Safeguarding Adult Review

Overview Report

Adult B

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1.0 Introduction

1.1 Adult B died in hospital on 27th April 2016 following surgery on a fractured hip. She was 84 years of age. She had been admitted to hospital following two falls in Care Home 1 on 16th April 2016. She had been a resident there since October 2014.

1.2 Lancashire Safeguarding Adults Board (LSAB) decided to conduct a safeguarding adult review (SAR) in July 2016 because of concerns about how agencies had worked together to safeguard Adult B and the suspicion that neglect may have been a contributory factor in her death. The Board decided to adapt the concise Welsh Child Practice Review approach for this review. A description of the process by which this SAR was conducted is shown at Appendix A.

1.3 Detective Chief Inspector Vicki Ellis of Lancashire Constabulary chaired the Panel established to oversee the SAR. (During the course of the review she was promoted to Detective Superintendent in Cumbria Constabulary) Membership of the SAR Panel is also shown at Appendix A. David Mellor was appointed as lead reviewer for the SAR. He is a retired chief officer of police and has over five years experience of conducting statutory reviews. He has no connection to any agency in Lancashire.

1.4 Care Home 1 had been inspected by the Care Quality Commission (CQC) during the month prior to Adult B's falls and a substantial number of concerns were identified about the standard of care provided. Adult B's death was one of a range of concerns which initially generated a criminal investigation which did not result in any charges. A safeguarding investigation also took place. The death of a further Care Home 1 resident (Adult B2) shortly after Adult B's fall led to a referral for an additional SAR. Lancashire Safeguarding Adults Board concluded that the criteria for commissioning a further SAR had not been met but decided that the concerns of Adult B2's family would be considered as part of the Adult B SAR.

1.5 An inquest has taken place in respect of Adult B. The coroner was initially provided with incomplete information about the factors which led to Adult B's death by the hospital in which she died. When this omission was rectified the original death certificate was voided. The inquest ultimately determined the cause of Adult B's death to be broncho pneumonia with osteoporotic facture left hip (operated) as a contributory factor.

1.6 Lancashire Safeguarding Adults Board wishes to express sincere condolences to the families of Adult B and Adult B2.

2.0 Terms of reference

2.1 The timeframe of the review is from 10th April 2015 until 27th April 2016. Any significant incident which occurred prior to this timeframe will also be considered, specifically the events leading to Adult B's placement in Care Home 1.

The purpose of the review is to:

- Determine whether decisions and actions in the case complied with the safeguarding policy and procedures of named services/ agencies and the LSAB;

- Examine inter-agency working and service provision for Adult B and her family;

- Determine the extent to which care was person centred and consistent with Making Safeguarding Personal;

- Examine the effectiveness of information sharing and working relationships between and within agencies;

- Examine compliance with valid consent and the Mental Capacity Act;

- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults;

- Identify any actions required by the LSAB to promote learning to support and improve systems and practice;

Glossary

Alzheimer’s disease is the most common cause of dementia. The word dementia describes a set of symptoms that can include memory loss and difficulties with thinking, problem-solving or language. These symptoms occur when the brain is damaged by certain diseases, including Alzheimer's disease.

Best Interests - if a person has been assessed as lacking mental capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests

Deprivation of Liberty Safeguards (DoLS) were introduced in 2009 and protect the rights of people aged 18 or above who lack the ability to make certain decisions for themselves and make sure that their freedom is not inappropriately restricted. No one can be deprived of their liberty unless it is done in accordance with a legal procedure. The DoLS is the legal procedure to be followed when it is necessary for a resident or patient who lacks capacity to consent to their care and treatment to be deprived of their liberty in order to keep them safe from harm. The DoLS can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings, and for children aged 16 and above the Court of Protection may authorise a deprivation of liberty.

NHS continuing healthcare (CHC) is a package of care provided outside of hospital that is arranged and funded solely by the NHS for individuals aged 18 years and older who have significant ongoing healthcare needs. When someone is assessed as eligible for CHC, the NHS is responsible for funding the full package of health and social care. In 2015-16, almost 160,000 people received, or were assessed as eligible for, CHC funding during the year, at a cost of £3.1 billion. (1)

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 came into force in 2007. It is designed to protect and restore power to those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by

illness or disability, or the effects of drugs or alcohol. The MCA also supports those who have capacity and choose to plan for their future. The MCA applies to everyone working in social care, health and other sectors who is involved in the support and treatment of people aged 16 and over who live in England and Wales, and who are unable to make all or some decisions for themselves.

Vascular Dementia is the second most common type of dementia (after Alzheimer's disease). As stated above, the word dementia describes a set of symptoms that can include memory loss and difficulties with thinking, problem-solving or language. In vascular dementia, these symptoms occur when the brain is damaged because of problems with the supply of blood to the brain.

4.0 Synopsis

4.1 On 13th October 2014 Adult B was placed in Care Home 1, initially for respite care, following a deterioration in her health. At that time Adult B had a diagnosis of vascular dementia and Alzheimer's. Prior to her admission, in July 2014, a dependency assessment had been carried out which disclosed that Adult B was mobile; required intermittent supervision and/or physical assistance for difficult manoeuvres only; needed assistance and constant supervision to wash/bathe; required intermittent supervision when dressing; whilst her communication ability was clear, she struggled to retain information and her skin presented as healthy and hydrated. In terms of her mental health, her ability to express her needs and make simple decisions were sometimes affected by her Alzheimer's as was her ability to weigh up risks and hazards.

4.2 Her two daughters chose Care Home 1 primarily because Adult B's late husband had spent the last few months of his life as a resident there. The family had been very satisfied with the care Adult B's husband received there and Adult B's daughters hoped that their mother would remember Care Home 1 and find it familiar. Unfortunately, this was not the case as a result of her difficulty in retaining information.

4.3 Adult B lived in the Wigan Council area of Greater Manchester. A social worker from Wigan Adult Social Care had carried out the dependency assessment referred to in Paragraph 4.1 above. Care Home 1 has a Wigan postal address but is situated just inside the Lancashire County Council area.

4.4 The owner and registered provider in respect of Care Home 1 is Tudor Bank Limited. (During 2017 there was a change of ownership of Care Home 1 but the owner/provider name remained the same.) The home provides a care home service with, and without, nursing and accommodated up to 40 adults. Adult B had been assessed as not requiring nursing care at the time her placement began. There is also a dementia care unit within the home which is known as the elderly mentally impaired (EMI) unit.

4.5 Care Home 1 had last been inspected by the Care Quality Commission (CQC) on 4th August 2014 and found to have met all standards with the exception of "cleanliness and infection control". The inspectors found that the cleanliness in several areas of the home was not of a good standard. There was a cleaning schedule in place which had not been completed. It was established that one cleaner had recently left employment and had not yet been replaced. Other than the

concerns about cleanliness and infection control, the CQC report was extremely positive.

4.6 The provider was required to submit an improvement plan by 9th September 2014 setting out the actions taken to address the area of non-compliance, and on 4th November 2014 the CQC carried out a further inspection to check on progress. They noted that domestic hours had been increased since the recruitment of a new cleaner which allowed more time for a thorough cleaning schedule to be followed. Additionally, the manager advised that she was enrolling a good percentage of workers, including domestic staff on an infection control course in the near future. The CQC found the standard of cleanliness had improved throughout Care Home 1 and no unpleasant smells were evident. However, they noted that the extractor fan in the ground floor disabled toilet was not working efficiently and in need of cleaning. This had been the situation at the time of the August 2014 inspection and the manager had incorrectly told them that these issues had been addressed. The manager assured the CQC this would be promptly rectified. CQC inspectors also observed lunch being served on the dementia care unit and noted that infection control guidelines were being followed in relation to food hygiene. The CQC concluded that the cleanliness and infection control standard had now been met.

4.7 Care Home 1 did not complete a chronology in respect of the care they provided to Adult B, advising that a number her records were missing and that it was unclear if they had been taken, lost or misplaced. Two weeks prior to the conclusion of this review, Care Home 1 provided a large file of photocopied documents in respect of their care of Adult B. It would have been good practice to complete a holistic care assessment at the time of Adult B's admission to Care Home 1, but after examining the file provided, there is no evidence that this happened.
Additionally, there is no indication that Care Home 1 had an admissions policy at that time.

4.8 It is not known if personalised care plans were created for Adult B on admission. In the large file provided recently by Care Home 1 there are handwritten care plans for Adult B dated 6th November 2015 and typed care plans which are dated 8th December 2015. These two sets of care plans appear to have been created over a year after her admission. Care Home 1 has provided no explanation for the absence of any record of care plans for Adult B prior to November 2015 other than their earlier reference to records relating to Adult B having gone missing. (Paragraph 4.7)

4.9 On 11th December 2014 a best interests meeting in respect of Adult B was held at Care Home 1. This was attended by Adult B's social worker and a senior social worker from Wigan Adult Social Care, the care home manager and deputy manager and Adult B's daughters. Adult B was deemed to lack mental capacity and the

meeting was called to consider whether it was in her best interests to return to live with her family or remain in residential care. It was decided that Adult B should remain in residential care in Care Home 1 permanently on the basis that the advantages of being placed there far outweighed the risks of returning home. It was concluded that Adult B's physical, emotional and social needs were currently being met in Care Home 1. Adult B's care package at Care Home 1 was for residential care only but it was noted that Care Home 1 could also provide a nursing care package.

4.10 The best interest meeting noted that Adult B was being supported on the elderly frail unit at Care Home 1. This was considered beneficial for her as she was able to freely communicate with other residents and gain greater social stimulation in comparison to the elderly medically impaired (EMI) unit of the home. However, it was acknowledged that should there be a further deterioration in her mental heath, a reassessment would take place and she could be considered for a placement on the EMI unit.

4.11 There was also discussion over whether Adult B could be considered to be being deprived of her liberty at Care Home 1 as Adult B had previously asked to leave the home which had a "locked door" policy in place. The deputy manager said she was in the process of initiating a request for a deprivation of liberty safeguards DoLS assessment. The large file recently provided by Care Home 1 includes a copy of a completed DoLS application dated 11th December 2014. Lancashire adult social care state that they have no record of any DoLS application in respect of Adult B being received. (A DoLS application was submitted to Wigan Council in respect of Adult B on 25th March 2016. This was shortly after the CQC unannounced inspection and may have been in response to CQC concerns about DoLS applications.)

4.12 Adult B transferred to GP practice 1 in January 2015. This practice was located closer to Care Home 1 than Adult B's previous GP practice. In April and May 2015 a GP from practice 1 visited Adult B in Care Home 1 because of chest infections. In June 2015 there was a further GP visit as a result of a "productive cough" and Adult B was referred for a chest X ray which was completed later the same month. No evidence of an acute infection was found.

4.13 In July 2015 a practice nurse from GP practice 1 visited Adult B at Care Home 1 to conduct a chronic obstructive pulmonary disease (COPD) review. One of Adult B's daughters was present. An expectation of this review is to assess whether there had been any deterioration in her condition. After reviewing chest X rays, no concerns were noted. Adult B was unable to perform a spirometry test as a result of her cognitive difficulties. She was prescribed medication for COPD and it was decided that no further action or follow up was necessary.

4.14 Later the same month the same practice nurse from GP practice 1 visited Care Home 1 to conduct an Over 75 review of Adult B. Care home staff were consulted on behalf of the patient. There is no reference to Adult B being consulted and her daughters were not involved in the review. An expectation of this review is that it would include cardiovascular screening, checks of body mass index (BMI) and blood pressure and blood tests for cholesterol and diabetes. Dementia screening and the use of the frailty index which helps identify adverse health outcomes for older people should also have been included. "No concerns" were documented and staff were advised to contact the surgery as needed. No further action or follow up was considered necessary. (It is difficult to tell whether this Over 75 review was consistent with good practice given the limited amount of information provided about it.)

4.15 In October 2015 care home staff contacted GP surgery 1 because they were concerned that Adult B had a UTI. The GP completed a telephone consultation and care home staff were instructed to complete a dipstick test which proved positive. Following this the GP prescribed antibiotics. In accordance with NICE guidelines there was no routine review as this apparently was Adult B's first UTI, although on admission she was said to have a history of UTIs.

4.16 As previously stated the only care plans for Adult B which have been shared with this review date from November and December 2015. The care plan covered sixteen key activities of daily living including:

- *Physical health* where a history of recurrent UTI's prompted advice to staff to be vigilant for changes in behaviour due to confusion arising from UTIs. The plan stated that Adult B should be offered 1.5 -2 litres of fluid daily. A history of ear infections was also noted.

- *Mental capacity* where the fact that she now lived in a care home with locked doors had led to a best interest decision to maintain her safety. She was said to have no insight into risks, fluctuating capacity, and whilst she could make basic decisions in relation to care needs, she was said to be unable to weigh up information in relation to care decisions.

- *Personal hygiene* where her need for assistance from a member of care staff was noted. She was described as a very smart lady who likes to look her best, loves a full body wash daily and bath or shower weekly. (Adult B's daughter says that her mother did not "love" a full body wash and would have much preferred a bath or a shower.)

- *Pressure Care/Tissue Viability* where she was said to be at risk of pressure ulcers due to incontinence (urine)

- *Mobility* where it was said that her environment needed to be free from clutter. She was able to mobilise independently, needed correct footwear to minimise the risk of trips and falls and occasional assistance from one staff member. (Adult B's daughter disagrees that her mother was able to "mobilise independently" by December 2015.)

There was no falls risk plan for Adult B. Care Home 1 has advised this review that they believe that the mobility plan was intended to encompass the risk of falls.

4.17 These care plans should have been reviewed on a monthly basis but the records provided by Care Home 1 indicate that they were reviewed twice with the final monthly review taking place in January 2016. The information recorded for the reviews is very limited. Care Home 1 has provided no explanation for the absence of evaluation of care plans.

4.18 Care Home 1 acknowledge that no food and fluid charts have been found to evidence that Adult B was being provided with the amount of fluid specified in her care plan. Nor is there documentation to confirm that Adult B's environment was checked for hazards although staff from that period who remain at Care Home 1 say that this was done as far as they were aware.

4.19 In November 2015 the practice nurse from GP surgery 1 visited Care Home 1 to carry out a dementia review for Adult B. An expectation of the review is that any deterioration in her condition would be highlighted. However, no changes or concerns were noted and no actions or follow ups were said to be required. (It is difficult to tell whether this dementia review was consistent with good practice given the limited amount of information provided about it.)

4.20 In January 2016 Adult B was seen at Care Home 1 by the out of hours GP service for a chesty cough which she had had for two days. No other symptoms were noted and she was prescribed medication.

4.21 Also in January 2016 Adult B's final dependency assessment was carried out which stated that she managed her mobility unaided. She was said to be totally reliant on a carer for washing and dressing. She was described as being able to feed herself independently, and her eyesight was noted to be good without spectacles. She was also noted to have mild hearing loss. (Adult B's daughter states that her mother had been deaf in her left ear since the age of 14. Her deafness had been accurately referenced in the dependency assessment carried out prior to her

admission. (Paragraph 4.1)) This dependency assessment appeared to be quite limited in comparison to the dependency assessment carried out prior to Adult B's placement in Care Home 1. (Paragraph 4.1)

4.22 A falls risk assessment was also carried out in respect of Adult B in January 2016. She was assessed as at high risk of falls. In the large file recently provided by Care Home 1 no information is provided about how staff were to manage this risk. The risk falls assessment states that this risk should be reviewed at least monthly. There are three monthly reviews recorded but although the month is recorded, the year is not. A bed rail review took place in January 2016 which stated that no bed rail was in use. Three further bed rail reviews took place with the same outcome but although the month the review took place is recorded, the year is not.

4.23 On 10th February 2016 Care Home 1 made a request for an assessment of whether Adult B's care package should be changed from residential to nursing. This request was sent to Southport and Ormskirk hospital and a telephone triage took place between the hospital and the care home the following day. The outcome of this conversation was that Care Home 1 were to contact the continuing healthcare (CHC) assessment team if Adult B deteriorated. Care Home 1 disputes this interpretation of the outcome, stating that their expectation was that the CHC assessment process would commence at that point. Whatever the outcome of the 11th February 2016 telephone triage, the CHC assessment team subsequently contacted Care Home 1 on 30th June 2016 to arrange to visit Adult B in order to complete the initial CHC screening tool and were advised that she had died.

4.24 On 22nd March 2016 the CQC conducted an unannounced inspection of Care Home 1. The overall rating was "requires improvement". The home was judged to "require improvement" in the areas of effectiveness, care, responsiveness and leadership. The home was judged to be "inadequate" in respect of safety.

4.25 At the time of this inspection the manager of Care Home 1 had been in post for a very short period of time and was in the process of applying for registration with the CQC. Although there seemed to be sufficient staff on duty on the day of their inspection and it was observed that staff were always present in the communal areas of the home, the CQC were told by residents that there were sometimes shortfalls in the staffing levels, particularly at night and records showed there was an excessive number of agency staff used over a short period of time.

4.26 The management of medicines was judged to be poor and there were areas of the environment and external grounds where improvements to safety were needed. The CQC also took the view that some areas of the home could have been cleaner and more hygienic and that infection control practice could have been better.

4.27 The CQC noted that care plans did not always reflect resident's assessed needs and some care records provided conflicting information. This did not give the staff team clear guidance about how people's individual needs were to be best met.

4.28 DoLS applications had not always been submitted, in line with the requirements of the Mental Capacity Act. Records showed that resident's mental capacity had not always been considered when developing their care plans and formal consent had not always been obtained before care and support was provided.

4.29 CQC inspectors observed that confidential records were sometimes left unattended on the nurses' station, although there was always a member of staff in the vicinity. The CQC felt that the provision of meals could have been better, although they saw residents being supported with their meals in a sensitive manner. Interaction by staff with residents was noted to vary in quality. Whilst some members of staff provided good, sensitive and caring approaches, others were noted to fail to promote people's dignity and respect.

4.30 The CQC also found that the system for assessing and monitoring the quality and safety of the service provided was not always effective. This did not allow for shortfalls to be identified and improvements to be made. Complaints were not always being managed well.

4.31 The CQC found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for person centred care, dignity and respect, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, need for consent, premises and equipment, receiving and acting on complaints and fit and proper persons employed.

4.32 The level of impact arising from the breaches was weighed against the likelihood of them happening again and the CQC decided to issue regulatory requirements which is their lowest form of formal enforcement action. The provider was asked to submit an action plan detailing how they would make the improvements required against which progress would be checked at the next inspection. The CQC also took into account the fact the previous registered manager had left just prior to the inspection and the new manager – in whom the CQC had some confidence - had only just started.

4.33 During the inspection the CQC asked the manager to make a safeguarding referral as they had observed a member of Care Home 1 staff being neglectful in supporting a resident with pain control. The safeguarding referral was made under the heading of "neglect medication misadministration". When making the referral the

Care Home 1 manager advised that it had arisen during a CQC inspection when a resident had been observed to request pain relief. The resident was prescribed codeine for breakthrough pain relief which had not been given. In the safeguarding referral, the Care Home 1 manager advised that the resident's GP had instructed that the codeine should only be given as a last resort as it affected the resident's mobility, placed her at high risk of falls and also increased her confusion. The manager advised that the CQC were unaware of this. This referral was screened in the Lancashire multi-agency safeguarding hub (MASH) and the outcome was that it was closed as there had been no significant harm to the resident.

4.34 The CQC did not notify Lancashire County Council of their findings or inform them of the enforcement action they had initiated. The CQC attended the monthly Radar meetings (a confidential multiagency information sharing group which receives information from a variety of sources when concerns are identified about residential, nursing or domiciliary care providers. The information received informs decisions about how best to support providers who have been identified as requiring improvement) chaired by a senior quality improvement practitioner from LCC. The Radar meeting provided an opportunity to share concerns which had arisen during the Care Home 1 inspection with the local authority and other commissioners but there is no record of Care Home 1 being considered within the Radar meetings prior to July 2016.

4.35 As stated above, when considering enforcement decisions, the CQC consider the potential impact of any breaches of regulations alongside the likelihood of the breach occurring again. Following the March 2014 inspection of Care Home 1, the CQC considered that seriousness of the breaches identified was "low" and that the issue of "requirement notices" in respect of the breaches identified was the appropriate response. Had the seriousness of the breaches been assessed at a "medium" level then warning notices could have been issued to Care Home 1, which would have been copied to the commissioners of placements. Given that the judgement of the CQC that the seriousness of the breaches was "low", there was no requirement at that time to share information with commissioners.

4.36 On 8th April 2016 the Lancashire multi-agency safeguarding hub (MASH) received two separate safeguarding alerts relating to Care Home 1. One alert was received from the daughter of a resident and related to a bruise on her parent's arm. This was allocated to the safeguarding team and was ultimately considered to have been "substantiated" although the cause of the bruising was not established. The second safeguarding alert received from Care Home 1 related to an agency staff member "mishandling" a resident. This was also allocated to the safeguarding team and was also found to be "substantiated" as the conduct of the agency carer was witnessed. The resident was uninjured and the matter was reported to the agency

which employed the carer for disciplinary action. Neither safeguarding referrals related to Adult B.

4.37 On 13th April 2016 the Care Home 1 daily record for Adult B stated that she was "very sleepy today poor mobility, walking with two staff, small diet, plenty fluids". There is no evidence that Adult B's care plan was reviewed in the light of her changed needs. Included in the large file recently provided by Care Home 1 are copies of forms which monitor residents being cared for in their bedroom which indicate that Adult B was cared for in her bedroom continually for 24 hours per day from 10th April 2016 and received half hourly visits from staff.

4.38 On 14th April 2016 staff at Care Home 1 contacted GP surgery 1 as Adult B was believed to have a UTI. It is assumed that medication was prescribed over the phone. Care staff were advised to re-contact the surgery for review if Adult B showed no improvement.

4.39 At 12.35am on Saturday 16th April 2016 an agency registered general nurse (RGN) who was working an 8pm-8am night shift at Care Home 1 was alerted by a care worker to the fact that Adult B had fallen out of her bed. She had been found on the floor of her bedroom during a routine check. The RGN attended to Adult B who was conscious. The RGN noted that she was able to move her legs and that there was no sign of shortening in either leg which could have been an indication of a hip fracture. A dressing was applied to a graze on Adult B's elbow. The RGN apparently recorded the incident on an accident report which was placed within Adult B's care plan. There is no evidence that any action to reassess falls risk or prevent further falls by Adult B was taken. There is also no indication that this incident was brought to the attention of the incoming day staff at 8am the same morning. In the large file Care Home 1 recently provided there are daily handover sheets in which the night staff leave messages about residents for the day staff and vice versa. Daily handover sheets up to and including 14th April 2016 are included. There is no handover sheet for 16th April 2016. Adult B does not feature in any of the handover sheets up to 14th April 2016 despite the UTI and its impact upon her health.

4.40 At around 9.30am on Saturday 16th April Adult B's daughter visited her. She would usually take her mother out shopping on Saturday mornings but when she went to her bedroom she says she found the curtains drawn and her mother soaked in sweat. She said that Adult B's pyjama bottoms were soaked in urine. She described the bedroom as "unbearably hot" and said that there were no drinks in the room despite her mother appearing dehydrated. She said that Adult B appeared delirious and whilst able to chat could not form sentences. The 8am-8pm RGN advised her that Adult B had been "knocked off her feet" by a UTI. Adult B's

daughter says that neither herself nor her sister had been informed of this. She added that her sister had visited Adult B on the Tuesday 12th April 2016 and said that she had seemed well enough although both daughters had noticed that Adult B was "chesty" and short of breath for a few weeks before the incident and say that they had pointed this out to care staff. The visit by Adult B's other daughter on 12th April was the day before her mother was noted to be unwell.

4.41 Adult B's daughter says that she stayed with her mother until 1.15pm that day and that no carer came into her mother's room until around 11am. The carer apparently told her that the home was really short staffed and asked her if she would feed her mother at lunchtime. When Adult B's lunch was brought in, her daughter mashed up the food and fed her. Apart from a cleaner she says that no-one else visited her mother whilst she was with her.

4.42 Adult B's daughter said that a birthday party was being planned for another resident that afternoon and saw that the Care Home 1 activities co-ordinator was involved in this. Adult B's daughter wondered if preparations for the birthday party were distracting staff.

4.43 Whilst she was with Adult B, her daughter repositioned her bed so that she could see out of the window and more easily watch the TV. Care Home 1 later said that the repositioning of the bed resulted in the sensor mat no longer being in the correct position to alert care staff to any fall or wandering. Adult B's daughter has advised this review that she never saw a sensor mat in the room and had not been told that a sensor mat had been placed in there.

4.44 When she left, she said that her mother was more hydrated and chatty. At that point she says she told the RGN that she had moved the bed and requested that Adult B was cleaned up, changed and supported to attend the birthday party in the main lounge of the home that afternoon. She says noticed that the RGN seemed "really stressed" that day. Adult B's daughter was aware that another resident was on end of life care and her needs appeared to be taking up quite a lot of the RGN's time that day.

4.45 At approximately 4.30pm on the same day a carer went into Adult B's bedroom for a routine check and found Adult B lying on the floor. She alerted a senior carer and the RGN. The RGN says that Adult B was distressed but not apparently in pain. In her statement to the Inquest, the RGN said that in falls of elderly people she always considers a neck of femur fracture and examined Adult B for any indications of this which she says were not present. When she gently moved her legs, the RGN says that Adult B did not express any pain. Adult B was lifted back onto her bed. The RGN says she noticed that the bed was not in the normal position and was advised

that a member of Adult B's family had moved the bed earlier. Although Adult B had shown no signs of a neck of femur fracture, the RGN decided to have Adult B checked out at hospital because she had sustained an injury to her head in the fall.

4.46 At 6.12pm the North West Ambulance Service (NWAS) received a 999 call from Care Home 1 to the effect that Adult B had suffered an unwitnessed fall from her bed where she had been resting as a result of a UTI. Adult B was said to have sustained bruising and swelling around her right eye. The call was passed to the clinical support hub for assessment. At 6.33pm a senior paramedic from the clinical support hub contacted Care Home 1 and was advised of Adult B's injuries which also included an abrasion to her right lower leg. Adult B had been assisted back into her bed and had eaten a meal. The Care Home 1 RGN advised the paramedic that Adult B's UTI and the movement of her bed by a family member had contributed to the fall. The paramedic advised that an ambulance would attend within 60 minutes but that Care Home 1 were to contact NWAS via the 999 system if Adult B's condition deteriorated.

4.47 Care Home 1 contacted Adult B's family and her second daughter arrived at the home around 6.30pm the same day. According to the family, she found that Adult B had still not been bathed or her clothing changed. She was lying on her bed to which she said cot sides had now been positioned. She said that Adult B screamed when staff tried to remove her pyjamas and paramedics noticed that one of her legs was longer than the other so they suspected she may have fractured her hip.

4.48 Adult B's daughter said that neither she nor her sister had been told that Adult B had fallen during the night. She feels that if she had been promptly told about this earlier fall she would have wanted to be reassured about plans for her mother's safety before she left at the end of her Saturday morning visit.

4.49 At 7.32pm the ambulance crew arrived at Care Home 1 and assessed Adult B. The crew were told that she had been found face down on the floor by a member of staff. Reduced movement in Adult B's left leg was noted but she was said to be not complaining of any obvious pain. However, it was not possible to calculate a pain score as Adult B was unable to understand the relevant questions asked.

4.50 Adult B was taken to the Royal Albert Edward hospital in Wigan by ambulance arriving at A&E at 8.17pm. She was examined and her left leg was noticed to be shorter and increased pain was experienced when rotated. A subsequent X ray disclosed a fracture of the neck of the left femur and Adult B was referred to an orthopaedic specialist.

4.51 The following day (17th April 2016) an orthopaedic consultant discussed the hip injury with Adult B's daughters. The risks of surgery, in particular infection and mortality were shared with the family. Adult B was deemed to lack capacity to make the decision to accept or decline surgery although no copy of a formal capacity assessment has been found.

4.52 In cases of this type the usual treatment is a hemiarthroplasty which is a partial hip replacement in which a replacement metal ball is fixed into the thigh bone. More conservative treatment is possible but the mortality rate, though high when operating, is higher still if no operation takes place. Additionally, a broken hip is very painful and the operation provides pain relief. Furthermore, a more conservative approach would require a lengthy period of bed rest which would be accompanied by complications such as chest problems and bed sores.

4.53 Adult B was taken to theatre for the hip operation on the same date (guidelines indicate that such an operation should take place within 36 hours or the mortality rate increases) but owing to low oxygen saturation levels it was decided not to proceed with surgery at that time. Further investigations were to be conducted in order to rule out a pulmonary embolism and check for any chest infection. The former was ruled out although there were indications of the latter. The operation took place the on the following day (18th April 2016) and Adult B was returned to the ward.

4.54 On 19th April 2016 the Care Home 1 manager made a statutory notification of Adult B's serious injury to the CQC. The notification was as follows: "Adult B commenced on antibiotics for a urine infection on 14.4.2016, confusion had increased due to infection condition poorly so nursed in bed, Adult B's daughter had visited and due to her mother being poorly had **moved her bed to reposition** so she could see out of the window or improved lighting. At 00.35hrs Adult B found on the floor by the night staff no injury reported supported back to bed, remained on bed rest and 30 minute obs. At 15.30hrs again Adult B found face down on the floor haematoma to right orbital area and redness to right side of face/cheek. All observations within range and body checked for any further signs of injury. Due to presentation of facial injury sent to A&E for full check up. Daughter aware and escorted Adult B." It is assumed that choice of words in bold type was made by the Care Home 1 manager. It is assumed that the time given for the second fall – 15.30hrs – is an error.

4.55 The statutory notification to the CQC asked whether the injury had been reported to a local authority. This question was answered in the affirmative by Care Home 1's manager. The Care Home 1 manager did inform LCC about Adult B's two

falls on 19th April 2016 but did not make a safeguarding referral. LCC MASH records of the information provided by the Care Home 1 manager is as follows:
"Manager reported that Adult B has previously been fully mobile but she has been suffering from a severe urine infection and has been experiencing some confusion. Manager reported that Adult B was nursed in bed the day prior to her suffering a couple of falls and her daughter did come into the home and moved the bedroom around so that her mother could see out of the window, however, in the early hours of the morning on the 16th April 2016 at approximately 12:30am, Adult B was found on the floor but she did not have any visible signs of any injuries. Later that day, in between the half an hour checks, Adult B was again found on the floor and on that occasion, Adult B had quite a lot of bruising to her right orbital area and also a haematoma. Manager advised that Adult B was admitted to hospital where it was discovered that Adult B has suffered a fractured femur. Manager advised that she was ringing this through as part of their protocol and that she does not have any safeguarding concerns in relation to this". There is no indication that the Care Home 1 manager was challenged by the MASH in respect of her assertion that she did "not have any safeguarding concerns".

4.56 On 20th April 2016 Adult B was noted not to be opening her eyes or responding to commands although she was rousable. Her oral intake was described as poor and she was reluctant to eat. Her "poorly condition" was discussed with her daughters who were advised that there was a high risk of her declining further.

4.57 Adult B remained poorly, continued to deteriorate and died on 27th April 2016.

4.58 The information shared by the hospital with the coroner about Adult B's death omitted reference to the fracture or subsequent surgery and as a result the original death certificate was inaccurate, referring only to "community acquired pneumonia" as the cause of death. This omission only came to light when a member of the Coroner's staff contacted Adult B's family to arrange for them to collect the death certificate. The death certificate was voided and was replaced with a death certificate which gave the cause of death as broncho pneumonia with osteoporotic facture left hip (operated) as contributory factors.

4.59 On 2nd May 2016 Care Home 1 made a further notification to the CQC following Adult B's death. This notification reiterated information from the earlier notification and added a brief description of her treatment in hospital and subsequent death.

4.60 The CQC inspection report on Care Home 1 was published on 14th July 2016.

5.0 Contribution to the review of Adult B's family

5.1 One of Adult B's daughters contributed to this review. She said that Adult B was widowed in 2011 and two years later was diagnosed with vascular dementia and Alzheimer's. She and her sister tried to support Adult B to live at home for as long as possible. During this period Adult B accessed care and support from a local day centre on weekdays. Adult B's daughter described the care her mother received there as "really excellent".

5.2 Adult B's daughter described how it eventually became unsafe to leave her mother on her own even for short periods and that she and her sister arrived at a crisis point. They came to the conclusion that Adult B needed 24 hour care and began to look at care home options, before eventually deciding on Care Home 1.

5.3 A key factor in choosing Care Home 1 was that Adult B's husband had spent a few months there prior to his death in 2011. Adult B's daughter regarded the care provided at Care Home 1 at that time as very good, noting "a positive camaraderie" amongst the staff group. She also hoped that Care Home 1 would be familiar to her mother as she had regularly visited her husband there. However, Adult B was unable to remember the home at all.

5.4 Adult B's daughter described how a social worker from Wigan Council's adult social care had assessed Adult B's needs prior to her placement in Care Home 1.

5.5 She said her mother moved into Care Home 1 in October 2014. Although she said the family were happy for Adult B to be placed there, they became aware of some differences from the time when their father had been a resident there three years earlier. They noticed some friction between staff and management and that some staff appeared frustrated. Adult B's daughter said that some "really lovely" care workers left a few months after her mother moved in and that she subsequently happened to meet one of them by chance. She remembered that former care worker telling her that she had resigned after being bullied by management and had recorded her last conversation with her manager on her phone as proof of verbal abuse.

5.6 The home was managed at that time by a mother-daughter combination. The mother was in overall charge and the daughter managed the first floor dementia unit. They later both left Care Home 1 together and Adult B's daughter said that they began "poaching" good Care Home 1 staff for the care home they had moved to. Adult B's daughter added that prior to their departure the mother/manager had been absent with illness for a number of months. She said that her sister had discovered this when she went to the office upstairs one day and saw piles and piles

of papers everywhere and the secretary had said that she was inundated with work as the manager had been off "for ages".

5.7 Adult B's daughter said she noticed staffing numbers began to decline and became really worried about staffing levels in the evening and overnight, particularly as her mother needed quite a lot of support during the night. For example, she was unable to switch on her bedroom light or operate the alarm button in her room. She was also aware of an increasing number of agency staff and remembered attending a meeting with Care Home 1 management and Adult B's social worker at which these concerns over staffing levels were aired. But she felt that the decline continued and probably accelerated from the beginning of 2016 when a particularly good nurse left.

5.8 As far as she was aware all of Adult B's health needs were met in Care Home 1 or by her GP. She remembered that she and her sister bought incontinence pads in for Adult B for quite a long time which didn't seem quite right to them. She didn't think that Adult B had been assessed as requiring help with incontinence at that time. She said that eventually Care Home 1 assumed responsibility for the supply of incontinence pads.

5.9 Adult B's daughter also recalled that when the hairdresser who regularly visited the home to cut and style residents' hair left, she wasn't replaced for four months. She decided to do something about this situation and contacted Age UK to see if they could recommend a hairdresser. She says that Age UK were very helpful and put her in touch with a hairdresser who then began work at Care Home 1. She later asked the hairdresser what she thought about Care Home 1 and she said she felt uncomfortable in there at times because she felt unsupported by the staff.

5.10 Adult B's GP practice changed when she went into Care Home 1. She left the GP practice who had known her for a long time and transferred to the the GP 1 practice which cared for residents of Care Home 1. She said that the family asked the new GP practice to inform them of any contact with Adult B but this never happened despite a clear instruction being placed in Adult B's GP patient record. For example, the surgery did not advise them that they had been consulted by Care Home 1 over a UTI on the Thursday prior to the incident (14th April 2016) when they prescribed medication over the phone. Nor did the GP practice ever tell them that Adult B had chronic kidney disease stage 3.

5.11 Turning to the day of the incident on which Adult B fell and fractured her hip, her daughter visited her as she normally did at 9.30am each Saturday. She would usually take Adult B out shopping at that time but when she went to her bedroom she found the curtains drawn and her mother soaked in sweat. She said that Adult

B's pyjama bottoms were soaked in urine. She described the bedroom as unbearably hot and says that there were no drinks in the room despite Adult B appearing dehydrated. Adult B appeared really delirious and whilst able to chat could not form sentences. The nurse in charge advised her that Adult B had been "knocked off her feet" by a UTI which neither herself nor her sister had been informed of. (Her sister had visited Adult B on the Tuesday prior to the incident and said that she had seemed well enough although both daughters had noticed that Adult B was "chesty" and short of breath for a few weeks before the incident and say they pointed this out to care staff.)

5.12 Adult B' daughter stayed with her mother until 1.15pm that day. No carer came into Adult B's room until around 11am. The carer told her that the home was really short staffed and asked her if she would feed her mother at lunchtime. When Adult B's lunch was brought in, her daughter mashed up the food and fed her. Apart from a cleaner no-one else visited her mother whilst she was with her.

5.13 She said that a birthday party was being planned for another resident that afternoon and saw that the Care Home 1 activities co-ordinator was involved in this. Adult B's daughter wondered if preparations for the birthday party were distracting staff.

5.14 Whilst she was with Adult B, she repositioned her bed so that she could see out of the window and more easily watch the TV. She says that she never saw a sensor mat in the room and had not been told that a sensor mat had been placed in there. When she left, she said that her mother was more hydrated and chatty. At that point she says she told the nurse in charge that she had moved the bed and requested that Adult B was cleaned up, changed and supported to attend the birthday party in the main lounge of the home that afternoon. She noticed that the nurse in charge seemed really stressed that day. Adult B's daughter was aware that another resident was on end of life care and her needs appeared to be taking up quite a lot of the nurse in charge's time that day.

5.15 When her sister went to Care Home 1 at around 6.30pm the same day after receiving a call to say that Adult B had fallen, she found that Adult B had still not been bathed or her clothing changed. She was lying on her bed to which cot sides had now been positioned. Adult B screamed when staff tried to remove her pyjamas and paramedics noticed that one of her legs was longer than the other so they suspected she may have fractured her hip.

5.16 Adult B's daughter said that neither she nor her sister had been told that Adult B had fallen during the night – at 12.35am. She feels that if she had been promptly told about this earlier fall she would have wanted to be reassured about plans for

her mother's safety before she left at the end of her Saturday morning visit. She added that when she later rang Care Home 1 to check what time Adult B had fallen and fractured her hip, she was told that she had fallen at 5.50pm and had been checked at 5.30m and been found to be OK. This account turned out to be incorrect as the family subsequently found that Adult B was found to have fallen and fractured her hip at 4.30pm.

5.17 Adult B's family say she was well cared for in hospital. They described the hospital staff as "brilliant". However, Adult B's daughter would like to have been informed that her mother had pneumonia before she was operated on as this would have helped better prepare the family for Adult B's death as they would have realised that things were more serious than perhaps they understood at the time.

5.18 Adult B's daughter said that the initial death certificate issued for her mother was incomplete in that it didn't mention her hip fracture and the operation which followed. This only came to light when the Coroner's office rang her to advise of arrangements for collecting the death certificate. The fact that Adult B had fractured her hip and been operated on only became known to the Coroner as a result of this telephone conversation with the Coroner's office. The Coroner then decided to void the original death certificate.

5.19 Adult B's daughter says that the question herself and her family would like to have an answer to is whether the fall which eventually led to her death could have been prevented by better care in Care Home 1?

Contribution of family of Adult B2

5.20 Both of Adult B2's daughters contributed to this review. They said that their mother was placed in Care Home 1 in February 2016 after being discharged from Whiston Hospital. She had experiencing very poor health for a number of years, including lung cancer, and had a diagnosis of vascular dementia. Whilst in hospital they said she had contracted shingles from which she had not fully recovered when placed in Care Home 1. Her placement in Care Home 1 was funded by Halton clinical commissioning group (CCG) under continuing health care (CHC). Her daughters said that at the time of their mother's placement in Care Home 1 her life expectancy was believed to be quite limited and it was suspected, but not confirmed, that her lung cancer had returned.

5.21 Adult B2's daughters said that eventually chose Care Home 1 for their mother because of the most recent CQC inspection report. (Published in December 2014) Initially they say they were impressed with Care Home 1. The manager quickly arranged for an assessment of their mother and the bedroom offered to her had

been freshly decorated. However, she didn't settle well and began saying that staff were being rough with her. Her daughters say that they didn't know how much weight to give to her comments as her dementia meant that she could be very confused. They say they decided to give Care Home 1 a couple of weeks to see how things went.

5.22 However, they said that they quickly began to be concerned about the care their mother was receiving and began to worry about whether it was safe to leave her there. They found her wearing someone else's socks rather than the special socks they had bought for her. The socks were too tight and caused indentations in her leg. And on another occasion they noticed a cut on her leg which they say that the staff had done nothing about. When this was brought to the attention of the nurse on duty (an agency worker), she said that they would call out the doctor. However, one of the daughters – a retired district nurse - said this wasn't necessary and dressed the injury herself. The daughters believe the cut to her leg was probably caused by being knocked against a wheelchair as they saw staff helping other residents in and out of wheelchairs and felt that they did not possess adequate "moving and handling" skills. When the daughter who had been a nurse attempted to provide the staff with advice, she felt they did not appear to be interested.

5.23 About 10 days after Adult B2 moved into Care Home 1 the daughters say they had a meeting with the manager who told them that she was managing with a lot of agency staff and asked them to give her 2-3 weeks to recruit more permanent staff which she anticipated would result in an improvement in care. The daughters agreed to this but didn't see any improvement. They felt that the new staff were not effective and many did not seem to have a good grasp of English which the daughters felt was essential.

5.24 The daughters recounted one incident in which a member of staff attempted to "force feed" their mother by ramming an egg mayo sandwich into her mouth. They didn't believe this member of staff to be a carer as they had only seen her working in the laundry prior to this. Adult B2 liked eggs and also wheetabix but they say that she was often left struggling to eat hard toast. When they pointed this out to staff they replied that they had asked their mother if she would like to eat toast and she had said "yes". The daughters felt that because of her dementia their mother may well have agreed to eat toast even though it was a poor choice for her. They felt that the staff did not seem to understand this and so they began to take food in for their mother.

5.25 The daughters considered the basic practice they observed at Care Home 1 to be very poor. They said that care staff didn't wash their hands, wear gloves when necessary, provide enough fluids and did not provide mouth care. They didn't keep

Adult B2's dentures clear of a build up of food and her finger nails were often dirty. They also noticed that hot drinks were not given to patients safely and they were concerned about feeding practices for patients who were at risk of aspiration. The daughters also said that on one occasion the staff laughed when Adult B2 ate her breakfast with her eyes shut. Her daughters say that their mother's eyes were shut because they were "stuck together" and required cleaning.

5.26 They didn't think that fluid and other charts were completed accurately or at the time they should have been. They say they saw staff removing charts from patient bedrooms. The staff would then gather all the charts together in the lounge or elsewhere and complete a large number of patient charts at the same time. Whilst they have no evidence that staff were falsifying chart entries they suspect them of doing so. On one occasion, when they were with their mother they say they saw the carer tick the chart for administering fluids even though no fluids had been given.

5.27 There say that they were unaware of any care plan for Adult B2 but after the CQC inspected Care Home 1 in March 2016, they were asked to sign something which may have been a care plan. Someone from the CQC spoke to them during the inspection and asked them if they felt their mother was safe and they say they replied "not really", although they added that they tried to keep her safe by being there with her for so much of the time.

5.28 The daughters described how protected meal times got longer and longer. These were times when visiting was restricted. They say that the regime was really inflexible and that no attempt was made to help residents feel like it was their home.

5.29 The daughters say that they saw a male resident running about without any pants on late at night. They say that the staff seemed to regard this as amusing rather than treating it as a potential safeguarding issue given the number of vulnerable female residents who might have been alarmed by the male resident's behaviour. They were worried about some of the things their mother began saying. They related how she would say "I hate men" when she had always previously enjoyed the company of men. She also talked of someone coming into her bedroom and "fondling" her at night. They don't know whether she said these things because of her dementia or whether something unpleasant may have been happening to her. They say they were so concerned that they purchased a camera clock to place in her room but Adult B2 died before they could do this. (When Adult B's daughter read this report she was reminded of concerns she and her sister had expressed to the management of the home about an apparently disinhibited male resident who did not appear to be well supervised by staff.)

5.30 They felt that the management did not appear to trust some of their staff. A nurse had apparently told them she had carried out an unannounced night visit which had led to the sacking of one member of staff. They also noticed that the fridges had locks on to prevent the theft of food.

5.31 They recalled that their mother contacted diarrhoea and vomiting and they asked if anyone else in the home was affected and were told "no" although they suspect another resident may also have been ill. They suspect that the home's infection control measures were not effective. After this one of the daughters moved in with Adult B2. When she did so, she says she found her mother in her bed with all her clothes on. When challenged, the staff apparently said they had got Adult B2 up and dressed her but when she became unwell they had put her back in bed without changing her into her pyjamas. The same daughter called the GP out who examined Adult B2 and found that the inside of her mouth was completely black. At this point end of life care was discussed. The daughters had previously agreed that resuscitation was not to be attempted.

5.32 On the Monday prior to Adult B2's death, the daughters say they considered arranging for an ambulance to move her out of Care Home 1 so that she could die at home but the infection she had picked up made that impossible.

5.33 In the final week of Adult B2's life, her daughters say she was seriously neglected. She was doubly incontinent but she went unchanged from the Monday until the Wednesday of that week. When they had previously challenged the staff about this they were apparently told that staff hadn't got time to bathe residents more frequently than once a week, which they felt was insufficient. They say that their mother was capable of using the toilet and they asked the staff to implement a toileting regime in which she was provided with support but this appeared to fall away after a couple of days.

5.34 During this final week the daughters say they pressed the buzzer in Adult B2's room because she needed more morphine but no carer responded for three hours.

5.35 The daughters say that the manager and deputy manager were in a relationship and so they tended to be off work at the same time. The daughters became aware that the deputy manager was not in good health and that when she was absent through sickness, the manager would also take time off to care for her. (This has been confirmed from a number of sources) During these periods it appeared to the daughters that the home was left to be run by the agency staff.

5.36 The daughters described how a hospice nurse came to Care Home 1 to plan Adult B2's end of life care. This nurse apparently told them that there were no care

plans for their mother and that the home did not have the necessary end of life medication available. The daughters were staying with their mother continuously by this point and they described how the staff had tried to give their mother what they believed to be the wrong end of life drug. When they challenged the staff they said that the drug they were planning to administer was the same as the drug they should have been giving her but the daughters state that this was clearly not the case. The daughters say that this happened on numerous occasions and that they had to check the medication given to their mother "every time".

5.37 The daughters say that they made a complaint which prompted a meeting, with the Care Home 1 manager and area manager on the day before Adult B2 died. The daughters say they told the management that they needed to get rid of inadequate staff because they were a danger to patients. The management response was the staff had all been trained. As far as the daughters could see the training was not improving practice but actually perpetuating poor practice because inadequate carers were training new staff.

5.38 Adult B2 died at 10.45am on Saturday 23rd April 2016. Just before her death staff noted marks on her back suggesting that she had not been turned frequently enough. The daughters say that the staff tried to blame them because they had declined her being turned a couple of times during the preceding night. They say that they were very upset about this as their mother was not being turned at all until they complained about it.

5.39 Looking back, the daughters feel that the management and staff never took their concerns seriously enough. For example, the home's activities co-ordinator – who they feel was good at her job – allegedly told them that they were being overprotective of Adult B2. And after her death the daughters returned to Care Home 1 to collect Adult B2's things and gained the distinct impression that they were "breathing a sigh of relief to see the back of them".

5.40 The daughters say that they called the GP out two or three times, including the week prior to Adult B2's death. Apparently the GP told them that he was concerned about standards at Care Home 1. The daughters also believe that there had been a change in the pharmacy used by the home which may have created difficulties in the supply of drugs.

5.41 The daughters say that they are concerned that Care Home 1 was allowed to deteriorate so badly without anyone apparently doing anything about it. And they say that they are really concerned that Care Home 1 has still not turned things around after the CQC inspection in 2016. They say that they had read that the CQC

had been back to re-inspect and that the situation had not improved. They added that it worried them that residents may still be suffering like their mother did.

6.0 Analysis

6.1 As stated earlier the purpose of the review is to:

a) Determine whether decisions and actions in the case comply with the safeguarding policy and procedures of named services/ agencies and the Lancashire Safeguarding Adults Board (LSAB)
b) Examine inter-agency working and service provision for the adult and family;
c) Determine the extent to which care was person centred and compliant with Making Safeguarding Personal;
d) Examine the effectiveness of information sharing and working relationships between agencies and within agencies;
e) Compliance with valid consent and Mental Capacity Act;
f) Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults;
g) Identify any actions required by the LSAB to promote learning to support and improve systems and practice.

6.2 It is intended to address the questions (a) to (g) in this section of the report.

6.3 Analysis of this case in order to identify learning to improve practice has been frustrated to a degree by the aforementioned failure of Care Home 1 to provide a chronology setting out the detail of their care of Adult B whilst she was a resident of Care Home 1 from October 2014 until April 2016. As previously stated a large file of photocopied records was provided to the review two weeks prior to this report being finalised from which many key records are missing. It was said that this file was found during an office move. Additionally, no member of staff from Care Home 1 participated in a practitioner learning event which is a core component of the methodology adopted for this review. Safeguarding Adults Reviews are statutory reviews and their effectiveness is undermined if a partner agency does not contribute. This issue was escalated to the independent chair of Lancashire Safeguarding Adults Board following which she convened a meeting with the owners and registered manager of Care Home 1. The owners apologised for the manner in which Care Home 1 contributed to this review.

6.4 In the absence of a chronology or participation in the practitioner learning event, an account of the care and support Adult B received in Care Home 1 has had to be pieced together from statements provided by former members of Care Home 1 staff to the inquest, chronologies from other agencies who had contact with Adult B whilst she was a resident in Care Home 1 (although her contact with agencies apart from her GP was very limited) and the account provided by Adult B's daughter. The recently provided large file has helped to fill in some, but far from all of the gaps.

The deterioration in care provided at Care Home 1

6.5 It is clear that the standards of care provided to residents of Care Home 1 deteriorated markedly between the CQC re-inspection of November 2014 (Paragraphs 4.5 and 4.6) and the unannounced CQC inspection in March 2016 (Paragraphs 4.24 – 4.33). However, it should be noted that the CQC inspection methodology had changed during the intervening period. The CQC has advised this review that this change in methodology is likely to have been a factor in the stark contrast between the CQC findings in November 2014 and March 2016. Under the methodology employed at the time of the November 2014 inspection, on average compliance with only five regulations was ever examined whereas under the methodology employed in March 2016 compliance with all regulations (which are now referred to as the "fundamental standards") were examined. The latter approach is considered to have greater depth and is more likely to unearth failings in a service. This has been born out by an increase in CQC enforcement since the introduction of the new methodology.

6.6 In the absence of more complete information from Care Home 1 it is difficult to definitively determine what the causes of the deterioration in care were or precisely when the decline began. However, it is possible to isolate a number of factors which appear to have contributed to the decline which are set out in the following paragraphs. (Paragraph 6.7 – 6.11)

6.7 The service had **not been consistently well led**. The home was managed for a time time by a mother-daughter combination. (The source of this information is Adult B's daughter and this has been confirmed by the CQC) The mother was in overall charge and the daughter managed the first floor dementia unit. Adult B's daughter says that they later both left Care Home 1 together and that she was told that they began "poaching" good Care Home 1 staff for the care home they had moved to. (This has not been confirmed but may help to explain how Care Home 1 began to rely so heavily on agency staff) Adult B's daughter added that prior to their departure the mother/manager had been absent with illness for a number of months. She said that her sister had discovered this when she went to the office upstairs one day and saw piles and piles of papers everywhere and the secretary had said that she was inundated with work as the manager had been off "for ages". (Again, this has not been confirmed but appears to be consistent with the picture of deterioration in care planning and record keeping.)

6.8 At the time of the CQC inspection in March 2016 a relatively new manager was in place who was in the process of applying for registration with the CQC. Inspectors received much positive feedback about her impact. However, the tone and content

of the feedback implied that the changes the new manager was introducing were necessary after a period of less effective management. One person said "The manager has made some great changes since she came in. She just needs some time I think" whilst another commented that "there have been some big changes here since she took over. I am really happy here now." However, the CQC found that notwithstanding the improvements introduced by the new manager, there remained a number of areas of significant management weakness including auditing of practice, staff competency assessments, supervision of staff and the handing of complaints. It seems possible that the CQC may have had more faith in the ability of the new manager to address these weaknesses than was justified.

6.9 In addition to the quality of leadership, another key factor which appeared to contribute to the decline in care was **the heavy reliance on agency staff** which the March 2016 CQC inspection described as "excessive". The CQC calculated that 35 night shifts were covered by agency care staff within a two week period which the lead CQC inspector, who contributed to this review, described as higher than at any care home she had previously inspected. Most of the agency staff were from the same agency and at least some of them had worked sufficiently regularly at Care Home 1 to become familiar with the service provided there. However, the feedback the CQC received on the reliance on agency staff was not positive. One person said that over reliance on agency workers led to a less person centred service and diminished accountability, adding that residents seem stressed and uncomfortable with agency staff due to communication difficulties linked to English being an additional language for some agency staff. People who lived at the home expressed concern with night staffing levels and said that whilst call bells were generally responded to quickly during the day, they felt less safe at night and had experienced slow responses to requests for medicines. (These concerns over agency staff and staffing levels were mentioned by the families of both Adult B (Paragraph 5.7) and Adult B2 (Paragraph 5.23))

6.10 A further factor in the decline appeared to be **the competence, skills and qualifications of staff** about which the CQC had a number of concerns particularly unsafe administration of medicines. When inspectors spoke to the new manager about their concerns, there was an absence of awareness on her part as to whether staff had completed competency assessments and whether or not they were being mentored. Key processes to maintain and improve staff competency such as supervision and appraisal had been neglected. The CQC described appraisals as "sporadic" and there was no record of any supervisions of staff conducted that year. The Lancashire Safeguarding Adults Quality Improvement Planning (QIP) process which was initiated after a number of safeguarding concerns came to light including those which related to Adult B, found "a lot" of general nursing residents had been inappropriately placed in the EMI unit as "they had not been assessed properly". A

key factor appeared to be the absence of any qualified mental health nurse (RMN) support or any member of staff with the appropriate training and skills.

6.11 Another factor in the decline appears to have been **the management of complaints** as an open and responsive approach to complaints is a key factor in maintaining and improving standards. The CQC found that complaints were not being well managed. They cited the "quite concerning" handling of a complaint in which family members had not been informed of a fall and the paramedics who responded were not alerted to relevant medical details. Whilst the circumstances were not identical to Adult B's fall at Care Home 1, the response of the home to concerns expressed by Adult B's family following her fall also raised concerns which will be more fully explored later in the report. Additionally, the family of Adult B2 felt that when they complained they were given bland assurances (Paragraph 5.37) or treated as a nuisance. (Paragraph 5.39)

The impact of the decline on key practices

6.12 Deficiencies in leadership, oversight and supervision of staff, the over reliance on agency staff and the unsatisfactory handling of complaints appears to have had a profound impact on key practices. Care planning is the foundation for the provision of good care but the CQC found that care plans varied in quality, did not consistently cover all assessed needs and sometimes provided conflicting information. In some plans they found many areas had not been reviewed for several months. Monthly evaluations of Adult B's care plan appeared to be very infrequent and ceased in January 2016. (Paragraph 4.17) Additionally, the aforementioned QIP process found that where care plans had been completed they were not person centred, did not reflect needs, were not reviewed as required, some references to reviews and checking were falsified, support information was not in place, documents were contained in the wrong files and indicated that referrals to appropriate professionals were not always made in a timely manner. The QIP process also highlighted concerns that residents had been left without fluids, or with fluids out of reach and there was no clear documentation of fluid intakes. This appears to be consistent with Adult B's daughter's concern that her mother was insufficiently hydrated whilst suffering from a UTI. (Paragraph 5.11)

6.13 Another key practice about which the CQC expressed concern was the management of medicines which they described as 'poor". On several occasions during their March 2016 inspection the CQC inspectors saw the medicine trolley left unlocked and unattended, sometimes with medicines on top of the trolley, including loose tablets in a dispensing cup. On one of these occasions an inspector waited by the trolley for several minutes for a staff member to return, as they were concerned about people's safety. On further investigation the CQC found this staff member was

not a registered nurse, but a supervised practice nurse (SPN) which meant that she was qualified as a nurse in her home country but had yet to complete the necessary adaptation course in the UK. The manager also told the inspector that the SPN had not yet passed the International English Language Test (IELTS). Inspectors saw this SPN administering medicines in what they considered to be an unsafe way on two occasions.

6.14 Inspectors tracked the pathway of care and treatment of a sample of residents including one whose medical administration record (MAR) chart showed he had no known allergies, but his hospital discharge summary showed that he had an allergy to aspirin and statins. This was pointed out to the nurse for immediate attention. Inspectors also noted that a number of residents were prescribed a thickener for their drinks to assist them to swallow safely. Only one person had specific quantities written on their MAR chart whilst all others seen stated, "as directed." Therefore, there was no guidance available for staff to indicate the correct amounts to be given. The QIP process found that some residents were on complex antipsychotic medication which staff were not appropriately qualified to administer. The CQC found that the home's most recent medication audit had been conducted the day prior to their inspection and a score of 89.6% had been awarded with a rating of "good." (Concerns about the administration of medicines were also raised by the family of Adult B2 in paragraphs 5.25 and 5.36)

6.15 Deficiencies were also noted in the key practice of risk assessments, many of which had not been reviewed for some time. Therefore, information provided was not always accurate and current.

6.16 The CQC also raised concerns about cleanliness and infection control practices, noting some areas of the home to be malodourous and visibly unclean. They found that the provider had not always ensured that risks associated with infection control had been appropriately assessed, in order to prevent, detect and control the spread of infections. Although Care Home 1 had a total of 20 en-suite bathing facilities, the CQC were concerned that at the time of their inspection there was only one working assisted bathing area for everyone who lived at the home. They noted that a high percentage of residents had complex nursing needs and required assisted bathing facilities for personal care. Inspectors were told that the assisted wet room was under repair following a leak and that two shower rooms were available. The daughters of both Adult B and Adult B2 raised concerns over cleanliness and infection control. Adult B's daughter expressed concern that her mother was left in urine soaked pyjamas on the day of her fall (Paragraphs 5.11 and 5.15) and Adult B2's daughters expressed concern that their doubly incontinent mother was assisted to bathe only once a week (Paragraph 5.33) and questioned the home's infection control practices when their mother contracted a virus. (Paragraphs 5.25 and 5.31)

6.17 The CQC also found that key legal safeguards were inconsistently handled. Some care plans showed residents lacked capacity and that Deprivation of Liberty Safeguards (DoLS) authorisations had been applied for, but some of these had been submitted some time ago and no outcome or indication they had been followed up was evident. (There is no record of any DoLS application for Adult B being received from Care Home 1 in December 2014 despite her wish to return home conflicting with the home's "locked door" policy (Paragraph 4.10)) Some DoLS authorisations lacked an underpinning mental capacity assessment. Staff members the CQC spoke with did not have a good grasp of the Mental Capacity Act (MCA) and DoLS.

6.18 The CQC also found some inadequacy in the practice of obtaining consent from the relevant person before care and treatment was provided. A good percentage of consent forms seen by Inspectors had been signed by family members. However, they were told by the manager that no Lasting Power of Attorney (LPA) authorisations were in place for those who used the service. (Consent can only be given by a person who has been authorised as having LPA, or a deputy from the Court of Protection.)

6.19 Moving and handling practice was noted to be inappropriate at times by the CQC. Two care workers were seen to lift a resident from a wheelchair to a lounge chair in an unsafe way which led the person involved to shout out. The QIP process later noted that staff training in this area appeared unreliable. The family of Adult B2 also expressed concern about moving and handling practices which they suspect resulted in a cut to their mother's leg. (Paragraph 5.22)

6.20 Dignity in care should inform all care practices and whilst the CQC noted some positive interactions and caring approaches towards residents, they also witnessed several inappropriate responses made by some staff who were working at the home. This was also a finding of the QIP process in which concerns about staff attitudes towards residents and families were noted.

6.21 Record keeping practices were also a cause for concern for the CQC with confidential care records often left unattended on the nurses' station, which was located in the lounge. The accurate and timely completion of records was an issue for the families of both Adult B and Adult B2 and will be explored in more detail later in this report.

6.22 Although it is not possible to be precise about when the deterioration in the standard of care provided in Care Home 1 began it appears to have become a very serious issue by January 2016 when routine practices such as the monthly review of

care plans appeared to cease. (Monthly evaluations of Adult B's dependency assessment appeared to cease after September 2015) The appointment of the new manager just prior to the CQC inspection of March 2016 appeared to partially arrest the decline but by this time deterioration had taken place across such a wide range of practices that it was probably beyond the capability of a single manager to turn around. The accounts provided by the families of Adult B and Adult B2 appear very credible given their consistency with what was found by the CQC and the subsequent QIP process.

6.23 At the time of writing Care Home 1 is in "special measures" following a further CQC inspection in January and February 2017. Although significant improvements were noted in a number of key areas since March 2016, the service as a whole was still considered to be "inadequate" with leadership and safety being the most significant concerns. When the CQC go back to re-inspect they find that most providers improve (53%), particularly those rated inadequate or as requiring improvement. (2) Unfortunately this was not the case with Care Home 1. (It is understood that the CQC carried out a further inspection of Care Home 1 in October 2017 but the outcome is unknown.)

Early warning of failing care providers

6.24 A common theme in the learning from both SARs and serious case reviews (SCR) is that information about poor and dangerous services was not collated or linked with other information so that intervention might have taken place before serious harm or death occurred. Local partnerships therefore need to have effective procedures for obtaining and sharing information in place to enable intervention to take place before a problem becomes a crisis.

6.25 The commissioners of social care and health are required to build safeguarding into commissioning strategies and service contracts, review and monitor services regularly and intervene (in partnership with the regulator) where services fall below fundamental standards or abuse is taking place. (3)

6.26 It appears that there were a number of commissioners of the care provided to residents of Care Home 1. Wigan Council commissioned Adult B's placement (although her family also made a financial contribution) and Halton CCG commissioned Adult B2's placement from CHC funding. However, it is assumed that a number of placements at Care Home 1 were commissioned by Lancashire County Council or from the Lancashire health economy. This review has received little information that would suggest that the deterioration in care at Care Home 1 came to the notice of commissioners. On 8th April 2016 (eight days prior to Adult B's falls) the Lancashire MASH received two separate safeguarding alerts relating to Care

Home 1. As stated in paragraph 4.35 one alert related to a bruise on a resident's arm which was ultimately considered to have been "substantiated" although the cause of the bruising was not established. The second alert related to an agency staff member "mishandling" a resident. This was also found to be "substantiated" as the conduct of the agency carer was witnessed. Although only limited details of these referrals have been shared with the review, the impression gained is that the two alerts appear to have been handled as isolated incidents. At the time of receiving these two alerts the local authority would have been unaware of the March 2016 CQC inspection.

6.27 The review has been advised that the LCC Contracts Monitoring Team had no involvement with Care Home 1 prior to July 2016 when the QIP process commenced. Care Home 1 was also monitored by the NHS Midlands and Lancs Commissioning Support Unit (CSU) which has advised the review that there was some difficulty in obtaining timely returns from Care Home 1 in 2015. Returns began to be submitted on a more timely basis from October 2015 and included details of serious incidents, falls and a staff training matrix. The CSU states that Adult B's falls were not included in the returns Care Home 1 submitted to them nor was there any serious incident incident notification following her death. The home submitted an annual falls and mobility audit for 2015-16 which contained no areas which required action by the provider. The CSU therefore deemed them to be compliant in all areas relating to falls and mobility. However, the CQC found in their March 2016 inspection that Care Home 1's internal audits could not be relied upon to provide an accurate picture of performance. (Paragraph 6.14)

6.28 Care providers are expected to show leadership and routinely monitor activity, meet the required service quality standards, train staff in safeguarding procedures and ensure they are effectively implemented, investigate and respond effectively to incidents, complaints and whistleblowers and take disciplinary action against staff who have abused or neglected people in their care. (4) When Care Home 1 began to fail to meet these expectations they could have sought external support from the local authority but there is no evidence that they did so.

6.29 The regulator (CQC) is expected to register, monitor, inspect and regulate services to make sure they provide people with safe, effective, compassionate, high-quality care, intervene and take regulatory action on breaches and publish findings including performance ratings. (5) The CQC met these expectations but the widespread failings their March 2016 inspection discovered raises the question of whether they should have alerted local commissioners prior to the publication of their inspection report in July 2016.

6.30 The relationship between the local authority and the CQC is referred to in relevant legislation. The Care Act requires a local authority to co-operate with "relevant partners" in order to safeguard adults. In their turn each relevant partner must also co-operate with the local authority. The CQC is not specified as "relevant partners" (Paragraph 14.10 Care Act guidance) However, the CQC is listed as a potential member of a local safeguarding adults board. As previously stated, the CQC did not notify Lancashire County Council of the outcome of their March 2016 inspection nor did they raise it at the monthly Radar meetings. (Paragraph 4.34) Additionally, the CQC has advised this review that the seriousness of the breaches of regulations identified by their March 2016 inspection was judged to be "low" and led to the issue of "requirement notices" about which it was not necessary to notify commissioners at that time. (Paragraph 4.35)

6.31 The CQC has advised the review that the arrangements for notifying commissioners of adverse inspections of services changed in November 2017. Under the new procedure the CQC must write to the commissioner of the service following the first "requires improvement" inspection. The revised procedure has been shared with this review. It is noted that the revised procedure does not stipulate timescales for writing to the commissioner.

6.32 One of the six key principles which underpin all adult safeguarding work is "prevention" with the Care Act guidance adding that "it is better to take action before harm occurs". (Paragraph 14.13 Care Act guidance) The aims of adult safeguarding are to:

- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- stop abuse or neglect wherever possible
- address what has caused the abuse or neglect (Paragraph 14.11 Care Act guidance)

Given the importance of prevention of harm and the importance of taking action to stop abuse and neglect, one could argue that the CQC should have alerted LCC in this case. Organisational abuse and neglect is defined in the Care Act guidance as "including neglect and poor care practice within an institution or specific care setting such as a hospital or care home…….. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation". (Paragraphs 14.16 and 14.17 Care Act guidance) The state of affairs found by the CQC in March 2016 appears largely consistent with this definition. Alerting LCC would have allowed the QIP process to have begun immediately rather than following the publication of the CQC Inspection report almost four months later.

6.33 There was the potential for other agencies to have picked up on declining standards of care at Care Home 1. At the time of their March 2016 inspection the CQC obtained written feedback from a group medical practice, which advised that the dementia care unit appeared to be well run but an increase in GP visits to the home had been noted in recent weeks. The GPs felt there was a clear shortage of qualified nursing staff resulting in one occasion when a GP was unable to leave medication instructions as there was no qualified staff available to communicate with. Another GP advised that instructions had not been carried out which had led to a medication error and impacted on a person's health. In general, the GPs felt that there were quite high stress levels and disorganisation around medication dispensing times and some communication breakdowns. The GPs put all of these problems down to the shortage of staff, as they felt that the staff who worked at Care Home 1 were caring and hard working. The only GP practice which has contributed to this review is the practice with which Adult B was registered. It had initially been assumed that this practice cared for the majority of Care Home 1 residents but this has been found to be incorrect. From the large file recently supplied by Care Home 1, it is clear Adult B received visits from district nurses. Other professionals seem likely to have visited the care home during the period in which care was declining.

6.34 The fact that a concerned GP practice did not share their concerns with local commissioners and that no other services likely to have been in contact with Care Home 1 either noticed or communicated concerns about the standard of care is an issue the safeguarding adults board may wish to reflect upon. Additionally, the families of Adult B and Adult B2 had concerns about the care provided but did not appear to be aware of the possibility of raising these concerns other than with the management of Care Home 1.

Concerns that neglect may have been a factor in Adult B's fall.

6.35 Turning to the two falls experienced by Adult B on 16th April 2016, the second of which resulted in the fracture which was a factor which contributed to her death in hospital eleven days later, a UTI was said to have "knocked her off her feet". Adult B's physical health plan referred to "recurrent" UTIs (Paragraph 4.16) yet the UTI which affected Adult B from 14th April 2016 appeared to be only the second UTI she is recorded as suffering from following her move into Care Home 1. (The earlier UTI was in October 2015 (Paragraph 4.14))

6.36 UTIs are particularly dangerous for older people with dementia because the symptoms of UTIs in older people such as confusion, agitation and withdrawal could go unrecognised because they are not dissimilar to dementia symptoms. If an unrecognised UTI went untreated as a result, it could spread to the blood stream and become life threatening. Adult B's UTI appears to have been picked up promptly

by Care Home 1 care staff and medication prescribed in a telephone consultation by her GP. Bed rest appears to have followed but there is a serious question mark against the extent to which Adult B was being provided with the fluids necessary to combat a UTI.

6.37 In Paragraph 5.11 Adult B's daughter described visiting her mother on Saturday 16th April 2016 and finding that there were no drinks in her room despite Adult B appearing dehydrated. Care Home 1 has provided no evidence of any food and fluid balance charts. However, the subsequent QIP process highlighted concerns that residents had been left without fluids, or with fluids out of reach and that there was no clear documentation of fluid intakes. (Paragraph 6.12) The subsequent safeguarding investigation found that the Care Home 1 daily log for Adult B recorded "encouraged fluids + +" but that the same daily log omitted any reference to Adult B's daughter's visit that day. The safeguarding investigation concluded on a balance of probabilities that staff did not go in to see Adult B regularly that day and that the documentation had been falsified. It seems possible that the reference to encouraging fluids may have been falsified also. Given that so many of the concerns expressed by the families of Adult B and Adult B2 have been confirmed by the CQC inspection and the QIP process, it seems reasonable to prefer the account provided by Adult B's daughter over the records maintained by Care Home 1 and conclude that the care they provided to Adult B in response to her UTI was neglectful.

6.38 It seems likely that Adult B's initial fall from her bed which was discovered at 12.35am on 16th April 2016 was not communicated by the Care Home 1 night shift to the day shift and there seems no doubt that this fall was not shared with Adult B's daughter when she arrived to visit her mother at 9.30am the same morning. There is no evidence that any action was taken by Care Home 1 staff in response to the 12.35am fall other than to record it and monitor Adult B for the remainder of the night. There should have been a complete review of both the falls assessment and care plan for Adult B following the fall which should have taken account of the significant change in Adult B's condition occasioned by her UTI. (6) There is no evidence that this happened.

6.39 Care Home 1 maintain that one measure they did take was to place a sensor mat next to Adult B's bed which would have alerted them to any movement out of her bed. Care Home 1 also maintain that the actions of Adult B's daughter in repositioning her mother's bed during the morning of 16th April 2016 adversely affected the usefulness of the sensor mat. Adult B's daughter states that she did not see any sensor mat although she acknowledged that she was unfamiliar with sensor mats and so there may have been a sensor mat present in her mother's room which she did not recognise. In any event a sensor mat would not have prevented Adult B falling from her bed but merely alerted staff after the event. It would appear that

alternative bed safety measures such as a low bed, crash mat, bed levers or a referral to occupational therapy were not considered.

6.40 It is unclear whether the repositioning of Adult B's bed impacted upon her safety. Adult B's daughter states that she advised the nurse of what she had done prior to departing the home. As the records provided by Care Home 1 are incomplete, it is not known whether there are any records to confirm, deny or remain silent on whether the home was informed of the repositioning of the bed. However, if a sensor mat was considered necessary as a result of the increased risk of falls arising from the effects of the UTI, one wonders why the sensor mat did not activate when Adult B fell out of her bed at 12.35am on 16th April 2016. In a statement for the inquest provided by Care Home 1 it was stated that Adult B was found on the floor of her bedroom during a routine check. (Paragraph 4.39)

6.41 It is also interesting to note how the Care Home 1 manager chose to refer to the repositioning of Adult B's bed in the statutory notifications she made to the CQC. In the first of these notifications on 19th April 2016 the repositioning of the bed is shown in bold type and in the sequence of events described in the notification, the repositioning of the bed appears *prior* to Adult B's first fall at 12.35am on 16th April 2016. (Paragraph 4.54) This had the potential to create a misleading impression of the sequence of events and primarily attribute blame for the fall on the family. Whilst the repositioning of the bed appears in the notification in bold type, there is no mention of any of Care Home 1's failings such as the night shift apparently not notifying the day shift of the initial fall. When the second statutory notification was made to the CQC following Adult B's death the same sequence of events appears in that the repositioning of the bed precedes the 12.35am fall. Additionally, in the LCC MASH record of the notification of Adult B's falls received from Care Home 1's manager, the repositioning of the bed again precedes the first fall. (Paragraph 4.55) The family of Adult B2 say that just prior to their mother's death, Care Home 1 staff attempted to blame them for marks on her back because they had declined offers to turn her during the preceding night. (Paragraph 5.38) Whilst it is not possible to confirm or deny this conversation but if it is true, the impression created is one of a provider which was prepared to attempt to displace blame onto bereaved family members rather than look critically at themselves.

6.42 Adult B's second fall took place at some point prior to 4.30pm on 16th April 2016 when she was found lying on the floor by a carer carrying out a routine check. (Paragraph 4.45) In her statement to the subsequent inquest, the RGN said that she gently moved Adult B's legs to ascertain any signs of a neck of femur fracture. The RGN said that Adult B did not express any pain at this point. The focus at this point was on a head injury which Adult B sustained in the fall. It was decided that Adult B needed to be checked over in hospital but the ambulance service was not called until

6.12pm – over one and a half hours later. (It is understood that the delay in calling an ambulance was to allow Adult B to have a meal prior to going to hospital.) The ambulance service arrived at Care Home 1 at 7.32pm and noted reduced movement in Adult B's left leg but she was said to not be complaining of any obvious pain. However, it was not possible to calculate a pain score as Adult B was unable to understand the relevant questions asked. The daughter of Adult B who decided not to contribute to this review had arrived at Care Home 1 by this time (Paragraph 4.47) and it is said that she witnessed her mother scream when staff tried to remove her pyjamas and that paramedics noticed that one of her legs was longer than the other so they suspected she may have fractured her hip. This account is not completely consistent with the account provided by the Care Home 1 RGN or the ambulance service and is not a first hand account.

6.43 Care Home 1 logs were examined as part of the subsequent safeguarding investigation and it was noted that an entry timed at 7.10pm on 16th April 2016 states that a full set of "neuro obs" were performed on Adult B. This entry is at the bottom of the page of the relevant log. The following page of the log begins with an entry timed at 7.30pm the same day which records the arrival of Adult B's daughter. However, written within the title box of the new page is the sentence "both legs appear normal – not rotated/ shortened". It appears that this sentence may have been entered after the log was completed. If this was the case, there may be a number of explanations for this. The RGN may simply have forgotten to include details of her observation that Adult B's legs were not rotated or shortened at the time the original entry was written up. If so, it would have been much more acceptable for the subsequently inserted entry to have been written in the log at the time the omission was noticed rather than inserted into the log without explanation. Another explanation for the apparently inserted entry may be that Adult B's legs had not been examined or not examined promptly. A body mapping record for Adult B's second fall has recently been shared with this review which makes reference only to her head injury and makes no mention of checking her legs.

6.44 A further indication that Care Home 1's handling of Adult B's second fall may have been somewhat disorganised is suggested by Adult B's daughter's account that when she later rang Care Home 1 to check what time her mother had fallen and fractured her hip, she was told that the fall had taken place at 5.50pm and that she had been checked at 5.30m and been found to be OK. (Paragraph 5.16) And in the statutory notification to the CQC Adult B's fall was said to have taken place at 3.30pm.

6.45 Care Home 1 did not make a safeguarding alert in respect of either of the falls which Adult B suffered on 16th April 2016. As stated in Paragraph 4.55, Care Home 1's manager notified LCC MASH of the falls but advised the MASH that she was

ringing this through as part of Care Home 1's "protocol" and did not have any safeguarding concerns in relation to Adult B's falls. It is difficult to understand how the Care Home 1 manager could have concluded that there were no safeguarding concerns. There is no evidence that the first fall triggered any risk assessment or preventative action and no evidence has been provided to this review that the first fall was even communicated by the night shift to the day shift. It is also concerning that there is no indication that the Care Home 1 manager was challenged by the MASH when she notified them of the falls. One would have expected the fact that there was a second fall on the same day as the first fall to have generated questions about any preventative measures put in place following the first fall.

6.46 The current Lancashire Safeguarding Adults Board guidance on when to make a safeguarding alert following a fall states that "where a resident sustains a physical injury due to a fall, and there is a concern that a risk assessment was not in place or was not followed, this must be raised as a safeguarding alert. The key factor is that the person has experienced avoidable harm." This guidance is dated January 2017. Assuming the same or similar guidance to have been in place in April 2016 there appears to be no question that a safeguarding alert should have been made by Care Home 1. Safeguarding alerts relating to Adult B's second fall do not appear to have been considered by the ambulance service or the hospital.

6.47 Care Home 1 provided a copy of the falls policy which would have been in force at the time of Adult B's falls at a very late stage of this review. It is not known if this falls policy is the "protocol" to which the Care Home 1 manager referred in Paragraph 4.55. If they were one and the same document, then Care Home 1's manager should have realised that the action taken in response to Adult B's first fall did not comply with the home's own policy which states that risk assessments needed to be carried out in order to decide what measure need to be taken. The falls policy advises that "safeguarding" should be informed about falls, "depending on the severity of the injury". No other criteria for making a safeguarding referral are included in the falls policy.

6.48 The Care Home 1 falls policy also states that person specific risk factors need to be assessed for each individual resident and incorporated into their care plan. It goes onto state that all risk factors need to be considered. Elsewhere in the policy it sets out a range of potential person specific risk factors for staff to consider including the effects of a UTI. The policy goes on to state that the when the care plan has been updated to reflect the falls risk, the care plan should include falls management interventions but does not provide any examples of such interventions. The policy stresses the importance of informing next of kin if a resident has a fall. Overall, the policy appears quite generic and does not provide a step by step guide related to the fall risk assessment documentation in use at Care Home 1.

6.49 Adult B's family's concerns about the manner in which their mother's falls on 16th April 2016 had been handled by Care Home 1 were found to be "substantiated" by the later safeguarding investigation. This finding was based on the fact that the home had no falls policy (although a falls policy was provided to this review at a very late stage - Paragraph 6.47 above); the home had assessed Adult B as at high risk of falls but there appeared to be no risk assessment management plan advising on how to reduce risk of falls; the initial fall did not appear to have been communicated to the day staff; after the second fall medical attention was not immediately sought; and staff had not apparently noticed that Adult B had fractured her hip.

6.50 The safeguarding investigation also substantiated that Care Home 1 had falsified records on the grounds that Adult B's bedroom monitoring form shows half hourly checks throughout 16th April 2016 including the period when her daughter was present with her from 9.30am until 1.15pm when the daughter states that there was only one visit by a carer; and that the form records "encouraged fluids + +" which is contradicted by the daughter who states that there were no fluids in the bedroom on her arrival.

The care of Adult B in hospital

6.51 Adult B's family have no complaints about the treatment of their mother in hospital other than saying they would like to have been advised of the fact that she contracted pneumonia. The treatment of Adult B appears to have been consistent with expected practice in that the emphasis was on operating on Adult B as promptly as her health allowed in order to give her the best chance of surviving the fracture and to relieve her pain.

6.52 As stated in paragraph 4.58, the information shared by the hospital with the coroner about Adult B's death omitted reference to the fracture or subsequent surgery and as a result the original death certificate was incomplete, referring only to "community acquired pneumonia" as the cause of death. This omission only came to light when a member of the Coroner's staff contacted Adult B's family to arrange for them to collect the death certificate. The death certificate was voided and was replaced with a death certificate which gave the cause of death as broncho pneumonia with osteoporotic facture left hip (operated) as contributory factors.

6.53 The review has been unable to clarify how this omission occurred. The hospital clinician who recorded the cause of death which was notified to the coroner has now left the trust and it has not been possible to communicate with them. It appears that

there may have been a conversation between the hospital clinician and the coroner's office which may have been a factor in the death certificate being incomplete.

CHC assessment

6.54 The reason for the passage of time between Care Home 1 initiating a request for an assessment of whether Adult B's care package should be changed from residential to nursing in February 2016 and the subsequent contact by the CHC assessment team in June 2016 is unclear. (Paragraph 4.23) Southport and Ormskirk hospital has advised this review that a telephone triage took place the day after Care Home 1 initiated their request, the outcome of which was that Care Home 1 were to contact the continuing healthcare (CHC) assessment team again if Adult B deteriorated. Care Home 1 has advised the review that their expectation was that initiating an assessment request in February 2016 would prompt an assessment.

6.55 Clinical commissioning groups (CCGs) are responsible for determining eligibility for CHC and for funding and commissioning this care if patients are assessed as eligible. The CCG is legally required to provide CHC funding for all those assessed as eligible. The national framework for CHC states that for most people the assessment process involves an initial screening stage. This uses a CHC checklist to identify people who might need a full assessment. A full assessment should usually be carried out by a group of professionals from across health and social care (known as a multidisciplinary team) who are familiar with the individual's care needs.
There is also a fast-track process, which does not require a full assessment, for individuals with rapidly deteriorating conditions who may be nearing the end of their life.

7.0 Findings

7.1 Lancashire Safeguarding Adults Board recently decided that final SAR reports will no longer include recommendations but instead the independent reviewer would be asked to document clear findings and learning points which will allow flexibility for decisions to be made locally on how best to implement learning and findings. Findings and learning points are set out below.

Decline in standard of care provided at Care Home 1

7.2 Between the CQC inspections conducted in November 2014 and March 2016 there was a steep decline in the standard of care provided to residents of Care Home 1. By the time of the second CQC inspection a more stringent methodology had been introduced which may have contributed to the contrasting inspection outcomes, but there can be no doubt that standards had deteriorated alarmingly. Key factors in this deterioration appeared to be deficiencies in leadership, oversight and supervision of staff, an over reliance on agency staff and the unsatisfactory handling of complaints.

Monitoring of provider effectiveness

7.3 One of the most concerning findings of this SAR is that the commissioners of placements at Care Home 1 appeared to have no inkling of the deterioration in standards until the death of Adult B. As stated earlier Lancashire County Council contracts monitoring team had no involvement with Care Home 1 prior to July 2016. (Paragraph 6.27) NHS Midlands and Lancs. commissioning support unit carried out some monitoring but were largely reliant on self reported information from Care Home 1 which was sometimes late and incomplete. (Paragraph 6.27) Relying on self reported information depends upon the integrity of the service supplying the information and this review has disclosed concerns about falsification of documentation within Care Home 1. (Paragraphs 6.41, 6.43 and 6.48) The CQC also found in their March 2016 inspection that Care Home 1's internal audits could not be relied upon to provide an accurate picture of performance. (Paragraph 6.14)

7.4 Both the Care Home 1 placements of Adult B and Adult B2 had been commissioned from outside Lancashire. Care Home 1 is situated just inside Lancashire on the border with Greater Manchester. It is not known how many Care Home 1 resident placements have been commissioned by agencies from outside Lancashire. Lancashire Safeguarding Adults Board may wish to consider the extent to which non-Lancashire commissioners of placements within Lancashire monitor those placements and share any concerns about placements with commissioners in Lancashire.

7.5 Additionally, a range of practitioners would have visited Care Home 1 on a fairly regular basis during the period when standards began to deteriorate. For example, Adult B was visited by practice nurses from her GP practice and district nurses. When the CQC conducted their March 2016 inspection, a GP practice which provided primary care to Care Home 1 residents was consulted and expressed a range of concerns (Paragraph 6.33) which had not previously been shared with commissioners.

7.6 The families of both Adult B and Adult B2 were actively engaged in their care and began to experience concerns about standards of care which were consistent with the findings of the March 2016 CQC inspection. They did not take these concerns further than raising them with the management of Care Home 1.

7.7 Lancashire Safeguarding Adults Board may wish to consider how pockets of intelligence which can indicate that a care home is beginning to struggle can be surfaced so that concerns can be addressed quickly, support provided and the potential for harm to residents minimised. In the case of Care Home 1, the decline in standards uncovered by the March 2016 CQC inspection had reached a point at which there were so many areas of concern requiring attention that arresting the decline was a task which was probably beyond the provider, registered manager and staff. The fact that Care Home 1 remains in "special measures" at the time of writing (November 2017) reinforces this point.

7.8 Specifically the Board may wish to consider how to encourage primary care services – particularly GP practices - and specialist care services to share any concerns they may have about care homes. The families of residents should also be considered to be a valuable, but on the evidence of this case, largely unexploited source of information. The Board may also wish to consider how other indicators of concern could be gathered. Practitioners who attended the learning event arranged to inform this SAR noted that neither specialist falls advice nor incontinence advice had been sought for Adult B by Care Home 1. This suggested that low take up or infrequent referral to specialist support and advice could be an additional indicator of concern about a provider's standards of care.

7.9 Three safeguarding concerns were raised in respect of Care Home 1 residents in the weeks prior to the falls which led to the death of Adult B. One of these safeguarding referrals was a direct result of the March 2016 CQC inspection and appears to have been closed with the minimum of enquiry. The registered manager of Care Home 1 made the referral and provided an explanation for what the CQC had perceived to be unsatisfactory management of medication. This explanation appeared to be accepted without question. It may have been beneficial to contact

the CQC to ascertain why they felt a safeguarding referral was justified. Had this been done, a fuller picture of the particular incident observed by the CQC would have been obtained. Additionally, the CQC may have shared some of their wider concerns about the management of medicines during their inspection and thus provided helpful context. The two other safeguarding concerns appeared to receive appropriate attention but the impression gained is that each of these safeguarding concerns was reacted to in isolation.

7.10 The MASH also accepted the Care Home 1 manager's notification of Adult B's falls at face value. (Paragraph 4.55 and 6.45) As stated in Paragraph 6.46, the current Lancashire Safeguarding Adults Board guidance on when to make a safeguarding alert following a fall states that "where a resident sustains a physical injury due to a fall, and there is a concern that a risk assessment was not in place or was not followed, this must be raised as a safeguarding alert. The key factor is that the person has experienced avoidable harm." Although this guidance dates from January 2017, one would have expected the fact that there was a second fall on the same day as the first fall to have generated questions about preventative measures put in place following the first fall.

7.11 Overall, Lancashire Safeguarding Adults Board may wish to consider whether monitoring of provider effectiveness is sufficiently proactive?

Information sharing between the CQC and Commissioners

7.12 The CQC decided against sharing their March 2016 inspection findings with commissioners in advance of the publication of their inspection report in July 2016. They applied their "enforcement decision tree" which requires them to consider the potential impact of breaches of regulations alongside the likelihood of the breaches reoccurring. (Paragraph 4.35) The CQC considered the seriousness of the breaches at Care Home 1 to be "low" which, at that time, did not necessitate formal communication with commissioners. However, the monthly Lancashire Radar meetings provided an opportunity to informally share information about the adverse outcome of the March 2016 inspection and this was not taken.

7.13 The draft terms of reference of the Radar group have been shared with this SAR. The terms of reference state that "where the group receives evidence of a significant number of concerns, about a provider of adult social /health care the following factors will trigger consideration of a QPIP (Quality and Performance Improvement Planning):

- Organisational abuse enquiries are ongoing or substantiated and no improvements, or limited improvements, have already been implemented by the provider.
- Where safeguarding enquiries have occurred within a care setting and wider concerns have been identified regarding the quality of care being provided.
- Concerns exist with organisational leadership and/or culture in which senior managers within the setting/organisation are implicated
- Significant breaches of the CQC's five essential standards of quality and safety resulting in special measures status.
- Where there are high levels of complaints or safeguarding activity indicative of wider quality issues within the setting/organisation which are a cause for significant concern.
- Where compliance and contract monitoring work identifies an ongoing failure to address actions identified in an LCC contract improvement plan.
- Where there is data via the quarterly quality returns to CSU – Contract Management Team that indicates there may be risks to the health and clinical needs of the people who use the service".

A QPIP was later triggered in respect of Care Home 1 following a number of safeguarding concerns including those arising from the death of Adult B. Had the CQC shared the concerns arising from their March 2016 inspection with the Radar group at that time, it is unclear whether consideration of a QPIP would have been triggered at that point, given that the CQC had judged the breaches uncovered to be at the "lower" end of seriousness.

7.14 Lancashire Safeguarding Adults Board may wish to further explore the role that the Radar group plays in gathering and triangulating information to inform decision making in respect of providers about whom concerns have been raised, in the light of the learning emerging from this SAR.

7.15 The new process by which the CQC will notify commissioners of "require improvement" inspections (Paragraph 6.31) would have given commissioners of placements at Care Home 1 earlier notification of the adverse findings from the March 2016 CQC inspection although it is not yet known what the timescales for notification will be. Lancashire Safeguarding Adults Board may wish to seek assurance that the new CQC commissioner notification system operates effectively and in timely fashion.

Preventing Falls

7.16 The fracture of the neck of her left femur which Adult B sustained as a result of her second fall at Care Home 1 contributed to her subsequent death. Both falls

were preventable but the second fall was particularly preventable. Once Adult B became ill with a UTI a falls risk assessment should have been carried out in accordance with Care Home 1's own falls policy but there is no evidence that this happened. Had a falls risk assessment taken place it would have informed changes to her care plan to reduce her risk of falling. There is no evidence that Care Home 1 took any action to prevent Adult B falling from her bed apart from the positioning of a sensor mat next to her bed which would not have prevented her falling in any event.

7.17 After Adult B's first fall shortly after midnight on 16th April 2016 there is no evidence that any action was taken to reduce the further risk of falls. No falls risk assessment appears to have been carried out, no preventative measures were put in place, her family were not informed and there is no evidence that the night shift advised the incoming day shift that the fall had taken place. Being definitive about this latter point is frustrated by Care Home 1's inability to find crucial records from that day which is extremely regretable.

7.18 It is known that falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore, falling has an impact on quality of life, health and healthcare costs. (7)

7.19 Lancashire Safeguarding Adults Board may wish to consider how awareness of the potential seriousness of falls, the steps to take to prevent falls and the circumstances in which a safeguarding referral following a fall is justified, can be increased amongst providers and their staff, including staff in the MASH. (Paragraph 7.10 refers)

Mental Capacity

7.20 The March 2016 CQC inspection found inconsistent practice in respect of mental capacity and deprivation of liberty safeguards (DoLS). (Paragraph 6.17) Some care plans examined showed residents lacked capacity and that DoLS authorisations had been applied for, but some of these had been submitted some time ago and no outcome or indication they had been followed up was evident. (There is no record of any DoLS application for Adult B being received from Care Home 1 in December 2014 despite her stated (to staff) wish to return home conflicting with the home's "locked door" policy (Paragraph 4.10)) Some DoLS

authorisations were found to lacked an underpinning mental capacity assessment. Staff members the CQC spoke with did not have a good grasp of the Mental Capacity Act (MCA) and DoLS.

7.21 In Adult B's case the November 2014 mental capacity and best interests documentation relate to the accommodation placement decision only, and did not appear to be considered in respect of other decisions about her care despite the fact that it had been concluded that Adult B was unable to understand, weight up, communicate and retain information.

7.22 Lancashire Safeguarding Adults Board may wish to reflect on the lack of a confident grasp of the implications of the Mental Capacity Act indicated by this case and consider whether any further action is necessary to increase practitioner knowledge in this area.

Engagement of the provider in the safeguarding adults review

7.23 The provider Tudor Bank has not fully co-operated with this SAR which is extremely regretable. It is recognised that private providers can find engaging in a SAR quite challenging and may require a degree of support and advice. However, the SAR process is statutory and so Lancashire Safeguarding Adults Board may need to gain assurance that the requirement to participate in SARs is fully covered in contracting arrangements. Given the difficulty in obtaining records from Care Home 1, such assurance may need to include arrangements for archiving records and the securing of records once notification is received that a SAR is to take place.

Helping families selecting a care home

7.24 At the learning event held to inform this SAR, practitioners expressed concern about the challenges faced by families in making a decision over which care home to chose for their family member. In this case the families were strongly influenced by the most recent CQC inspection report (November 2014). As this case illustrates, it may not be wise to rely too strongly on the report of a CQC inspection which is no longer current. Lancashire Safeguarding Adults Board may wish to examine ways in which families could be provided with advice on useful questions to ask when choosing a care home. (Adult B's daughter expressed her strong support for this proposal.)

Single Agency Learning

7.25 Lancashire Safeguarding Adults Board may wish to ask the agencies which have participated in this SAR to provide the board with information about any

learning their agency has derived from this review and any changes that agency is implementing or has implemented as a result.

7.26 As stated in Paragraphs 6.52 and 6.53 it has not been possible to clarify why an incomplete death certificate was initially issued in respect of Adult D. Lancashire Safeguarding Adults Board may wish to request that Wrightington, Wigan and Leigh NHS Foundation Trust review the process by which they record cause of death and notify this to the coroner and advise the Board of the outcome.

7.27 Responsibility for improving the standard of care provided at Care Home 1 rests with the providers, supported by the QPIP process and inspected by the CQC as regulator.

7.28 At the learning event to inform this SAR, practitioners expressed the view that there needed to be a change in culture over how complaints were handled in care homes. Practitioners took the view that providers needed to be more open to complaints and actively encourage them in order to foster an environment of continuous improvement. This is an approach that the providers at Care Home 1 may wish to adopt on a pilot basis and advise Lancashire safeguarding Adults Board of the outcome.

7.29 After reading this SAR report, Adult B's daughter suggested the following additional improvements:

- Provide families of residents in care homes with details of where to take concerns about the care of their family member, if they are not satisfied with the response of the management of the care home.

- Encourage care homes to establish groups at which the families of residents can meet with the management of care homes. Adult B's daughter said it would have been helpful to speak to other families of residents and find out that it was "not just us" who had concerns about standards of care.

8.0 References

(1) Retrieved from https://www.nao.org.uk/wp-content/uploads/2017/07/Investigation-into-NHS-continuing-healthcare-funding.pdf

(2) Ref - http://www.cqc.org.uk/sites/default/files/20170718_CQC-annual-report-and-accounts-201617.pdf

(3) Retrieved from http://www.cqc.org.uk/sites/default/files/20140416_safeguarding_adults_-_roles_and_responsibilities_-_revised_draf....pdf

(4) Ibid

(5) Ibid

(6) When to consider making a safeguarding alert following a fall - LSAB February 2017

(7) Retrieved from https://www.nice.org.uk/guidance/cg161/chapter/Introduction

Appendix A

Process by which safeguarding adults review (SAR) conducted and membership of the SAR panel

A panel of senior managers from partner agencies was established to oversee the SAR. The membership was as follows:

Role	Organisation
Independent Chair	Cumbria Constabulary
Panel Member	Care Home 1
Panel Member	Care Quality Commission
Panel Member	Greater Preston, Chorley, South Ribble and West Lancashire CCG
Panel Member	Lancashire Constabulary
Panel Member	Wrightington, Wigan and Leigh NHS Foundation Trust
Panel Member	Wigan Adult Social Care
Business Coordinator	LSAB
Business Support	LSAB
Independent Reviewer	Independent

- Policy and Performance Officer, MSCB
- Business Support Officer, MSCB
- David Mellor, Independent Lead Reviewer

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

Specifically, it was decided to adopt the Welsh concise child practice review methodology which focusses on recent practice and places strong emphasis on engagement in the SAR of practitioners and managers involved in the case.

Chronologies which described and analysed relevant contacts with Adult B were completed by the following agencies:

- Care Quality Commission
- Greater Preston, Chorley, South Ribble and West Lancashire CCG
- Lancashire Constabulary
- Lancashire County Council multi-agency safeguarding hub (MASH)
- North West Ambulance Service
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Wigan Adult Social Care

As previously stated, Care Home 1 did not submit a chronology.

The SAR panel analysed the chronologies and identified issues to explore with practitioners and managers at the learning event facilitated by the lead reviewer which was attended by representatives of nearly all of the various disciplines involved in this case.

One of Adult B's daughters contributed to the review as did the daughters of Adult B2.

The lead reviewer then developed a draft report which reflect the chronologies, the contributions of practitioners and managers who had attended the learning event and the contributions of the families of Adult B and B2.

With the assistance of the SAR panel, the report was further developed into a final version and presented to LSAB.

The daughter of Adult B has had the opportunity to read and comment on the final draft of this report. A similar opportunity has been offered to the daughters of Adult B2 but they will not be available to meet the lead reviewer until January 2018.