mother was not well. Nurse 1 came and saw Mrs Rogers was comfortable and alert in her bed. Jane told the nurse that Mrs Rogers was not one hundred percent. Jane was advised by the nurse that she would keep 'very close observations'.
1650 hours	Nurse 1 saw Mrs Rogers and noted that her speech was slightly slurred and her face red. Mrs Rogers had low blood pressure [86/38], normal pulse and a high respiratory rate. An ambulance was called.
1803 hours	Mrs Rogers arrived at Stepping Hill Hospital. She was short of breath, had left side weakness and was responding to commands.
1913 hours	Cardiopulmonary Resuscitation [CPR] began.
1928 hours	CPR ended and Mrs Rogers died.
1928 hours	Her family disclosed safeguarding concerns to the nursing staff and an Adult Safeguarding Alert form was completed.

5. ANALYSIS AGAINST THE KEY LINES OF ENQUIRY

5.1 Introduction

5.1.1 Each key line is examined separately. Commentary is made using the material gathered during the SAR, including the family's views, and the panel's debates.

5.2 Key Line 1

Establishing what Mrs Rogers' wellbeing was before admittance to hospital on 16 July 2015.

5.2.1 Mrs Rogers was living independently with support from her family. She was mobile and undertook her own intimate care. Mrs Rogers visited her GP on 15 July 2015 and was prescribed pain relief for a pulled muscle. In the early hours of 16 July 2015 Mrs Rogers fell at home and summoned an ambulance. Mrs Rogers told ambulance staff that a few weeks before falling she twisted her hip while bringing in the washing. Such domestic activity suggests her mobility was reasonable. However, that has to be balanced by her remark to the ambulance crew that she had been unable to get into the bath for about six weeks. This restriction was unknown to her family and was typical of Mrs Rogers' view of not wanting to make a fuss or bother people. There is no suggestion or evidence that Mrs Rogers did not have full capacity to make her own decisions. Her family believed she had capacity. Mrs Rogers was described as a cheerful person who simply got on with life.

5.2.2 The panel felt that prior to Mrs Rogers' fall she was coping relatively well with good support from her family but unbeknown to them she was struggling to undertake all daily activities.

5.2.3 The panel did not identify any good practice or lessons under this Key Line of Enquiry.

5.3 Key Line 2

Determine what discharge planning was done and whether it complied with contempory policies and practice and met Mrs Rogers' needs.

5.3.1 The background to this Key Line is that Mrs Rogers fell at home on 16 July 2015 was admitted to hospital and discharged the same day.

Discharge Planning[10]

5.3.2 Mrs Rogers felt she could manage at home but had been struggling to get around in the previous week. Ann told staff that Mrs Rogers could get herself up and dressed but was unable to use the shower or bath and was struggling to sort out meals and drinks. Ann had an additional concern that

[10] Technically Mr Rogers had not been admitted to hospital as she was seen in Accident and Emergency and went to the clinical Decision Unit.

Mrs Rogers may get pressure damage because she always sat in the same position.

5.3.3 Mrs Rogers' discharge planning involved her being seen by a nurse and physiotherapist from Community Assertive in Reach Team to assess whether any additional support was required at home. The outcome determined that Mrs Rogers was able to mobilise approximately ten meters with a wheeled Zimmer frame and was able to transfer from sitting to standing independently. Mrs Rogers requested a kitchen trolley to assist her mobility. Her daughter agreed to collect it from a local retailer. It was agreed with the patient that Community Assertive in Reach Team would complete a home assessment the following day to provide additional support if she experienced any difficulties following discharge. It was noted in the hospital records that Mrs Rogers did not have stairs in her home and had pull cord and pendant alarms. The record noted that Mrs Rogers and her daughter were happy with the plan and that, 'family will support'.

5.3.4 The Panel discussed what the phrase, 'family will support' meant and without wanting to place additional administrative burden on staff felt a brief description would be beneficial. For example: 'Mrs Rogers has three daughters who between them will visit their mother twice a day to ensure she is safe and well'.

5.3.5 The SAR panel looked at the Edmonton Frail Scale[11] and without knowing the answer to all the questions it is difficult to say what Mrs Rogers would score. However, using the information reported by the family Ann it is likely that Mrs Rogers was frail.

5.3.6 While there is no mention of a capacity assessment**[12]** it has to be recognised that Mrs Rogers' presentation did not suggest she required one.

5.3.7 An Equipment and Adaptation Team assessment was completed by a Referral and Information Officer from the Contact Centre at Stockport Adult Social Care. The referral was for a bathing assessment with the request for a level access shower. Louise had made the referral on behalf of Mrs Rogers. The referral indicated that bathing equipment had previously been provided but over the past few months Mrs Rogers had begun to struggle to use the equipment to bathe. She had been strip-washing for some months and washing her hair over the sink. Mrs Rogers had been told by the hospital not to use the bath for the next six weeks and this is when Louise first learnt that her mother had not been able to use the bath for some time. The Referral and Information Officer advised Mrs Rogers to strip wash until the assessment.

5.3.8 The referral for a bathing assessment was prioritised by the Duty Occupational Therapist as low. The referral was put on a waiting list for allocation to an Equipment and Adaptation Officer. The panel thought the low priority was appropriate given the information in the referral. Had the

[11] See Appendix C

[12] Mental Capacity Act 2005

Duty Occupational Therapist been aware that Mrs Rogers was experiencing difficulties with other transfers/mobility the referral would have been given a higher priority.

5.3.9 The panel felt that the discharge arrangements for Mrs Rogers were appropriate given she had family support.

5.4 Key Line 3

Explore what services were provide to Mrs Rogers in the weeks after her discharge from hospital and before she was admitted to a Hub Bed.

5.4.1 On 17 July 2015, a home visit to Mrs Rogers was completed by a physiotherapist and a nurse from the Community Assertive in Reach Team. Mrs Rogers' transfers were assessed[13]. Her ability to manoeuvre her kitchen trolley was assessed and Mrs Rogers was given advice regarding its safe use. A chair was moved in the sitting room to allow better access for the trolley. Mrs Rogers reported that she had been independent with her personal care and her meals and had no further concerns. She was discharged from Community Assertive in Reach Team with no further intervention. It appeared to the panel that in the first week after her discharge from hospital Mrs Rogers was functioning with the support of her family and the minor adaptions.

5.4.2 The Community Assertive in Reach Team's planned visits to Mrs Rogers on Saturday 18 and Sunday 19 July 2015 were cancelled because she did not require them.

5.4.3 The next contact was on Thursday 23 July 2015 when Louise reported to Adult Social Care that Mrs Rogers had fallen in the bathroom while getting off the lavatory. Adult Social Care advised the Rapid Response Team and a GP visited Mrs Rogers at home and noted, 'Discharged from hospital as felt could cope at home but not coping… Fell this morning… Taking Naproxen[14] with PPI[15], paracetamol… Agreed Rapid Response referral and further painkillers'. The panel thought the visit by the GP was a proportionate and appropriate response and complied with the Rapid Response policy.

5.4.4 The case was allocated to Social Worker1 who visited Mrs Rogers at home on Friday 24 July 2015 under the Rapid Response arrangements. The arrangements require that such visits and assessments are undertaken jointly by a social worker and a nurse/therapist. In this case that did not happen. Social Worker1 has left Stockport Adult Social Care and it has not been possible to determine why they visited alone. The panel heard the normal practice was to visit jointly and this episode seems an exception.

[13] Transferring from bed/chair to lavatory and back.
[14] Nonsteroidal anti-inflammatory drug
[15] Proton Pump Inhibitors

5.4.5 Firstly Social Worker1 found no evidence to displace the presumption that Mrs Rogers had mental capacity to make decisions about her care and accommodation.[16] Social Worker 1 completed a Rapid Response assessment[17] and in turn requested the Equipment and Adaptation Team to undertake an assessment for a lavatory seat raiser. The referral was given a high priority by the Duty Occupational Therapist for a visit on the next working day; Monday 27 July 2015.

5.4.6 The panel noted that the fall reported by Mrs Rogers' daughter on Thursday 23 July 2015 was the second time Mrs Rogers had fallen while getting of the lavatory; the first was 16 July 2015. An urgent referral could have been made by Social Worker1 on the 23 July 2015 to the Duty Officer [Adult Social Care] who could determine whether an Equipment Officer should visit the same day. The panel believed that action should have been taken on Thursday 23 July 2015 to assess and deal with Mrs Rogers' needs.

5.4.7 The panel chair wondered whether Social Worker1 could not have simply 'authorised' a lavatory seat raiser during the visit on Friday 24 July 2015 and why it was necessary to ask for an assessment by a specialist therapist for what appeared to the chair to be a straightforward issue. Social work professionals on the panel said such assessments had to be undertaken by trained staff and that it could be unsafe for unqualified people to determine what adaptions might be necessary. However, the panel was concerned that the assessment had to wait until after the weekend when the likely need was identified on a Thursday.

5.4.8 The GP record shows that Mrs Rogers was seen at home by Mastercall on Saturday 25 July 2015 because of reduced mobility and worsening pain. The doctor noted that a social worker was involved and a Rapid Response referral had been made and that someone would be attending at 5pm that day. A Reablement assessment was undertaken on Saturday 25 July 2015 by Adult Social Care which determined that Mrs Rogers needed help in her home. On Sunday 26 July 2015 Mrs Rogers received two support visits, one at 9.40 am the other at 5.15 pm. The panel noted that the Reablement Service operated daily while the Equipment Service worked Monday to Friday. However, that is under review with a view to extending the Equipment Service's hours.

5.4.9 On Monday 27 July 2015 Mrs Rogers received another two support visits, from Reablement, one in the morning and the other in the late afternoon. These visits are non-chargeable services. The same day Louise telephoned Adult Social Care saying Mrs Rogers was unable to wash, dress or feed herself but did not want to move to residential respite care. Louise believed that Mrs Rogers needed carers to visit four times a day to meet her needs

[16] The Mental Capacity Act 2005 is underpinned by five principles, which are contained within the act and explained in the Mental Capacity Act code of practice: Principle 1 is a presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.

[17] A service designed to prevent avoidable admissions to hospital. See Appendix D.

and supplement the family support. A formal assessment was not undertaken by Adult Social Care. At the time care packages were being commissioned by Stockport Adult Care Services at the local authority rate. However, there was a shortage of them. The family felt the time allowed for each visit was wholly inadequate to meet the needs of Mrs Rogers.

5.4.10 This position is a national problem and in that respect Stockport is not alone in facing immense challenges in providing services for adults in need of care. The Panel heard from a senior manager in Adult Services that this problem is being actively worked on and therefore the Panel does not make a recommendation.

5.4.11 On Monday 27 July 2015, an equipment and adaption officer saw Mrs Rogers at home. The ensuing assessment identified that Mrs Rogers had difficulty with lavatory and bed transfers. It was reported that she found it difficult to walk and used a wheeled Zimmer frame to traverse short distances, but tired easily. The assessment showed that Mrs Rogers needed to: access toileting facilities at night; to get in/out of bed and on/off the lavatory more easily. She had unspecified family support. The family said they were visiting daily but wanted the security of a permanent arrangement. The equipment and adaption officer recommended the provision of a bed lever, raised lavatory seat with frame and a standard commode via a prescription to be redeemed locally. The panel queried why this assessment was not made on Thursday 23 July 2015 thereby shortening the time that Mrs Rogers was at risk of further falls. The reason appears to be that Mrs Rogers was being supported by some care provision, her family which together with the adaptions already made would suffice until longer term planning could be undertaken.

5.4.12 The equipment and adaption officer noted that Mrs Rogers was being supported to strip wash with carer assistance until a functional bathing assessment could be carried out once the pelvic fracture had healed.

5.4.13 On 28 July 2015, there was no support available for the morning visit to Mrs Rogers, but the late afternoon one took place. The family filled this gap and saw to their mother's needs.

5.4.14 The panel concluded that prior to Mrs Rogers' admission to the hub bed her mobility deteriorated and services were organised to support her. The panel thought it took too long to assess her equipment needs and that ideally the equipment assessment should have been done before the weekend. The lack of companies offering care provision also caused a gap in the services that Adult Social Care thought Mrs Rogers should have.

5.5 Key Line 4

Identify the reasons Mrs Rogers was admitted to a Hub Bed in the care home.

Description of the care home and Hub Beds[18]

5.5.1 The care home is a purpose built 59 bedded facility offering dementia, nursing, residential and end of life care using a mixture of care and nursing beds. The nursing beds have twenty four hour nursing cover; care beds do not. The care home's five hub beds were not nursing beds and the commissioning arrangements recognised this.

5.5.2 The hub bed scheme was designed to prevent admissions to hospital and to enable people to return to their homes when able.

Reason for Mrs Rogers' admission to a Hub bed in the care home

5.5.3 The position with Mrs Rogers on Tuesday 28 July 2015 was this:

- Her mobility was deteriorating.
- It was not possible to provide the four home visits her family felt she needed.
- The morning visit on the 28 July 2015 was not undertaken.
- The afternoon visit took place.
- Mrs Rogers' family was concerned about her wellbeing and while supporting her could not fill the gaps in her assessed care needs and wanted a permanent solution
- A senior manager in Adult Social Care took a pragmatic decision that Mrs Rogers should be admitted to a hub bed because the only realistic alternative seemed to be hospital.
- Mrs Rogers was admitted to the care home at 9.55 pm on Tuesday 28 July 2015.

5.5.4 By the 28 July 2015 Mrs Rogers' mobility had deteriorated and she was unable to move or transfer without assistance and the provision of services in her home to overcome these matters was unavailable. Mrs Rogers accepted that she needed short term residential care to help her recover from the pelvic fracture. The move to the care home was also supported by her family who felt she need rehabilitation before returning home.

5.5.5 The SAR panel thought that the decision to approve a hub bed for Mrs Rogers was a practical and defensible solution to a difficult problem.

5.6 Key Line 5

Examine the admittance procedure and in particular whether Mrs Rogers' full medical history was ascertained and recorded.

5.6.1 The current manager at the care home explained that admissions to the care home are normally planned twenty four to thirty six hours in advance. The

[18] Hub beds are a non-chargeable service

planning includes visiting the client in their current place of residence [hospital, home] making a full assessment of their needs and obtaining their medical history from the general practitioner. Had the admission been from a hospital the person would have arrived with a discharge letter setting out the medical history, including current medication, relevant to the person's care. The Panel noted that, but felt that as hub beds are not planned admissions there should have been a process for dealing with short notice admissions. In this case the care home had about seven hours to prepare. The point is not currently applicable to the care home as they no longer provide hub beds.

5.6.2 Adult Social Care faxed a care plan to the care home. The fax appears to be timed/dated 12.34 pm on 28 July 2015. An ambulance was booked with Arriva and was scheduled to collect Mrs Rogers between 4.30 pm and 8.00 pm. The social worker contacted the family who said that someone would be with Mrs Rogers for this time to support her with the move. The out of hours service [OOH] received a call from Mrs Rogers' daughter at 8.02 pm advising that the ambulance had not arrived. The ambulance was report en-route and Mrs Rogers arrived at the care home at 9.55 pm on Tuesday 28 July 2015 as an 'emergency' admission. Mrs Rogers' daughters Louise and Ann were present.

5.6.3 Mrs Rogers' medical history was:

Mrs Rogers' Medical History and Medication		
History and medication	**Known to her GP**	**Known to the care home at the point of admission**
Stroke 2007	✓	✓
Diverticula[19] of intestine since 2012	✓	X
Lisinopril: used to treat hypertension [high blood pressure]	✓	✓
Amlodipine: used to treat hypertension	✓	✓
Bendroflumethiazide: a diuretic [common treatment for hypertension]	✓	✓
Clopidogrel: an antiplatelet medicine, used to reduce risk of blood clots	✓	✓
Pravastatin: a statin, used in combination with diet, exercise, and	✓	X

[19] Small bulges or pockets [diverticula] in the lining of the intestine.

weight loss for lowering cholesterol and preventing cardiovascular disease		
History and medication	**Known to her GP**	**Known to the care home**
Naproxen is a nonsteroidal anti-inflammatory drug	✓	✓
Lansoprazole used to treat and prevent stomach and intestinal ulcers	✓	✓
Allergic to Penicillin	✓	✓
Fractured pelvis	✓	✓

5.6.4 Mrs Rogers' family recall telling the duty Registered General Nurse they were concerned about Mrs Rogers' swollen stomach. The nurse told Louise and Ann that the GP would visit the next day and check Mrs Rogers. Staff knew that Mrs Rogers had a fractured pelvis.

5.6.5 Part of the admissions procedure includes completing a body map to identify any skin marks or pressure damage. Mrs Rogers' care home notes state: 'Unable to do body mapping as Mrs Rogers wanted to sleep. Very unsteady on arrival and difficult to stand even with two staff. Nurse identified Mrs Rogers' needs a referral to physio'.

5.6.6 Post Mrs Rogers' death, the care home reported that Mrs Rogers' '…admission was late at night and there was a lack of information regarding Mrs Rogers' medical history. Due to time of admission, staff were unable to contact Mrs Rogers' GP'.

5.6.7 The panel thought that while Mrs Rogers' arrival the care home at 9. 55 pm was not the preferred time of admission it was nevertheless completed successfully in the circumstances, albeit there was a very long wait for the ambulance. The family said admission gave them peace of mind that their mother was safe and cared for. The late hour prevented the care home from access to a summary GP records. Her immediate medical needs were obtained from the family. The record of her admission could have been fuller but there is no evidence that this detracted from the care she received.

5.7 Key Line 6

Look at Mrs Rogers' care during her residency in the care home.

Introduction

5.7.1 This Key Line also addresses the six concerns of the family.

5.7.2 Mrs Rogers was in the care home for eleven days from 9.55 pm on 28 July 2015 until she left by ambulance about 5.50 pm on 7 August 2015 for admission to Stepping Hill Hospital.

Mrs Rogers' History in The care home

5.7.3 Set out below is a summary of Mrs Rogers' eleven day history:

28.07.2015	Took up residency at the care home. See Key Line 5 at 5.6 for details.
29.07.2015 0350 hours	Daily Statement of Well Being: 'Mrs Rogers settling well, able to use Nurse call when assistance required. Refusing position changes despite daughters' concern about Mrs Rogers' bottom getting red. Identified that Mrs Rogers was sitting for long periods at home. No Waterlow[20] done, resident had the capacity to make this decision'.
29.07.2015	Ann visited Mrs Rogers in the morning and felt her mother was fine. Staff told Ann that a GP would visit her mother that afternoon.
29.07.2015 GP says likely to be early afternoon	Initial admission review at the care home by GP. Mrs Rogers was looked after under level 2[21] The GP says that the notes he recorded [see below] would have come from the nurse on duty, rather than by direct assessment, though he would have seen Mrs Rogers that day. • Mrs Rogers needed a walking aid in the home; • She was independent in transferring from a chair/bed; • Bowels: she was fully continent; • Bladder: she had the occasional accident; • She was independent in the toilet; • She was able to perform personal care activities; • She fed independently; • She was dependant for bathing; • She needed help dressing.

[20] The Waterlow pressure ulcer risk assessment/prevention policy tool is, by far, the most frequently used system in the U.K. and it is also the most easily understood and used by nurses dealing directly with patient/clients.

[21] See Appendix E for the levels of care.

	The GP had not received any correspondence about Mrs Rogers' medical history. This was requested and a summary was received on 30.7.2015. She was apparently taking Paracetamol 500mg tablets, and these were issued. The GP has no recollection of anyone mentioning abdominal pain and would usually document this and any examination.
29.07.2015	A moving and handling assessment revealed she was at 'Amber' risk. Amber risk meant that Mrs Rogers needed the help of a carer and/or an aid such as a Zimmer frame to walk. There was no mobility care plan identified.
29.07.2015	A MUST[22] [Malnutrition Universal Screening Tool] was completed and a fluids and diet chart started.
29.07.2015	Body map completed, bruise to finger noted.
29.07.2015	Checked with GP about pain relief. Ok to take paracetamol 1 gram 4 times daily as required. No written documentation to support this or care plan for medication
29.07.2015	Louise visited Mrs Rogers in the evening and was told by her mother that she has seen the GP. Louise then discussed her mother's case with a nurse at the care home and they had different views on whether a fall could cause an inflamed peritoneum. The nurse confirmed that the GP had seen Mrs Rogers. Ann and Louise do not believe that the GP was sighted on their concerns about their mother's stomach.
30.07.2015	Mrs Rogers was visited by a Rapid Response nurse who agreed a referral to a physiotherapist and suggested a lower chair.
30.07.2015	Ann visited Mrs Rogers in the morning. She thought Mrs Rogers was depressed but well cared for. Ann discussed her mother's care with an agency nurse.
30.07.2015	Summary of Mrs Rogers' GP history received by fax at the GP surgery covering the care home. It contained:

[22] http://www.bapen.org.uk

	A standard "Summary printout" which details a person's "Active" problems, "Significant Past" problems, Current medication, Allergies, Past immunisations, Last 3 consultation entries & recent blood results. "Diverticula of intestine" is noted in the "Active problems", dated 9.10.12. There are no medications specifically prescribed to treat this. The GP consulted by the serious adult review commented, 'We often use a bulking laxative called Fybogel in people who struggle with abdomen discomfort relating to diverticular disease. It should be noted that not all people with diverticular disease are symptomatic. The prevalence of diverticular disease in people over 80 years old is between 50-66%'.
30.07.2015	Louise visited in the evening, Mrs Rogers told Louise that a nurse had examined her the previous night and she was fine.
01.08.2015 1700 hours	Mrs Rogers settled, medication given as prescribed, good diet and fluids, no conditional changes noted.
02.08.2015	Bruise on back of right knee and right buttock. Positive – identified bruising – although no indication to state if this was new or old bruising.
02.08.2015	Ann told care staff that Mrs Rogers' room smelled of urine and faeces. Louise queried this with nurse on duty who is reported as saying that Mrs Rogers was not ringing her bell in time to receive assistance with her continence. This exchange is not in Mrs Rogers' notes.
03.08.2015	Louise visited Mrs Rogers and found she was unable to get out of her chair and was soiled. Louise noted that Mrs Rogers was rubbing her stomach and said she was unable to sleep. Louise found balls of faeces in the plughole of the sink in Mrs Rogers' room which staff could not account for. Nothing in Mrs Rogers' notes about the above. Mrs Rogers' bed would not rise up or down, a point the staff were aware of. The family understood from a nurse that a new referral would be made to a GP for a reassessment. Nothing about this in Mrs Rogers' notes

	Later that day Louise found her mother happy and chatty.
03.08.2015 1515 hours	Mrs Rogers assisted to wash and dress, mobility encouraged, medication as prescribed. Noted Lisinopril 10mg out of stock, contacted family and also GP to obtain urgent supply. Mrs Rogers arrived with a stock of 4 Lisinopril. Staff requested GP to prescribe and took corrective action. The GP said 'it was not possible to say what the impact of missing two days medication would be, but thought Mrs Rogers' blood pressure may have been a bit more raised but this would not have an impact and would certainly not lead to a perforated diverticulum'.
03.08.2015	GP issued prescription for Mrs Rogers' routine medications.
04.08.2015 1400 hours	Mrs Rogers visited by physiotherapist who encouraged staff to mobilise Mrs Rogers. Louise saw staff assisting Mrs Rogers to stand and use her walker.
05.08.2015	Louise visited Mrs Rogers in the morning. She had soiled herself and the room smelled of faeces. Louise told staff that Mrs Rogers was a completely different person. Staff felt Mrs Rogers had lost her confidence. Ann visited in the afternoon and noted a horrendous stench in Mrs Rogers' room. There was no clean clothing. Ann could not find Mrs Rogers' pyjamas and her night clothing appeared to have been lost. Mrs Rogers was incontinent of faeces and her stools very loose. There were faeces in the sink, the lavatory had not been flushed and Mrs Rogers' clothes were strewn on the floor. Ann discussed Mrs Rogers' continuing deterioration with a nurse but there was no offer to have Mrs Rogers reassessed by a GP. Nothing of the above is recorded in the notes.
06.08.2015 The GP believes the visit would have taken place in the morning.	Mrs Rogers was encouraged by care staff to walk short distances with her frame. A GP saw Mrs Rogers [in Jane's presence] and said that apart from recovering from a fractured hip there were no concerns that she was unwell. Her medication was not altered. The GP has no recollection of anyone mentioning

	abdominal pain and would usually document this and any examination. Mrs Rogers' cousins visited in the afternoon and believed she had deteriorated since Tuesday [04.08.2015] and had to clean her because of faecal incontinence. They noted that Mrs Rogers seemed tired and gagged on her food. Not recorded in notes
06.08.2015	Mrs Rogers was reviewed on the weekly ward round. Dr recorded that she had a history of adverse reaction to penicillin, information which was present on her medical record from her registered GP. Dr recorded that Mrs Rogers was mobilising with a frame, and was keen to get home when more confident.
07.08.2015	Staff noted Mrs Rogers had a settled night and slept well. Date of Mrs Rogers' death.
07.08.2015 1015 hours	Jane felt Mrs Rogers seemed distressed and that her call button was out of reach on the floor by her chair. Mrs Rogers told Jane that she had not eaten breakfast because the tray was out of her reach. Jane recalls a carer saying that Mrs Rogers had a bowel explosion in the night. This is not in Mrs Rogers' notes.
07.08.2018 1100 hours	A carer noted that Mrs Rogers had eaten her breakfast. No concerns were noted.
07.08.2015 Lunch Time	Jane assisted Mrs Rogers to eat her lunch. However Mrs Rogers vomited. Care staff do not recall this. Jane noted that Mrs Rogers' was lethargic, her speech was slurred to the extent that Jane could not understand her.
07.08.2015 Between 1500 hours and 1545 hours	Jane told carers she was worried about her mother. Carers asked Nurse 1 to see Mrs Rogers. Nurse 1 saw Mrs Rogers. Carers said we will ask Nurse 1 to keep a close eye on her. Jane telephoned Louise to update her.
07.08.2015 1630 hours	Jane asked staff to look at her mum as she did not look well. Nurse 1 came and assessed Mrs Rogers and told Jane that she would keep a 'keep very close observations' on Mrs Rogers.

07.08.2018 1650 hours	Jane alerted the carers to her mother's unusual eye movements. The carers called Nurse 1 to Mrs Rogers who noted she was able to answer questions correctly, but her pupils were fixed and she was not blinking. Nurse 1 called an ambulance.
07.08.2015 1803 hours	Mrs Rogers arrived at Stepping Hill Hospital. She was short of breath, had left side weakness and was responding to commands.
1913 hours	Cardiopulmonary resuscitation [CPR] began
1928 hours	CPR ended and Mrs Rogers died and family disclosed safeguarding concerns at the care home.

Family's Concerns [next]

5.7.4 The family's six concerns identified at 2.10.1 of this report are examined here.

Concern 1

In the week before Mrs Rogers' death on 7 August 2015 the family shared their concerns with care staff at the care home that her health deteriorated. The family's concerns were ignored.

5.7.5 The panel noted a discrepancy between the family's account of Mrs Rogers' residency at the care home and what the care home staff recorded in her notes. There are some entries which identify the family's concerns. For example on 29 July 2015 it was noted that a daughter was concerned that Mrs Rogers' bottom was getting red. The staff thought this was due to Mrs Rogers sitting at home for long periods. There is no evidence that a formal pressure damage assessment was done. However, there was no evidence at post mortem of pressure damage.

5.7.6 Later the same day Louise suggested to a nurse that the peritoneum could become inflamed after a fall.[23] Louise reported feeling 'belittled' at the brusque rejection of this by the nurse. This episode is not in Mrs Rogers' notes. While Mrs Rogers' medical history was not available when she was admitted to the care home late on the 28 July 2015, a faxed summary was received from her GP on 30 July 2015 which included the following entry: 'Diverticula of intestine.' This is noted in the 'active problems', dated 9 October 2012. However, there are no medications specifically prescribed to treat this. The GP providing the information to the reviews commented, ' We often use a bulking laxative called Fybogel in people who struggle with

[23] At this time it was not known that Mr Rogers had an inflamed peritoneum. Louise recalls the conversation in that way in a statement she made after her mother's death.

abdominal discomfort relating to diverticular disease' adding, ' It should be noted that not all people with diverticular disease are symptomatic. The prevalence of diverticular disease in people over 80 years old is between 50-66%'.

5.7.7 The family do not believe that their concern about Mrs Rogers' sore stomach was passed on to the doctor who saw her on the 29 July 2015. The doctor who saw Mrs Rogers has no recollection of any mention of abdominal pain on 29 July 2015 [or the 6 August 2015]. The doctor said that he would usually document this and any examination, so the absence of any information in this regard suggests that it was not brought to his attention. There is no entry in Mrs Rogers' notes to say this information was known or shared with the care home GP. That visit happened before the summary of her health was received from her GP. There is nothing in the notes of the visit to say that Mrs Rogers identified any concerns about her stomach. The panel recognised that elderly patients are generally stoic and do not always disclose all their concerns to doctors because of that stoicism. Mrs Rogers' family say she was not one for complaining and felt that staff should recognise that many elderly people share this trait and treat their answers to questions of wellbeing, with caution.

5.7.8 The panel understood that family members knew Mrs Rogers very well and would be finely attuned to changes in her. Mrs Rogers' cousins felt she had deteriorated in appearance and looked unwell. On 30 July 2015 Ann visited Mrs Rogers in the morning and thought her mother was depressed but otherwise well cared for. Ann discussed her mother's care with an agency nurse who said another nurse had checked Mrs Rogers' stomach last evening and everything was fine.

5.7.9 In the absence of seeing care home staff the panel relied on what was written in Mrs Rogers' notes and the statements made by the family and some care home staff to Stockport Adult Social Care. The panel felt there was limited evidence that care staff reacted to the family's concerns about Mrs Rogers' health. For example on the day Mrs Rogers died a carer noticed that Mrs Rogers' sacrum [the largest of the pelvic bones] was red and 'ordered' bedrest for her. Other concerns from the family do not appear to have been acted on. For example on 30 July 2015 Ann told staff that Mrs Rogers was depressed but there is nothing recorded and no evidence of any action being taken. The family strongly believe the staff did not listen to them; they knew their mother best and could easily recognise her deterioration. The family thought the explanation from staff that their mother had 'lost confidence' meant they did not look for other reasons for Mrs Rogers' decline.

5.7.10 Independent of care home staff, Mrs Rogers was seen several times by other health professionals; a doctor and a Rapid Response nurse. A physiotherapist saw Mrs Rogers on 4 August 2015. On 6 August [one day before Mrs Rogers' death] a GP saw Mrs Rogers and said that apart from recovering from a fractured hip there were no concerns that she was unwell.

Her medication was not altered. At this time Mrs Rogers' summary of her health was available to the GP. Mrs Rogers unexpectedly died two days later.

5.7.11 The panel heard for senior managers in Adult Social Care that there was a slight tension between the care home and the commissioners in that the needs of residents occupying non-nursing hub beds attracted the time of nursing staff which meant that less time was available for dealing with the needs of residents in nursing beds. The panel believe that there is limited evidence the family's concerns were taken seriously but does understand how they arrived at a different view. What is apparent is the lack of record keeping about the family's concerns. The Panel was quite clear the standard of record keeping was very poor and unacceptable. Had it been better it would have enabled clarity on what the family's concerns were and how they were responded to. The independent medical care provided by the doctors and other health professionals who visited the care home and saw Mrs Rogers did not detect any shortfalls in her care while in the care home. However, the family believes that is all part of the general lack of care given to their mother, in that professionals did not recognise what was happening to Mrs Rogers nor did they recognise or appreciate the rapid decline in her health.

Concern 2

On 7 August 2015 the family told care staff at the care home that Mrs Rogers' was unwell. The family's concerns were ignored.

Concern 3

On 7 August 2015 care staff at the care home did not call an ambulance until it too late.

5.7.12 Concerns 2 and 3 are examined together. The care home records show that Mrs Rogers had a good night on 6 August 2015. During the morning of the 7 August 2015 a carer told the family that Mrs Rogers had a bowel explosion during the night. It is not known what that phrase means and there is no reference to it in the care home notes. What is known is that twelve hours later Mrs Rogers died of peritonitis and a perforated colon. The panel cannot say whether the reported 'bowel explosion' and Mrs Rogers' death are connected but fully understood the family's concerns in this respect.

5.7.13 There is an unresolved anomaly between the care home notes which show Mrs Rogers ate breakfast, and Mrs Rogers' account to Jane that she had not eaten because the breakfast tray was out of reach. Jane helped Mrs Rogers with her lunch and Mrs Rogers vomited after eating. Jane recalls telling care staff about the vomiting. Care and nursing staff who were working that day do not recall Mrs Rogers vomiting and say it was not brought to their attention. About 1.0 pm Mrs Rogers was put back into bed and Jane noted that Mrs Rogers was lethargic, her speech was slurred to the extent that Jane could not understand her.

Jane's Recollection of Events

5.7.14 Jane recalls two events. The first was about 3.0 pm she told carers she was worried about Mrs Rogers and got them to lift her up in bed. Jane says the carers fetched Nurse1. Jane says Nurse1 did not physically examine Mrs Rogers but did get an affirmative response to the question of whether Mrs Rogers was alright. Jane states Nurse1 noted Mrs Rogers responded appropriately and was alert. Nurse1 then left the room. Jane recalls the carers saying, 'don't worry, we'll get her to come back and keep a close eye on her'. There is nothing in Mrs Rogers' notes to say whether, or when, the carers asked Nurse1 to keep a close eye on Mrs Rogers. There are no entries on Mrs Rogers' record such as, blood pressure, temperature, pulse and respiratory rates to suggest 'a close eye' was kept. However 'a close eye' does not necessarily need such detail. Jane said she recalled the time when the carers said they would ask Nurse1 to keep a close eye on her mother, because she telephoned Louise at work between 3.0 pm and 3.45 pm to update her. Her sister leaves work at 3.45 pm and therefore would not have been there to take the call had it been made after 3.45 pm. When the panel chair saw the family, Louise confirmed the timings.

5.7.15 Jane's second event is timed at about 4.45 pm when Mrs Rogers' showed signs of distress. Her eyes were going back and forth. The carers came in and saw them. Jane said, 'now can you see what they are like'? Nurse1 was called back by the carers and saw Mrs Rogers who was able to answer questions correctly. Her pupils were fixed and she was not blinking. Nurse1 immediately rang 999 and laid Mrs Rogers flat. Her blood pressure was 86/38. A rapid response ambulance attended 5 minutes later and took Mrs Rogers and her daughter to hospital.

Nurse1 and the Carers' Recollection of Events

5.7.16 Nurse1 and the two carers had a different timeline which did not include two assessment visits by Nurse1 to Mrs Rogers. Nurse1 said that after lunch she began her medication round and said that Mrs Rogers was in her room when she administered the prescribed medication. Nurse1 was asked in March 2017 what time the medication round was. She felt the passage of time precluded her from being definitive but her usual practice was to begin about 1.0 pm and end about an hour later. However, these timings varied if she was engaged on other matters that required immediate attention.

5.7.17 Nurse1 did not have any concerns nor were any raised with her by the family.

5.7.18 Nurse1 noted that about 4.30 pm two carers asked her to see Mrs Rogers as she was not very well. Nurse1 assessed Mrs Rogers and reported she was sitting up in bed, alert and had no complaints. Mrs Rogers appeared comfortable and there was no apparent compromise of her airway. Nurse1 said she told Jane that she would keep 'very close observations' on Mrs Rogers. This account is supported by the two carers.

5.7.19 Nurse1 recalls being asked by the carers to re-assess Mr Rogers about 4.50 pm to assess Mrs Rogers. It was at this time that Nurse1 called an ambulance.

5.7.20 The accounts of summoning the ambulance are consistent between the care staff, Nurse1 and family except for a five minute time difference. Jane recalls that the crisis, described in paragraph 5.7.15 happened about 4.45 pm and Nurse1 noted it was 4.50 pm.

5.7.21 The following timings have been received from North West Ambulance Service.

Time	Event
5.14 pm	Call made by Nurse1 who agreed to take responsibility until the ambulance arrived
5.23 pm	Sole response paramedic arrived
5.31 pm	Double ambulance crew arrived
5.49 pm	Left scene
6.00 pm	Arrived hospital

The SAR Panel's Thoughts on the Timings

5.7.22 Outside of the North West Ambulance Service, there are no contemporaneous records.

5.7.23 The panel can say with confidence that the ambulance was called at 5.14 pm as evidence from North West Ambulance Service records and was disappointed that Mrs Roger's records did not more accurately reflect when the ambulance was called.

5.7.24 Therefore Jane's and Nurse1's recollection of when the ambulance was called is not consistent with the ambulance service records, unless Nurse1 attended to Mrs Rogers for about twenty four minutes [4.50 pm to 5.14 pm] before calling he ambulance.

5.7.25 Nurse1 was asked in March 2017 whether she could recall why there was a difference in the timings. Not unreasonably she said, '… I cannot recall the assessment I made before telephoning the ambulance but I am again guessing that I would have been in her room checking her responses and making a decision as to whether or not I felt an ambulance was needed at that time as I know I would not delay in making that call without good reason'.

5.7.26 However, the timings apart there seems to be agreement that Nurse1 acted promptly when she assessed Mrs Rogers as needing urgent medical attention.

5.7.27 After the ambulance left Nurse1 updated Mrs Rogers' record as follows.

'Mrs Rogers had a fairly settled day. Medication given as prescribed, diet and fluids tolerated well, had been sat out and assisted with personal care as required'.

Concern 4

The family said that on several occasions when they visited Mrs Rogers in the care home that they found her in her own faeces and that there were faeces in the sink in her room.

5.7.28 It is worth recalling that when Mrs Rogers was examined by a doctor in the care home on 29 July 2015 [the day after her admission] he recorded:

Bowels: she was fully continent;[24]
Bladder: she had the occasional accident;
She was independent in the toilet;
She was able to perform personal care activities;
She fed independently;
She was dependant for bathing;

5.7.29 The table at 5.7.3 contains five separate reference to matters connected with personal care, including two occasions when family members found faeces in Mrs Rogers' sink. The family also found Mrs Rogers sitting in soiled clothing. There were no cleaning cloths. Ann could not find Mrs Rogers' pyjamas and her night clothing appeared to have been lost. They describe a lavatorial stench in Mrs Rogers' room. They report bringing all these matters to the attention of staff.

5.7.30 Nothing is recorded in Mrs Rogers' notes about these matters. The family's statements are critical of the personal care afforded to Mrs Rogers by the care home. The family recall staff saying that Mrs Rogers did not ring the call bell in time when she needed assistance with going to the lavatory. On another occasion a staff member is reported as saying that Mrs Rogers had lost confidence when responding to a complaint of soiling. The current manager at the care home says that 'cleaning cloths' are wet wipes and are always in plentiful supply because they are a core care item.

5.7.31 The SAR panel thought it was unacceptable not to have the family's consistent concerns about Mrs Rogers' personal care and hygiene recorded in her notes. The SAR panel thought a plan should have been made to explore the family's concerns and if necessary take remedial action.

5.7.32 The SAR panel also felt the responses from staff as reported by the family were disappointing. Staff who said that Mrs Rogers did not ring the bell in time to seek assistance when wanting the lavatory could be seen as 'blaming' her for the incontinence. This simply misunderstands the nature of incontinence. Suggesting that Mrs Rogers had lost confidence was not a solution to dealing with her incontinence. There was no evidence that any

[24] See Appendix F for results from a continence study in care homes.

thought was given as to why in the space of a few days Mrs Rogers had gone from being occasional incontinent of urine to dual incontinence. That merited further investigation, and as a minimum required a plan to support Mrs Rogers during a difficult period. In that respect the SAR panel felt the care afforded to Mrs Rogers could have been better.

Concern 5

The family reported that no rehabilitation had been undertaken with Mrs Rogers during her residency at the care home.

5.7.33 Two reasons were found in the SAR papers for Mrs Rogers' presence in the care home. On the day of admission a nurse at the care home noted that Mrs Rogers was accepted for short term residential respite. The second stems from Mrs Rogers' admission under level 2 Residential Rehabilitation. Appendix D describes this as:

'…short term programme of therapy and re-ablement in a residential care home setting for people who are medically stable but requiring a short period of rehabilitation in order to return safely to their own home. Services may be 'step down' following a stay in an acute hospital or 'step up', following a community referral and full assessment.'

5.7.34 At the time of Mrs Rogers' admission she could fairly be described as medically stable. Her underlying need was for rehabilitation following her fractured pelvis. It was noted on admission to the care home that Mrs Rogers was unsteady on her feet and there was need to make a referral to physiotherapy. Mrs Rogers was assessed as facing an 'amber risk' of falling[25] but there was no written care plan to manage that risk. On 30 July 2015 a Rapid Response nurse visited Mrs Rogers and said she would refer Mrs Rogers to physiotherapy. The next reference to mobility is on 3 August 2015 when a care home nurse noted, 'mobility encouraged'. There is no description of what form that encouragement took and whether it was confined to verbal coaxing and/or practical help. On the same date Louise told staff that Mrs Rogers' bed would not rise up or down. The staff member said they were aware. There is no reference to the bed malfunction in the care home notes or any information on whether it was fixed or replaced. Having an adjustable bed can aid patients with transfers; hence it is directly linked to mobility and rehabilitation.

5.7.35 The current manager at the care home demonstrated the functionality of an electric profiling bed to Paul Cheeseman and David Hunter during their visit and explained the trouble shooting and maintenance regime for the beds. When the police visited the care home the day after Mrs Rogers' death they did not find anything the matter with the bed in her room.

5.7.36 On 4 August 2015 a physiotherapist saw Mrs Rogers and left written instructions for staff on what and how they could help Mrs Rogers with her

[25] https://cks.nice.org.uk/falls-risk-assessment#!topicsummary

mobility. Mrs Rogers was tired and the physiotherapist noted she would visit in another week. Later that day a care home nurse [the same one referred to in 5.7.34] noted the physiotherapist advice and encouraged Mrs Rogers to walk short distances. Two days later - 6 August 2015 – the same nurse worked with Mrs Rogers on her mobility. Later on 6 August 2015 Mrs Rogers was seen on a 'ward round' by a doctor who recorded, 'Mrs Rogers was mobilising with a frame, and was keen to get home when more confident'.

5.7.37 The SAR panel believed that rehabilitation was considered by the care home but that more should have been done by staff to motivate Mrs Rogers to mobilise. Staff told the family that Mrs Rogers had lost her confidence. The panel believed that having recognised this the staff had an additional responsibility to motivate Mrs Rogers. The family is very critical of this aspect of their mother's time in the care home. They anticipated she would be home after four to six weeks of rehabilitation. They expected there would be a specific rehabilitation plan which set out the daily routine. Had that been in place Mrs Rogers's deteriorating mobility would have been spotted and investigations commenced as to why she was deteriorating.

Concern 6

The family said that Mrs Rogers had request that only female staff provide care but that after two days male staff were providing care to Mrs Rogers.

5.7.38 There is no record of Mrs Rogers' request for same gender carers. The current manager of the care home said that if residents express a preference for same gender carers every effort is made to provide them. However, there will be occasions when it is not practical and the residents' preferences cannot always be met.

5.7.39 The following case sets out the legal position on same gender carers.

5.7.40 Warwickshire council has been criticised by the Local Government Ombudsman (LGO) for failing to provide a disabled woman in her thirties with a same sex carer.

'The woman, who had significant needs and was not able to communicate verbally, received regular respite care from a residential centre so her parents could take breaks from their caring responsibilities.

The couple became concerned about staffing levels in the centre when it changed hands in 2011.

Warwickshire was not able to guarantee that the care home, which was owned by the council, would provide the woman with a female member of staff for her intimate care needs including washing and using the toilet.

The mother felt the new staff would be unfamiliar with her daughter's hand signals and that her needs would not be provided for if she was left there. She was forced to cancel a holiday to stay with her.

While there is no legal requirement to provide same sex carers, ombudsman Dr Jane Martin said it was not good enough for a provider to say they could not guarantee it'.

'They need to demonstrate they have made every effort to ensure the service is delivered in the way that is best for the recipient.'

Source http://www.communitycare.co.uk/2014/11/17/good-enough-council-say-guarantee-sex-carers/

5.8 Key Line 7

To understand the reasons for Mrs Rogers' subsequent admission to hospital and whether the timing was appropriate.

5.8.1 This key line has been dealt with when looking at the family's six concerns. In brief, Mrs Rogers' health deteriorated on 7 August 2015 when she was admitted to hospital and had probably been deteriorating for some days; albeit a doctor who saw her one day before her death said that she was well apart from her fractured pelvis. When staff found Mrs Rogers unresponsive they immediately called an ambulance. The arguments about whether that call should have been made earlier appear above.

5.9 Key Line 8

Involving Mrs Rogers' family in the SAR.

5.9.1 The family's concerns and views as represented to Adult Social Care and the panel chair are reflected in the report.

5.9.2 The family raised the following previously unconsidered point with the panel chair. When Mrs Rogers was admitted to the care home all her medication was taken from her and stored centrally ready for handing out by care or nursing staff. The family thought this further undermined Mrs Rogers' independence, in that it was an element of her life she was no longer in control of. The family said Mrs Rogers was always very careful to take her medication at the right times and had no difficulty doing so. The panel thought that was a very fair point.

5.9.3 The current manager at the care home helpfully explained to the panel chair the current procedures. The manager or nominee, would undertake an assessment with the resident to decide which medications would remain in the care of the resident. This could be all of them. Residents would keep them in a locked drawer in their rooms and take them at the prescribed times. Part of the assessment would include whether the resident was physically able to reach medicines if they were stored in their room and whether they had the capacity to remember to take them.

5.9.4 The family was not present during either of the doctor's visits and would have liked the care home to have given them notice of the visits so they could arrange to be there.

5.10 Key line 9

Meeting with staff involved with the care of Mrs Rogers.

5.10.1 Paul Cheeseman and David Hunter met with the current manager of the care home, who was not in post when Mrs Rogers was a resident, and what she said applied to the current policy and practice.

5.10.2 The Panel felt it would not be appropriate or practical to approach the three carers who have since left the care home. The Panel relied on the written transcripts of interviews they gave the care home managers on 12 August 2015.

5.10.3 Nurse 1 is the registered director of a nursing agency and at the time was working in the care home via a health care provider. Nurse1 made a written statement on 11 August 2015 which was given to Stockport Adult Social Care. The Panel felt it would help the review if Nurse1 could expand on her statement particularly around the timings of events on the day Mrs Rogers died.

5.10.4 Nurse1 was approached through the health care provider who agreed to send an extract from the report together with specific questions from the Panel. That arrangement did not initially produce a response and the chair of the review panel eventually made direct contact with Nurse1 who responded to the questions posed.

6. LEARNING POINTS

6.1 The Panel identified the following as learning points.

1. Prior to Mrs Rogers' admission to the care home there was a delay in assessing and providing her with adaptive equipment.

2. The review panel felt that the decision by Adult Social Care to place Mrs Rogers in a hub bed was a practical and pragmatic solution that provided for her immediate and short term needs with the objective of rehabilitation and if possible a return to her home with the appropriate care package.

3. The care home would have benefitted from an emergency admissions procedure so that the incoming resident's needs could be appropriately assessed in the most efficient way. In particular, the plan should have included the need to obtain GP medical information relevant to the resident's effective care as soon as practicable.

4. The standard of record keeping by the care home was very poor with scant entries. There were also some gaps in the records of Adult Social Care. Together they hindered the SAR Panel from a more thorough analysis because it was not always possible to say what happened and when it happened. Examples of this are the incomplete information on the referral form from Adult Social Care to the care home, the absence of any complaints by the family in the care home's records and the times they recorded for the ambulance attendance.

5. Potentially and subject to a formal assessment, Mrs Rogers could have stayed in her home had Adult Social Care been able to secure a provider to undertake additional daily home visits. This would have had several benefits including: being in familiar surroundings and perhaps greatest of all, direct contact between her family and health professionals had it been needed.

6. Mrs Rogers ran out of a prescribed blood pressure medicine: a position that could and should have been avoided by competent management.

7. Sharing of information between professionals involved in Mrs Rogers care could have been better. This could, in part, have been compensated by an excellent written care plan. However Mrs Rogers' care plan was poor, meaning she was not afforded the best level of care.

8. The term, 'family support' was used in Mrs Rogers' documentation without specifying what it meant. The review panel felt that the details of 'family

support' should have been recorded. This would have helped professionals who were assessing Mrs Rogers' needs and providing services, to build the family support into the overall care package. An example of this might be that the family could have contributed to Mrs Rogers' mobilisation regime.

9. Commissioners of care services need to be clear with providers that they have a duty to cooperate with Stockport Safeguarding Adult Board's safeguarding adult reviews. Providers in turn need to build this duty to cooperate requirement into the contracts of staff they employ directly and the contracts of third party staff they recruit to provide services. For example, health care companies who act as recruiting agencies should make the requirement to cooperate with safeguarding adult reviews part of their contract with the 'recruit'.

7. NOTABLE GOOD PRACTICE

7.1 The SAR panel was unable to identify any specific examples of notable good practice despite careful consideration. There were examples of competent practice by staff from Adult Social Care which complied with most policies.

7.2 However, the panel thought that credit has to be given to Stockport Adult Social Care and its partners for developing the systems and processes that were in place that enabled Mrs Rogers to be placed in a hub bed via the Rapid Response procedures.

8. CONCLUSIONS

8.1 Mrs Rogers lived by herself and was independent in her daily routines with practical support from her three daughters. She was generally in good health and her high blood pressure was well controlled by medication. Her diverticulitis was also well managed. Unbeknown to her family Mrs Rogers had been unable to use the bath from sometime in June 2015.

8.2 In early July 2015 Mrs Rogers recalled twisting her hip while bringing the washing in. She did not go to her GP at the time. On 15 July 2015 Mrs Rogers saw her GP and complained of pain in her hip. She was given pain relief for a pulled muscle. In the early hours of 16 July 2015 while walking with a stick in her flat, she stumble and fell. Mrs Rogers summoned an ambulance.

8.3 Mrs Rogers was taken to hospital on 16 July 2015 and diagnosed with a fracture to a pelvic bone and discharged the same day. Discharge planning was undertaken and Mrs Rogers was seen and assessed by staff from the Community Assertive in Reach Team. It was thought that Mrs Rogers would be able to manage at home with the support of her family. Mrs Rogers and her family were reported as being content with the discharge plan.

8.4 Louise made a referral for a bathing assessment which was given a low priority because Mrs Rogers had been advised by medics not to use the bath for six weeks. The Community Assertive in Reach Team visited Mrs Rogers at home the following day and did not identify any additional needs and discharged her from their service.

8.5 In the following twelve days Mrs Rogers' mobility needs became more acute and her family alerted Adult Social Care when they could no longer meet her needs. Adult Social Care provided twice daily visits and following an assessment may have increased them to four times daily if the provision had been available. The provision of care services for people living at home is limited because of commercial reasons.

8.6 Mrs Rogers' mobility continued to deteriorate and Adult Social Care felt she needed urgent residential rehabilitation and approved an emergency placement in a hub bed at the care home.

8.7 Mrs Rogers took up residency at the care home late on the evening of 28 July 2015. From then until her death on 7 August 2015 her experience as a resident as described by her family was very poor. They believe that Mrs Rogers' rehabilitation was woeful, their concerns about her health were ignored or not taken seriously and the standard of Mrs Rogers' personal care appalling. The family's litany of complaints against the care home, as told to Adult Social Care after Mrs Rogers' death, do not appear in Mrs Rogers' records held by the care home. The family say they were not listened to.

8.8 The SAR panel had the benefit of seeing Mrs Rogers' records and statements from the family and some care home staff and could clearly see a worsening of Mrs Rogers' mobility and her general health from the time she 'twisted' her hip to her death.

8.9 This decline happened within about four weeks and increased in intensity during the last six or so days of her life. Mrs Rogers was seen daily by one of the Registered General Nurses albeit she was not in a nursing bed. In particular Mrs Rogers was seen by a doctor during his ward round the day before her death. He believed that apart from her fractured pelvis she was well.

8.10 The events on the day Mrs Rogers died as portrayed by the family show a lack of concern by the care home staff for what they thought was Mrs Rogers' rapid deterioration. The family recall the carers saying at about 3.0 pm they would get Nurse1 to keep a close eye on Mrs Rogers. There is no evidence that the carers asked Nurse1. About 4.30 pm Nurse1 told Louise that she would keep 'very close observations' on Mrs Rogers. There is no record of what was done nor the nature of the 'very close observations'.

8.11 What is clear is that Mrs Rogers died from peritonitis and a perforated bowel that had not been diagnosed or treated. It is not possible to say how long she had endured that condition but her family say they told staff at the care home when Mrs Rogers was admitted that she had stomach ache. They believe this was never passed on to the doctor who examined her on 29 July 2015. It is not in Mrs Rogers' notes.

8.12 Medical opinion is generally settled in that the chances of recovery from a perforated bowel increase with early diagnosis and treatment. The doctor who reviewed Nurse1's actions on 7 August 2015 said it was hard to determine if the outcome would have been any different due to the fact that the resident deteriorated quite quickly.

8.13 The family's concern was around the care provided to Mrs Rogers in the days before her death and the manner of her death. They felt there was no dignity shown to their mother.

9. PREDICTABILITY AND PREVENTABILITY

9.1 The SAR panel thought very carefully about whether Mrs Rogers' death could have been predicted or prevented.

9.2 Mrs Rogers died of peritonitis and a perforated bowel. Had it been known that Mrs Rogers' bowel was perforated then it is reasonable to say that peritonitis might follow and action could have been taken to treat the infection.

9.3 'Peritonitis needs to be diagnosed and treated quickly to prevent possibly fatal complications developing, so you will usually be admitted to hospital for tests and treatment. The underlying infection will be treated with injections of antibiotics or antifungal medication, depending on the cause. In some cases, surgery may be required to repair the peritoneum or treat the underlying cause of the infection'.[26]

9.4 Mrs Rogers had diverticulitis but was not under active investigation or treatment for the condition. She was seen by doctors twice while in the care home and daily by a registered nurse and once by a Rapid Response nurse. At no time before the ambulance was called at 5.14 pm on 7 August 2015 did any nurse or doctor know or suspect Mrs Rogers' bowel had perforated.

9.5 A carer told the family that Mrs Rogers' bowel exploded during the night before her death, but there was no further description of what that meant and it was not in Mrs Rogers' notes.

9.6 The rapid onset of Mrs Rogers' acute symptoms meant there was very little time for effective medical intervention.

9.7 The SAR panel conclude it was not reasonably possible to predict or prevent the death of Mrs Rogers.

[26] http://www.nhs.uk/conditions/Peritonitis/Pages/Introduction.aspx

10. RECOMMENDATIONS

10.1 The review panel made the following recommendations.

1. That Stockport Adult Safeguarding Board has processes in place that identifies potential safeguarding adult reviews at the earliest opportunity and submits the details to the relevant screen panel.

2. That Stockport Adult Safeguarding Board satisfies itself that the processes in place for assessing and providing adaptive equipment are timely and meet the needs of those who may require it.

3. That Stockport Adult Safeguarding Board satisfies itself that those commissioning and authorising the use of hub beds have clear criteria for doing so.

4. That Stockport Adult Safeguarding Board satisfies itself that residential homes have effective emergency admission procedures which include early access to GP medical information relevant to the resident's effective care.

5. That Stockport Adult Safeguarding Board satisfies itself that the standard of care plans for people entering residential homes in an emergency is of a good professional standard.

6. That Stockport Adult Safeguarding Board satisfies itself that the stand of record keeping in residential homes is of a good professional standard.

7. That Stockport Adult Safeguarding Board satisfies itself that residential homes have effective process in place that ensure residents do not run out of prescribed medicines.

8. That Stockport Adult Safeguarding Board satisfies itself that care homes have meaningful and auditable processes in place to record residents or families concerns or complaints and which provides feedback on the action taken in response to the points raised.

9. That Stockport Adult Safeguarding Board satisfies itself that residential care homes understand and have processes that provides dignity of care for residents.

10. That Stockport Adult Safeguarding Board satisfies itself that residential homes and other organisations providing staff and services to residential homes are contractually committed to engaging with Safeguarding Adult Reviews in accordance with Section 45 Care Act 2014.

APPENDIX A

SAFEGUARDING ADULT REVIEW CRITERIA

1. Section 44 Care Act 2014

Safeguarding adults reviews

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

APPENDIX B

SAFEGUARDING ADULT REVIEW PANEL MEMBERSHIP

Name	Agency
Stephen Dawson	Workforce Development Service Manager Stockport Metropolitan Borough Council [SMBC]
Wendy Stewart	Named Nurse Adult Safeguarding Stockport NHS Foundation Trust
Katie Murphy	Social Worker Adult Safeguarding and Quality Service SMBC
Susie Meehan	Service Manager of Stockport Adult Safeguarding Quality Service
Vincent Fraga	Head of Marketing and Commissioning SMBC
Andria Walton	Designated Nurse, Stockport Clinical Commissioning Group [for first meeting only]
Sue Gaskell	Designated Nurse, Stockport Clinical Commissioning Group [meeting two onwards]
Lee Woolfe	Business Manager Stockport Safeguarding Adult Board
Heather Simpson	Minute Taker SMBC
Paul Cheeseman	Independent Support for Chair-Author
David Hunter	Independent Chair-Author

Appendix C

The Edmonton Frail Scale

Frailty Domain	Item	0 Points	1 Point	2 Point
Cognition	Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of 'ten after eleven'	No errors	Minor spacing errors	Other errors
General Health Status	In the past year, how many times have you been admitted to a hospital	0	1-2	≥2
	In general, how would you describe your health?	Excellent /very good/good	Fair	Poor
Function Independence	With how many of the following activities do you require help: meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications	0-1	2-4	5-8
Social support	When you need help, can you count on someone who is willing and able to meet your needs?	Always	Some-times	Never
Medication Use	Do you use five or more different prescription medications on a regular basis	No	Yes	
	At times, do you forget to take your prescription medications?	No	Yes	
Nutrition	Have you recently lost weight such that your clothing has become looser?	No	Yes	
Mood	Do you often feel sad or depressed?	No	Yes	
Continence	Do you have a problem with losing control of urine when you don't want to?	No	Yes	
Functional performance	I would like you to sit in this chair with your back and arms resting. Then when I say 'Go', please stand up and walk at a safe and comfortable pace to the mark on the floor (approximately 3m away), return to the chair and sit down.	0-10 seconds	11-20 seconds	>20 seconds, patient unwilling or requires assistance
Total	Final score is the sum of column totals			/17

Scoring the Reported Edmonton Frail Scale (/17):

Not frail	0-5
Apparently vulnerable	6-7
Mild frailty	8-9
Moderate frailty	10-11
Severe frailty	12-17

Appendix D

Rapid Response

Stockport NHS Foundation Trust

Intermediate Care - Stockport

Intermediate care is for people resident in Stockport over the age of 18 who have been assessed as being medically stable, do not require hospital care and have short term therapy goals. Intermediate care is a service that is provided on a short term basis either within a service user's home or within a designated residential home.

About Our Service

Intermediate Care is delivered in partnership between primary and secondary health care and local government. There are three arms to the service:

1. Rapid Response – designed to **prevent avoidable admissions** by providing rapid assessment/diagnosis between 8.30 am and 8.30pm, and rapid access to short term therapy/nursing support and personal care in the patient's own home; this may not always lead to a referral into the intermediate care service.

2. Residential Rehabilitation – short term programme of therapy and re-ablement in a residential care home setting for people who are **medically stable** but requiring a short period of rehabilitation in order to return safely to their own home. Services may be 'step down' following a stay in an acute hospital or 'step up', following a community referral and full assessment.

3. Homebased service– a short term period of nursing and therapeutic support in a patient's own home, it includes a package of home care support. Sometimes supported by community equipment and/or housing based support services. Services may be 'step down' following a stay in an acute hospital or 'step up', following a community referral and full assessment.

How to Use the Service

Access to Intermediate Care services from the localities is via a joint assessment by a social worker and a nurse/therapist. Access to Intermediate Care services from hospital is via the Section 2 notification route and an assessment in conjunction with the Multidisciplinary Team by a hospital social worker and a nurse / therapist.

Appendix E

Levels of Care

There are 3 levels of care commissioned within care homes.

1. Standard care – GPs will visit as requested to assess a resident's health. Under the GP development scheme commissioned by Stockport CCG, GPs will visit each of their care homes weekly but will only review those who need to see a GP.

2. Rapid Response – GPs will visit & see every week, regardless of whether the resident is "ill" or not. They can also be asked to visit in between weekly visits if the resident is unwell. The resident will be first seen by the GP in the first "routine" ward round, unless their clinical condition means they need to see a GP sooner.

3. Intermediate care – GPs will attend to "clerk-in" the resident within 24-48h of arriving in the care home. This will happen regardless of when the next "routine" ward round is. They will then also be reviewed on a weekly basis even when not "ill". The GP can be asked to visit to assess someone in between weekly ward rounds if required.

Mrs Rogers was looked after under number 2. It appears that at this review the GP did not have access to any admission paperwork and did not know fully why she had been admitted to a Rapid Response bed. He did not at the time of first seeing her, have her full medical notes or GP summary.

Appendix F

Incontinence in BUPA Care Homes

Continence

Just under 70% of all BPA care home residents experience incontinence (Table 21).

Table 21: Bupa Resident Census – UK – 2009 –

Continence % within age group	Under 65	65–74	75–84	85–94 95 and over All Age	95 and over	All Age
Continent	29.7%	29.1%	29.6%	31.8%	33.9%	30.8%
Urinary incontinent	12.6%	13.8%	13.9%	16.2%	17.3%	15.0%
Faecal incontinent	1.1%	6%	4%	7%	8%	6%
Duel incontinent	56.6%	56.5%	56.2% %	51.4%	48.0%	53.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

N= 15,875

Levels of urinary incontinence alone increase consistently with the age of the resident but the overall proportion who are continent changes little with age. Counter-intuitively, residents over the age of 95 are those most likely to be rat 'continent' and least likely to experience 'dual incontinence'

Continence may be viewed differently by different respondents. For some, a resident whose incontinence is managed effectively by catheterisation or wearing pads may be viewed as continent. In the United Kingdom 4.9% of residents wearing pads and 6.6% of residents who were catheterised were described as 'continent'. In New Zealand the percentages were 11.2% and 10.0% respectively.

Source http://www.cpa.org.uk/information/reviews/changingroleofcarehomes.pdf

Appendix G

Closed pelvic fractures: characteristics and outcomes in older patients admitted to medical and geriatric wards

Robert O Morris, Adeniyi Sonibare, Desmond J Green, Tahir Masud

Abstract

Objective

To investigate the characteristics and outcomes of older patients with pelvic fracture admitted to medical and geriatric wards.

Methods

All patients admitted to medical and geriatric wards with a pelvic fracture over a four year period were identified using the hospital clinical coding database. Data were collected from case notes, hospital and Family Health Services Authority databases. Where available, pelvic radiographs were graded according to the Singh index.

Results

The case-notes of 148 patients (126 women) were studied; 83% (n=123) of patients suffered a pelvic fracture in low energy trauma.

Mean (SD) length of hospital stay was 21.3 (17.6) days.

Single breaks of the pubic rami accounted for 47.2% (n=68) of all fractures.

Inpatient mortality was 7.6% and at one year was 27%.

There was a marked adverse effect on the mobility of survivors with all patients using at least a walking stick at discharge and 51.1% (n=70) needing assistance for mobility.

Although 70.9% (n=83) of patients admitted from home (or warden aided accommodation) were able to return there, 84.3% (n=70) of them required extra community support.

Rates of institutionalisation rose from 20.9% (n=31) at admission to 35.8% (49/137) of survivors at discharge. Altogether 93% (n=107) of 115 patients, in whom adequate quality pelvic radiographs were available, were assigned a Singh index grade of 4 or less indicating the presence of osteoporosis.

Conclusions Pelvic fractures are often the result of low energy trauma. They are associated with appreciable inpatient and considerable one year mortality. They also have marked negative effects mobility in the short term. They result in increased levels of dependency in terms of higher levels of community support and rates of institutionalisation. On the evidence of Singh index grading, pelvic fractures are associated with low bone density**.**

Source:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1741752/pdf/v076p00646.pdf