SERIOUS CASE REVIEW REPORT

EXECUTIVE SUMMARY

REPORT- ADULT D

REDACTED VERSION

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1.0 Introduction

Adult D died on 26th April 2011, following discharge from the acute hospital back to Y Care Home on 18th April 2011.

Following Adult D's death a Safeguarding Adult referral was made and a subsequent investigation carried out. The alleged perpetrator was a qualified nurse working within the Y Care home. The Local Authority appointed a Safeguarding Manager and Investigator. The outcome of the investigation found that on the balance of probability abuse had occurred and an outcome of neglect was substantiated in respect of the alleged perpetrator.

The subsequent Case conference held on 20TH April 2012 recommended that a Serious Case Review (SCR) be submitted to Doncaster Safeguarding Adults Partnership Board (DSAPB) for consideration in respect of Adult D.

The time period over which events in the case are being reviewed is 24.04.10 – 26.04.11.

The family of Adult D were consulted and included in the SCR process as they wished.

2.0 Process of the review

This SCR was recommended and commissioned by Doncaster Safeguarding Adults Partnership Board. This review began on 7th September 2012 and was concluded when it was approved by the Doncaster Safeguarding Adults Partnership Board on 7th November 2013.

An author for the review was appointed. In establishing an author for this process and report, consideration was given to the independence of the identified author. It was concluded by the Chair of the Doncaster Safeguarding Adults Partnership Board that given the role and nature of the care delivery to Adult D then the identified author and Chair of the panel meetings would provide sufficient independence and would not compromise the review.

The SAR Panel, held on 7th September 2012, requested that the following agencies/bodies identified and commissioned an independent author of sufficient experience and seniority to undertake an Individual Management Review (IMR). These are:

- Emergency Care Practitioners
- Primary Care General Practice
- Rotherham Doncaster and South Humber NHS Trust (RDaSH)
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT)
- Doncaster Metropolitan Borough Council
- X Care Home
- Y Care Home

3.0 Individual Management Reviews

The objective of the Individual Management Reviews (IMRs), which form the basis for the SCR, is to give as accurate as possible account of what originally transpired in an agency's response to Adult D. To evaluate the content of the findings consider fairly, and if necessary to identify any improvements for future practice. The purpose of an IMR is to propose specific solutions, which are likely to provide a more effective response to a similar situation in the future.

The overarching report and this executive summary report is based on the IMRs commissioned from professionals who are independent from any involvement with Adult D. A responsible officer in each organisation has signed off the IMRs.

The report's conclusions represent the collective view of the SAR Review Panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations that arise from the review.

In addition a comprehensive chronology of agency involvement and significant events from the period 24th April 2010 to 26th April 2011 has been compiled and analysed by the SCR author and the SAR Review Panel.

4.0 Summary of the Case

Adult D was an elderly lady who, following being cared for initially in a different residential home transferred to X Care Home on 24th April 2010. She had previously been treated for a number of physical health problems including: Vascular disease, Hypothyroidism, Gout and Dementia. She had had a number of other procedures and medical problems during her lifetime. She was receiving prophylactic antibiotics for recurrent urinary tract infections. In 2006 Adult D had received a diagnosis of late onset Alzheimer's disease.

In light of her changing needs Adult D's placement at X Care Home was reviewed by DMBC Adult services and she subsequently moved to the Y Care Home on 24th February 2011.

There were also a number of safeguarding investigations regarding her care undertaken by DMBC; these were completed in conjunction with an overarching multi-agency review of services at X Care Home.

Within the timeframe of the review Adult D received care form the Emergency Care Practitioner (ECP) services, her GP, Mental Health Services for Older People and more latterly from the acute hospital. On the 9th of April 2011 Adult D sustained a fracture of the neck of the left femur following a fall at the Y Care Home.

Following her discharge back to Y Care home on 18th April 2011 from hospital, Adult D continued to be cared for at the Y until her death on Tuesday 26th April 2011.

Following the death of Adult D a safeguarding referral was made regarding the care provided to her in the preceding days up to her death. The outcome of the investigation was that abuse had been substantiated.

In light of this and the need for further exploration of the care provided a serious case review was instigated.

The serious case review has reviewed the care provided to Adult D however given the absence of detailed information from the last nursing home she received care; the findings from the review are restricted to the knowledge provided in the remaining IMR's.

5.0 Conclusion of the case

Adult D was an elderly frail lady who though her numerous physical conditions and complex mental health needs presented a challenge to care providers.

Individually each agency provided care to Adult D; however this was carried out in pockets with little sharing and communication.

This led to a fragmentation of her care with little evidence that she was consulted in choices and decisions. With the exception of the Mental Health Services for Older People, whilst individually the reports provided by agencies report that her inability to take part in decisions was considered, no action was then undertaken by professionals to assess her mental capacity and consult on her best interest. The only detailed consultation considered was with her family. There was some evidence of enquiry regarding capacity and best interest decisions, but little documentation and only one example of appropriate documentation being used. While this single act represents an element of good practice, little regard has been afforded to Adult D in relation to the assessment of her mental capacity, in relation to where she lived of the care provided, very few professionals who had come into contact and or that were involved in her care considered her mental capacity needs.

Her physical health needs, have through this review, appeared to have been similarly neglected. There is evidenced of documented weight loss, over a stone in 6 months, and yet no consideration to what may be behind this was taken. It is recorded in the primary care IMR decision process regarding further investigations, however again this was not broadly communicated or connected to any decisions regarding her end of life.

Agencies had different perceptions on her care, with some indicating that they had assessed her as being at the end of her life and communicated to this effect, however this was never explicitly stated and not shared between agencies. This resulted in a conflict of anticipation about what care should be provided to Adult D and potentially what the expected outcome would be.

Equally there is reference to Adult D self-catheterising at the beginning of the review period, yet no formal recording of this, other than the issuing of catheters can be found. The point in time when she could no longer undertake this is not recorded. This is significant in terms of the impact of the recurrent UTI's and the need for prophylactic antibiotics.

It is noted through a number of the IMR's that Adult D made several attempts and on occasions succeeded to leave, the care homes. However there is no evidence that these attempts were connected and a clear care planning process about how to prevent such risks and to engage Adult D in her own care appear to have been explored. There was no consideration of deprivation of liberty safeguards, given the attempts made by her to leave the home and actively asking staff to go home.

The IMR's of the two care homes do not provide evidence of individualised care planning.

This serious case review has identified that the death of Adult D was not preventable; however the quality of her experiences could have been improved. The recommendations are made in cognisance of this.

6.0 Lessons to be learned

Following review of this case each agency were requested to identify lessons to be learned through the IMR. These are detailed within section eight.

In addition a number of lessons can be learned from this review. These centre on two key areas, that regarding the care provided to Adult D and those relating to the overarching process of carrying out a review into care provided.

Whilst there were different approaches by each agency regarding mental capacity, there was very little evidence of a documented approach to the assessment and recording of Adult Ds capacity and little evidence that any information regarding this was shared between organisations. Equally there was an absence of the use of advanced decisions and information regarding this being shared across organisations. This is particularly key in relation to the reference to the End of Life Care Pathway.

Adult D had complex physical and psychological health needs and was elderly and frail. This did not appear to be taken into account across organisations and within the nursing homes. In particular, the use of the End of Life Care Pathway and the physical health needs of people within care homes, including nutrition, hydration, weight management and self-catheterisation.

With regard to the SCR process this review has found that there does not appear to be a requirement for independent care homes to cooperate with the Safeguarding Adults procedures particularly in relation to SCRs. In addition the process of undertaking a serious case review requires review and the support of additional systems and resources.

7.0 Recommendations

The recommendations identified below will be addressed by the development of an action plan with clear timescales. This will be performance managed within individual organisations where applicable and by DSAPB.

7.1 Emergency Care Practitioners

1. A routine review of safeguarding procedures within the organisation will be carried out with specific reference to the Doncaster Emergency Care Practitioners Service.
2. A training/update day will be facilitated. Part of this day will be to review procedures around safeguarding and safety netting. Particular reference will be made to vulnerable adults and children.
3. A review of patient report form forms has shown a high level of clear and detailed documentation in line with expectations of a practitioner working at this level of autonomy. A further review of patient report forms across the service will be undertaken.
4. A named Emergency Care Practitioners will be assigned to perform a monthly analysis of the audit database. The Emergency Care Practitioners will identify patients who receive multiple visits or contacts with the service and the results will be built into a cumulative report which will highlight trends relating to specific patients.
5. Results from recommendation 4 will support the wider health care community in a multi-agency forum where joint action plans can be produced to ensure the best possible care is given to vulnerable patients.

7.2 Primary Care - General Practice (GP)

1. Review and improve communication with patients and families regarding;
    - The use of Advance Directives
    - End of Life pathways

2. Review approach to and method of communication of End of Life care planning and the fact that a patient is approaching the end of their life with the patient and family.

7.3 Rotherham Doncaster and South Humber NHS Trust (RDaSH)

1. Review the Trust Safeguarding Adult policy to ensure it is in line with the current on-going review and multi-agency (South Yorkshire) Safeguarding Adult procedures.
2. Review Trust clinical supervision, with particular regard to Safeguarding Adult supervision.
3. Review the Trust approach to the coordination of complex care and MDT decision making that guides best practice in decision making, with particular regard for multi-agency service provision and 'transitions' between service providers.
4. Older Peoples Mental Health and Doncaster Community Integrated Service managers should review staff training compliance records with regard to;
   - Safeguarding adults
   - Mental Capacity
   - Falls prevention
5. Review services available with regard to non-pharmacological approaches to working with people living with a dementia, that enhances more therapeutic, evidence based, person focused ways of working with people living with a dementia.

7.4 Doncaster and Bassetlaw NHS Foundation Trust (DBHFT)

1. The Management Team within the Orthopaedic Clinical Service Unit should audit the process for the management of specimen results in order to demonstrate practice change.
2. The chair of the Patient Safety Review Group should enable the presentation of this case by the Orthopaedic Clinical Service Unit in order to disseminate learning as a result of this review.
3. The Complaints Manager should review the Complaints policy to strengthen the monitoring of compliance with the Policy, within the Trust.

4 The Head of Risk and Legal Services should review the Policy for the Reporting and 'Management of Incidents and Near Misses' to strengthen the monitoring of compliance with the Policy, within the Trust.

5 The Lead Professional for Safeguarding should ensure all Safeguarding Adult training materials reviews and strengthens the importance of documentation.

7.5 Doncaster Metropolitan Borough Council

1. Where there is an overarching multi-agency safeguarding response in a care home, individual issues should be documented comprehensively so that rationale for decision making is clear.
2. Where there is a multi-agency piece of work in a home there needs to be co-ordination of the action and visits undertaken to a care home so that the day to day running of the home is not impeded.

3. Reference and attention needs to be given to the wishes and feelings of the individual regardless of capacity of the individual.
4. There needs to be clarity around category of placement for an individual in a timelier manner. This should include an escalation process in the event of any delays.
5. There should be a clear quality assurance process for carrying out safeguarding investigations and the subsequent report.
6. Mental capacity and best interest decisions should be formally recorded as does protection planning.
7. Improvements need to be made to how work is coordinated for individuals within overarching multi-agency actions in a care home
8. Training and procedures for the management of overarching multi-agency safeguarding cases should be provided.

7.6 X Care Home

1. A review of all assessments and care planning for residents should be undertaken; this should specifically include issues with regard to physical health.
2. A review of the process for making referrals to other health agencies for specific physical health needs should be undertaken, this should include the appropriate recording of such referrals and the response received.

7.7 Y Care Home

1. There should be a review of safeguarding training, knowledge and skills across all staff groups within the home and also home managers and senior staff.
2. There should be a review of Mental Capacity, Best Interest Assessor and DOLS knowledge and skills across all staff groups within the home.
3. A review of all prescriptions and the obtaining of medications out of hours should be undertaken.
4. A review of the role of the ECP service and GP input to the home should be undertaken. This should include clarity regarding the responsibility for the overall care of the residents.
5. A review of the process for the assessment of a patient's category of care prior to their discharge from hospital should be undertaken by the home manager, deputy and Social Worker.

7.8 Overarching Recommendations

Within this review a number of individual agency recommendations have been made. These originate from the individual agency's own reflections on the care provided to Adult D. However in order to progress care across agencies and Doncaster as a whole there are a number of recommendations that are made to support individual agencies own approaches. These are identified within two categories, care provision and the SCR process.

Care provision:

1. There should be a coordinated approach to the assessment, recording and communication of individual patient's mental capacity across all agencies providing care to individual patients. This should include a review of how the assessments are acted on by relevant teams and services.
2. There should be a review of the process of sharing of information and communication across all care providers.
3. A review of the use of Advance Decisions for Dementia should be undertaken across services.
4. Physical Heath care:
    a. A review should be undertaken on the use of the End of Life care Pathway. This should include how decisions are made, adherence to the Mental Capacity Act and Best Interest decisions. It should also include how decisions made with are communicated to all care providers and the family.
    b. A review of the monitoring of patients physical health needs within care homes should be undertaken. This should specifically include nutrition, hydration, weight management and Self-Catheterisation.
5. A review of the care planning process and documentation including quality standards should be undertaken within care homes.

SCR Process:

6. A review of the commissioning process for all independent care homes to include a duty to cooperate with Serious Case Reviews should be undertaken.
7. There should be a review of the process for undertaking serious case reviews. This should include specific training for independent care homes and supporting resources, for example tools to complete the chronology.

The Doncaster Safeguarding Adults Partnership Board will now be responsible for overseeing the implementation of lessons learned as part of the Serious Case Review process. Agencies identified within this report will be asked to submit action plans to respond to the recommendations and evidence to support their implementation.