Rotherham
Safeguarding Adults

silp™
Significant Incident Learning Process

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

Phyllis

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Contents

(Note – appendices to be removed prior to publication)

1. SUMMARY OF THE FINDINGS OF THE REVIEW

1.1. Phyllis was a resident of a Care Home from late in 2012 until she died on 9th June 2013. Phyllis was a 90-year-old woman with a diagnosis of mixed type dementia and a recent history of depression, and agitation. In mid 2011 she was assessed as being at high risk of falls and following ongoing social care assessment was admitted to residential care for the elderly mentally infirm in late 2012.

1.2. During the period from February – May 2013 the level of falls was significant and ultimately led to the death of Phyllis on 9th June 2013 following a fall that resulted in a head injury.

1.3. A safeguarding investigation carried out at the time, concluded that neglect was substantiated and a subsequent coroner's inquest concluded in July 2015 that Phyllis died from traumatic head injury. The coroner raised concerns related to the care and treatment Phyllis received regarding the falls and issued a Regulation 28 report to prevent future deaths to which the Local Authority duly responded.

1.4. This review concludes that the physical and mental health conditions that Phyllis suffered contributed to her falls. The number of falls that Phyllis suffered were significant. Phyllis had recovered well from previous significant falls that had led to two fractured neck of femurs to the surprise of her care team. The agencies working with her did all they could to keep her safe, in spite of this Phyllis continued to fall, and she died from a head injury sustained during a fall.

1.5. The review found that falls in the elderly frail, who have dementia and other physical health issues cannot be always be prevented. Actions were undertaken to support the care home to prevent falls as far as possible and respond to actual falls as quickly as possible.

1.6. It is of note that Phyllis's care needs did not trigger assessment for NHS continuing healthcare funding following her second fracture. This review concludes that it should have been considered as a borderline case and that this would have provided robust evidence that her needs had been considered from a multi-agency perspective with full family involvement.

1.7. There were also other missed opportunities within the Local Authority by the Care Home Managers and/or commissioners to reassess safety and care needs via investigation and learning from serious incidents and following further falls in May 2013.

1.8. Neglect was found to be substantiated in a safeguarding investigation, related to the final incident. This review noted that this was related to the delay in seeking medical attention following an unwitnessed fall. The review found that there were unprecedented circumstances with serious health concerns of several residents on the morning that Phyllis fell in June 2013 and it is acknowledged that without the necessary skills to assess and understand fully the nature of head injuries, that mistakes were made in the assessments and decisions made on that morning. This resulted in a delay in Phyllis's conveyance to hospital. The review was also told that Phyllis would not have survived the head injury due to her advanced brain disease, even if she had been conveyed to hospital sooner.

1.9. This review also acknowledges that it is now some three years since Phyllis's death. The review has heard of the many changes that have been made, not only as a result of Phyllis's death, but for other reasons not least because agencies constantly review their practice and procedures and many because of other legislative changes and reviews e.g. Care Act 2014.

1.10. By providing a window on the system, the review has found opportunities for learning on some elements of care and communication in this case and offers recommendations to Rotherham Safeguarding Adults Board to develop actions to safeguard the wellbeing of frail elderly adults and other adults with care and support needs in Rotherham thereby providing safer futures.

2. INTRODUCTION AND SCOPE OF REVIEW

2.1. Phyllis was a 90-year-old woman with a diagnosis of dementia, osteoporosis, chronic kidney disease with a recent history of depression, and agitation. In mid 2011 she was assessed as being at high risk of falls and following ongoing social care assessment was placed in residential care for the elderly mentally infirm in late 2012 where she remained until she died on 9th June 2013.

2.2. During the period from February – May 2013 the level of falls was significant and ultimately led to her death following a head injury sustained during a fall.

2.3. A safeguarding investigation and subsequent case conference carried out at the time concluded that neglect was substantiated in respect of acts of omission by three carers (not a unanimous decision in respect of one of the three) and institutional abuse was substantiated but was not a unanimous decision. A subsequent coroner's inquest concluded in July 2015, that Phyllis died from traumatic head injury.

2.4. The coroner raised concerns relating to the care and treatment that Phyllis received regarding the falls and issued a Regulation 28[1] report to prevent future deaths to which the Local Authority duly responded.

2.5. The circumstances surrounding Phyllis's death and the care she received leading up to her death have been subject of a safeguarding investigation and a coroner's inquest. It is not the intention of this review to revisit or reinvestigate the forensic nature of those reviews but to provide a learning opportunity for safer futures for elderly people at high risk of falls.

2.6. The review takes into account agency involvement **from October 2012** during the time that Phyllis was being assessed for suitable care providers from her second mental health inpatient admission until the date of her death. Lessons learned directly following the event and actions undertaken both then and following the issue of the Regulation 28 will be acknowledged in the improvements section (9) of this report.

2.7. There are two hospitals trusts who delivered care to Phyllis; one offered services in relation to her mental health needs and will be referred to in this report as 'the Mental Health Trust' the other supported Phyllis's physical health care and for the purposes of this report will be referred to as 'the Foundation Trust'

3. THE SIGNIFICANT INCIDENT LEARNING PROCESS (SILP)

3.1. 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. 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.

3.2. The Rotherham Safeguarding Adult Board (RSAB) SAR Sub Group agreed to use the 'Significant Incident Learning Process' (SILP).

3.3. SILP is 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.

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

- Proportionality

[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, organization, 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

- Learning from good practice
- The active engagement of practitioners
- Engaging with families
- Systems methodology

3.5. SILPs are characterised by involvement of family, friends and carers. A large number of practitioners, managers and safeguarding leads then come together for a Learning Event. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again to study and debate the first draft of the Overview Report

3.6. The SILP model;

- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- is transparent about the way data is collected and analysed and
- makes use of relevant research and case evidence to inform the findings.
- engages with families
- and uses systems methodology

The Lead Reviewers

3.7. 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 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 RSAB and its partner agencies.

Process

3.8. Following the decision by RSAB to commission a SAR, a scoping meeting and authors' briefing took place on the 20th January 2016 to agree the Terms of Reference with representatives for RSAB and to introduce the SILP model process and expectations to authors of agency reports.

3.9. All agency reports were completed within the timescale and a Learning Event took place on 10th March which was well attended by authors, mangers, practitioners and safeguarding leads from the organisations involved in Phyllis's care.

3.10. A recall event took place on 19th April 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.

3.11. The final report was presented to RSAB on 16th May 2016.

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

4. FAMILY INVOLVEMENT WITH THE REVIEW AND FAMILY HISTORY

4.1. The author and the RSAB Manager met with Phyllis's son and daughter in law on Wednesday 9th March 2016 in order to inform the family of the review process and to hear about their mother and their view of the services that she had received.

4.2. Phyllis's son told the author that Phyllis and her husband had three children; two sons and a daughter. The other two children were both were very much older than the son who was involved in this review and both have now passed away.

4.3. Phyllis's son shared that his Father was a miner and after leaving the pit he set up a milk business that he and Phyllis ran for many years. His father originally rented land to have the milk delivered to and then bought the land that the family live on to this day. Phyllis's husband had a stroke in 1977 and Phyllis became his main carer until he died in 1993. Phyllis was a hard worker with a very active mind, she was very good with numbers from her years running the milk business's customer accounts.

4.4. In the initial stages of Phyllis's dementia, the family noted that she became increasingly frustrated if there were differences of opinion in discussions and as things progressed the family sought help from services when it became clear that Phyllis's mental health was deteriorating. The family views on the services and events that took place will be referred to throughout this report.

4.5. The draft report was sent to Phyllis's son and some amendments were requested which have been included. Arrangements were made to share the final report prior to publication.

5. BACKGROUND PRIOR TO THE SCOPED PERIOD

5.1. In August 2011 Phyllis had been admitted to a ward within the Mental Health Trust's older people's mental health services for assessment of her mental health following increasing concerns expressed by her family and Community Psychiatric Nurse (CPN) related to paranoia, hallucinations and agitation. She was reported to be very unwell and thought to be in the early stages of dementia. At this stage it was Phyllis's anxiety and depression that were the pressing need for intervention.

5.2. Following treatment, Phyllis's mood improved and she was discharged home with a package of care to try and enable Phyllis to remain in her own home as this is felt to be the most beneficial place for adults to reside. Phyllis's son told the author that he was very angry with this decision. He stated that she wasn't safe to be on her own and needed more than the arranged package of care could offer. Indeed, the arrangement broke down in 3-4 days and due to safety concerns Phyllis was readmitted for further assessment. Phyllis was identified as being in need of 24-hour care and Care Home 1 was chosen. She soon settled into this placement and at the six-week review the social worker deemed that the placement was successful and the case was closed to individual social work, albeit that the Local Authority assessment and care management team remained responsible for Phyllis's care provision.

6. KEY EPISODES

Key Episode One - Placement decision and falls history (October – November 2012)

6.1. Following a relatively settled period, in October 2012 Phyllis's mental and physical health was causing concern and she was readmitted to a mental health ward in the Mental Health Trust.

6.2. It was now clear to the team working with Phyllis and her family that her needs were changing and that the care home (to be referred to in this report as Care Home 1) was no longer a suitable placement. The social worker carried out an assessment, drawing information from the mental health team as well as views of the family. This appears to have been thorough and as assessment of Phyllis's mental capacity deemed that she did not have capacity for decisions related to her care needs, a best interest decision was made. This indicated that Phyllis would benefit from a placement in an Elderly Mentally Infirm (EMI) residential placement. The family were offered choices of suitable placements and chose a care home to be referred to as Care Home 2 in this report.

6.3. Care Home 2 is registered with the Care Quality Commission (CQC) as a residential home caring for people over the age of 65 with dementia and mental health conditions. During the time that Phyllis was resident the home was inspected by CQC and received a rating of 'good' for all elements of the inspection. Phyllis's son questioned how the inspection could have been rated as such given his view of the care his mother received. Further comment on this issue is raised in the analysis section.

6.4. During the Learning Event there was discussion and debate as to whether, at that time, given her level of need, that a nursing home might have been more appropriate. It was suggested that, the checklist used to assess care and nursing need did not trigger the need for nursing, that a person with the needs related to dementia that Phyllis had, required social input and interaction and that those needs could be met in an EMI residential placement. This debate is revisited in the next episode and analysed further later in this report.

6.5. It was very clear at this time is that Phyllis was at high risk of falls due to her dementia[2] [3], and ongoing difficulties with suspected urinary tract infections (UTI) and frailty and that injury from falls was likely due to Osteoporosis[4]. It was noted that most of the residents in Care Home 2 would also be deemed to be at high risk of falls due to the nature of their needs. Care Home 2 reported that they are used to falls prevention strategies and also had additional support for mental health issues from the Care Home Liaison Service[5] of the Mental Health Trust as well as being able to call on other health and social care professionals for support when required.

6.6. Staff from Care Home 2 visited Phyllis on the mental health ward to undertake further assessment that they were able to meet her needs. Discharge planning took place and arrangements were made to transfer Phyllis to Care Home 2 on 12.12.2012.

6.7. Although Phyllis had improved and had gained some weight, her son remained concerned about her condition and that she was not ready to transfer. As a result, her transfer was delayed and she did not move until 19.12.2012.

6.8. Phyllis's son told the author that he was not happy that she had been moved on 19.12.13 as he felt she still was not ready. He stated that the staff on the mental health ward insisted to Phyllis's daughter in law that Phyllis moved to the care home as they could provide all the care she needed. Phyllis's daughter in law states that she felt pressured and therefore agreed. Her son was not happy as he stated that it should have been him that staff approached.

6.9. When decisions made by family were discussed at the Learning Event, staff were clear that the daughter in law was the person they saw most often, they stated that they thought this was due to the son's work commitments, and that the daughter in law often made decisions. They assumed that if the daughter in law was not happy about something and that she did not feel able to make a decision then she would contact her husband. This is discussed further in the analysis of family involvement.

6.10. it is clear within the social care records that the ward round meeting on 18.12.2012 identified that, despite a debate between the consultant psychiatrist and Phyllis's son, it was made clear to her son that Phyllis was well enough to transfer to Care Home 2 and would be doing so the following day. The psychiatrist informed Phyllis's son that although she was still having some hallucinations, that they were not distressing her and that it was not in her best interests to remain on an acute mental health ward.

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[2]Van Doorn, C et al J Am Geriatr Soc. 2003 Sep;51(9):1213-8.
[3] Perkins C. Dementia and falling. N Z Fam Physician. 2008;35(1):44–46.
[4] Osteoporosis is a condition that weakens bones, making them fragile and more likely to break. It is particularly common in the elderly and post menopausal women
[5] The Home Liaison Service is a multidisciplinary team of health professionals who support various aspects of care in the care home setting.

Care Home 2 were able to meet her needs, including her dietary needs. Phyllis's son was given a list of contact details for the social worker, care home liaison team and the dietician service should he need to make any contact. Phyllis's son has told the author that he maintains that it was not safe to transfer her to Care Home 2 at this point and that he did not agree with the decision. Phyllis's daughter in law was not in attendance at this ward round.

6.11. The best interest meeting was held the next day to which Phyllis's son had been invited but was not able to attend and his wife attended. It was therefore Phyllis's daughter in law that signed the relevant paperwork in readiness for the previously planned transfer.

6.12. This is highlighted as a key episode as it evidences the reason for the placement at Care Home 2 and addresses the issues of falls history knowledge required within the Terms of Reference.

Key Episode 2: Falls prevention and management (Dec 2012-June 2013)

6.13. Care Home 2 is a large purpose built building with four separate units. The unit that Phyllis was admitted to is a 15 bedded unit with eight bedrooms on the first floor and seven bedrooms on the ground floor. As well as care staff, there were four activity coordinators and a café where residents can socialise.

6.14. Phyllis's bedroom was on the first floor next to the office area.

6.15. When Phyllis was admitted to Care Home 2 she was reported to be independently mobile, walking with the aid of a stick. Staff reported that Phyllis liked to look nice and always liked to wear her jewellery.

6.16. Care plans at this point were evolving as staff were getting to know Phyllis. Staff at this time did not develop a 'falls specific care plan'. Having had no reported falls, staff state that the usual falls prevention interventions would have been evident in various aspects of the care plan e.g. ensuring that she had the right footwear, being reminded to use her stick for increased balance.

6.17. The term 'high risk of falls' that had been used for Phyllis at this time created much debate at the Learning Event and is discussed further in the analysis. There were no falls reported during December 2012 and January 2013.

6.18. The first fall happened on 11.02.2013 when Phyllis fell in the lounge. There were three small bruises noted but it was felt that medical advice was not required at this point. This fall did not trigger anything specifically as a result. Staff followed their accident reporting policy and felt that they could continue to manage Phyllis's care with the support of the team from the Mental Health Trust and Advanced Nurse Practitioner(ANP).

6.19. On 13.02.2013 social work case notes record a placement review with Phyllis's son in attendance. The review did not identify any issues and therefore the social worker closed the case to individual worker allocation and the case remained under social work team responsibility. It is of note that the fall that occurred on 11.02.13 was not discussed at this meeting.

6.20. On 20.02.2013, Phyllis had another fall, an ambulance was called due to the pain that Phyllis was in and she was admitted to hospital and diagnosed with right fractured neck of femur. Phyllis progressed well post-surgery and returned to Care Home 2 on 28.02.2013. A package of support had now been put in place by the hospital to include falls prevention service physiotherapy provided by The Foundation Trust Care Home Support Team. On return to Care Home 2 Phyllis was immobile and frail so was at limited risk of falls at this time and it was Phyllis's mental and physical health that gave cause for concern over the following couple of weeks.

6.21. On 11.03.2013 staff found Phyllis half way out of bed, staff noted that Phyllis had been feeling a little brighter and saw that falls risk may be increasing so contacted The Foundation Trust Care Home Support Team. Staff were dissuaded from using bedrails after establishing, following discussion and risk profiling by the physiotherapist, that they would be dangerous to use in someone who was attempting to mobilise due to the risk of climbing over them. Care Home 2 agreed to continue to monitor Phyllis.

6.22. On 15.03.2013, Phyllis had a fall in the morning and was seen by the ANP who reported that Phyllis was fine. Coincidentally, the Physiotherapist from the Care Home Support Team visited and recommended that the home use an alarm mat that would alert staff if Phyllis got up. The Physiotherapist stated that the home could borrow one from the care home support team until they could purchase their own. The mat was delivered to the home on the same day.

6.23. The next day Phyllis had two falls during the night, the alarm mat alerted carers each time and the ANP was called into check on Phyllis. The Physiotherapist contacted the care home on 18.03.2013 to offer further support regarding falls. During the following week there were again concerns about Phyllis's physical and mental health. The Physiotherapist visited on 26.03.13 and indicated that there was now a newer version of the alarm that had a pager that staff could carry and that she would order one for Phyllis.

6.24. On 29.03.2013 staff were alerted to Phyllis's alarm going off. Phyllis was found on the floor with pain in her legs. An ambulance was called and family informed. Phyllis was diagnosed with left fractured neck of femur.

6.25. On 1.04.2013 Phyllis's daughter in law telephoned the care home at her husband's request to arrange a meeting with the social worker and the home regarding the increasing number of falls.

6.26. Phyllis was slower to recover from this fall which was not surprising given her co morbidities[6] (see also Key Episode 3)

6.27. Prior to discharge Phyllis's needs were reassessed:

6.28. The Continuing Healthcare (CHC) checklist [7] was completed by the the Discharge Coordinator and an orthopaedic ward manager at The Foundation Trust in conjunction with the ward based multi-disciplinary team that had been looking after Phyllis. This did not trigger the Decision Support Tool (DST) for continuing health care assessment for NHS funded care.

6.29. This decision is discussed further in the analysis as it forms part of the terms of reference and is an issue that was raised by both the coroner and the family.

6.30. Care Home 2 reported at the Learning Event that they visited the hospital to assess and ensure that they could still meet Phyllis's needs. It was noted that Phyllis was more frail, had lost weight, was not mobile and had a very poor diet as previously noted (see also Key episode 3). Care Home 2 staff assessed that they were still able to meet her needs and it is reported by those at the Learning Events that the family were happy for Phyllis to return to Care Home 2. Phyllis's transfer back to Care Home 2 was delayed by a

[6] COMORBID: existing simultaneously with and usually independently of another medical condition
[7] The Continuing Healthcare Checklist and the Decision Support Tool form part of the National framework for NHS continuing healthcare and NHS funded nursing care https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

couple of days at a date and time requested by the Care Home to ensure that all were happy with the arrangements.

6.31. Phyllis arrived back at Care Home 2 on 25.04.2013. Staff were anticipative of Phyllis becoming more mobile and arrangements were made for further assistive technology in the form of a mat with pager and staff were asked to ensure that the alarm mat was in place wherever Phyllis was.

6.32. During the next few weeks Phyllis slowly recovered and by the 11.05.2013 she is recorded as bright and chatty.

6.33. On 17.05.13 the bed sensor that the home had purchased was set up by the physiotherapist but it was noted that it was too big for the chair and another one was ordered. A chair ribbon alarm was loaned to the home whilst purchase was arranged.

6.34. Between 23.05.2013 and 28.05.2013 Phyllis started to fall again with four further falls in this period. These were managed in varying ways with various assistance being sought. The physiotherapist noted that all assistive technology was in place. It now appeared that despite all falls management strategies that were being utilised and all the support that was put in place for Care home 2, that Phyllis was still falling which is discussed further in the analysis. It is of note that the Physiotherapist was told that the home staff could undertake 30 minute observations but not more frequently; it is not clear that this information was communicated across all the staff.

6.35. On 9.06.2013 Phyllis fell, she was assisted back to bed after some initial first aid to a cut on her head. The care staff monitored Phyllis at various intervals but did not note any signs of head injury symptoms and left Phyllis to sleep as she was usually a later riser than other residents. The care home senior at the time of arrival on shift that morning describes an unprecedented issue of having two other residents whose condition was of grave concern. The ANP had been called to attend to these residents and when she arrived she was informed by the senior carer that there was a concern for Phyllis also. The ANP attended the other patients and then attended Phyllis. Phyllis fell at 4.50; the ANP attended Phyllis at 09:30 where her deterioration was noted and an ambulance was called. Phyllis died later in hospital. Although the delay in gaining medical assistance was significant it was noted by the Accident and Emergency consultant, in a statement read out during the coroner's inquest, that Phyllis would have died from the head injury she received following that fall.

6.36. This is a key episode as there were concerns expressed by coroner and family that Care Home (EMI Residential) may not have been a safe placement particularly following the second fractured neck of femur and is subject to further analysis.

Key Episode 3: Physical and mental health

6.37. The GP agency report identifies that Phyllis had several co-morbid conditions; the following may have impacted on falls

- Dementia (Mixed type Vascular and Alzheimer's)
- Chronic Kidney disease
- Osteoarthritis of both knees
- Osteoporosis

6.38. In October 2012, during her admission highlighted in Key Episode 1, Phyllis's physical health was of greater concern than her mental health and she also spent a period of time in The Foundation Trust due to concerns about poor weight and eating, possible dehydration and UTIs. These were treated, her

physical health improved and she returned to the Mental Health Ward. It was during this time that Phyllis was diagnosed with dementia.

6.39. During the latter stages of Phyllis's stay in Care Home 1, a dietician referral was made. When Phyllis was admitted to Care Home 2 one of the main concerns of the family and staff at this time was Phyllis's weight loss and eating issues. Being underweight and not eating enough to maintain adequate nutrition may also have added to her falls risk. This was assessed immediately on entering Care Home 2 and having a MUST[8] score of 2, food and drinks were to be fortified and diet charts were commenced. Staff at Care Home 2 stated that Phyllis was generally a very poor eater and often had paranoid concerns about her food and refused to eat. Staff were able to encourage her by telling her that her son and her doctor had said the food was safe and that she should eat it. On admission to Care Home 2 Phyllis is reported to have weighed 7st 3lb; in June, just before she died, her weight was recorded as 5st 10lb. Staff at the Learning Events noted that with the nature of disease progression in dementia[9], particularly in advanced stages and with kidney disease, weight loss would be a feature.

6.40. UTIs (some diagnosed and some suspected from symptoms) were also noted to be an issue in the management of Phyllis's health. It was on occasion noted that Phyllis was showing signs of urgency to use the toilet and being unwell. Increasing confusion is one of the key symptoms of UTIs in the elderly. In patients with dementia this can be thought to be associated with dementia rather than UTI. Phyllis often showed signs of increased confusion and hallucinations and it is not known how much of this was because of UTIs.

6.41. The Learning Event heard that whenever symptoms were noticed, urine samples would be sent for analysis and antibiotics prescribed if indicated. There is not a clear picture of urine infections and associated treatment and recovery. Various agency reports mention the issue. The GP states that some of the samples showed contamination, which is not uncommon in the elderly, so had to be repeated. Staff in general felt that whenever symptoms were highlighted, treatment was prescribed by the ANP and therefore impact on falls may have been minimal staff but at the Learning Events felt that it was unrealistic to be certain of this.

6.42. This is a key episode as Phyllis's' medical conditions impacted on her falls and her falls impacted on her health and increasing frailty. This is discussed further in the analysis.

Key Episode 4: Safeguarding alert April 2013

6.43. On the 05.04. 2013 following the second fracture a telephone call was made to Care Home 2 by the care home service manager. Staff at Care Home 2 were informed that any fall that results in a serious injury must be reported through to safeguarding.

6.44. The Local Authority (LA) safeguarding team screened the alert and on the information received, felt that everything was in place from a falls prevention perspective and the alert was 'screened out' and did not proceed to a strategy meeting. An entry logged by the safeguarding team notes the call was received from the senior carer stating that Phyllis was at high risk of falls defined within the risk assessment and care plans, that she had experienced numerous falls and about the previous hip fracture. The information received indicated that Phyllis had been seen seven times by the Advanced Nurse Practitioner over the last three weeks and by the GP for a full medication review. She had also been visited by the CPN who

[8] MUST = Malnutrition Universal Screening Tool used to assess nutritional status and actions required. The score takes into account Body Mass Index, recent weight loss and current disease status. A score of 2 or more is the highest risk and requires treatment.
[9] Alzheimer's society: The progression of Alzheimer's disease and other dementias https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1772

had reviewed her anti-psychotic medication. It was also noted that Phyllis had a falls mat in place and walked with a frame. Given this information the safeguarding team came to a decision that, given the information received, there was no evidence of neglect of Phyllis's needs and that the home had appeared to have sought timely advice and support in seeking to minimize the risk of falls. This is also recorded within the safeguarding adult alert form; the safeguarding manager signed the alert form indicating that the threshold to move to strategy meeting was not met on the basis that the care home had appeared to have taken all appropriate steps to reduce falls.

6.45. The family were not informed of this alert by the LA safeguarding team. Information about this alert was not shared with the hospital staff where Phyllis was being cared for at the time. The decision and information gathering and sharing about this alert is discussed further in the analysis.

6.46. At this point the family also requested a meeting to discuss their concerns about the falls and the service manager for Care Home 2 at the time informed Phyllis's son about the safeguarding investigation and that the issues would be picked up within that process. The requested meeting took place on 10.04.2013 with the care home team leader, social worker, CPN and Phyllis's son. The safeguarding alert was discussed, with the team leader informing the meeting of her conversation with the safeguarding team and that they were satisfied that Care Home 2 were doing all they could to minimize the risk of falls.

6.47. On 15.04.2013 The Foundation Trust discharge coordinator submitted a safeguarding alert due to concerns about the level of falls following information they received from Phyllis's son. This alert was started by the Ward Manger but not completed. The Discharge Coordinator was asked by the hospital adult safeguarding lead, to complete, and then documentation was returned to the safeguarding lead for submission.

6.48. On 17.04.2013, the hospital safeguarding lead contacted the Discharge Coordinator to inform her of a strategy meeting that had been arranged for 24.04.2013. At this point it was agreed that Phyllis should not be discharged until the outcome of the safeguarding strategy meeting was known. It appears that the safeguarding lead was unaware that the previous alert had been screened out and had therefore provisionally arranged a strategy meeting, as was process at the time. The LA safeguarding team, recognising that this was an alert for the same issues, contacted the hospital safeguarding lead and agreed that no investigation was necessary. During the Learning Events, clarity was gained regarding the strategy meeting that was arranged and never went ahead as it was not clear from social care or hospital records why a strategy meeting was apparently arranged and then cancelled.

6.49. The confusion of all involved, lack of detailed recording and information not being shared robustly with all involved in Phyllis's care makes this a key practice episode and will be the subject of further analysis.

7. ANALYSIS BY THEME

7.1. The agency reports, Learning Event and discussion with the family gave rise to several themes for analysis. Focussing on the systems that practitioners were working in at the time leads to important information and learning. Some systems, however, have changed significantly since 2013 and are highlighted in Section 9.

Co-morbidity, falls management and prevention

7.2. This review identifies that, for Phyllis, and many other frail elderly people with complex mental and physical healthcare conditions, falls prevention may be a misleading goal. This analysis argues that in some cases, following application and exhaustion of all preventative strategies. falls management becomes the focus.

7.3. Agency reports quoted that Phyllis was at 'high risk of falls' and this would seem to suggest that certain actions would be undertaken in order to prevent falls.

7.4. On admission to Care Home 2, staff report that falls were not the main focus of their care planning or risk assessment, other than the reported fact that all residents were likely to be at risk of falls. The system of care planning was that various elements of the care plan would lead to a position of supporting falls prevention rather than any obvious falls prevention care plan.

7.5. In risk management terms, risk assessment is undertaken to identify what harm may occur and then putting measures in place to control and mitigate the risk. It did not appear that the risk identified had been transferred into any specific actions or observations for Phyllis on admission to Care Home 2 over and above falls prevention strategies in the care plan as stated above.

7.6. The term 'high risk of falls' was discussed at length during the Learning Events. Practitioners questioned whether the term is used too often without having the backing of a risk assessment but merely refers to a group of predisposing factors. In Phyllis's case it may have been that her dementia and osteoporosis were the basis that led to the statement being made and would have been correct. The agency report for the older people's mental health services, did clearly state the falls risk and referred to an occupational therapist and physiotherapist. This did not appear to have been translated into the same concern on admission to Care Home 2. In the first couple of months in Care Home 2, Phyllis was independently mobile with a stick and did not fall so it can be seen why falls was not a problem that came to the fore at that time.

7.7. According to NICE Guidance[10] 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. This did happen after the first fall that resulted in a fracture in February 2013. A referral was made to the Care Home Support Team of The Foundation Trust and Phyllis was followed up by the physiotherapist once she was discharged. A falls screening tool was used but not all of the multi-factorial interventions mentioned in the NICE Guidance were appropriate for Phyllis, 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.

7.8. Phyllis was already in a purpose built care home setting that had her room next to the office with an en suite toilet so that access to the bathroom was easy. Her medication was under constant review. An appointment for vision assessment was arranged but Phyllis was not well enough to attend. Phyllis would not have been able to manage strength and balance training nor did she have the cognitive ability to understand her risk of falls and that she required assistance to mobilise safely. Strategies like use of crash mats were considered but discounted as they would be a trip hazard for Phyllis if she was getting up without assistance. Staff at the Learning Event were not aware of specialist beds that were not only height adjustable but have protective padding around the headboard and base that may prevent injury on falling. Although these are now available from a specialist manufacturer it is not clear if they were available at the time.

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

7.9. The Learning Event heard how assistive technology was new in relation to prevention and monitoring falls and in fact Phyllis was the first resident that this equipment was used for in Care Home 2. The equipment that was used in the first instance was a pressure mat that would alarm within the room when Phyllis got out of bed or her chair. Whilst this was a way of trying to prevent falls, in many cases the alarm was activated but Phyllis had already fallen before staff could get to her. This was usually because staff, particularly at night, were busy with other residents and could not get to her quickly enough (there were only 2 staff on duty at night). The alarm could also be distressing as it was very loud in order to alert staff. The Mark II alarm system had a pager carried by staff that would alert them but would be silent within the room. This did not alleviate the issue of the carers not being able to get to her in time to prevent falls. What the equipment was able to do was to ensure that staff were alerted and could attend promptly to ensure action could be taken as quickly as possible. Not all of Phyllis's falls received the required attention that they should or were recorded robustly and there have been lessons learned and action already implemented by Care Home 2 that are included in section 9.

7.10. It appears, therefore, that falls prevention was limited and indeed given all of the issues, falls were very likely to continue and therefore the support offered was by means of assistive technology to try and detect when Phyllis was up and moving. It is not unusual for older people that have suffered one fracture to suffer another and the more falls and injuries that occur the more likely that recovery takes longer. In fact, hospital staff report that Phyllis's recovery from two hip fractures was remarkable.

7.11. The family say that they were not aware that falls could not be prevented but this is disputed by staff who say that there was a clear understanding that falls risk would always be present and that everything that was being done may not be able to prevent falls. Social care notes identify that this was clarified in the meeting on 10.04.2013 that due to Phyllis's dementia, unsteady gait and physical healthcare conditions that falls risk could not be eliminated. At this meeting, Phyllis's son had asked for bedrails to be used. It was explained that this is very dangerous in mobile patients and especially where there is cognitive impairment. Research [11] has shown that the restraint of patients at risk of falls increases risk and serious injury as a result of restraint. This type of action would amount to a Deprivation of Liberty[12] under the Mental Capacity Act (2005) and would require authorisation but would breach rights and dignity and would not have been in Phyllis's best interests so was rightly not an option. Phyllis's son stated that he still struggled to understand why his mother could not be prevented from falling and used a baby in a cot analogy to illustrate his point.

7.12. Phyllis's son also asked for a room on the ground floor for his mother as he felt she would be safer. Care Home staff explained that the nature of the building meant that no one room was nearer to care assistants than others and in fact Phyllis's room was located next to the office. From the visit the author undertook to the home, it was observed that movement to a ground floor room would not have been any safer in terms of falls risk. The nature of the work undertaken by staff is such that they are largely occupied away from the office area, attending to the needs of the residents. From an observation perspective therefore, being closer to the office would not necessarily have afforded greater safety. As it was, there was no vacant room on the ground floor and it could be argued that in cases of dementia movement to a new environment can be more disorientating thereby contributing to increased falls risk. It would also have meant moving another resident from their room, which could have caused distress to the resident being moved.

7.13. Phyllis's care received regular three monthly reviews at Care Home 2. Staff from other agencies acknowledged that whilst it would be ideal if they were able to attend these reviews, with the number of

[11] Castle NG, Engberg J. The health consequences of using physical restraints in nursing homes. Med Care 2009;47:1164-1173.

[12] Mental Capacity Act (2005) Schedule A1 (Hospital and care homes deprivation of liberty) http://www.legislation.gov.uk/ukpga/2005/9/schedule/A1

residents in care homes who have complex needs, this is not possible so that a multi-disciplinary approach to these meetings can only be taken from what other professionals have recorded within the resident's notes.

7.14. A suggestion at the Learning Events was that by ensuring this type of recording, the regular review meetings could produce a 'wrap around, person centred multi-disciplinary team care plan' for all of the MDT o have access to when carrying out their own assessments, interventions and reviews.

7.15. It was concerning to hear that GPs have often refused to record in the records within the home, stating that they would only record in their own records possibly thought to be due to time constraints of GP visits. This may well be alleviated with the new GP alignment project discussed within the improvements section (9).

7.16. It could be argued that national guidance on falls should provide staff with more information about how to manage falls as safely as possible where saturation point is reached on all preventative strategies. This would enable staff to be more supported in their work and not left feeling that prevention is always possible and that they are therefore failing if and when falls continue.

7.17. It is acknowledged that the care home staff had a limited understanding of the impact of head injuries and their management and although the delay in seeking appropriate medical attention may not have prevented her death, Phyllis should have been assessed by a health professional and conveyed to hospital much sooner than happened. The Learning Event heard about the improvements that have been made on this issue and they are included in section 9 below.

Learning Point:
Whilst accepting that falls prevention should be the main aim, nationally there is very little support or guidance for staff across agencies when falls prevention is not possible. This leaves staff feeling at a loss and that they have failed. **(Recommendation 1)**

Due to the challenges of how information from the whole MDT can be included within reviews and how outcomes and actions from reviews are shared, robust recording by all involved with the resident are vital to ensure that decisions are based on holistic assessment. **(See Improvements Section 9.6-9.10 & 9.16. Recommendation 2c)**

Assessment

7.18. It can be seen in the Key Episodes that following the second fracture that the checklist completed by staff within the hospital setting did not identify that Phyllis's needs triggered a Decision Support Tool (DST) for further assessment of CHC funding for nursing care. From what the family have stated it is also clear that they were not aware that this could have been challenged, and they were not given any details of how to do this.

7.19. It could be argued that in at least two domains within the checklist, i.e. nutrition (Care Home 2 identified a MUST score of 2 and significant weight loss; The Foundation Trust did not undertake a further MUST score as this was not common practice at the time) and mobility (two admissions for fractured neck of femur), there was a high risk. Her advancing dementia and mental health status with ongoing evidence of hallucinations as well as her difficulties with urinary problems should have triggered a more in depth assessment. The CHC checklist requires that two high risk domains (A) indicate the need for DST to be applied or one high risk and four medium (B).

7.20. The CHC checklist was completed with the knowledge that the hospital staff had of Phyllis in the 'here and now' as well as information contained within the case notes. It is not clear from the documentation

or the agency report that Mental Capacity was assessed in respect of decisions about future care needs and how decisions from a Best Interests perspective was reached.

7.21. The Foundation Trust information collated states that no other agency disagreed with the decision, nor did they recognise the need to alert the continuing healthcare service of possibility of eligibility for continuing healthcare. It is not clear how transparent the process was from the documentation reviewed.

7.22. The guidance states that for borderline cases, a DST can be undertaken

> "there may also be circumstances where a full assessment for NHS continuing healthcare is considered necessary, even though the individual does not apparently meet the indicated threshold."

The checklist completed by the hospital did in fact indicate one high risk domain (A) and three medium (B). One of the B scores was due to a urinary catheter in situ that would have been removed prior to discharge so would have changed to a C. Given the earlier comment about nutritional status though, it could be argued that the checklist identified Phyllis could have been considered as borderline.

7.23. Progression from the Checklist to completion of the DST would have been more comprehensive and would have been inclusive of the wider multi-disciplinary team, as is is required, so would have included the Care Home as well as GP and the mental health team which would have collated all the information about Phyllis's needs at the time.

7.24. It could be argued that CHC funding may not have been approved, but the DST would have provided evidence that practitioners were alert to the possibility that Phyllis's needs were increasing and that the checklist presented a borderline case. The assessment would have been a joint one with involvement of health commissioners within the commissioning support unit that, at the time, managed these assessments on behalf of the Clinical Commissioning Group. The Framework clearly states that family should have been told they can appeal if not happy with the checklist decision.

7.25. From a systems perspective the system for application for assessment of CHC funding for nursing care was not effectively used. The system, used efficiently and applied robustly provides evidence that care needs are being met at the right level of care within the right placements.

7.26. In November 2012 the Department of Health issued guidance on the revised National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. Foundation Hospital Trust staff at the Learning Events indicated that documentation of the CHC checklist, which was part of this revised guidance, was new and recording of associated Mental Capacity Assessments and Best interests' decisions were not embedded and there was no robust system in place for staff to follow when completing the checklist. The Learning Events heard how this has significantly improved in 2016.

Learning Point:
Practitioners must be supported to apply the systems that are in place to identify how individual needs are best met. These should be routinely applied; making assumptions about the possible outcome should not be a barrier to its application. **(See improvements Section 9.14-9.15 Recommendation 2a &3b)**

Management of incidents and serious incidents

7.27. Good governance and a culture of learning and improvement includes learning from incidents. In this case the two incidents that resulted in fractured neck of femur in Care home 2 would have benefitted

from in-depth investigation and analysis in order to reduce the risk of further harm occurring. At the Learning Event it was established that incidents within Care Home 2 were recorded in the accident book but that these incidents did not trigger further reporting or investigation. Investigation and analysis may have identified some key issues that could have contributed to a consideration of what might have been necessary to keep Phyllis safe.

7.28. Colleagues at the Learning Event from the NHS stated that there would have been an investigation if the hip fractures had occurred within a healthcare setting as part of the NHS Serious Incident Framework[13]. Social care staff identified that there is no such system for social care settings. Within Care Home 2 a system is in place for manager analysis of serious incidents but social care staff staff stated that fractured neck of femur did not trigger this process as it was not considered a serious incident.

7.29. All Care homes are registered and regulated by the Care Quality Commission (CQC). Regulation 18 covers the notification of serious incidents to them as the regulator. Whilst there is not a list of incidents Paragraph 2 b states:

"any injury to a service user which, in the reasonable opinion of a health care professional, requires treatment by that, or another, health care professional in order to prevent—

i. the death of the service user, or

ii. an injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a);"

where paragraph (a) includes:

i. changes to the structure of a service user's body,

ii. the service user experiencing prolonged pain or prolonged psychological harm, or

iii. the shortening of the life expectancy of the service user;[14]

7.30. It could be argued that fractured neck of femur, and more specifically a second fractured neck of femur, should have warranted notification to the CQC.

7.31. Notification to CQC may also have led to further inspection activity given that there was a previous rating of 'good' and may have been further opportunity to assess any care issues at the time.

7.32. If the incidents had resulted in the threshold being met for a safeguarding investigation, then there may have been opportunities for learning, recommendations, and a multi-agency review of Phyllis's care and safety. The incident did not meet the threshold for safeguarding as there was no suggestion that the care home had been neglectful in their management of, or response to, the fall, and there was no other system in place to review incidents of this nature.

Learning Point:

Social care residential settings would benefit from a more robust understanding of what constitutes a serious incident or an incident where learning could occur, then engaging in analysis in order for learning to take place to prevent future harm. The role of commissioners and regulators in this process needs to be understood more fully. (**Recommendation 2b**)

Communication and coordination

[13] https://www.england.nhs.uk/patientsafety/serious-incident/

[14] Care Quality Commission (Registration) Regulations 2009: Regulation 18

7.33. There were several areas where communication and coordination featured that are worthy of further analysis.

Safeguarding

7.34. Whilst it is accepted that the threshold may not have been met at the time for a wider investigation into neglect or acts of omission, the communication related to the alert and outcome was not robust.

7.35. It could be argued however that the Safeguarding procedures in place[15] at the time were confusing. The Thresholds flow chart within those procedures indicate that a strategy discussion should take place where a person lacks capacity. Discussion at the Learning Events indicated that this is only where an alert becomes a referral due to the safeguarding threshold being met. It was agreed that the flow charts in the procedures did not make it clear that the process had several 'exit' points

7.36. Notwithstanding that the safeguarding alert following the second fracture was raised pre Care Act (see section 9 below), the family should have been contacted by the LA safeguarding team to inform them that the alert had been raised, what that meant and that the outcome was for no further action. 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[16] to ensure outcome focussed, person centred responses to adult safeguarding rather than it being a process that happened to people without knowledge. Albeit that the LA safeguarding team did not make contact with the family they did contact the social worker and the issue was further discussed in the meeting on 10.04.2013.

7.37. Gathering information from key partners in the care of an adult to ascertain if there were any other safeguarding concerns or considerations to be taken into account before a 'No Further Action 'decision is taken would be best practice. The LA safeguarding team made contact with Care Home 2 and the social worker who, having informed the Safeguarding Team of all that was in place to prevent falls, the decision was to take no further action as there was no evidence of neglect or acts of omission. At this time Phyllis was in hospital but the hospital team were not contacted nor was the GP or the Mental Health team. Whilst the decision may have been the same, it would have been better supported by evidence that all the multi-agency partners agreed that they had no safeguarding concerns.

7.38. Phyllis's son told the author that he was concerned that the investigation that had been carried out by the safeguarding team at that time was not robust and that there was no evidence to support that any investigation had been undertaken and indicated that he thought that records had been lost or destroyed. Evidence provided to the review indicated that entries had been made on the system about the alert and the decision was recorded. Learning Event attendees were also informed that the decision was also recorded in the Safeguarding Adults Form 1, Alert/Referral Form. The review found that the information gathering and sharing of the outcome was poor but did not find any evidence that records had been lost or destroyed. This was confirmed by those attending the Learning Event.

7.39. In essence the ensuing 2nd alert from the hospital would not have happened as hospital staff would have been involved in the information sharing when the first alert was made. Albeit that it is a minor issue, it then led to confusion about a strategy meeting and a delay in discharging Phyllis until the safeguarding issue was assessed. A meeting also took place with the family and the team leader from the care home

[15] Safeguarding Adults: South Yorkshire's Adult Protection Procedures 2007
[16] Lawson, J. Sue Lewis, S & Williams, C. (2014) Making Safeguarding Personal 2013/14 Summary of findings London, LGA

and the mental health team due to concerns about the falls expressed by the family.

7.40. The family have struggled to understand why they did not know this meeting on 10th April was not a safeguarding meeting, having been told about the safeguarding alert by the Care Home Service Manager. Staff at the Learning Event stated that Phyllis's son could have asked more about the safeguarding issue within the meeting when the conversation between the safeguarding team was relayed by the team leader; the meeting actually focussed on the equipment that was in place to keep Phyllis safe from falls. The outcome of the safeguarding investigation was not challenged by any of the attendees at this meeting.

> **Learning Point:**
> Ensuring that there is multi agency decision making and full involvement of families (where appropriate) and service users is key in the transparency of application of safeguarding procedures to ensure the promotion of safety and well-being of adults with care and support needs. (**See Improvements section 9.11-9.13. Recommendation 3a)**

Communication with the family

7.41. Phyllis's son told the author that he did not feel included in decisions that were made about his mother. This is disputed by staff in all agencies stating that Phyllis's daughter in law was the person that they saw most often and that they always communicated with her about progress and changes. Phyllis's son was at some meetings and did visit his mother and staff say that they always informed him of anything that was happening at those points. Phyllis's son stated that he understood that his wife was often the one that was more visible due to his work commitments but that he was her son and next of kin so it should have been him that was involved in decision making. Staff have said that they had assumed that if Phyllis's daughter in law felt that she could not make a decision that she would check it with her husband.

7.42. There are occasions where there are communication difficulties between families and professionals. Families would benefit from the provision of some advocacy, and staff would benefit from support and guidance to help prevent communication breakdown.

> **Learning Point:**
>
> It is important for agencies working with those who do not have capacity to make decisions for themselves, to be very clear about how families would like to be involved in decisions e.g. who should be the key point of contact, who can make decisions, whether there is a power of attorney/s in place and how families want to be contacted. This should be clearly documented to avoid confusion.
> Communication difficulties can lead to difficult relationships and communication breakdown which can in turn lead to the loss of the voice of the service user. **(Recommendations 3b, 3c, 3d, 4 &5)**

7.43. Phyllis's son also felt that he did not always understand the processes that were being undertaken and did not know what 'safeguarding' was until the Service Manager of Care Home 2 mentioned it. Staff at Care Home 2 said that there were posters displayed within the home about safeguarding. Staff at the Learning Event stated that the family were given details of independent organisations who could offer support at the point of diagnosis e.g. Age UK and Alzheimer's Association.

Learning Point:

For families to feel fully involved, or even to take that to a higher level of being integral in the care of their family member, agencies should challenge themselves on how best this can be achieved. Agencies should ensure that families have a full understanding of what can feel like very complicated systems and processes, albeit that they are well known to the individual agencies. Reminders to families of the voluntary and charitable organisations who can support them, should be given when families appear to be having difficulties. **(Recommendations 3a-d 4 &5)**

Physical Healthcare

7.44. Communication and coordination related to some of Phyllis's physical healthcare needs do not appear to have been clear. With many different professionals and care staff involved, clarification and communication is a key point. This can be achieved by having a central coordination point of contact and robust care planning. The Learning Event heard that care plans in Care Home 2 were reviewed regularly not less than 3 monthly or when needs change. Care plans do not always involve the whole MDT, being specific to the home. Phyllis suffered with recurrent suspected UTIs and it is not clear how robustly these were managed. The Learning Event was told that whenever she had symptoms, samples were taken and antibiotics were prescribed but this is not always evident in the records of the GP and assumptions that treatment had been effective were made.

7.45. The ANP would sometimes treat and sometimes it would be GP. Where any treatment was provided by the ANP, the details were faxed to the GP and put on SystemOne (a shared record system between the GP and the community services of The Foundation Trust)

7.46. A question raised in the Learning Events was whether Phyllis would have benefitted from prophylactic antibiotic treatment of UTIs. This was debated and concluded that Phyllis could have been referred to the continence service at an earlier stage (only this service could discern if, following thorough assessment, prophylaxis[17] would be beneficial). It was also discussed that prophylactic treatment appears to move in and out of what is considered to be best practice. At the time it was in fact 'out of favour.'

7.47. This review found that despite Phyllis's weight loss and eating issues, that there was no referral to a dietician. Staff at the Learning Events were confident that the staff at Care Home 2 were able to fortify her drinks and diet to ensure a high calorie intake. It was also accepted that weight loss may well be a feature of advancing dementia.

Learning Point:

More robust oversight and coordination can provide a clearer picture and consideration for different treatment options as well as clarity of overall physical health and well-being. It is therefore important for all issues of health to be recorded within the records within the residential setting. **(See improvements Section 9.9.6-9.10 & 9.16. Recommendation 2c & 5)**

Other Communication

7.48. There were other areas where communication issues were noted:

[17] prophylaxis: action taken to prevent disease, especially by specified means or against a specified disease

- At the point of first review of placement by the social worker following Phyllis's admission to Care Home 2, the first fall had happened on the previous day, neither the CPN or the Social worker were alerted to this incident.
- Most of the staff involved in Phyllis's care were of the impression that once the case was closed to individual social work intervention (e.g. when placement was settled) that any concerns would need to be re referred for assessment. The Learning Event heard how this was not the case and that all cases where placement is being funded by social care, would remain open to the team and would not require re referral to the assessment team. Improvements related to this issue were noted in the Learning Events and are discussed in section 9.
- The agreement to undertake 30 minute observations by care staff in May 2013 was not communicated clearly across all staff in Care Home 2.

General Communication

7.49. In circumstances such as this case presents, communication and coordination is helped with having a key worker approach. In the case of Phyllis this would have been the social worker. Once the case was no longer open to individual social work, the coordinator function is less clear. A discussion at the Learning Event indicated that this then generally falls to the care home. It was accepted that this was a 'big ask' in that the staffing of a care home is mostly by well-trained but unqualified staff. It was agreed that albeit it is complex, staff at the Learning Event could not see another way forward.

Learning Point:

This review suggests that a model for robust communication between agencies may be beneficial to multi agency working with adults for Rotherham. The ASK-DO-SHARE model is one offered for consideration. (Appendix 2) **(Recommendation 4)**

8. GOOD PRACTICE

8.1. In gathering information for this review it is evident that there were many elements of good practice. Practitioners at the Learning Event endorsed and offered examples.

8.2. Staff from Care Home 2 visited Phyllis each time she was due to return from hospital to their care and liaised with all practitioners to ensure that they were aware of, and still able to meet, her current needs. On Phyllis's second discharge from hospital a delay was agreed to to ensure that the home were ready to receive Phyllis back to their care.

8.3. Care home 2 were experienced in managing nutritional needs of residents, negating the need for a dietetics referral.

8.4. Records in Care home 2 evidenced all communication with the family.

8.5. Care Home 2 fundraised to accelerate the purchase of assistive technology equipment.

8.6. Care Home 2 stated that they were very supported by the multi-agency team and that they were always able to access support to manage Phyllis's care.

8.7. The agencies that were involved with this review were very open and transparent in discussing their difficulties and there was very good attendance at the Learning and Recall Events.

8.8. Staff in various agencies have implemented changes and supported learning within the care home environment following early learning from Phyllis's death, especially related to unwitnessed falls and head injuries.

9. IMPROVEMENTS ALREADY IMPLEMENTED

9.1. At the time of this review, Phyllis's death had occurred almost three years previously. The incident that led to her death had a profound effect on her family and those that cared for her. As a result, and due to other investigations e.g. coroner's inquest, some practice changes have already been implemented. In addition, processes and practice have naturally moved on within three years as highlighted below.

Falls response and training for care home staff

9.2. As part of the Regulation 28 Response prepared by the council a Head Injury Policy is now in place, developed by health care professionals that supports all care homes with the necessary interventions and protocol following a fall. New documentation to record and evidence observations following a fall has also been put in to place. This has been rolled out across all council residential services. Shift supervisors check and sign off the checklist at the end of each shift to ensure that all actions following a fall have been implemented. In-house training has been given. The new protocols have also been embedded in team meetings, individual supervisions and Personal Development Reviews.

9.3. The Learning Event heard how the Care Home Support Team from The Foundation Trust have also shared this learning with all of the other care homes that they cover.

Provision of assistive technology and associated training

9.4. At the time that Phyllis was in Care Home 2, assistive technology was very new. Staff report that they had difficulty obtaining equipment and had limited knowledge of its use.

9.5. Assistive technology is now more widely used, indeed at the time of the Learning Event there were more than half the residents in Care Home 2 where assistive technology was in use. The equipment is now provided to care homes via a loan system and it does not need to be purchased, thereby increasing availability and timeliness of equipment being available.

Record keeping

9.6. An element of the Regulation 28 response states that record keeping in care homes and the importance of accurate documentation has been further embedded in training programmes, team meetings, supervisions and personal development reviews. Regulatory service manager site visits include random sampling of care records and informing the registered manager of any remedial actions required.

9.7. The response also included information that a new Quality Assurance system for LA run care homes would be in place by December 2015 which would include monitoring of care records.

9.8. At the Learning Events staff from other agencies highlighted that they always record their interventions within the residents' records within the Care Home.

Support mechanism within Care Home 2

9.9. It was concerning that senior staff were not always aware of issues affecting residents and decisions were often left with more junior staff. The Regulation 28 response and information heard at the Learning Event indicates that now all changes to a resident's needs are reported directly to the senior carer. It is the senior carer who documents whether an unplanned review of residents is required and contacts the appropriate team to arrange this.

9.10. During a visit to Care Home 2, the author was able to view records and identified that care planning and review is robustly documented.

Safeguarding post Care Act 2014

9.11. The Care Act 2014 has changed the way that safeguarding is managed. Putting the adult and the family at the heart of safeguarding and involvement right at the start of the process is now mandatory. In Rotherham, the changes are still embedding but staff report a greater understanding of safeguarding processes and the associated documentation is more robust. The council's response to the coroner indicated that safeguarding documentation has been re-engineered to be Care Act compliant and to ensure the customer journey is captured and recorded. More detailed recording is now standard practice to confirm what documents have been scrutinised, dates, people spoken to etc. whilst in the screening stage to enable the decision maker to make informed and conversant decisions before exiting. Staff at the Learning Events all told how the new procedures mean greater involvement from all with communication much improved.

9.12. Work by Rotherham Safeguarding Adults Board (RSAB) to develop a Safeguarding page on the internet so that all staff and public have access to related policies and procedures is nearing completion.

9.13. RSAB now has a 'Making Safeguarding Personal'(MSP) sub group of the board who have a remit within its terms of reference to monitor and audit the embedding of the MSP agenda across all agencies.

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

9.14. The Foundation Trust Trust have introduced a more robust system of application of the National Framework including consent forms for patients and families and full involvement of families. Robust application and recording of Mental Capacity Act and best interest's decisions are now more embedded within this process.

9.15. There have also been other changes in practices in regards to CHC; The Clinical Commissioning Group now has a dedicated team to complete assessments once referred into the service rather than frontline staff. Every checklist is now received by the CHC service even if they have been screened out so that the service can challenge if an individual should be reviewed.

GP practice alignment

9.16. Care Home 2 at the time had seven GP practices which, systemically made liaison related to medical needs of residents complex. As part of Rotherham's transformation agenda, GP surgeries are being aligned to care homes within their locality as a way of easing communication and coordination. The Learning Events heard how, although it is early days, Care Home 2 is now aligned to one practice and GPs are running clinics from the care home with dedicated clinical time. GPs are also now being asked to write in the records and staff feel that this is positive and that they will be able to build better relationships and links.

Adult social care locality teams

9.17. In Adult Social Care there are plans underway to move to locality teams receiving referrals, assessing and care manging all within one team, negating the need for cases to be moved between teams from assessment to care management.

10. CONCLUSIONS AND LESSONS LEARNED

10.1. The circumstances that led to the death of Phyllis had a deep impact on her family and those working with her and the sense that her falls could not have been prevented was clear. Several changes have

already been implemented as described above.

10.2. This review has shown that caring for elderly frail residents within a care home setting offers significant challenges when those residents have complex co-morbidities and are subject to multiple falls.

10.3. The review found that despite some of the processes and record keeping that could have been more robust, that staff in general caring for Phyllis did so to the best of their ability and continually looked to try and afford her safety from falls.

10.4. The review concludes that falls 'management' in some cases is a more helpful term than falls 'prevention' so that all involved (families and professionals) are aware that when all prevention strategies have been exhausted, that managing to minimise harm is more achievable albeit that this is not always possible.

10.5. Care homes such as Care Home 2 rely heavily on the support offered by the multi-agency, multi-disciplinary teams who are not based on site. It is therefore vital that the system of ensuring that service users are in the best placement available, in order that their needs can be met, is robustly used and recorded.

10.6. There were two key areas that could have provided for a reassessment of Phyllis's needs;

- Robust application of The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.
- A system for investigation and application of CQC notifications guidance may have led to a further assessment of Phyllis's safety and care needs.

10.7. There were several areas covered by this review where communication was challenging and less than robust. This review has suggested a model for improved communication between agencies is developed along with support and guidance for staff and families where communication has become difficult.

11. RECOMMENDATIONS

1. RSAB should be assured by a review of policies across all sectors ensures that the focus on falls reduction and management in cases where falls prevention is not possible.

2. RSAB's Performance and Quality Group should assure itself via Multi Agency Case File Audits, that its relevant member agencies:

    a. Can evidence an improved system of recording and application of National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care that is robust and in line with the published Department of Health Guidance.

    b. Have a system to investigate incidents, that includes guidance on the reporting threshold and specifically to ensure that CQC Notifications Guidance is adhered to.

    c. Evidence robust record keeping, and in the case of residential settings, that the needs of residents are clearly communicated and that the whole MDT have access to, and can record within those records.

3. RSAB should assure itself and test out using auditing processes that communication between professionals, service users and their families is robust in the following areas:

a. Embedding of the safeguarding element of the Care Act 2014 (especially section 42 and 45) and Care Act Guidance Chapter 14 including key elements from this review i.e. Advocacy for service users and Making Safeguarding Personal.

b. Information and support for families provided by all agencies to manage the systems and processes that service users may be subject to.

c. Signposting and reminders for families about independent support agencies such as those offered by charities and voluntary organisations.

d. Guidance and support for staff and service uses and their families in managing complex communication issues that may arise, that includes guidance on escalation processes and advocacy and support for families.

4. RSAB to consider a model for multiagency communication such as that suggested within this review.

5. RSAB should look at a range of mechanisms and develop protocols for the use of care coordinators in complex cases in the community setting.

6. RSAB to ensure that all the learning points from this review have been disseminated.

7. The following recommendation is made by the family:

> 'Whenever a person goes into a care home the family should be given a clear understandable document which sets out the policies, and the responsibilities of all involved and who to contact when you have issues. Also a questionnaire for the family to test their understanding of the policies and on the care given. This way a clear measure of care can be rated.'

12. BIBLIOGRAPHY (Not referred to in footnotes)

Beech, R. & Roberts, D. (2008) Falls Briefing, Social Care Institute for Excellence Research Briefings

Kato-Narita et al.(2011) Alzheimer's: falls and functional capacity Arq Neuropsiquiatr;69(2-A):202-207

APPENDIX 1
Terms of Reference

The request for a safeguarding adults review was agreed by the Independent Chair of RSAB on 5 November 2015.

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—

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

condition 1 or 2 is met.

Condition 1 is met if—

the adult has died, and

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—

the adult is still alive, and

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—

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

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 RSAB multi-agency procedures

The six principles are as follows:

• Empowerment – Personalisation and the presumption of person-led decisions and informed consent.

> "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

• Prevention – It is better to take action before harm occurs.

"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

• Proportionality – Proportionate and least intrusive response appropriate to the risk presented.

"I am sure that the professionals will work for my best interests, as I see them and they will only get involved as much as needed."

• Protection – Support and representation for those in greatest need.

"I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able."

• Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me."

• Accountability – Accountability and transparency in delivering safeguarding.

"I understand the role of everyone involved in my life."

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.

Agencies involved in the review and who provided Reports for the Review

- Rotherham Metropolitan Borough Council Adult Social Care and Housing. (Assessment and Care Management.)
- Rotherham Metropolitan Borough Council Adult Social Care and Housing (Adult Safeguarding Team)
- Rotherham MBC Care Home Team – regarding Care home 2)
- Rotherham NHS Foundation Trust (Hospital Inpatient Admissions)
- Rotherham NHS Foundation Trust (Physiotherapist)
- Rotherham NHS Foundation Trust (Care Home Support Team)
- Rotherham NHS Foundation Trust (Advanced Nurse Practitioner)
- Rotherham Doncaster and South Humber NHS Foundation Trust (Older People Mental Health Team and Psycho Geriatrician)
- GP Practice
- Yorkshire Ambulance Service

Questions to be answered by the Agency Reports and considered by the Overview Report.

- What was the role of your agency in the prevention and management of falls for Phyllis?
- What was the response of your agency to each fall?
- When did your agency, if relevant, seek specialist advice from the RHFT Falls Prevention Service? What was the advice given and was it communicated to all those who needed to know?
- Did your agency have an individual care plan for Phyllis? If so, how was this shared with other professionals involved in her care?
- Did care plans for Phyllis include a falls prevention strategy and, if so, were the right professionals in your agency aware of this at the time?
- What was the understanding in your agency regarding unwitnessed falls, particularly in regards to head injury?
- What consideration was given to whether Care Home 2 was the right placement for Phyllis given the risk of falls, both at the start of her placement and through-out her stay?
- Provide information regarding whether the safeguarding alerts provided the required scrutiny and response, in line with procedures at the time?
- What was the family involvement in Phyllis's on-going care at your agencies key decision making points?

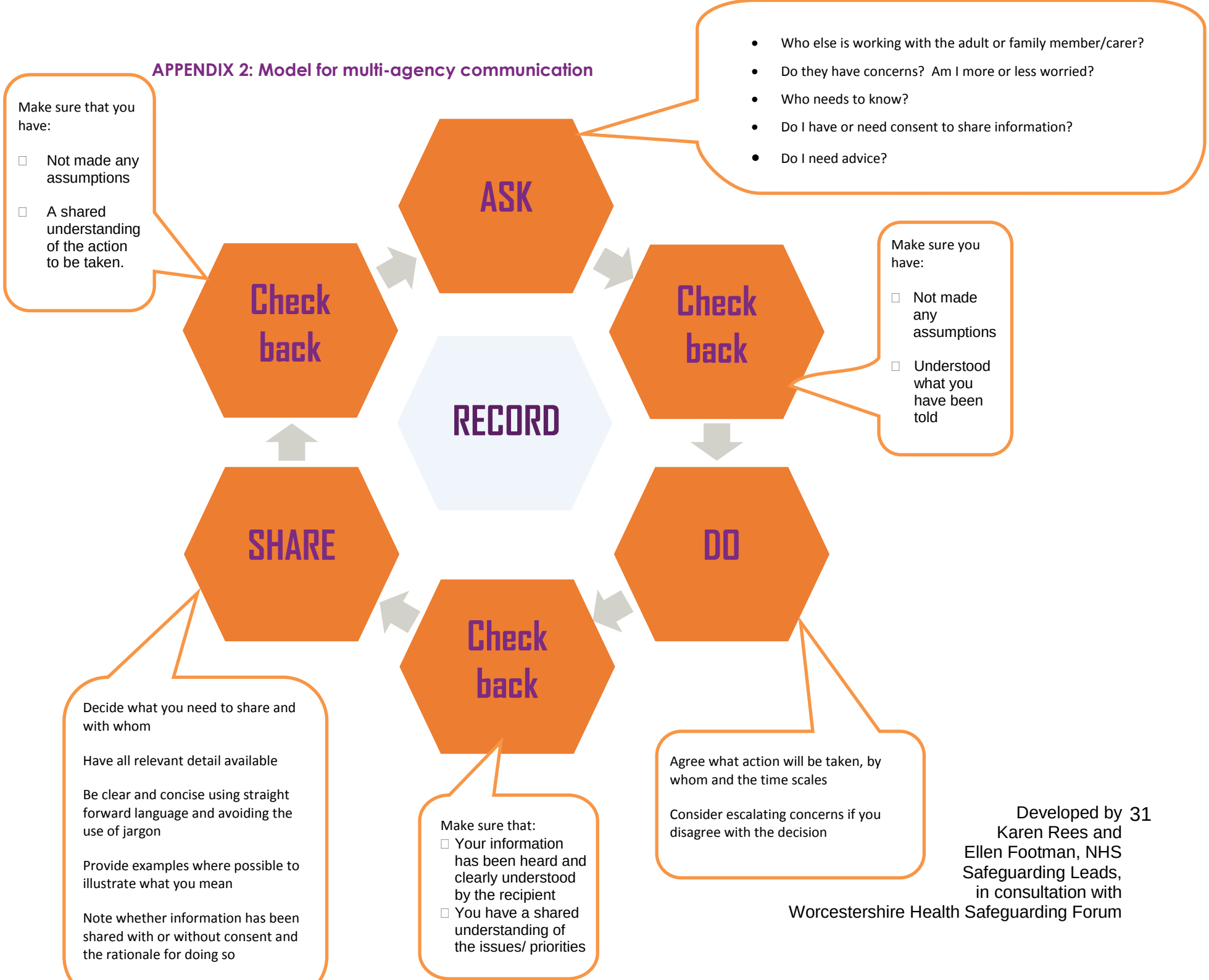
- Demonstrate whether your agency/service heard and responded to Phyllis's views, wishes and feelings, and those of the family.

- What relevant changes have been instigated in your agency post-incident?

- What impact has the NICE Guidance 2015 had on falls prevention in your agency?

- Outline any good practice in this case.

APPENDIX 2: Model for multi-agency communication



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