Darlington Safeguarding Adults Partnership Board

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Significant Incident Learning Process

SAFEGUARDING ADULT REVIEW USING THE SIGNIFICANT INCIDENT LEARNING PROCESS OF THE CIRCUMSTANCES CONCERNING

Gladys

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1. INTRODUCTION AND SCOPE OF REVIEW

1.1. Gladys was an 86-year-old with mixed Alzheimer's and vascular dementia. She was placed in a care home, initially as an emergency as her husband was not coping. After less than 36 hours back at home she returned to the same care home on a permanent basis on 15th December 2015. Between her admission and 14th January 2016, she fell 12 times.

1.2. On the 14th January, following a series of falls and a visit from the GP Gladys was admitted to hospital where several injuries were found that were thought to be caused by falls. At this point she was placed on end of life care pathway and died on 31st January. The coroner returned a verdict of accidental death following a succession of falls.

2. THE SIGNIFICANT INCIDENT LEARNING PROCESS (SILP)

2.1. The Care Act 2014 Statutory Guidance states that the process for undertaking Safeguarding Adult Reviews (SAR) should be determined locally according to the specific circumstances of individual cases.

2.2. The DSAPB agreed to undertake this review using the Significant Incident Learning Process (SILP), a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted in a certain way at the time.

2.3. The SILP model of review adheres to the principles of:

- Proportionality
- Learning from good practice
- The active engagement of practitioners involved at the time
- Engaging with families
- Systems methodology
- Avoidance of hindsight bias

This SAR has been undertaken in a way that adheres to these principles.

The Lead Reviewers

2.4. Karen Rees is from a nursing background, having worked for 36 years in the NHS. Latterly Karen worked in safeguarding roles at a strategic level in two NHS organisations. Karen has worked with both Safeguarding Adult and Safeguarding Children Boards over a number of years and specifically on Serious Cases and Case Review sub groups. The review was co-chaired by Nicki Pettitt. Nicki is an independent social work manager and child protection consultant who is an experienced chair and author of safeguarding reviews. The lead reviewers are entirely independent of DSAPB and its partner agencies.

Process

2.5. Following the decision by DSAPB to commission a SAR, a scoping meeting and authors' briefing took place on the 28th September 2016 to agree the Terms of Reference with representatives for DSAPB and to introduce the SILP model process and expectations to authors of agency reports.

2.6. All agency reports were completed within the timescale and a Learning Event took place on 29th November 2016 which was well attended by authors, managers, practitioners and

safeguarding leads from the organisations involved in Gladys's care.

2.7. There were two NHS Foundation Trusts who provided reports for this review. For the purposes of this review, Mental Health services will be identified as 'the Mental Health Trust' with all other hospital services provided by 'the NHS Foundation Trust'

2.8. A Recall Event took place on 19th January 2017 prior to which the first draft of the report was circulated for comment. The Recall Event tested out the learning and gave opportunity for participants to give their perspectives.

2.9. The final report was presented to DSAPB on 23rd March 2017.

2.10. It is the expectation that this review will be published in line with Care Act (2014) requirements.

3. FAMILY INVOLVEMENT WITH THE REVIEW

3.1. The husband of Gladys asked agencies to refer to his son any correspondence and communication related to the death of his wife and the safeguarding adult review. As such contact was made to engage the family in the review in order that their views on the care that Gladys received could be gathered. The Son informed the social work manager that his father did not want to be involved and felt that he had closure following the inquest. The son felt that he had shared all previous concerns in the safeguarding meetings he had attended. The author had access to these documents and information from these was included in the review.

3.2. In a telephone conversation with the Local Authority Senior Manager, Gladys's son was clear that he wanted the review to identify where things could have been done earlier to prevent the final outcome. He also stated that the family were not looking to apportion blame but that they wanted professionals to recognise where practice could have been better. Gladys's son indicated that he would like practice to improve and for learning to take place in order that other vulnerable people do not suffer as his mother did. Gladys's son was unable to meet with the author but requested that he would like the final report emailed to him.

4. PARALLEL PROCEEDINGS

4.1. There were no criminal proceedings as a result of the death of Gladys. Several organisations undertook their own reviews and internal investigations and are in the process of putting actions into place. These action plans were shared with the author and have been taken account of in this review.

4.2. The coroner's inquest took place 28th and 29th September 2016 and returned a verdict of accidental death following a series of falls. The coroner did not issue any Regulation 28 report[1] but did ask that the Care Home and the NHS Foundation Trust informed him of improvements that had been made.

[1] **Reports to Prevent Future Deaths**. Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

5. BACKGROUND PRIOR TO THE SCOPED PERIOD

5.1. Gladys was born and raised in Darlington. She had been married to her husband since 1952 after they met at a dancehall and had been together since that time. Together they had two children. Gladys worked as a secretary in her earlier years doing accounts until she stopped after her mother became ill and to look after her children. Gladys was described by care home staff as a gentle and loving lady. It is known to the Safeguarding Adult Review that both her adult children have moved away from the local area, living many miles away. No agency highlighted any significant involvement with Gladys prior to the scoping period.

6. KEY EPISODES

6.1. The significant and important account of events leading to the death of Gladys are included below in key episodes. Gladys came to the attention of services in October 2015 and died at the end of January 2016. There are four key episodes during that time that lead to areas for analysis and are therefore detailed below. Gladys had been referred to Mental Health Services in July 2015 by her GP; on the day of the appointment at the end of July, Gladys's husband contacted Mental Health Services and informed them that the situation had resolved and Gladys no longer needed to be seen. Gladys was therefore discharged from the service and a letter was sent to the GP.

Key Episode One – Diagnosis, assessment and emergency placement (October 2015-15.12.2015)

6.2. Gladys attended an appointment at the local Mental Health Trust on 28.10.2015 following a further GP referral on 30.09.2015. Gladys was accompanied by her husband and daughter. She was seen in clinic by the consultant psychiatrist and the community psychiatric nurse (CPN) for full assessment of her memory recall and functioning. During this assessment, various tools were used to assess memory and daily functioning. These included ACE-III[2] and The Bristol Activities of Daily Living Scale[3]. These tests indicated that Gladys had moderate to severe cognitive impairment thought to be due to dementia. It was felt by the attendees at the Learning Event that it is not unusual for patients to be diagnosed in the latter stages of dementia. This is thought to be for several reasons; families living with patients with dementia may well not recognise changes as the decline in cognitive functioning is gradual. There may be also elements of denial that there is an issue alongside fear of separation and loss. Families may believe that they will be able to manage and cope at home and not always keen to seek alternative care and support.

6.3. During the assessment, it was identified that no one in the family had Lasting Power of Attorney[4] for Gladys and an information leaflet was given about this. A carer's assessment for

[2] **Addenbrookes cognitive examination-III-** The Addenbrooke's Cognitive Examination-III (ACE) is one of the most popular and commonly used cognitive tests used in dementia clinics and in the assessment of other neurological disorders. ACE-III replaced the previous ACE and ACE-R versions in November 2012.It provides a sensitive, reliable, secure and easy to administer clinical tool for you and your team to assess cognition as part of the process of assessing for dementia. The ACE-III includes five subdomains, which provide a cognitive score out of a maximum of 100.

[3] **The Bristol Activities of Daily Living Scale** (BADLS) is a 20-item questionnaire designed to measure the ability of someone with dementia to carry out daily activities such as dressing, preparing food and using transport.

[4] **A lasting power of attorney** (LPA) is a legal document that lets a person (the 'donor') appoint one or more people (known as 'attorneys') to help the person make decisions or to make decisions on the person's behalf. This gives the person more control over what happens to them if, they lack mental capacity'.
There are 2 types of LPA:
- health and welfare
- property and financial affairs

Gladys's husband was also offered and declined.

6.4. During this appointment, the suggestion that memory medication, which can slow the progression of cognitive impairment, was discussed. A head CT scan[5] was also requested as this helps in the diagnosis of the type of dementia. Thus, a likely diagnosis of mixed Alzheimer's and vascular dementia was made. It was also found that Gladys had macular degeneration[6] and hearing loss. The Mental Health Trust Agency Report identifies that some aspects of daily functioning such as mobility were difficult to ascertain as her husband appeared to be confused at times. Although Gladys's daughter was present, she did not live locally and was not able to provide clarity to all areas of the assessment.

6.5. In order to commence the memory medication, it was necessary to assess Gladys's physical health. This is done via attendance at the Titration Clinic. An appointment was made and Gladys attended with her husband on 07.12. 2015. At this appointment, it was noted that Gladys had high blood pressure and that this would need to be under control before memory medication could be commenced. Contact was made by the Mental Health Team with the GP and the GP duly prescribed the appropriate medication to treat the high blood pressure. This was timely intervention and collaboration of care between the GP and the Mental Health Trust.

6.6. On 10.12.2015 Adult Social Care duty team took a referral from a dementia advisor relating to concerns about Gladys's dementia and domestic situation. Agency reports do not identify how the dementia advisor came to be involved and it is assumed that the family may have self-referred for advice, help and support.

6.7. The next day (11.12.2015) saw an escalation of events. The GP contacted the consultant psychiatrist following a call from Gladys's husband. Her husband had informed the GP that Gladys was very agitated, shouting and threatening to jump from the window. The GP indicated that a visit would be undertaken and requested advice from the psychiatrist regarding management. The advice given was that if Gladys settled then consider use of Lorazepam[7] over the weekend but if concerns continued to make contact again and consider need for Mental Health Act Assessment or respite care. The consultant psychiatrist contacted the CPN and a decision was made for an immediate home visit to reassess the situation.

6.8. Whilst the CPN was at the home of Gladys and her husband, the GP arrived and identified no physical health cause for her agitation.

6.9. On the same day a further call was made by the dementia advisor. On this occasion it was to the Multi Agency Safeguarding Hub (MASH) regarding information that Gladys's husband had fallen at home and had suffered a nose bleed and bruising. The MASH manager deemed that this was not a safeguarding incident but that a care and support assessment was required in respect of Gladys's husband. Care and support needs of Gladys's husband fall outside of the scope and remit of this review as it relates to another adult and therefore

5 **A CT scan** makes use of computer-processed combinations of many X-ray images taken from different angles to produce cross-sectional (tomographic) images (virtual "slices") of specific areas of the body

6 **Age-related macular degeneration** (AMD) is a painless eye condition that causes loss of central vision, usually in both eyes.

7 **Lorazepam** belongs to a group of drugs called benzodiazepines. It affects chemicals in the brain that may be unbalanced in people with anxiety. Lorazepam is used to treat anxiety disorders.

are not explored further.

6.10. Following the call from the Dementia advisor on 10.12.2015 and a telephone call to Gladys's husband to arrange a care and support assessment in respect of Gladys and a carer's assessment in respect of Gladys's husband, a home visit by the duty social worker was undertaken. The social worker has indicated that she was not aware of the information that Gladys had been threatening to jump from the window. The CPN, on hearing that the duty social worker was going to be visiting, waited at the family home so that they could together agree a way forward. It is important to note that this visit took place on a Friday afternoon.

6.11. It was assessed that Gladys did not have capacity under the provisions of the Mental Capacity Act[8] to decide about her care and support needs. Gladys had calmed down when the CPN was at the home and it was not necessary to consider a Mental Health Act Assessment. Gladys's husband was described at the visit as having memory problems of his own and he was struggling to recall exactly what had happened. It was recorded that he had two bruised eyes that had happened because of the fall that he had sustained.

6.12. A carer's assessment was not completed at this visit. However, it could be argued that the important focus was the safety of both Gladys and her husband at this crisis point.

6.13. Although at first being resistant to the idea of respite care, Gladys eventually agreed to three days over the weekend. This is discussed further in the analysis as it had been deemed that Gladys did not have capacity to make this decision so should have been a best interest decision.

6.14. Telephone contact was made with Gladys's daughter during the visit and she agreed for an emergency placement over the weekend for respite and that she would plan to visit for a few days to make suitable arrangements. The CPN recorded that the daughter confirmed that her father also had some memory problems but she felt that he would manage if Gladys was in respite.

6.15. During the visit, the duty social worker completed a care and support needs assessment in respect of Gladys and also identified that Gladys would be self-funding. It appears that the self-funding request came from the daughter but it is not clear how or why the daughter made this decision. This had an impact in the next stages of Gladys's journey and is discussed further in the analysis.

6.16. The duty social worker telephoned a few homes without being able to secure a placement. The duty social worker then contacted The Care Home. It was identified that an emergency respite placement was required. The Home Manager agreed to the admission, the social worker gave a verbal handover and Gladys was admitted to the residential care floor of the home.

6.17. The Care Home is registered with the Care Quality Commission to provide residential care and care for people living with Dementia. At the last inspection in November 2014, the Care

[8] **The Mental Capacity Act 2005** (c 9) is an Act of the Parliament of the United Kingdom applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.]

Home was rated good in all areas.

6.18. Although the Care Home is registered for Residential Care and Elderly Mentally Infirm (EMI), Gladys was admitted to the residential section of the home. The Care Home stated at the Learning Event that they were not aware of the need for an EMI placement but had been made aware of the self-funding status of the placement.

6.19. The duty social worker took Gladys and her husband in her own car to the Care Home. The duty social worker ensured that Gladys was settled before leaving. At this point, the care and support assessment was handwritten and not recorded in the electronic record but was not shared in any form due to Gladys's placement being self-funded. The social worker had a further visit to undertake after settling Gladys and wrote up the assessment in the electronic record on the following Monday (the next working day).

6.20. The Care Home did not receive any written assessment of Gladys's needs and were not able to obtain any information from healthcare professionals due to the time and day. This is subject to further discussion in the analysis.

6.21. The Care Home discussed with Gladys's husband, details of her routines and medication. Information did not come to light about any falls and Care Home staff did not complete any risk assessments at this stage.

6.22. The next day a CPN on duty for the weekend called the Care Home to enquire how Gladys had settled. It was noted that she was restless but that this was not a management problem. The CPN stated that she would make contact again the following day. This was identified as positive practice in supporting the Care Home.

6.23. On 13.12.2015 Gladys was found on the floor[9]. Staff at the Care Home are trained to deal with falls and make a body check for injuries and document any actions. Staff are required to seek medical or nursing attention from community health staff if injuries are found on residents following falls. On this occasion Gladys refused a full examination, but was observed and monitored frequently. When the CPN telephoned to see how Gladys was the care home staff informed the CPN about the fall and stated that she had settled to sleep afterwards.

6.24. Gladys's husband appeared to be struggling to cope with his wife being at the Care Home and had wanted to take her home on the night of 13.12.2015 but was persuaded to wait until the morning as planned. This information was shared with Adult Social Care via the MASH. Gladys's husband arrived at the Care Home at 10.30 the next day and took her home. He did not wait for her to be dressed and took her home in her nightdress.

6.25. Later that day, Gladys's daughter arrived at the Mental Health Trust Hospital for support after her mother had been taken home by her father. The daughter requested details of domiciliary care agencies from Adult Social Care.

6.26. On 15.12.2015 the case was allocated to a social worker. Social work case notes show that the GP had confirmed that Gladys had advanced dementia. The CPN contacted Adult Social Care and recorded that a list of care companies had been emailed to Gladys's

[9] **Found on Floor** is a term used when residents have been found but it is not clear how they came to be on the floor. It is always assumed, however, that the resident has fallen unless it can be proven otherwise.

daughter and that she had indicated that she would like to take her parents to live with/near her.

6.27. The GP recorded that Gladys had a blood pressure check on 15.12.2015 and that as it remained high, the dose of her medication was increased.

6.28. At 14:00 Gladys's daughter made direct contact with the Care Home and spoke to the manager. The daughter was expressing concerns about the care that they could provide at home and the level of Gladys's anxiety, stating that the family were willing to self-fund. The manger indicated that on this readmission, with the knowledge of Gladys from her respite admission, the top floor dementia unit would be more suitable as the levels of staffing were higher and the staff were trained in dementia care.

Key Episode 2: Permanent placement and falls 16.12.2015-10.01.2016

6.29. On 16.12.2015 the Care Home contacted the GP regarding Gladys's levels of anxiety and agitation; the GP prescribed Lorazepam to be taken twice a day.

6.30. There were several telephone calls between professionals and the family on that day updating each other on the events that had resulted in Gladys being readmitted on a permanent basis to the Care Home. Following discussion with the team manager, the allocated social worker discontinued plans for assessment as it was agreed that this was no longer necessary due to Gladys's care arrangements being made on a private basis. The case was then to be closed. The CPN, on finding out the information from Gladys's daughter contacted the Care Home to ask them to apply for an urgent DoLs[10].

6.31. On readmission, the Care Home carried out assessments and formulated care plans. These were not robust assessments and did not identify Gladys as being at high risk of falls and did not trigger enhanced care plans that are available for staff to use. This issue has been subject to internal review within the Care Home following Gladys's death and is discussed further in the analysis and improvements section of this report.

6.32. On the evening (19.25) of 17.12.2015 Gladys was found on the floor; she was in a sitting position. Senior carers monitored her condition and later that evening identified that Gladys had pain in her shoulder and a possible fractured clavicle. A carer called 111 at 20:20 and following triage by a 111 clinician an ambulance response was requested. The ambulance service graded this call as requiring a one hour response time. In the meantime, due to the time of evening Gladys was put to bed.

6.33. At 23.50 the ambulance still had not arrived and Gladys was again found on the floor. The ambulance service was called again and the call was upgraded to a 30-minute response time. When still no ambulance had been dispatched at 01:30 an ambulance service internal governance system in respect of falls automatically upgraded the call to a 20-minute response and an ambulance arrived at the Care Home at 02:16. This delay has been subject

[10] **The Deprivation of Liberty Safeguards** (DoLs) are an amendment to the Mental Capacity Act 2005 that apply in England and Wales. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. Care homes or hospitals must ask a local authority if they can deprive a person of their liberty.

to an internal investigation by the ambulance service and was due to the high levels of calls, sickness and a shortage of qualified paramedics. Ambulance response times are a national issue and under constant review.

6.34. In this case the delay in the ambulance arriving and Gladys being in pain may well have increased her agitation leading the further fall. At the Learning Event, it was ascertained that it would have been good practice for someone to have sat with Gladys whist the ambulance was awaited. It was acknowledged, however, that the staff would have changed to the night staff at 8pm and that the ratio of staff at night is much less and staff were caring for other residents and preparing them for bed.

6.35. Gladys returned from hospital at 07:00 the following morning (18.12.2015) with a confirmed fractured clavicle and a follow up appointment for 21.12.2015.

6.36. As is routine, when a patient has been seen in Accident and Emergency for a fall, the NHS Foundation Trust Intermediate Care Team[11] receive information. As per the policy, the Intermediate Care Team contacted the Care Home to identify what support, advice and assessment was required. The Carer informed the Intermediate Care Team Lead Therapist that Gladys was new to the Care Home and that this unfamiliar environment had increased her falls risk and did not feel that she needed a physiotherapy assessment but would make contact again if this should change. This is subject to further analysis following discussion at the Leaning Event.

6.37. On 20.12.2015 at 20:30, Gladys was again found on the floor, she was reluctant to allow carers to examine her but when they did it was noticed that she had a graze to her knee. The carers cleaned the wound and helped her to bed. They did not call for any medical or nursing assistance.

6.38. On 21.12.2015 Gladys was taken to the fracture clinic for her follow up appointment and was to continue with her sling and have a further review on 04.01.2016.

6.39. On 22.12.2015 Gladys was not taken for her blood pressure check. The Care Home were not aware that Gladys's blood pressure was under review and that the reason was because she was to start on memory medication once her blood pressure was stable.

6.40. On the same day, Gladys's husband had attended the GP surgery enquiring with the GP why he had been billed for his wife's care. As a result of this the GP contacted the mental health duty worker asking why the NHS was not funding care for Gladys. The duty worker relayed to the GP the information that had been gleaned from social care regarding the self-funding that the daughter had requested. The mental health duty worker contacted Adult Social Care duty team to enquire whether a financial assessment had been carried out and was told that assessment had been offered to Gladys's husband but that he put the phone down. On further investigation during this review, it appears that there was miscommunication about this issue and this is discussed in the analysis. The GP requested that someone should contact the daughter so that she could explain to her Father that the bill was because the family had requested self-funding.

[11] **The intermediate Care Team** is available every day between 08:00-20:00 for people over the age of 18. This includes local health and social care working together, along with the independent sector. The team also includes community therapy by Occupational Therapists and Physiotherapists, for example falls assessment and prevention.

6.41. On the same day Gladys's daughter contacted the allocated social worker and expressed concerns about her Father's confusion. It is possible that this was because of his reaction to the bill for his wife's care. The social worker advised her to contact the GP. Gladys's daughter also raised concerns about the cost of the placement and was advised about the threshold for self-funding and that once that was reached she should contact the local authority for assessment.

6.42. Because of the defaulted appointment, the GP made a visit to the Care Home to check Gladys's blood pressure and for a general welfare check. Due to the falls that had occurred the GP reduced the dose of Lorazepam as it is known to increase the falls risk. The new dose was halved and was to be given in the morning. This was particularly important as all of Gladys's falls had been in the evening.

6.43. On 27.12.2015 at 04:00 Gladys was found on the floor; no injury was noted and there was no further action.

6.44. The next day, carers reported that Gladys's legs were red and swollen. As a result, a referral was made to the Community Matron service[12] from the NHS Foundation Trust who, as part of the role, support care homes in the locality. They visited the Care Home to assess Gladys but found no evidence of reddened or swollen legs at this time. As this was the first referral into the Community Matron service and was new to the caseload, there was a requirement to carry out a holistic assessment in order to fully assess Gladys's needs. This was not carried out, and as the original reason for referral (swollen legs) was not apparent there was no treatment or management plan associated with this visit. There is no evidence that the falls that had occurred were known to the Matron that visited and this is subject to further discussion in the analysis, learning and recommendations.

6.45. Gladys remained at the Care Home over the Christmas and New Year period and both her son and daughter visited with their father.

6.46. It is noted that on 08.01.2016, Gladys was referred into the Osteoporosis service as part of routine follow up from fracture clinic.

6.47. On 09.01.2016 Gladys had a total of five falls. The falls happened in various ways, once she missed the chair she was about to sit on and once she was walking and lost her balance. One of these falls resulted in a cut to the head. It was noted that Gladys had a raised temperature and that wax was coming out of her ear. It is known that ear infections are likely to contribute to balance issues and therefore increase the risk of falls. A senior carer called for a Community Matron to visit.

6.48. Gladys was reluctant to be examined by the Community Matron, she was agitated and wanted to move away. This gave the Matron confidence that Gladys was not injured from her falls and so as not to increase agitation, the Matron did not pursue further examination. The symptoms that Gladys was displaying were indicative of an ear infection and chest infection and was therefore prescribed antibiotics and pain relief. The Matron advised the Care Home staff to observe and re refer if symptoms worsened.

[12] The Community Matron Service consists of registered nurses with advanced clinical skills who support GP practices and Care Homes. They are also independent prescribers and work using a 'see and treat' model. They are able to see patients on the same day as referral between the hours of 8 am and 8 pm.

6.49. On 10.01.2016, Gladys was found on the floor in another resident's room, there was no injury on body check and no further action was taken.

Key Episode 3: Escalation and admission (11-14.01.2016)

6.50. On 12.01.2016, the CPN contacted Gladys's daughter to discuss if she was still keen for her to have the memory medication. The daughter shared her concerns about the falls and that her mother was now taking the blood pressure medication. The CPN stated that she would make a visit to the home to see how things were and gather more information.

6.51. On 12.01.2016 Care Home staff called the Community Matrons service as they were concerned about increased confusion, falls and pain in ribs. When the Matron arrived, Gladys was walking from her room to the lounge. She was accompanied back to her room with the carer. Gladys allowed the Matron to fully examine her. The history of falls was given and the Matron found no bruising and no pain on palpation of her chest. Gladys did not show any signs of injury and was not short of breath. The Matron conducted a dip stick test of her urine which did not indicate any infection. Carers could not provide information on when Gladys had last opened her bowels so the Matron suggested Senna[13] to be given as a precaution with a view that constipation may increase agitation. The Matron suggested to continue pain relief. The Matron noted that although the electronic records showed that Lorazepam was prescribed twice a day, the Carer indicated it was only being given once. The Matron therefore suggested that the extra dose be given as a way of alleviating some of Gladys's agitation. There was a communication issue here as it is apparent that the GP had reduced the dose previously due to falls.

6.52. The Matron advised that a further visit would be arranged for 15th and that the Care Home could make contact anytime between 8am and 8pm and outside of that time could call the GP if worried.

6.53. Care Home staff continued to be concerned that Gladys was complaining of pain in her ribs and agitation was increased so they once more called the Matron service. On telephoning the Care Home the Matron ascertained that the 2nd dose of lorazepam that had previously been advised had not been given. It was therefore advised to give this and that the Matron would visit later.

6.54. It was only at the Learning Event that it became clear that the prescribed dose on the medication sheet at the Care Home was for once a day and that the changed dose had not been entered onto the electronic record by the GP that the Matrons were referring to. Without a new prescription, care home staff could not give a different dose.

6.55. Gladys continued to be restless overnight and the Care Home once again called the Community Matrons. On this occasion the Community Matron found that, on exanimation, constipation was the likely cause of the increased confusion. Gladys was reluctant to be examined but was tender over the rib area, but otherwise more settled. The Matron prescribed a stool softener. There was no bruising noted. A discussion at the Learning Event concluded that even if it had been thought that Gladys had fractured her ribs in a fall, without any other symptoms, the treatment would be pain relief and rest. It was argued that it would not have been in her best interests to go to Accident and Emergency as the

[13] Senna is a medication from the group of stimulant laxatives which help relieve symptoms of constipation

unfamiliar environment was likely to increase agitation and distress and there would be no other treatment provided by hospital attendance even if X-Ray identified fractured ribs.

6.56. At 00:10 on 14.01.2016 Gladys was found on the floor and in pain. At 09:00 care home staff called the GP. The GP visited later that morning and made a referral to Accident and Emergency. The surgery arranged an ambulance, which duly arrived at 14:36. The CPN arrived at the same time as the paramedics. The CPN noted that Gladys did not respond to questions about her pain.

6.57. Gladys was admitted to hospital and found to have several rib fractures, a punctured lung and a slight bleed on the brain. Active treatment was felt to be inappropriate and following agreement with the family was placed on end of life care pathway. Gladys died on 31.01.2016

Key Episode 4: Safeguarding Strategy Meetings

6.58. Due to concerns raised regarding the Safeguarding Adult Process, this SAR has also reviewed how the process was followed and why issues of concern arose. Issues identified have been clarified and recommendations duly made.

6.59. The local authority safeguarding team received two alerts, the first was from Gladys's son on 18.01.2016 and the second from the hospital on 20.01.2016. The first alert resulted in two strategy meetings, the initial one being on 21.01.2016 and a review meeting on 18.03.2016 which was some weeks after Gladys's death.

6.60. Safeguarding procedures were followed and the first strategy meeting was called within the identified timescale. The second alert was seen to be for the same incident as the first one so was not processed through to strategy as, due to the way the system works, this would have resulted in two strategy meetings being triggered. The second referral however, was not merged with the first and the information within it, with crucial details from the Accident and Emergency department, were therefore not available. Professionals from the NHS Foundation Trust were not in attendance at the first meeting; therefore, the referral from the hospital and the details of those concerns were not shared at the first meeting.

6.61. The first referral from Gladys's son focussed on concerns that the community matrons had failed to recognise that Gladys's symptoms were as a result of injuries from her falls.

6.62. The procedures state that persons implicated in possible abuse or neglect should not attend strategy meetings but that this is at the discretion of the Chair. On this occasion, the adult safeguarding team state that they had difficulties in identifying an appropriate person to attend on behalf of the community matron service. When it came to the date of the meeting, the manager of the service along with one of the community matrons who had visited Gladys attended. The Chair was not happy with this but it was stated that the Community Matron was insistent that attendance would provide relevant information and therefore this was allowed.

6.63. At this point in the process, the Police were still undertaking enquiries to ascertain whether there was a criminal element to this case and therefore would not have wanted anyone implicated in the care of Gladys to be at this meeting. The Police were not aware in advance who would be present and, given that Gladys's son was present, did not feel that they could challenge the attendees once the meeting had started. This was discussed at

length at the Learning Event and is included in the analysis section leading to learning and recommendations.

6.64. Between the two safeguarding meetings, the Police made the decision that there would be no prosecutions but, as Gladys had since died, had compiled their report for HM Coroner.

6.65. When the second meeting took place, the information from the second referral was available as staff from the NHS Foundation Trust were in attendance. The information was significant as it became apparent that the second safeguarding alert had been raised because of the severity and nature of the injuries. This was enough for the Police to have to review their information and revisit the possibility of criminal action. On review, there was not enough concern to proceed with criminal investigation, but the Police raised concerns that had this not been the case, the criminal investigation may well have been compromised by the procedural difficulties detailed above. This is therefore subject to further discussion in the next section.

7. ANALYSIS BY THEME

7.1. The agency reports, chronology and Learning Events provide details of the journey of Gladys from diagnosis of dementia until her death. Focussing on the systems that practitioners were working in at the time leads to important information and learning related to multi agency working to safeguard adults.

Diagnosis and treatment

7.2. Gladys was seen by Mental Health Services following a referral from her GP. She was seen in a timely manner and there was a robust assessment of her difficulties that led to a diagnosis of mixed Alzheimer's and vascular dementia. The family agreed to treatment with memory medication which, in some patients, can slow down the deterioration in memory. This was agreed at the outpatient appointment on 28.10.2015. Gladys did not receive this medication before she died therefore it was a topic for discussion and learning. At the Learning Event, Mental Health colleagues identified that the medication does not always work, particularly in the later stages of dementia and that some patients do not tolerate it. There are tests that are carried out to ensure that a patient is physically fit enough. Patients then attend a titration clinic to identify the correct therapeutic levels for each individual.

7.3. In Gladys's case, she was found to be hypertensive[14] and required treatment before memory medication could commence. The GP duly prescribed medication to reduce Gladys's blood pressure and made an appointment to review her on 22.12.2015. The Care Home were not made aware of the need to monitor Gladys's blood pressure or that the reason was to reduce it so that she could commence memory medication. Gladys's GP visited her at the Care Home the next day and undertook a general wellbeing check and blood pressure. The result of the blood pressure check is not recorded but the CPN noted that it was satisfactory.

7.4. On 12.01.2016 the CPN and Gladys's daughter had a conversation about the commencement of the memory medication, and it was believed that Gladys's daughter assumed that as Gladys was in a Care Home now, that the medication would no longer be

[14] Hypertension: **high blood pressure** is considered to be 140/90mmHg or higher.

required.

7.5. At the Learning Event, Mental Health colleagues stated that this type of medication can increase the risk of falls and therefore it would not have been in Gladys's best interests to commence treatment with this medication once she had started falling. It is not recorded whether memory medication was still thought to be appropriate and if this is the reason that it was not pursued.

7.6. It does not appear that conversations about the progress of ensuring Gladys had memory medication, as was the original plan, or the reasons for her never having received it were shared with The Care Home.

> **Learning Point 1:**
> Communication of treatment plans and any subsequent changes must be communicated to those who provide daily care for a patient **Recommendation 3**

Assessment

7.7. When Gladys's condition deteriorated and her husband was finding it difficult to manage, a referral was made to Adult Social Care. Both the CPN and the Duty Social Worker visited to ensure that there was good information sharing and that the couple got the best support they could. On that Friday afternoon, Gladys's daughter indicated that the respite placement would be self-funded. The duty social worker carried out a care and support assessment, but as the place was being self-funded, a support plan was not formulated and details of the assessment were not shared. (See Section 7.41)

7.8. The care and support assessment should have continued, after the emergency placement had been agreed and the Care Home should have been given a full copy of this given the circumstance in which it was commenced i.e. a direct referral to the local authority for support.

7.9. The Care Home policy for new admissions is that they receive either, a care and support assessment and/or plan from the assessing social worker, or information to inform care planning from the relevant health professionals. Neither of these happened and this was discussed at the Learning Event.

7.10. There were several contributing factors that led to Gladys being admitted into respite care with no robust assessment on which to build good care plans:

- The admission on a Friday afternoon was not ideal as access to the relevant health professionals was not possible nor would they be available over the weekend. The Home Manager agreed as the family were in crisis.
- Gladys was self-funding and the social worker believed that therefore the care and support assessment that had been undertaken was not required.
- Gladys's husband was struggling to remember details, was stressed from the events of earlier that day and that his wife was requiring respite when he would have preferred for her to remain at home.
- Gladys's daughter, who could provide relevant history and details, was not present; the Care Home did not ask for these details from her over the telephone.

7.11. This lack of assessment information led to Gladys being admitted to the main residential area of the Care Home, as opposed to the EMI unit. Staff at the Care Home were not aware of the diagnosis of dementia, nor were they aware if there had been any falls at home.

7.12. The Care Home should have ensured a thorough assessment of Gladys's needs pre-placement and in the case of this emergency placement, should have accessed the relevant information from healthcare professionals regarding her treatment, diagnosis and care. It was the case that this was a Friday afternoon, but there was a duty mental health team over the weekend that could have provided the information; the CPN having been present at the home during the emergency assessment. Care home staff could also have asked the Social Worker if any assessment had been undertaken, given that it was the social worker who had arranged the admission.

7.13. It is also the case that there is duty social work cover over weekends with access to social care records and although the social worker had not written up the assessment, there would have been details of the initial referral.

7.14. It is of note that when Gladys was readmitted to the EMI unit as a permanent resident there were still gaps in assessment within the Care Home. Details on this occasion were gathered from her daughter but falls were not mentioned. At this stage the Care Home staff knew more about Gladys and had details from her daughter, but the assessments were not robust and did not draw on information from healthcare professionals. Whilst Gladys had been in respite care within the Care Home she had a fall; this information did not inform the falls risk assessment and did not trigger more detailed care planning that is available to Care Home staff in respect of falls prevention.

7.15. These detailed assessments were new to the home at the time and the senior care staff were not well versed with their use.

7.16. As a result of the issues that this case raised The Care Home management company instigated a critical incident analysis. This resulted in notification to all managers that Friday afternoon admissions can only happen with agreement from a regional manager and only if all information and care and support assessments have been undertaken. This is identified in the improvement section (see 9.1) and therefore further recommendations related to this are not made directly from this SAR.

7.17. This was discussed further at the Learning Event as attendees were left confused by what should therefore happen in crises situations on Fridays and presumably at weekends if care homes all decide not to admit in these situations. The NHS Foundation Trust Intermediate Care Team representative, reminded partners that they are available to support staff in these situations alongside Adult Social Care Emergency Duty Team and that other NHS or social care may have been available.

Learning Point 2:
It is important for all assessing practitioners who respond to emergency care situations to be aware of the arrangements when approaching or during weekends and bank holidays. **Recommendation 2**

7.18. When the Community Matrons attended Gladys for the first time on 28.12.2015 a holistic assessment to fully assess her needs was not carried out. This was discussed at the Recall Event. Initially this was because the Matron who attended had technical issues and could not access the form electronically as required. On further discussion, the Matrons indicated that time is often a factor and that the assessment form is extremely lengthy with much of the form and assessment often not relevant to the Matron's service or for residents of care homes. This was put forward as a reason why the assessment is often not being completed. There is no way of flagging that the assessment remains outstanding and therefore many are never completed. Representatives of the NHS Foundation Trust indicated that the assessment remained a requirement and Matrons indicated that they are completing more now but could not identify what percentage are outstanding and never completed. This element of care from the Matron's forms part of the NHS Foundation Trust action plan as a result of this case and it appears to remain an outstanding issue, therefore further learning and recommendations are made as a result.

Learning Point 3:
Where staff are required to undertake an assessment It is important that barriers to completion are addressed in order that patients/clients receive the assessments that provide evidence of the level of need and care required.
Where assessment has been identified as being required, reasons for not undertaking that assessment should be recorded as evidence of robust decision making
Recommendation 4b & 6a

Falls management and prevention

7.19. In the one month period that Gladys was a resident at the Care Home, both in respite and as a permanent resident (11.12.2015-14.01.2016), she fell a total of 12 times. Most of these falls were recorded as 'found on floor' incidents and so were unwitnessed.

7.20. At the Learning Event, the Care Home staff explained their procedure for falls and confirmed when they would call for medical or nursing assistance. When a resident falls, or is 'found on floor', an alarm is raised and a senior carer attends. Senior carers are Level 3 NVQ trained and are able to assess for injuries and administer basic first aid. Staff from the home stated that they use a range of indicators such as pain, body language, observation and verbal communication to identify if any injuries are apparent. If all appears well, a period of observation and monitoring follows, family are informed and the fall is documented.

7.21. Care Home staff went on to explain that if an injury is found, then assistance will be called for from either paramedics, GP or nurse. The decision on which service is the most appropriate to call will depend upon the severity and need as well as availability e.g. The home is well supported between the hours of 8am and 8pm by the Community Matron Service but out of these hours it would be the GP out of hours service that would be called. On all but one occasion (20.12.2015 when Gladys had a graze to her knee) when Gladys was noted to have injuries, the Community Matrons or paramedics were called as well as when the falls escalated on 9th January.

7.22. On most occasions therefore it could be argued that the Care Home's falls policy was followed in this practical management of individual falls. What did not happen, however, is a review of Gladys's care plans or a trigger for more focussed falls prevention specific care plans. A referral to The Intermediate Care Team for specialist advice and support regarding

falls was also not instigated.

7.23. The Intermediate Care Team were notified of Gladys's fall of 17.12.2015, when she fractured her clavicle, but on contacting the Care Home, support was declined as Care Home staff felt that this was due to Gladys being new to them and that she was in an unfamiliar environment. Whilst this may be true, that fall did not trigger any other internal assessment within the home of Gladys's needs from a falls prevention perspective.

7.24. There were several factors leading to her falls risk:

- Medication; her lorazepam medication to calm her agitation leading to increased risk of falls and hence the reduction in dose by the GP
- Dementia and confusion
- Unfamiliar environment
- Macular degeneration
- Constipation
- Ear infection

7.25. According to NICE Guidance[15] older people over 65 who have received medical attention for falls should be subject to a multi-factorial risk assessment. Dependant then upon risks identified, should have a multi-factorial intervention programme. As detailed in 7.24 this was commenced but support and intervention was declined by the Care Home. Not all the multi-factorial interventions mentioned in the NICE Guidance were appropriate for Gladys, given her diagnosis, they include

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal

The NICE guidance falls short of providing guidance where strategies do not prevent falls in residential settings.

7.26. When Community Matrons were called, there were several issues identified that could have contributed to a delay in recognising the seriousness of the injuries as they escalated. At the Learning Event, it was evident that although the Matrons had been called as a result of falls, there were identified gaps in how these calls were managed.

7.27. The Matrons rely on information from Care Home staff regarding all the circumstances related to the reason for the call. It appears that on occasions, by the time the matrons had arrived, there had been a change of shift. Matrons have reported that in those cases, staff that had called the Matron may no longer be available and information regarding details of the reason for the call may not be available. Matrons at the Learning Event confirmed that it was not usual for them to look in the residents records due to the large nature of those records and the time factors. In this case, Matrons stated that they were not initially aware of the level of falls and how significant that number of falls might be.

7.28. This issue led to a discussion of the use of a handover document for Care Home staff to give to visiting practitioners where they have been called to attend residents to provide key

[15] Falls in older people: assessing risk and prevention (National Institute for Health and Social Care Excellence, (2004 &updated in 2013)

points and recent history. Attendees from the Clinical Commissioning Group made a suggestion of the use of a SBAR[16] tool that could be formulated for this purpose.

Learning Point 4:
When attending health practitioners arrive at the Care Home it is important that they are able to be given accurate information about the reason for the attendance and all relevant recent history and medication. **Recommendation 3**

7.29. It was often the case that as well as the injuries that may have been apparent, it was important to also consider falls prevention and therefore to look for other reasons that could be contributing to falls. On more than one occasion it was evident that there were indeed indications of infection and on one occasion specifically, an ear infection that could well have been contributing to balance issues. On another occasion constipation was obvious and that may well have been increasing agitation leading to increased confusion and contributing to falls. It was therefore important to recognise these conditions and treat them.

7.30. As is often the case where residents have dementia, being able to complete assessment of pain and injury can be complex. People with dementia who are in pain may have increased agitation and be reluctant to be examined and not always able to give reliable history of how they came to be found on the floor. On the occasions where this was apparent with Gladys, Matrons always asked Care Home staff to call again if they continued to have concerns. It could be argued that opportunities should be taken to call back to reassess if it has not been possible to carry out a full examination.

7.31. In the period from 09.01.2016-13.01.2016 three different Matrons attended a total of four times due to concerns of increasing pain and agitation believed to be caused by falls. Although the matrons could find possible causes for this presentation, further medical assessment was not sought as to whether there was more than the infections and constipation causing the concerns. The Community Matrons use electronic records so could see what the previous Matron had found and recommended.

7.32. As well as the treatments for specific obvious conditions, the Matrons were also asking for the lorazepam that was showing on their electronic system linked to the GP practice, to be given in the dose of twice a day. The system was not showing that, due to falls, the dose had been changed and therefore the dose could only be given once a day by carers. The suggested use of an SBAR tool to enhance communication between home staff and visiting practitioners should include current medication. If this had been the case, the error may well have been identified and rectified.

7.33. There were also issues of care home staff being able to access prescribed medication in a timely manner. The home receives medication on a delivery basis from the local pharmacy but this can take 48 hours. For more urgent medication carers will often go to the pharmacy themselves. Care homes do have a 'homely remedies' cupboard for standard over the

[16] SBAR (Situation, Background, Assessment, Recommendation) is an effective and efficient way to communicate important information. SBAR offers a simple way to help standardize communication and allows parties to have common expectations related to what is to be communicated and how the communication is structured.

S=Situation (a concise statement of the problem)
B=Background (pertinent and brief information related to the situation)
A=Assessment (analysis and considerations of options — what you found/think)
R=Recommendation (action requested/recommended — what you want)
http://www.ihi.org/resources/pages/tools/sbartoolkit.aspx

counter medication. It is the case that Senna is included in this cupboard but that stool softeners are not. In this case, given that the stool softener took a while to access via prescription, the author questioned that as it is a regular over the counter medication used in early prevention and treatment of constipation that it should be considered as available for care homes in the homely remedies cupboard.

7.34. The issue of 'homely remedies' is covered in NICE Guidance[17] and therefore any addition to, or giving of, medication by care home staff from the homely remedies box can be undertaken provided that NICE Guidance is followed.

7.35. The Community Matrons also raised the issue of not being able to refer directly for X Ray. They stated that if this had been an option as opposed to sending Gladys to Accident and Emergency, then they may have used that more direct route as it would have been less stressful for Gladys. The Matrons indicated that some GPs do allow the matrons to make this decision on their behalf and others do not.

7.36. The NHS Trust that employs the Matrons has clarified that decision to X-Ray is not a nursing clinical decision and is outside to the sphere of responsibility for community matrons and that all X Ray requests must be passed to the relevant GP.

Learning Point 5:
It is important that care homes who provide homely remedies ensure regular review of their contents in line with NICE guidance. Associated policies should stipulate that each resident's needs, in respect of treatment with homely remedies, is discussed with their GP. Medication polices are reviewed as part of the regulatory visits by CQC and Local Authority contract compliance reviews. **Recommendation 1**

Learning Point 6:
Whilst the role of the Community Matrons is an enhanced nursing role, expanding the role to include requesting of X-rays is outside of that role. Requests for X-ray should be passed to the GP for a clinical decision on the need. **Recommendation 4a**

7.37. It is clear that carers at the Care Home continued to be concerned and indicated at the Learning Event that they did not feel it was an option to continue to call the Matron Service when their concerns for Gladys were escalating and this resulted in a call to the GP.

7.38. This led to discussion at the Learning Event related to respectful challenge. Carers stated that, as the Matrons were qualified nurses who they know to have undertaken advanced practitioner skills training, they did not feel that it was their place to challenge the decisions that had been made. All present at the Learning Event, including the Matrons, recognised that respectful challenge of colleagues where there are differences of opinion should be possible regardless of perceived 'rank', in order to affirm positive professional relationships in the best interests of the client group in receipt of those services.

7.39. At the Learning Event, it was identified that the treatment for any fractured ribs would be rest and pain relief and that conveying to hospital would increase confusion and agitation for someone with dementia and therefore was not the preferred option. What was not considered though, was that the head injury on 09.01.2016 had not received medical

[17] NICE 2014 Homely Remedies Guidance

attention. It was stated at the Learning Event that there was no obvious lump to the head. Gladys had been found on the floor on several occasions so that it could not be ruled out that head injury was sustained; external, obvious injuries are not always evident with head injuries. Ongoing monitoring should have been instigated and continued following head injury protocols (NICE Guidance[18]). This should have been advised by Matrons and followed up to ensure there were no ill effects. The decision not to X-Ray also meant that the nature of any fractured ribs and any complications (e.g. punctured lung) or other injuries were not ruled out.

7.40. Following the learning that has taken place in the Care Home, all found on floor incidents and observed falls where head injury is noted, are followed with a period of monitoring for 72 hours.
Further work is now undertaken regarding falls (see improvements section 9)

Learning Point 7:
All unwitnessed falls should be treated as potential head injuries and require a period of monitoring for evidence of such injuries. In patients/residents with cognitive impairment where there have been unwitnessed falls, head Injury should be considered as a possible cause of agitation. **Recommendation 5**

Management of Self-Funding Clients

7.41. There appeared to be misunderstandings and confusion about assessments and processes related to self-funded clients. It is also not clear that the family understood all the implications or costs of self-funding.

7.42. It is not unusual for self-funded clients to access care and support under private arrangements with no assessment of needs from the local authority. Under Care Act (2014)[19] arrangements this should be available to those clients who require care and support assessments and specifically where care is needed in an emergency, regardless of whether the local authority eligibility criteria for funding is reached.

7.43. In this case, Gladys and her family were in crisis and required the support of the local authority. Despite the family's ability to self-fund, this should not have impacted on her entitlement to a full assessment that was robust in informing the care package that the family would be paying for.

7.44. The Care and Support Statutory Guidance[20] states that a copy of the final assessment must be given to the person. This did not happen and indeed the assessment did not get written up in full once it was known that care would be self-funded. At the Learning Event, local authority managers confirmed that self-funding is not a barrier to full care and support needs assessment.

7.45. There was also a discussion at the Learning Events regarding what the family understood by self-funding. Gladys's husband had met with the GP confused and angry about receiving a

[18] NICE GUIDANCE Head injury: assessment and early management https://www.nice.org.uk/guidance/CG176

[19] HM Government, 2014, The Care Act, London The Stationery Office
[20] HM Government Care and support statutory guidance available online at:
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

bill and this may have been down to his own memory issues. The GP then phoned the mental health team who in turn phoned Adult Social Care. An Adult Social Care duty worker told the mental health duty worker that on the offer of assessment to Gladys's husband he had put the phone down. This conversation is not recorded in social care records and the allocated social worker stated at the Recall Event that a financial assessment was not offered as the family were going to be funding the care themselves. In fact, the author now believes the assessment and phone call being referred to was the care and support assessment and carers assessment offered on 11.12.2015 before the initial visit; a financial assessment was never offered other than by the daughter being told she could request one when the threshold (£23,250) had been reached.

7.46. It is not clear that the daughter fully understood the charges, and this was borne out by the question being raised by the daughter when the bill for respite was received. Given what was known about how Gladys's husband was struggling and that he may have had his own memory problems and that the daughter was trying to manage things from a distance, documentation of a more robust approach was required.

7.47. Statutory care and support guidance requires that eligibly criteria for funded care, details of what self-funding means as well as signposting to independent financial advice are made available to families. It is not clear that this happened and it seems that as soon as the daughter indicated that the family were prepared to self-fund, further exploration of the reasons for this were not investigated e.g. was this decision made as it was believed that care could be accessed more quickly or that the care would be of a higher standard? This was a family that had tried to manage at home long after care and support needs became apparent and where Gladys's husband was struggling to come to terms with not being able to care for his wife.

7.48. Social work support could have continued until it was clear that Gladys was in the right placement for her needs despite the fact that the local authority were not going to be charging for this. It could be argued that given the distance that her children lived from her, that this would have been reasonable action.

Learning Point 8:
Under The Care Act requirements, self-funded clients must still receive a robust assessment of care and support needs where the family make an approach for support. **Recommendation 6a**

Learning Point 9:
It is important that families are made aware of the Local Authority eligibility criteria, the arrangements and possible charges for self-funding the care of their family member. The Care Act recognises the need to offer of financial assessment and families should be signposted to independent financial advice. **Recommendation 6b**

Mental Capacity, advocacy, carer support and family involvement.

7.49. During the visit on 11.12.2015 by the social worker and the CPN, it was established that Gladys did not have the mental capacity to decide on her care needs and where she could be safely cared for. Initially she was refusing to go into respite care, given that she did not have capacity to make decisions on this issue, this should have led to a best interest decision. Her daughter was contacted by telephone and agreed to the respite. This was good use of

advocacy from a family member and shows that consideration was given to the stress and difficulties being displayed by her husband at that time.

7.50. That said, the record shows that eventually Gladys agreed to respite care, even though it had previously been determined that she did not have capacity. The mental capacity assessment would have included assessment that Gladys would not be able to retain information and therefore any apparent agreement by Gladys may not have been remembered by her. The action to place Gladys in respite was the right one but should have been recorded as a best interest decision as opposed to Gladys agreeing this action. This should then have led to an application for an urgent DoLs, this did not happen until Gladys was readmitted to a permanent placement.

7.51. The care and support statutory guidance states that it is reasonable to have a family member as an advocate for a person who lacks capacity. In this case, the Home Manager did apply for independent advocacy services, but this was declined based on family involvement. It could be argued that Gladys's husband may not have been able to act in her best interests given his level of stress and difficulties with his own memory and that he would have preferred have been able to care for his wife at home.

7.52. It is clear that Gladys's daughter was able to be an advocate, however there were indications in a phone call to the social worker on 17.12.2015 from Gladys's son, that he and his sister did not speak and therefore this may not have been the best arrangement. It was ascertained that there was no power of attorney for health and well-being in place. It could be argued that professionals should have asked the family who they were happy to act as Gladys's advocate and how that was to be done.

7.53. As it was, the lack of an independent advocate does not appear to have impacted on this case. There was no challenge to the decision that Gladys should become a permanent resident in the EMI unit at the Care Home and there were no significant medical treatment decisions to be made. It is of note, however, that there does not appear to have been very much contact between community matrons and the family regarding the decisions and medical issues that were escalating in the early part of January.

7.54. The original safeguarding concern raised by the Dementia Advisor to the MASH indicated that although the decision had been that the incident did not indicate that the safeguarding threshold had been met, the decision had been that a social care assessment should be offered for Gladys's husband. This did not happen. The daughter had stated that she felt that her Father would be better without the worry keeping his wife safe. It is not clear how he managed following her becoming a permanent resident and none of the agency reports mention him from an ongoing perspective.

7.55. There is no record that anyone spoke to Gladys's husband or any family member about the referral into MASH for the injuries that were apparent on 11.12.2015. This should have happened in accordance with Safeguarding Adult Procedures and provisions of the Care Act 2014.

7.56. Attendees at the learning and Recall events from The Care Home indicated that he appeared to have accepted that his wife was now safe and was appreciative of the care she was receiving. He and other family members were informed of her falls and other issues when matrons were called. Since this incident, the matrons indicated that they now more routinely have contact themselves with families related to the medical and nursing

diagnoses treatment and care of residents.

7.57. Care home staff encouraged Gladys's husband to attend activities at the Care Home, and he visited regularly and was joined by his son and daughter over the Christmas period. This was seen as good practice in order that the Care Home could support the family as well.

7.58. Although there are discrepancies about what assessments were offered to Gladys's husband and whether or not they were refused, professionals were aware that Gladys's daughter was making arrangements to ensure that his needs were met. This SAR has not looked further into this issue as it falls outside of the terms of reference.

Learning Point 10:
In order to comply with Care Act requirements, it is advantageous, particularly where there is no power of attorney in place, to robustly record who is to be the advocate for a person who lacks capacity where it is family members who are undertaking that role.
Recommendation 6a

Learning Point 11:
Where carers are offered any social care assessment, either to support their caring role or as a suspected victim of abuse by the person they care for, the rationale for not undertaking this should be recorded. Caring roles do not cease when the person being cared for goes into residential placement. Duties under the Care Act 2014 require that suspected victims of abuse are spoken to and that their wishes and feelings are recorded with regard to any ongoing safeguarding investigation and protection plan.
Recommendation 6a

Safeguarding Processes

7.59. From the events that took place related to the safeguarding process it was possible to identify learning and areas for improvement.

7.60. Police colleagues found several flaws in their experience of the strategy and review meetings:

- They were concerned that criminal investigation conversations could not take place in front of family members
- A person who was possibly implicated within the preliminary allegation was present
- Vital information only came to light at the second meeting

7.61. The Making Safeguarding Personal (MSP) initiative began as far back as 2009 and was an attempt by the Local Government Association and Association of Directors of Adult Social Care[21] to ensure outcome focussed, person centred responses to adult safeguarding rather than it being a process that happened to people without knowledge. This has since become enshrined in the Care Act (2014) and requires that the adult and /or their representative is part of the safeguarding process.

7.62. It was agreed at the Learning Event that it was important to have the son there on two points i.e. he was the referrer and he was the representative for the adult with care and support needs (Gladys). It was also agreed that where the police are still undertaking investigations

[21] Lawson, J. Sue Lewis, S & Williams, C. (2014) Making Safeguarding Personal 2013/14 Summary of findings London, LGA

as to possible criminal proceedings, that family members should be excluded from part of the meeting if necessary. This would enable professional conversations, whilst maintaining the confidentiality that the Police require.

7.63. The issue regarding a person possibly implicated in a safeguarding incident being involved in a strategy meeting was discussed and it was recognised that there were two issues:

- The Chair was not made aware of who was attending the meeting
- The manager of the person implicated, and the person themselves were not familiar with the safeguarding strategy meeting process. The manager had asked the person who may have been implicated to attend the meeting.

7.64. The person in question, at the Learning Event, had felt that it was important to have an opportunity to explain to the son the care that had been given with a rationale for the decisions that had been made. It was agreed that this could have happened outside of the safeguarding process.

Learning Points 12-14:
Where there are possible criminal investigations ongoing, although the Local Authority maintain lead responsibility for the safeguarding process, it is important that conversations take place and that the police are able to ask for family members to be excluded for part of the meeting.

The police should be made aware of who is attending the meeting and have the ability to challenge where a person potentially implicated is due to attend, prior to the start of the meeting. This will require the Chair to be clear about the people and roles of those attendees.

It is important that staff who attend meetings are aware of their role within it, and whether it is appropriate for them to attend.
Recommendation 7

8. GOOD PRACTICE

8.1. It is important to note that most practitioners offer a good level of service to their clients/patients and follow policies and procedures that are provided to guide practice. Whilst recognising gaps in practice, Safeguarding Adult Reviews can also provide evidence of this as well as practice that goes over and above what is expected. Agency Reports and attendees at the Learning Events were asked to identify these from their own and other agencies. It is important to highlight these as areas where learning can occur and to recognise good practice.

- The social worker and CPN worked collaboratively when the family were in crisis and were tenacious in finding a solution and respite for the weekend. They both worked beyond the end of the working day to ensure a positive and safe outcome.

- The Care Home accepted Gladys on a Friday afternoon in order to offer the much-needed support despite the lack of available assessment from other professionals.

- The Care Home recognised that Gladys's needs would be better met on the dementia unit when she was readmitted.

- Gladys and her needs remained the focus, albeit that professionals struggled to manage her falls.

- The CPN ensured that a duty CPN called the Care Home over the weekend of the respite placement to offer support and advice.

- Gladys's own GP visited her in the Care Home to follow up monitoring of her blood pressure.

- Professionals supported the family by contacting each other for clarity on issues when the family had made contact. This was despite the fact that intact may have been made to the 'wrong' agency e.g. when Gladys's husband contacted the GP regarding the bill for care.

- The Care Home encouraged Gladys's husband to attend activities within the home to support him.

- Matrons attended in a timely manner whenever the Care Home called them to see Gladys.

- The Safeguarding strategy meeting was undertaken in a timely manner following the referral from Gladys's son

9. IMPROVEMENTS ALREADY IMPLEMENTED

9.1. The circumstances leading to Gladys's death led to an immediate Critical Incident review within the Care Home and its wider company. This has resulted in several changes and improvements in practice, policies and procedures:

- The Care Home now ensure that a detailed pre-admission assessment that also includes the gathering of information from other agencies information regardless of whether a client is self or local authority funded.

- The Care Home company have made many changes to what is recorded post fall or found on floor incidents. This includes not only monitoring of any changes over the following 24hours to identify any developing bruising or symptoms but a wider contextual recording of cause and locations of falls thereby mapping any hotspots within the setting that may be issues for all residents. Any residents found on floor or wo have sustained obvious head injuries are now monitored for 72 hours.

- The Care Home company have introduced a system of quality circles based on the Kaizen[22] methodology with a focus on falls where all employees and introduce new ideas and state what is working well or what can be improved.

[22] Kaizen: from the Japanese for good change is a method of using a process of continuous improvement across all levels of employees in regular 'quality circles' meetings.

- The Care Home management company have increased funding for homes in respect of falls management and training particularly if it is attached to the Kaizen quality improvement programme.

- The Care Home have also introduced documentation training has been introduced and encourages more detailed recording.

- Improvements in asking outside agencies to support falls assessment and care planning

9.2. These improvements are monitored through audits from regional managers.

9.3. All Community Teams in the NHS Foundation Trust have undergone sensory awareness training to enable better understanding of falls risks.

9.4. Where The Intermediate Care Team are notified of falls, this is referred to the community matrons where falls have happened within a care home. Matrons are able to act more quickly than the Intermediate Care Team that cannot offer a same day service. The Intermediate Care Team will then offer support to identify any outstanding need.

9.5. The community matrons and the Intermediate Care Team are part of a working group who are looking at post falls assessment documentation for community use.

9.6. There has also been a coincidental change resulting in more robust communication between care homes, GPs and community matrons as a result of all care homes being aligned to GP practices. There are now regular ward rounds that include GPs, care home staff and community matrons.

10. CONCLUSIONS AND LESSONS LEARNED

10.1. Gladys came to the attention of Mental Health services late in 2015. Her deteriorating cognitive ability and behaviour associated with her diagnosis of dementia led to a crisis in December 2015 leading to her death at the end of January 2016.

10.2. This review has focussed on a very short time during which there was much activity. It is important that the learning that this case highlights is shared across the partner agencies and care providers in the locality. That said, it is also important to recognise that dementia is a terminal illness, and whilst the disease progression will be different for all those with the condition, the falls that Gladys suffered were at the stage of her dementia that falls prevention strategies were largely not possible.

10.3. Initially Gladys was placed on a unit that is not set up to manage residents with dementia but the lack of pre-admission assessment did not provide the Care Home with the relevant. diagnosis and information about her care needs. Even when Gladys became a permanent resident her needs were not comprehensively assessed in order that a robust falls prevention care plan could be formulated.

10.4. What should have happened was a more robust response to her falls and recognising the impact on her of repeated falls and the associated head injury risk of unwitnessed falls.

10.5. The biggest area for learning within this case has been regarding communication and it is possible to see the system issues that contributed to the communication failures many of which have led to recommendations:

- Memory medication had been agreed but never received by Gladys. It is not clear in records that there was a clear view that it was no longer indicated.
- The GP did not update the electronic system to identify a medication change.
- Adult Social Care system for self-funded clients did not have Care Act changes embedded and managers encouraged closure of cases for such clients.
- Community Matrons did not have a good history from Care Home staff of the falls.
- Care Home staff did not feel that they could challenge qualified nurses.
- There was confusion related to what assessments had been carried out and by who and what they related to.
- The family were not robustly encouraged to be involved in decision making related to health and well-being.

10.6. What is seen is ostensibly good practice that failed in its quality of intervention due to a lack of robust assessment and communication systems.

11. RECOMMENDATIONS

11.1. Where agencies have made their own recommendations in their Agency Reports, DSAPB should seek assurance that action plans are underway and outcomes are impact assessed within those organisations.

11.2. The following recommendations are made as a result of the learning in this case and require that **DSAPB seeks assurance from** the appropriate partners that the following are addressed:

1. That the lessons learned within this review are shared across all commissioners of care provision in the locality (All learning Points).

2. That providers who have staff who are in a role of assessing and placing people in appropriate care settings are aware of the process for weekends, evenings and bank holidays (Learning Point 2).

3. That the CCGs lead the development of an effective and succinct information sharing pathway for health professionals to use when visiting care homes for the purposes of assessing residents and providing advice and treatment. Models such at the SBAR tool should be considered (Learning Point 1 & 4).

4. That the NHS Foundation Trust ensures:

    a. that the Community Matron service is operating within the sphere of responsibility and that where an X-ray is required, that the request is passed to the relevant medical clinician for approval (Learning Point 6)

    b. That barriers to the completion of holistic assessment by the community matrons is addressed and that, if they are a requirement, these are always completed and flagged as incomplete until done. (Learning Point 3)

5. That commissioners ensure there are Head Injury policies and procedures in place across care settings in the locality that meet NICE Guidance (Learning Point 7).

6.

a. That assessments, including financial and carer's assessments, and advocacy arrangements are Care Act (2014) compliant and are robustly recorded and shared appropriately. Rationale for not undertaking full assessments should also be recorded (Learning Points 3, 8,10 &11).

b. An information leaflet for families should be produced with the details of what eligibility criteria is, what self-funding means and signposting to independent financial advice (Learning Point 9).

7. That the appropriate sub group of DSAPB updates the multi-agency safeguarding adult procedures to strengthen the guidance on the following (Learning Points 12-14):

- Agreement with police in advance of a strategy meeting anyone who should not be included.
- Excluding family members from part of the meeting, if relevant, to allow for professional conversations.
- Chair of meetings being made aware of who is attending, role and purpose
- To ensure all multi-agency procedures reinforce the importance of all relevant and historical information to be considered (including information from multiple referrals) for safeguarding meetings and decision making.

Appendix One

Safeguarding Adults Review
Gladys
Terms of Reference and Scope

Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

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

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

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

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

Condition 2 is met if—

(a) the adult is still alive, and

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

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

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

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

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and DSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;

- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;

- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did;

- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;

- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;

- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;

- Make use of relevant research and case evidence to inform the findings of the review;

- Identify what actions are required to develop practice;

- Include the publication of a SAR Report (or executive summary);

- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

Case Summary
Gladys was an 86-year-old lady with dementia. She was placed in a Care Home initially as an emergency as her husband was not coping, after a trial back at home she returned to the Care Home on a permanent basis on 13th December 2015. Between her admission and 14th January, she fell 12 times. On the 14th January, following a further fall and a visit from the GP Gladys was admitted to hospital where several injuries were found that were thought to be caused by falls. At this point she was placed on end of life care pathway and died on 31st January. The coroner ruled that the injuries were involved in the cause of death and that there would be a jury inquest.

Decision to hold a Safeguarding Adults Review
The request for a safeguarding adults review was agreed by the Independent Chair of DSAPB following a letter sent on 22nd March 2016

Key Issues to be addressed

1. **Assessment**
    a. What assessments were undertaken by your agency regarding the care home provider setting being the most appropriate place for Gladys to receive respite and then full time care?
    b. What was the outcome of those assessments? Please ensure you comment on mental capacity and Best Interests decisions
2. **Falls**
    a. What falls prevention programmes and care planning were undertaken regarding the care of Gladys?
    b. What is your agency's falls protocol and what training do staff have on its implication and application?

c. Using evidence from this case please comment on how clear and effective these policies and protocols are.
d. Please comment on how well agencies work together on falls management in the locality

3. **Communication and Coordination**
    a. Either: How are Homes such as the care home provider setting supported by your agency?
    b. Or: What support did the care home provider setting receive from other agencies?
    c. What communication and recording mechanisms are used for MDT communication? Please comment on how effective any communication and coordination was in this case?
4. **Medicines Management**
    a. What were the arrangements for prescribing, recording, reviewing and communicating medication for Gladys?
    b. Please comment on how effectively this was managed from a systems perspective
    c. Please comment on any positive or negative impact this may have had on Gladys and her progress
5. **Safeguarding**
    a. What was your agency's involvement in the safeguarding concern being reported and strategy meeting in January 2016?
    b. What information did your agency share for the investigation?
    c. Please comment on the decision making that ensued from the information that was shared and application and compliance with the Darlington Multi-Agency Policy & Procedures to Safeguard Adults at Risk from Abuse.
6. **Escalation and challenge**
    a. What policies and protocols are in place in your agency to support both intra and inter agency respectful challenge?
    b. How were these utilised?
    c. Were there occasions where use of respectful challenge would have been indicated and beneficial to the outcome for Gladys?
7. **Voice of GLADYS and Family Support and involvement**
    a. How were the wishes and feelings of Gladys demonstrated in the care given to Gladys? Please comment using examples
    b. How well were the family of Gladys supported by your agency?
    c. Please comment on any issues this case raised for your agency in respect of souring and communicating with families
8. **Improvements**
    a. Please indicate any learning that your agency has already addressed following this case and what changes have been implemented as a result
9. **Resourcing and Systems**
    a. Please comment on any systems issues, staffing or resourcing issues that may have impacted on the way that your agency offered services

Scope
The review should take into account agency involvement from October 2015 during the time that Gladys was being assessed for dementia and suitable safe accommodation was being sought when it became apparent that she could not be safely cared for at home until the date of her death on 31st January 2016.

Method of Review
The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

In 19th July 2016, the SAR Sub Group agreed to use the 'Significant Incident Learning Process' or 'SILP' via the independent review organisation ***Review Consulting.*** This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.

Independent Reviewer and Chair

The named independent reviewer commissioned via Review Consulting is **Karen Rees.**

Organisations to be involved with the review:

Mental Health NHS Foundation Trust (Mental Health Services)
The NHS Foundation Trust – (All services that touched the life of Gladys:
- Community Services
- A and E
- Intermediate Care Team

The Care Home Healthcare Homes Limited
Adult Social Care (To include Safeguarding)
NHS CCG (for GP)
Ambulance Service
Police

Engagement with family

The author and DSAPB Business Manager will meet with the Husband of Gladys before the Learning Event as well as prior to publication of the final report.

Parallel proceedings

This review will take account of the Coroner's Inquest

Timescales

1.	Scoping Meeting	28/09/16
2.	Terms of Reference agreed	28/09/16
3.	Agency Authors' briefing	28/09/16
4.	Agency Reports submitted	11/11/16
5.	QA and distribution to all Learning Event attendees	22/11/16
6.	1st Learning Event	29/11/16
7.	1st Draft of Overview Report Distributed to all attendees	09/01/17
8.	Recall Event	19/01/17
9.	Circulate V2	06/02/17
10.	Comments on V2 by	20/02/17
11.	V3 Overview report presented to SCR Subgroup and/or DSAB	23 March 2017