Safeguarding Adults Review Report
"Neil"
Deceased 6 January 2016
Aged 78

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Document Control

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Acknowledgements

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Foreword

Neil died on the 6 January 2016. Concerns were raised by his family, initially with the Worcestershire Clinical Commissioning Group, about the events leading to his death. Subsequently, and following due process, the Chair or the Worcestershire Safeguarding Adult Board (WSAB) decided that the circumstances surrounding Neil's death met the Safeguarding Adults Review criteria as laid down in the Care Act 2014. It was decided that the Review would focus on the period from the 1 January 2015 to the date of Neil's death, 6 January 2016.

I was appointed by the WSAB in late August 2016 to assist them in the preparation of the Safeguarding Adult Review (SAR) report. I am an independent social care consultant and a qualified social worker having previously been a Director of Social Services for fifteen years in large county local authorities. Subsequently, I have held senior Board level positions in the NHS and as a non- Executive Director with a large voluntary housing association.

The purpose of a SAR is to gain, as far as is possible, a common understanding of the events that led to death, to identify if partner agencies, individually and collectively, could have worked more effectively and to suggest how practice could be improved. A SAR is about learning, not blaming, and aims to improve future practice.

The Terms of Reference for this Review are given at Appendix 1. For the purposes of this report and in line with standard practice for Safeguarding Adult Reviews, the agencies and individuals providing information to the Review are not identified.

1.0 Introduction

Neil was aged 78 at the time of his death. He was a tall man of slim build. It is understood that he had worked as a sales representative for a plastics company for most of his working life. He had three sons, two of whom live locally. Neil had largely brought up his three sons single handily. In the latter part of his life, he lived alone in a two bedroomed, privately owned property. He had a cleaner to call once a week but could garden, drive his car and do all his own shopping. He was quite a private man but was sociable with his neighbours and had a friend with whom he enjoyed a coffee. Neil was a moderate smoker and would have an occasional, social drink.
[Note: In October 2016 and January 2017, with the WSAB Board Manager, I met with one of Neil's sons and the son's partner. These were very helpful meetings - in gaining a full understanding of the family's concerns and gaining their views on this report. It is at the son's request that his father is referred to as "Neil" throughout this report.]
Neil had Type 2 diabetes and, in 2014, he suffered a minor stroke. Also in 2014, Neil was referred to the Community Neurological Team as there were concerns about cognitive decline. (It is understood that Neil's mother had

suffered from dementia.)

2.0 A Summary Chronology of Key Events: 1 January 2015 – 6 January 2016.

Note: The SAR Panel received extensive and very helpful reports (Individual Management Reviews – IMR's) from each of the agencies involved in Neil's care. Of necessity, in the interests of brevity, the following section can only include key events.

2.1 Events Leading to Neil's Admission to Residential Care

January 2015 – mid July 2015

Throughout this period, Neil received several services from Primary Care, including diabetic podiatry assistance. In January, there had been some concerns about weight loss and in March 2015, he underwent colonoscopy and gastroscopy examinations. A colonic polyp was removed – there was no evidence of invasive malignancy and by late April, Neil's weight was steady.

On **27 July 2015** Neil attended the local Minor Injuries Unit having fallen in the bath. He had sprained his ankle but was otherwise uninjured but he did experience some resultant loss of confidence. On **2 August 2015,** a referral was made by an Out of Hours Doctor to the Enhanced Care Team (ECT) for rehabilitation support. The Admission Prevention Team became involved who gave advice and appropriate equipment to Neil.

At the start of **August 2015**, the GP made a referral to the local Older Adult Mental Health team (OAMH) as there were concerns from the ECT that Neil was displaying signs of cognitive decline, delusional ideas and a degree of paranoia. It was reported that he was taking his medication erratically. In **late August 2015**, a Community Psychiatric Nurse (CPN) visited Neil, with a colleague, having previously spoken to one of Neil's sons to gain background information. Neil appeared well but complained of loneliness, albeit he refused any suggestions as to how he might broaden his social life. Antidepressant medication was discussed but refused. A range of screening tests were administered and the CPN noted some loss of orientation and recall: mild cognitive impairment. The GP was informed of this.

The CPN made a further visit on **7 September 2015** when no significant further factors emerged.

On three occasions in **October 2015** Neil had contact with Primary Care services about foot pain.

On **8 November 2015**, at 5.42 am, Neil attended a local Police Station saying that he had been burgled. He appeared confused and could not recall his personal details. An ambulance was called and Neil was taken home, where there was no sign of any break in. The emergency services were worried

about Neil's mental health and he was therefore taken to the local A&E Department. (The police recorded this as a Vulnerable Adult Incident.)

One of Neil's sons was with his father at the hospital. A wide range of diagnostic tests were undertaken and it was concluded that there were no significant medical issues but Neil was somewhat confused. He was medically fit for discharge. Neil was seen by a Rapid Response social worker at the hospital who arranged for Neil to receive ongoing domiciliary support from the Urgent Promoting Independence (UPI) service which was actioned the next day.

On **11 November 2015**, the UPI assistant found Neil at a bus stop and returned him home.

On **12 November 2015**, one of Neil's neighbours called an Ambulance as Neil had been seen in the street, in a confused state, and the neighbour was concerned for his immediate safety. The police located Neil and returned him home. One of Neil's sons attended. It was decided to make an urgent referral to the GP who, in turn, referred Neil to the OAMH Team. The GP made an urgent home visit and administered a series of medical and cognitive functioning tests. The GP concluded that there may be a problem with dehydration and/or cognitive decline. Later that day, a nurse and Health Care Support worker from the Enhanced Care Team (ECT) visited Neil – a meal was prepared for him and he stated that he would put himself to bed.

On **13 November 2015**, an Occupational Therapist (OT) visited, when one of Neil's son's partner was present. There were worries about Neil's use of his medication – appropriate action was taken. The OT recorded that a "mental health nurse also required".

On Saturday **14 November 2015**, the OT and a colleague, made a follow up visit. Neil was not at home but the front door was ajar. They searched the surrounding area for Neil but one of Neil's sons arrived saying that his father had fallen while out walking and had been taken in by a neighbour who had telephoned him. Neil was returned home. It was found that he had a flesh wound on his right leg which was treated by the OT's. Over quite a lengthy period that day, the OT's gave Neil and the family support. It was recorded that "All safe on leaving".

On Sunday **15 November 2015**, a Registered Mental Health Nurse from the ECT visited. Family members were present - they had been considering seeking a place for Neil at a local care home. Both they and the ECT worker were concerned about Neil's mental health. Contact was made with the Out of Hours GP, with the Rapid Response social work team and the Psychiatric Emergency Team. The Out of Hours GP visited and concluded that there were no immediate medical interventions necessary. The family agreed to support Neil overnight.

In the morning of **16 November 2015**, Neil was calmer but hallucinating. Social workers, CPN's, the GP, other professionals and the family all worked

together to address Neil's needs. The CPN and the Rapid Response social worker undertook a home visit. It was concluded by the CPN that Neil was not "sectionable" under Mental Health legislation but the rapid decline in Neil's functioning over the last 2 weeks, taken together with him wandering away from home, led all to agree that it would be in Neil's best interests if he could have a period of respite care in a residential care home for people with dementia. This home has secure facilities. A Mental Capacity assessment was completed. In the late afternoon, Neil was admitted to a relatively local residential care home by one of his sons – the home had received faxed copies of the needs assessment, the mental capacity assessment and a summary medical record. Neil appeared to settle quite well.

2.2 Events Leading to Neil's Admission to Hospital

Neil was resident at the care home for one day short of five weeks. The initial period of care, one week, being extended on at least two occasions, in Neil's best interests. On admission, Neil was fully risk assessed and he was put on15 minute observations.

Neil's family noticed a gradual improvement in his physical condition. He was eating and drinking adequate amounts (Neil had been underweight on admission) and he began to join activities with other residents. Neil's family members were kept informed throughout his stay and they visited him frequently.

From the 24 November, and over the next 3 weeks, Neil's behaviour became more challenging being both verbally and physically abusive to members of staff and other residents. A total of eleven such incidents are recorded. He was seen to enter other residents' rooms, without permission. He was generally very agitated.

During his stay, Neil was found on the floor, but with no injury, on two occasions (the 21 and 27 November 2015) and on 7 December 2015 he was found with an unexplained bump on his head.

Neil was visited by health professionals on six occasions during his stay, to review his declining mental state and adjust medication. A District Nurse visited on 19 November 2015 to dress the wound Neil had suffered on the 14 November. On 20 November 2015, Neil was referred for an urgent CT scan in relation to his continuing cognitive and behavioural decline (this took place on 3 December 2015). A Deprivation of Liberty Safeguards (DoLS) authorisation was applied for on the 25 November 2015.

On **13 December 2015**, at 8.30 in the evening, Neil was found walking along a corridor with a swollen and bruised face. The social care emergency duty team were notified and the Out of Hours medical service were contacted. At 9.45 pm, an ambulance arrived and, after an initial examination, Neil was taken to hospital by ambulance but otherwise unaccompanied. Home staff contacted one of Neil's sons and the Safeguarding Team to let them know of

the admission to hospital. It was not until the next day that the reasons for Neil's injuries came to light: an assault by another resident.

2.3 Neil's Stay in Hospital 13 December 2015 – 4 January 2016

Neil was admitted to the A&E Department of the hospital at 11.10 pm. He had a small laceration and haematoma over his left eye and swelling to most of the left side of his face. X-ray and CT scans (the latter undertaken on 15 December) showed no fractures. [Note: At the post mortem, a fracture of a cheekbone was identified.] It appeared to A&E staff that these injuries were consistent with an assault. In the morning of **14 December 2015**, the hospital raised a formal Safeguarding Alert with the Local Authority and the Patient Safety Lead at the hospital advised that Neil should not return to the care home until further investigations could be undertaken: Police to be notified.

At 10.13 am the police were notified of the assault by the hospital. On investigation, it emerged that Neil had been assaulted by another resident at the care home when, reportedly, he had found Neil in his room and an altercation had ensued. The assault was admitted.
[Note: the SAR panel considered if this other resident was inappropriately placed at the care home. It was concluded that although the placement was appropriate, the risk assessments provided to the home had failed to mention previous aggressive behaviour albeit he was described as being verbally abusive/aggressive. This is discussed further in Section 4.]
A full investigation was completed by the police and, in due course, an advice file was submitted to the Crown Prosecution Service who recommended no further action as there was no realistic prospect of conviction.

Later that same day, Neil was transferred from A&E to a medical ward where he was reviewed by a Consultant Physician who noted no fractures and clear chest x-ray. [It should be noted that the consultants are now of the opinion that Neil should not have been transferred to the medical ward – he should have returned to his residential home but there were concerns about his safety there – hence the earlier safeguarding alert.] The Consultant requested that Neil be referred to the Mental Health Liaison Team (MHLT) and for a mobility assessment. In the late evening (11.00 pm) it was documented that Neil was "very confused and wandering around the ward".

On the **15 December 2015**, Neil was again seen by a Consultant Physician. It was noted that "he had a period of aggression".

On the **16 December 2015**, the Lead Nurse Adult Safeguarding (LNAS) at the hospital reviewed progress on the Safeguarding Alert and advised that ward staff should ensure that Neil's mental capacity be formally assessed regarding his ability to consent to being accommodated in hospital in order to receive care and treatment and that if lacking capacity, a decision on a Deprivation of Liberty Safeguards (DoLS) application would need to be considered. Neil was being very aggressive and tried to physically attack staff. He was also pulling

at other patients' intravenous lines and using other patients' belongings. The next day, an urgent DoLS application was made.

It is recorded in the files held by the residential care home from which Neil was admitted to hospital, that a senior member of the home's staff contacted the hospital, on **17 December 2015**, and was told that a decision had been made that Neil should be transferred to a Community Hospital for continued care. He was much less aggressive. By the following day, it was concluded that Neil was not yet medically fit for transfer – he was not eating or drinking. His name to remain on the waiting list for a Community Hospital.
On the **19 December 2015**, Neil was again very agitated and being aggressive to other patients and relatives. Neil was moved to a side room, with continued one-to-one supervision which had been in place since the date of his admission to the hospital. Note: the requested referral for assessment by the MHLT (first requested some 5 days earlier) had still not been actioned.
On **20 December 2015** Neil was reviewed by a Consultant Physician: "delirium and aggressive behaviour noted - referral to MHLT required".

On the **21 December 2015**, the LNAS reviewed Neil and documented the urgent DoLS authorisation would expire at midnight on 23.12.15 and therefore all decisions in relation to care and treatment were to be made and documented as being in Neil's best interests.
Neil still not medically fit for discharge/transfer to Community Hospital. The referral to the MHLT was made and a Consultant Psychiatrist reviewed Neil's care and treatment, adjusting medication and requesting further blood tests. To be reviewed in 2 days.

At 3.30 pm on the **21 December 2015**, ward staff sought advice from a Doctor as Neil had had an unwitnessed fall from his bed. It is not clear if bed rails had been fitted to Neil's bed but, in any event, the required one-to-one supervision was not in place due to staff shortages. Neil was taken for x-ray but he declined/was too confused for the x-ray to be undertaken safely.

On the **22 December 2015**, Neil was seen by a Consultant Physician who noted that Neil was distressed: "possible fractured neck of femur due to fall and awaiting x-ray".

Later that morning, apparently coincidentally, the Consultant Psychiatrist requested a MRI brain scan (subsequently booked for 11 January 2016) as the CT scan recently undertaken was showing atrophy of the brain.

At 11.40 am, x-rays were taken of Neil's pelvis and hips and a fracture of the right neck of femur was confirmed. Bed rest with no weight bearing prescribed.

On **23 December 2015**, in the morning, Neil was seen by an Orthopaedic Consultant and an Anaesthetist. Neil was still confused, aggressive and delirious. The LNAS was informed of the unwitnessed fall and fracture and she discussed this with the Patient Safety Lead who confirmed that the events would be reported externally as a serious incident and that a Root Cause

Analysis would be undertaken. In the late evening, Neil was transferred to an Orthopaedic Ward.

In the morning of the **24 December 2015**, Neil was seen by the Consultant Psychiatrist who advised that Neil's delirium may increase post-operatively.

Neil was operated upon later that day and his right hip was replaced. Records state that his initial recovery was uncomplicated.
Note: After the operation, Neil's top set of dentures could not be located.

Over the next few days, Neil continued to make reasonable progress medically, so much so that on **29 December 2015**, a doctor recorded "impression is [Neil] is fit for discharge from a medical point of view and possible community hospital if orthopaedics happy". (The doctor repeated this assessment the next day.)

On the **30 December 2015**, a request was made to Neil's home area Health and Social Care Patient Flow Centre for him to be provided with a rehabilitation bed at a Community Hospital.

On the **31 December 2015**, the Patient Flow Centre advised that a local nursing home would be the best placement for Neil post discharge: Neil's rehabilitation prospects were limited and therefore he would be assessed for a permanent placement at the nursing home. A senior member of staff from the nursing home visited Neil in hospital and confirmed that they would be able to offer care to him. Meanwhile, Neil was again assessed as medically fit for discharge, sitting out in a chair.

By the morning of the **2 January, 2016**, Neil is assessed as "fairly settled, episodes of confusion at times, [being] closely observed". However, later that day, he is described as unsettled and finding it difficult to swallow. (During his stay in hospital, Neil had developed oral thrush for which treatment was prescribed.)

On **3 January 2016**, Neil is mobilising with the assistance of a frame and one person.

On **4 January 2016**, Neil was sleepy in the morning and unable to take his medication orally. The day before, he had been prescribed oral morphine although the reason for this is unclear. He was assessed as being in some pain. At 11.15 am on the 4 January, Neil was seen by a consultant physician who considered that Neil was medically fit for discharge. At 1.10 pm, Neil was reviewed by an Orthopaedic Doctor who noted that Neil was "mobilising with frame and one person, otherwise medically fit".

That evening Neil was transferred from the hospital ward, on a stretcher, to a Worcester nursing home. A telephone handover call from the hospital to the home was effected. Note: No written handover was sent to the home.

2.4 Neil's Brief Period of Care at The Nursing Home

As stated above, Neil was admitted to the nursing home on the 4 January, at approximately 6.20 pm. He was transferred straight to a bed. He was showing some distress and appeared to be in pain. An Out of Hours doctor was contacted to advise on pain management: Neil was finding it difficult to swallow medication. Staff were advised to crush his tablets.

On **5 January 2016**, Neil received a visit from his new GP practice due to moving to Worcester. Additional pain relief was prescribed and a referral for community physiotherapy made. The GP would also chase up the MRI scan requested on 22 December. Neil was settled throughout the day with regular pain relief.

During the night of the **5/6 January 2016** Neil was observed at regular intervals. At 3 am, Neil was given a drink and was settled. At 05.20 am on the **6 January 2016,** the Registered Nurse on duty heard an unfamiliar noise from Neil's bedroom. On investigation, Neil was found to be retching and vomiting dark green fluid, very pale in colour. The Registered Nurse sat him up to protect his airway. Base line observations were completed – the 111 service was called and staff were advised to ring the GP if there were any changes. Neil's son was made aware of the current situation. Staff commenced 15 minute visual observations to monitor Neil's wellbeing. Once washed, Neil seemed comfortable. The Registered Nurse on duty observed him at 7.45am and noticed that his circulation appeared compromised with no cardiac output. A colleague commenced CPR whilst the Registered Nurse rang for paramedic assistance. The ambulance crew arrived within 5 minutes and they continued resuscitation. Tragically, this was unsuccessful and Neil was pronounced dead at 8.10am. Due to the suddenness of his death, police attended and the family were informed.

Subsequently, a full forensic post-mortem was carried out and on the 10 November 2016 the coroner confirmed that the medical cause of death was pneumonia and the verdict was that Neil had "died as the result of an accident, to which neglect contributed".

3.0 Specific Areas for Consideration as Listed in the Terms of Reference.

A series of sixteen specific questions were included in the Terms of Reference for this Review, partly as raised by Neil's family. These can be answered as follows (some of the information below may unavoidably reiterate some of the information already given):

1. *How agencies held Making Safeguarding Personal[1] at the centre of services provided to Neil?*

[1] **Making Safeguarding Personal** is a sector led initiative which aims to develop an outcome focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. It is about engaging with people about the outcomes they want at the beginning and middle of working with them, and

It can be difficult in circumstances where someone is suffering from significant cognitive decline, as experienced by Neil, to engage with the person in a meaningful way. However, from the reports received, the GP's and other health and social care professionals, especially the CPN and the various support workers who visited Neil in his own home, endeavoured to do so. When Neil's cognitive decline became worse, immediately prior to and after his admission to the residential care home, contact and involvement with Neil was maintained, very creditably, by the CPN, who worked in partnership with other health and social care professionals within the older adult mental health integrated team. When required, extensions to Neil's stay were granted, however, there is a lack of evidence to suggest that there was a clear coordinator of his care to ensure person centred practice fully maintained.

During Neil's stay in hospital, the local Safeguarding lead played and maintained a very active role.

2. *How and When Mental Capacity Act and Deprivation of Liberty Safeguards were applied and how this was documented.*

In the period prior to Neil's emergency admission to the residential care home, the health and care professionals were conscious of Neil's declining mental capacity. A Mental Capacity Assessment and Best Interests Decision(BID) was made by the social worker and the CPN, with the assistance of the family, and documented by the social worker. It is not clear if a copy of the BID was supplied to the care home.
A Deprivation of Liberty urgent authorisation should have been made upon Neil's admission to the residential care home: he was to be held in a secure environment. A statement was eventually completed nine days after admission. Within 16 hours of Neil's arrival at the hospital to which Neil went from the care home, the need for Deprivation of Liberty to be considered was noted. Appropriate documentation was duly completed and the application sent to the local DoLS team who then passed it, the next day, to the DoLS team in Neil's home area.

3. *Concerns expressed by family members about not knowing who all the professionals were, they did not have contact details. How was communication managed?*

To quote from a letter of complaint written by one of Neil's sons, that after Neil returned home there were "seemingly random visits by an assortment of people from varying care teams .... each with their own agenda for care, but very little in the way of communication to us, Dad's family".
These understandable concerns relate predominantly to those professionals who were offering/providing various services to Neil when he was at home. There is an inevitability that in multi-handed GP Practices, patients will not always see the same doctor. This is generally understood and accepted.

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then ascertaining the extent to which those outcomes were realised at the end.

[Note: on a related issue, it became apparent that when circumstances demanded that Neil be seen by a "temporary GP" – in the nursing care settings - records were not routinely available (there is a significant time-lag in medical records being transferred). This is a national problem but one which needs to be urgently addressed by the NHS England.]
The Enhanced Care Team, the CPN and the Rapid Response team all ensured that Neil's family were regularly contacted, that the family knew who these staff were, what their role was and their contact details. However, this was not true for other agencies although the police did ensure that during the investigation into the assault on Neil, the family were made aware of who they should contact.
At the time of the safeguarding referral being raised, on 14 December 2015, it is apparent that the safe guarding team in Neil's home area failed to contact the family – it was the family who contacted the OAMH Team to find out what was happening.

Communication between agencies (as is, sadly, so often identified in SAR's) and with relatives was not universally satisfactory. From the information made available to the review, some professionals did not know that colleagues from other agencies were involved. This is clearly unacceptable and the Worcestershire Safeguarding Adults Board will need to address this further.

4. *In relation to the person who assaulted Neil at the residential care home, what level of information had been made available by the placing authority to the care home and what risk assessments had been done?*

As stated earlier, the person who assaulted Neil was appropriately placed at the care home. However, the pre-admission assessment the home received for this person, prepared by an adult services area team social worker stated that he could be verbally abusive/aggressive but no mention was made of physical assaults. The assessment had been completed 2 weeks prior to the admission to the care home and pre-dated an incident at the previous care home where the person who was later to attack Neil had assaulted a member of staff. It was this incident that prompted the transfer to the care home. Clearly, the formal assessment should have been updated although it can be assumed that the care home must have been made aware of this incident as the person was subject to police bail at the time of transfer. However, none of this negates the appropriateness of the placement.

5. *Neil's medication potentially added to the risk of falling. Was this reflected in the risk assessment(s)?*

The SAR Panel members and I are satisfied that GP, care homes and hospital staff all took the increased risk of falling due to medication into account. The hospital to which Neil was admitted in December 2015 undertook a specific falls risk assessment.

6. *How appropriate were Neil's placements at the residential care and nursing homes? How were his needs met, what risk assessments were in*

place and how did these consider contact between Neil and other residents?

The placement in the residential care home was appropriate. Indeed, as noted by family members, Neil's physical condition gradually improved, he was eating and drinking adequate amounts and he was taking his medication regularly. He also began to join activities with other residents. The home reports that a full risk assessment was carried out upon Neil's arrival including consideration of personal attributes such as mobility and behaviour. Risk assessments were continually reviewed and updated during Neil's stay. The pre-admission documentation had stated "no aggression" It was not until Neil had been in the home for eight days that Neil's challenging and aggressive behaviours began to emerge. Contact between Neil and other residents was a factor in the risk assessments and regularly monitored.
As stated earlier in this report, hospital staff had been liaising with the Health and Social Care Patient Flow centre in Neil's home area which was exploring the possibility of Neil moving from the acute hospital to a community hospital. Neil was transferred to the nursing home rather than a community hospital because, on 31 December, it had been decided by the Patient Flow Centre that a placement in a nursing home rather than a rehabilitation unit would best meet his needs. The placement at the nursing home was appropriate although the pre-admission assessment recorded some concerns about the degree of Neil's ill-health and pain levels. Comprehensive risk assessments were completed and his basic care needs were well met.

7. *What level of information was shared between the residential care home and the mental health team – was information relating to incidents shared?*

The CPN made four visits to see Neil at the care home. On each occasion, he had discussions with the Team Leader/Senior on duty and was given access to the care record and made aware of Neil's challenging behaviours. However, it is not clear if the CPN was fully cognisant of assaults on other residents as well as assaults on staff.

8. *What consideration was given to Neil's weight loss?*

As referred to earlier, Neil underwent appropriate procedures for weight loss in early 2015. After that, his weight remained steady and while in the residential care home, his weight increased.
However, it is reported that during his stay in hospital in December/January, Neil's weight dropped from 72.5 kg on 15 December to 65kg on 31 December. This is probably attributable to the fact that Neil's dietary intake was generally poor, the "nil by mouth" prior to his operation, the loss of his top dentures apparently after the operation and the oral thrush he developed while in hospital. The hospital dietician prescribed nutritional supplements and Neil was prescribed appropriate treatment for the oral thrush.

9. *How was Neil's dementia managed by his GP(s)?*

There was no formal diagnosis of dementia until 15 December 2015 and it would have been inappropriate to prescribe specific dementia medication before then. Until the formal diagnosis, “cognitive decline” had been the major concern together with other aspects of Neil’s mental health, for example, his paranoid feelings.
Neil’s cognitive decline was regularly tested and monitored in liaison between the GP’s and the mental health services. The GP’s also sought to eliminate any physical explanation for Neil’s confusional state.

10. *What decision making processes were used in relation to the reporting of the assault that took place at the residential care home?*

When Neil was first found injured on 13 December, it was not immediately apparent that he had been assaulted. The care home’s first duty was to get Neil the medical attention he urgently needed although they did notify the social care emergency duty team that Neil was injured. It was A&E staff who identified that Neil’s injuries were consistent with an assault and informed the police on the 14 December. (As far as can be ascertained, neither the residential care home nor the CPN, who was informed of the incident by the care home, raised a formal safeguarding referral.) The hospital made a safeguarding referral to the home area safeguarding team on 14 December 2015. The police and, subsequently, the Crown Prosecution Service, followed all due processes. The Safeguarding Team concluded, in late December, that as the alleged perpetrator of the abuse had been relocated to a more secure placement, he no longer posed a risk to others at the care home. Therefore, under Section 42 of the Care Act (2014), it was not necessary to pursue the matter further. [Comment: It is not known, neither is it within the remit of this SAR to establish, if the new secure placement to which the alleged perpetrator was transferred was made fully aware of the assault upon Neil.]

11. *How was Neil’s care plan reviewed in response to the level of incidents [at the residential care home?*

As a matter of course, all care plans at the care home are reviewed monthly. However, the level of incidents involving Neil led to almost daily reviews in which other professionals (e.g. the OAMH/CPN) were involved, as appropriate.

12. *How was Neil’s pain assessed and managed immediately before and after the transfer from the hospital to the nursing home on 4 January 2016?*
13. *What was prescribed for Neil to manage the pain following the neck of femur fracture and hip replacement?*
14. *How were Neil’s pain relief and nutrition managed throughout the day of transfer to the nursing home?*

Due to the dementia, Neil may not have been able to express a level of pain. There is little in the nursing or medical record (and, therefore the Individual Management Review (IMR)) referring to pain assessment other than use of the ‘National Early Warning Score’ system on 5 occasions between 23

December and the 2 January. Neil's pain levels were generally assessed as low but as would be expected after surgery, the regular administration of analgesia confirms that Neil was in pain. There is no evidence that the hospital's Pain Assessment procedure was utilised.
Neil was prescribed regular paracetamol and, as required, codeine phosphate, for pain relief following his fall and the drugs chart shows that these were administered appropriately up to and including 3 January 2016. On that day, he was also prescribed oral morphine, as required four hourly. (There is no information available as to why this was prescribed.) On the day of transfer, 4 January, Neil was given a dose of oral morphine at 3 am (it is not known if this was a first dose) and a dose of codeine phosphate at 5.15 am.
Neil was sleepy at the time of the 9 am drug round so he was not given any pain medication nor his dietary supplements. Shortly afterwards, Neil's medication chart was sent to the Pharmacy Department for preparation of his discharge medication. This meant that Neil was not given any medication at the lunchtime drugs round. Indeed, there is no evidence of any pain relief being administered between 5.15 am and Neil's transfer to the nursing home which was not effected until after 6 pm. The Electronic Discharge Summary records that Neil was transferred with oral paracetamol.
In relation to the issue of nutrition, as already reported, the hospital dietician had prescribed nutritional supplements for Neil. There is no reference in the IMR to nutrition on the day of transfer.

15. How was Neil's oral thrush managed?

Neil was prescribed appropriate medication (Nystatin) on the 2 January 2016. However, not all doses had been signed for on the drugs chart and this could well have impacted on Neil's ability to swallow. If Neil refused medication, this should have been noted on the drugs chart. A prescription for Nystatin was included with the Electronic Discharge Summary.

16. What care plans and risk assessments were in place around Neil's discharge from the hospital he attended on 8 November 2015?

Prior to discharge home on 8 November, Neil was assessed by a Rapid Response social worker. One of his sons was present who had no concerns about Neil returning home if some support could be offered at lunchtime each day to ensure that Neil was eating. The son agreed to approach Age UK to see if they could supply an electronic 'Lifeline' alarm. The social worker arranged for two calls a day from the Urgent Promoting Independence Team (UPI) who would make further assessments of Neil's needs and abilities. This was put in place. However, and as stated by adult social care in their IMR, the assessment, while proportionate, only considered Neil's presentation at A&E albeit the UPI team were to make a further assessment once Neil returned home

4.0 Analysis and Comment

4.1 Evidence of Good Practice

From a careful analysis of the Individual Management Reviews made available to me and the SAR Panel, it became clear that there were several examples of good practice in the way in which the various agencies offered care to Neil. These include:

- The police response on the 8 and 12 November 2015 was sensitive and proportionate;
- On the 12 November, to help reduce Neil's confusion, the way in which a member of the ECT gathered all Neil's medication together and took those no longer required to the local pharmacy for disposal;
- The fact that, on the 14 November, members of the ECT searched Neil's home and the surrounding neighbourhood, for a considerable time, to try and locate him and ensure his safety;
- The various GP Practices provided excellent primary care services to Neil. One GP spent time with Neil and one of the sons establishing a rapport, explaining what he was doing and, additionally, trying to rule out a physical explanation for Neil's deteriorating mental health. GP Practices proactively sought out information from a variety of sources, such as from care home staff and records, from social care agencies and through contacting previous practices (when known) to gain vital information about Neil's on-going needs:
- The sensitive and medically thorough way in which the hospital Neil attended on 8 November responded to his needs;
- The way in which social workers worked with other professionals and the family to find Neil the emergency respite placement in the residential care home;
- Members of the Enhanced Care Team and the Community Mental Health Team worked well together, ensuring that, as far as possible, there was continuity in the personnel visiting Neil. The CPN maintained close contact with Neil's family and continued to liaise with colleagues and the sons about Neil's health and wellbeing when Neil was in the residential care home and the hospital;
- The awareness of A&E staff, on 13/14 December, to the possibility that Neil had been subject to an assault and the fact that this was raised as a formal safeguarding alert in a timely manner, and the way in which the local Safeguarding lead played and maintained a very active role.
- The alertness of the nursing home staff to Neil's worsening and critical medical condition in the early morning of the 6 January and the speed of response by the ambulance service.

4.2 The Critical Events

There were four critical events which, arguably, culminated in Neil's sad death:

- The assault on 13 December 2016

- The transfer to a medical ward on 14 December 2016
- The fall at the hospital on 21 December 2016
- The discharge to the nursing home on 4 January 2017

In addition, bearing in mind that Neil died barely 38 hours after the discharge to the nursing home on 4 January 2016, there must be a concern that he was not truly ‘fit for discharge’.

The assault: It is in the nature of such facilities as those provided by the care home that such incidents can occur. That is why comprehensive risk assessments are undertaken and updated as required. Such incidents may, at times, be predictable, but they cannot always be prevented. While the unit in which Neil was living was a secure facility, the free movement of residents within the unit was an essential part of daily life for all. Had the further incident of the fall at the hospital not occurred, then the assault, albeit regrettable (to say the least), would not have such significance.

The transfer to the medical ward: the hospital staff were very concerned about Neil’s safety at the residential care home and, therefore, provided a place of safety for him at the hospital within a medical ward. Other options for a discharge to a more suitable placement should have been considered. This could have included a return to the care home from which Neil had been admitted to hospital: the care home could have given Neil a room in a different wing to his attacker. There was no clinical need, at the time, for Neil to remain in hospital – it was a few days later that Neil’s health began to decline to the point at which he became not fit for discharge. A hospital environment can be detrimental for a person with dementia due to the noisy, brightly lit, crowded and bustling ward surroundings which are an inevitable feature of a busy medical ward.

The fall: The coroner found the cause of death to be “pneumonia on a background of a surgically repaired hip” and that Neil died “as the result of an accident, to which neglect contributed”. Clearly, the ‘accident’ was the fall from the bed and the ‘neglect’ was the failure, that day, to ensure that Neil had the one-to-one supervision which was considered essential – it had been predicted that Neil may experience difficulties that required constant staff attendance. The hospital at which Neil had the fall is in a relatively rural location. When there are staff shortages or, as in this case, a person calls in sick, there is not a large pool of trained and qualified staff in the local area, either regular staff or agency staff, to call upon. Having said that, as far as can be ascertained, when the unavailability of staff cover, both internal and external, was identified, the appropriate escalation policy was not invoked and neither were the family approached to see if one of their number could come and sit with Neil. There is no way of knowing if the escalation processes would have resolved the staffing difficulties but the fact remains that had staff been with Neil that afternoon, the fall may have been prevented – the Coroner was clear that this was the case.

The discharge to the nursing home: As stated above, Neil died just 38 hours after his admission to the nursing home. Was he fit for discharge from the

hospital? (The nursing home did raise a "problematic discharge" form but this related to the lack of written communication/discharge summary rather than matters relating to Neil's ill-health.)
I am told that bacterial pneumonias[2] are typified by a sudden onset of symptoms and rapid illness progression. Those whose immune system is compromised are particularly at risk and this certainly applied to Neil. He had recently undergone major surgery, he had oral thrush, he had lost a considerable amount of weight, he was quite elderly and suffered from Type 2 diabetes. In addition, at this point, Neil appeared unable to verbalise: he could not tell staff of any symptoms he might be experiencing and the pain from which he was suffering could well have masked other warning signs.
The authors of the IMR provided by the hospital state:
"*in [our] professional opinion, having reviewed and considered the documentation and observation charts, [Neil] should have remained in hospital for a further period of observation and review. His clinical presentation showed a potential declining picture."* They add "*However, it should be noted that if [Neil] had remained in hospital, the eventual outcome may still have been the same*".
I would concur.

4.3 A Further Matter of Concern

Once Neil was admitted to the residential care home, and thereafter, Neil was seen, appropriately, by several GP's who had no prior knowledge of him. Out-of-Hours GP's were also consulted. On each occasion, the Doctor concerned had to offer care and treatment without the benefit of Neil's medical history.
(In Worcestershire, the Emis web is the recognised platform for all GP services, during practice hours: services have full access to their own patient case load, but do not have access to the other practices in the County. Worcestershire GP practices have authorised the Out of hours (OOH) GPs/ Advanced Nurse Practitioners (ANP) to have access. The OOH service need to gain the patient's consent to use the Emis system to review their records, except in a life threatening medical emergency. The same applies for Temporary Registered Patients - if the patient gives consent then the Doctors can access their Summary Care Record for details of medication, adverse reactions and allergies.)

I am aware that, for several years, NHS England (and its predecessors) have been endeavoring to develop an Electronic Patient Record which can be accessed, remotely, by duly authorised people, at any time, using the patient's NHS number. Full implementation has still not been achieved. While lack of access to Neil's medical history was not a critical factor, the case brings this issue into sharp relief.

[2] The information available does not specify if the pneumonia was bacterial, viral or of some other aetiology. However, a bacterial infection is assumed to be the most likely cause here.

5.0 Recommendations for Action

5.1 Individual Agency Recommendations and Action Plans

One of the main purposes of a SAR is to seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and to ensure that those lessons are applied in practice to prevent similar harm occurring again. As part of the Individual Management Review process, and in most cases, the authors of these Reviews identified several areas in which their agency's practice could be improved (not all of which relate directly to Neil's care) and have made recommendations and drawn up action plans accordingly. These have been reviewed by the SAR Panel and we would:

Recommend to the Worcestershire Safeguarding Adult Board (WSAB) that the Board approves and adopts the Single Agency Action Plans and ensures that these are audited, over time, to ensure completion of the actions.

The Single Agency Action Plans are attached at Appendix 2.

5.2 Recommendations to The WSAB Itself

I have found nothing to suggest that the Adult Safeguarding Inter-Agency Policies and Procedures for which the WSAB is responsible are in any way lacking, albeit, in some instances, adherence to these policies and procedures has not been acceptable (for example, in the raising of formal safeguarding concerns).
However, there are matters arising from this detailed examination of the circumstances leading to Neil's sad death which, in addition to actions being taken by Single Agencies, the WSAB, as an Inter-Agency body, should consider. I would

Recommend:

(i) That the WSAB ensures that the Lead Professional/Key Co-ordinator role is embedded across the partnership. Providers of services must ensure that the Lead Professional/Key Co-ordinator role is in place

- **when commencing an episode of care, or**
- **when a package of care is reviewed, or**
- **when the patients/client's needs and level of risk begin to escalate and a multi-agency, coordinated response is required to manage their needs, levels of risk and complexities arising.**

A co-ordinated response will improve communication and co-ordination of care and facilitate a holistic approach, reducing the risk

of silo working between professionals and improve outcomes for the service user and their family/carer.

(ii) That the WSAB seeks assurances from partner agencies that there is adequate and appropriate support and information given to care and nursing facilities to enable them to provide emergency placements for people and prevent them from becoming inappropriately risk averse so that adults with care and support needs are appropriately cared for and safeguarded in the right place.

(iii) That the WSAB makes representation to NHSE to encourage the full implementation of access to the full primary care Electronic Patient Record, to ensure that GP records are available (with consent or in a life-threatening situation) to duly authorised personnel, at all times, thereby ensuring that these records are immediately available for out of hour's services and during temporary placements such as in residential and nursing homes.

If these recommendations are accepted, the Board will wish to draw up action plans for implementation and keep these under review until completed.

6.0 Closing Remarks

The last few months of Neil's life were a tragedy for all concerned. As his family pointed out, in the early and mid-part of 2015, "[Neil] was active, living on his own, driving and engaging in a relatively normal life [but he] is no longer with us". The onset of his cognitive difficulties (with some additional mental ill-health symptoms) and dementia was rapid. Dementia is known to be a life shortening condition but it is apparent that the assault in December (while possibly inconsequential on its own) and the fall and broken hip Neil suffered later the same month, accelerated his decline and resultant death.

While not universally the case, there are lessons for several of the agencies involved to learn: we owe it to Neil and his family to do so.

Robert Lake
November 2016

7.0 Appendix 1

Worcestershire Safeguarding Adults Board
Safeguarding Adult Review: Neil

TERMS OF REFERENCE

1. Introduction:

1.1 Neil had care and support needs and was in receipt of care. He died while receiving care. There is evidence of one incident of physical abuse by another resident and concerns were raised about the standard of care in the months prior to his death. Neil's family made a complaint to the CCG and requested that a SAR be considered.

1.2. Neil had been assessed by Older Adult Mental Health Services, but at that time there was insufficient evidence to confirm a diagnosis of dementia and the case was closed. He attended A&E and returned home with support from the Urgent Promoting Independence Service. He became confused/delusional and the Enhanced Care Team took over care. He was found a mile away from home/at a neighbour's house (discrepancy). A Mental Health Act assessment took place, but it was stated detention/admission to a psychiatric ward was not required. Neil was admitted to a care home. He experienced some falls and presented with behaviour that challenges. Neil was assaulted by another resident, Mr B. He was then admitted to Hereford Hospital where he fell and fractured his neck of femur. He was discharged to Redhill Care Home who raised concerns regarding the discharge and the lack of pain management. Neil died shortly afterwards.

2. Supporting Framework:

2.1. The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

2.2. Section 44, Safeguarding Adult Reviews**:**

(i) A 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.

(ii) 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).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

2.3. This Safeguarding Adult Review is being held in accordance with the Worcestershire Safeguarding Adults Board Safeguarding Adults Review Protocol criteria **1**. This states that "*the Worcestershire Safeguarding Adults Board must*

arrange for there to be a Review if the statutory criteria prescribed in section 44 of the Care Act 2014 are met. Statutory Guidance on these criteria is provided in Chapter 14 of the Care and Support Statutory Guidance, at paragraphs 14.133 and 14.134. Therefore, the Board ***must*** *undertake a Safeguarding Adults Review under the following circumstances;*

> *when an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) dies and the Worcestershire Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)."*

3. Methodology:

3.1. This Safeguarding Adults Review will primarily use an investigative, systems focused and Individual Management Review (IMR) approach. This will ensure a full analysis by the IMR author to show comprehensive overview and alignment of actions.

3.2. This will ensure that practical and meaningful engagement of key front line staff and managers will be carried out by the IMR author on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.3. This is more likely to embed learning into practice and support cultural change where required.

4. Scope of Safeguarding Adult Review:

4.1. Adult: Neil — Date of Birth: 28/11/1937
Date of Death: 06/01/2016

4.2. <u>Timeframe</u>

The scope of the SAR will be from 01/01/2015 to 06/01/2016

4.3. In addition, agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of this adult and include information around wider practice at the time of the incident as well as the practice in the case

5. Agency Reports:

5.1. Agency Reports will be commissioned from:

- The County Council in whose area Neil lived
- The local Health and Care NHS Trust
- The NHS Trust providing the hospital to which Neil was admitted in December 2015
- The local Clinical Commissioning Group and associated GP Practices
- The Residential Care Home to which Neil was admitted in November 2015
- The Nursing Home to which Neil was admitted in January 2016

- The Police
- The NHS Trust providing the hospital in which Neil received A&E services in November 2015

5.2. Agencies will be expected to complete a chronology and IMR.

5.3 Any references to the adult, their family or individual members of staff must be in a non-identifiable format.

5.4 Any reasons for none cooperation must be reported and explained.

5.5 All Agency Reports must be quality assured and signed off by a senior manager within the agency prior to submission

5.6 It is requested that any additional information requested from agencies by the SAR Independent Author is submitted on an updated version of the original IMR in red text and dated.

5.7 It is requested that timescales are strictly adhered to and it should be noted that failure to do so may have a direct impact on the content of the SAR.

5.8 Agencies will be asked to update WSAB on any actions identified in section 8 of the IMR prior to the completion of the SAR which will be fed into the final report. Updates will then be requested until all actions are completed.

6. Areas for consideration:

1. How the agency held Making Safeguarding Personal at the centre of the services provided to Neil?

2. How and when MCA and DoLS were applied and how this was documented

3. Neil's family raised concerns that they did not know who a lot of the staff involved with Neil were, their contact details and there appeared to be a lack of communication. How was this managed?

4. What level of information was passed to the residential care home by the county council that demonstrated the suitability of the placement for the person who assaulted Neil given there had been previous incidents? What risk assessments were in place?

5. Neil's medication potentially added to his risk of falling, was this reflected in risk assessments?

6. How appropriate was Neil's placement at the two nursing homes? How were his needs met, what Risk Assessments were in place and how did these consider contact between Neil and other residents (particularly the person who assaulted Neil)?

7. What level of information was shared between the residential care home and the mental health team – was information relating to incidents shared?

8. What consideration was given to Neil's weight loss?

9. How was Neil's dementia managed by his GP?

10. What decision making processes were used in relation to the reporting of the assault that took place at the residential care home?

11. How was Neil's care plan reviewed in response to the level of incidents?

12. How was Neil's pain assessed and managed immediately before and during his transfer, in January 2016, from hospital to the nursing home?

13. What was prescribed to Neil in order to manage the pain of the NOF?

14. How were Neil's pain relief and nutrition managed throughout the day of his transfer from hospital to the nursing home?

15. How was Neil's oral thrush managed?

16. What care plans and risk assessments were in place around Neil's discharge from the A&E hospital in November 2015?

7. Engagement with the individual/family

7.1. While the primary purpose of the Safeguarding Adult Review is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in and across agencies and services, it is imperative that the views of the individual/family and details of their involvement with the SAR are included in this.

7.2. Firstly, this is in recognition of the impact of Neil's experience/death. In doing so it ensures that this enshrines the principles and practice of Making Safeguarding Personal, a core value signed up to by all agencies working as part of the Worcestershire Safeguarding Adults Board.

7.3. Worcestershire Safeguarding Adults Board are responsible for informing the family that an Independent Reviewer has been appointed.

7.4 All IMRs are to include details of any family engagement that has taken place or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the SAR.

8. Media Reporting

8.1 In the event of media interest all agencies are to use a statement approved and provided by WSAB.

9. Publishing

9.1 It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

9.2 The media strategy around publishing will be managed by the Community Awareness and Prevention subgroup of the WSAB and communicated to all relevant parties as appropriate

9.3 Consideration should be given by all agencies involved in regards to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware in advance of the intended publishing date

9.4 Whenever appropriate an 'Easy Read' version of the report will be published.

10. Administration

10.1 It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via a secure e-mail account or the WCC Cisco system. Failure to do so will result in data breach.

10.2 The Board Co-ordinator will act as a conduit for all information moving between the Chair, IMR authors, Panel members and the Case Review sub group.

11. Timetable for Safeguarding Adult Review

Item	Date
Scoping Meeting to agree on Panel members, terms of reference, methodology etc. Letter to IMR agencies to identify authors and secure documents	July 2016
First introduction and discussion with the family	September 2016
Panel Meeting and Authors' briefings	27th September 2016 10am -1pm
Completion date for IMRs	31st October 2016
2nd Panel (scrutiny of IMRs) and IMR author presentations	14th November 2016 10am-4pm
First draft of Report circulated to Panel members	28th November 2016
Comments back to Chair	5th December 2016
Practitioner event	15th December 2016 10am – 4pm
Update on Single Agency Action Plans feedback to SAR Author by IMR Authors for inclusion in final report	22nd December 2016
Final draft of report completed and 2nd	10th January 2017
Meeting with family to consider final draft and suggest amendments. Any amendments made to final draft following meeting with family	W/c 16th January 2017
3rd Panel meeting to approve final draft of the report and draft multi-agency recommendations. Any amendments made to final draft following panel meeting	6th February 2017 10 am – 1pm
Safeguarding Adults Review Sub Group meets to consider final draft report and multi-agency recommendations	TBC
Final draft report and multi-agency recommendations circulated to Worcestershire Safeguarding Adults Board members.	TBC
Worcestershire Safeguarding Adults Board meets to consider final report.	TBC
WSAB Sub Group Chairs meet with SAR Author to determine multi-agency action plan from the SAR recommendations	TBC

8.0 Appendix 2 – Single Agency Action Plans

No	Recommendation	Key Actions	Evidence	Target Date	Status	Agency
1	To update and embed the Recording Policy into practice and ensure it is adhered to.	Managers to discuss the recording policy with staff at team meetings and in supervision. To ensure a letter template is available for sending to families and is sent and recorded by all staff when transferring a case. To ensure copies of assessments and support plans are sent to all the relevant people in line with the recording policy. Frameworki as accurate information on all contacts with relevant people.	Recording Policy Reviewed and updated, on e-guide, embedded in practice through team meetings, supervision.	30/04/17	In Progress	WCC
2	To ensure Making Safeguarding Personal principles are adhered to	All staff are expected to liaise with relevant people and keep them fully informed throughout the safeguarding process and they should be informed of the outcomes/decisions.	Case audits	30/04/17	In Progress	WCC
3	To develop a policy specifically for short term emergency placement.	To develop a policy in partnership with relevant others, including OAMH Teams, to inform staff of the expected procedures when making an emergency placement.	Audits	30/04/17	In Progress	WCC
4	Providers to consider DOLS for all people who have been assessed as lacking capacity to consent to the placement	Brokerage requests to include a tick box to alert providers when a person is placed in their best interests to prompt consideration of a DOLS authorisation to the relevant Local Authority.	Brokerage requests	31/12/16	Completed	WCC

No	Recommendation	Key Actions	Evidence	Target Date	Status	Agency
5	To ensure UPI service have a clear, recorded handover when care transfers to another provider such as ECT's/Dom care providers	UPI to follow recording policy and ensure transfer summaries are completed and shared with new providers	Frameworki	30/04/17	In Progress	WCC
6	Specific risks relating to individuals are always identified in any reassessments	Staff to read history and previous risk assessments and ensure this knowledge is considered carefully in future care planning and is recording in the latest assessment documentation.	Assessments - audits	30/04/17	In Progress	WCC
7	Medical Practice(MP) 1, 2, and 3 to ensure all GPs, Trainee GPs and other clinical staff undertake Mental Capacity/DoLS Training . MCA/DoLS Competency Framework will be re-sent to MP 1, 2, 3 .	1.Training dates to be disseminated to the three GP Practices .	Medical Practice (MP) 1, 2, and 3 to ensure all GPs, Trainee GPs and other clinical staff undertake Mental Capacity/DoLS Training . MCA/DoLS Competency Framework will be re-sent to MP 1, 2, 3 .	8/11/16	Completed	CCG
8	See above	2. GPs and other relevant staff will book onto and complete MCA/DoLS training.	Evidence will be submitted to the Named Professionals that relevant staff identified to undertake MCA/DoLS training have completed this training by 31.05.2017	31/05/17	In progress	CCG

No	Recommendation	Key Actions	Evidence	Target Date	Status	Agency
9	To share with all GPs the model of best practice that some GP Practices have made the choice to develop a Named GP visiting service (within their own GP Practice) for all patients in the community who are unable to get to General Practice, which provides continuity of care for patients .	To disseminate across GP Practices in Worcestershire this model of best practice and that this may be a model GP Practices, wish to consider.	To be disseminated on the weekly brief to all GPs	31/12/16	Completed	CCG
10	GPs should undertake MCA/DoLS training to increase knowledge and improve application of MCA/DoLS in practice.	Disseminate information to GPs about training opportunities available. Re-send MCA/DoLS Competency Framework and ask GPs to incorporate into appraisal process to GP Practices (through GP Weekly Brief).	Findings from RCGP/CCG Safeguarding Audit evidences year on year % increases in training completed by GPs	31/12/16	Completed	CCG
11	As above	Dip Sample	Findings from RCGP/CCG Safeguarding Audit evidences year on year % increases in training completed by GPs	30/09/17	Not started	CCG
12	As above	Report back to WSAB	Findings from RCGP/CCG Safeguarding Audit evidences year on year % increases in training completed by GPs	31/10/17	Not started	CCG

No	Recommendation	Key Actions	Evidence	Target Date	Status	Agency
13	Staff to receive training in how to identify, act upon and report safeguarding incidents.	Book training .	Home training matrix.	ASAP/ongoing	Completed	Haresbrook
14	Pre-admission assessments to be in place before admission of service user.	Requirement to be added to Admission Checklist.	Admission Checklist	Immediate	Completed	Haresbrook
15	DoLs to be applied immediately upon admission.	Requirement to be added to Admission Checklist.	Admission Checklist	Immediate	Completed	Haresbrook
16	All entries on documentation to be signed by the author.	All staff to be instructed in the importance of provenance.	Supplementary Documentation	Immediate	Completed	Haresbrook
17	Improve the understanding of professional responsibilities in relation to implementation of Mental Capacity Act and standard of documentation of assessments of mental capacity and rationale of best interest decisions through targeted training.	MCA training to be added to essential training profile for all clinical staff band 5 and above including Doctors.	Training figures.	31/03/17	In Progress	WHCT

No	Recommendation	Key Actions	Evidence	Target Date	Status	Agency
18	Improve the understanding of professional responsibilities in relation to implementation of Mental Capacity Act and standard of documentation of assessments of mental capacity and rationale of best interest decisions through targeted training.	Associate professional safeguarding adults to work with clinical teams to put theory into practice.	Quarterly reports to Integrated Safeguarding Committee.	30/04/17	In Progress	WHCT
19	Improve the understanding of professional responsibilities in relation to implementation of Mental Capacity Act and standard of documentation of assessments of mental capacity and rationale of best interest decisions through targeted training.	Repeat audit of DoLS and MCA in community Hospitals.	Audit report.	31/03/17	In Progress	WHCT

No	Recommendation	Key Actions	Evidence	Target Date	Status	Agency
20	Red Folders used by the Enhanced Care Team to be retrieved from patients home on the last visit.	The last member of the Enhanced Care Team to discharge the patient will collect the red folder from the patients home. This will then be amalgamated with the Base Records.	Audit report.	30/12/16	Completed	WHCT
21	Self-Neglect Guidance to be embedded in the Enhanced Care Team.	All Enhanced Care Team staff to have a good understanding of the self-neglect Guidance. Evidence in documentation that they have considered Self-Neglect, Self-Neglect exists, made reference to the Guidance.	Audit report.	31/03/17	In Progress	WHCT
22	Correspondence to a permanent G.P also needs to be sent to the local G.P whilst a patient resides in respite care.	To remind all staff of the importance of including the temporary health care professionals into any correspondence.	Audit Checks	29/02/16	Completed	WHCT
23	Staff to be reminded to escalate issues with staffing	Escalation policy recirculated to all inpatient areas	E-mail confirmation of policy circulation	31/07/16	Completed	WVT
24	Where input from the MHLT is required, individuals must be referred at the earliest opportunity	Awareness to be raised via the Safety Summit and Trust Talk	Attendance at Safety Summit and article in Trust Talk	31/12/16	Completed	WVT
25	Pain to be appropriately assessed in individuals with advanced dementia	Roll out of pain assessment for individuals with advanced dementia	Copy of pain assessment. Dates of roll out	30/04/17	In Progress	WVT

No	Recommendation	Key Actions	Evidence	Target Date	Status	Agency
26	Additional support and training regarding mental capacity and best interest decisions	Additional targeted training for staff on the medical and orthopaedic wards in this case	Training dates Attendance records	30/04/17	In Progress	WVT
27	Additional training on the completion of falls assessments and bedrails assessments	Additional targeted training for the medical ward involved in this case	Training dates Attendance records	30/04/17	In Progress	WVT
28	Improve staff understanding about nutrition and hydration in patients with advanced dementia	Additional targeted training for the medical and orthopaedic wards involved in this case	Training dates Attendance records	30/04/17	In Progress	WVT
29	The authors of this review to present the case to the WVT Dementia Matters Group	Attendance at the Dementia Matters Group meeting in January 2016	Attendance at meeting and minutes	18/01/17	Completed	WVT