**INDEPENDENT CASE REVIEW OF THE CARE AND TREATMENT OF MRS S BETWEEN 1st AND 29th JUNE 2018.**

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# BACKGROUND.

* 1. This review was requested by North Yorkshire Adult Safeguarding Board and commissioned by NHS Scarborough and Ryedale CCG. It examines the care and treatment of Mrs S in the final few weeks of her life. Mrs S was born in 1926 and had lived with dementia and other conditions for several years. According to the GP notes submitted for the review, these included osteoarthritis, peripheral vascular disease, cerebrovascular disease, hypothyroidism, dysphagia and epilepsy.
	2. Mrs S spent her final years in a Care Home in Scarborough. Latterly, this was funded through the Continuing Healthcare budget by NHS Scarborough and Ryedale CCG.
	3. On 14th June 2018, due to a choking episode where she went blue and became unresponsive, an ambulance was called by Care Home staff after they had initiated emergency treatment. She was conveyed to the Emergency Department of Scarborough Hospital and then admitted to a ward. Hospital staff assessed and treated her, and plans were put in place for her discharge. However, her condition deteriorated, and she died in hospital on 29th June 2018.
	4. The review focuses on the quality of Mrs S’s care and treatment in the last few weeks of her life. This was driven in part by family concerns about the episode of illness leading to her hospitalisation. It complements a previous review, yet to be published, which looked at a longer period and had broader terms of reference, including examination of multi-agency partnership working associated with her care.
	5. The author, Geraldine Sands, has undertaken this work for Eventus Health PLC as an independent consultant. Formally, she worked regionally for NHS England as a Deputy Director of Nursing with a remit for quality, safety and safeguarding. She had no involvement in, or prior knowledge of, the care and treatment of Mrs S.

# AIM AND SCOPE OF THE REVIEW.

* 1. The aim of this review is to provide an independent assessment of the care and treatment of Mrs S during the final two weeks of her residence at the Care Home and during her short period of hospital care as an inpatient. The timeframe under review is restricted to 1st June to 29th June 2018 and the scope does not include consideration of care and treatment falling outside this time period. The reviewer was tasked with summarising any learning and recommendations for practice.
	2. This review can be described as a ‘table top review’. The reviewer never met Mrs S and it was not intended that recommendations were developed from direct clinical assessment or observation. She has therefore been dependent on the information submitted by contributing organisations and individuals, and her professional judgements concerning this information.

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# METHODOLOGY.

* 1. An email was sent to the relevant organisations by the CCG asking them to submit chronologies to the reviewer using an agreed template, by 22nd February 2019. The reviewer was tasked with completing a report within 12 weeks of receiving the chronologies.

The methodology includes 3 stages.

* 1. Stage 1.

The CCG requested chronologies from participating organisations. The completed templates were to include:

* + - An indication of the appropriateness and quality of care plans, treatment and care, in light of any identified health needs.
		- An indication of the adequacy of risk assessments and risk management in place pertaining to the care and treatment.

The organisations from which the CCG requested chronologies included the following:

* + - The Care Home
		- The GP Surgery
		- The Hospital
		- The Ambulance Service
		- The Local Authority.
	1. Since Mrs S was receiving care and treatment funded through NHS Continuing Healthcare (CHC), the CHC commissioner had responsibility for overseeing its quality. Therefore, the reviewer asked for similar information from the CCG Continuing Healthcare Team.

Family members were also given the opportunity to contribute to the review. One of Mrs S’s daughters (daughter 1) responded to this opportunity by submitting several documents to the reviewer.

* 1. Face to face meetings were to be organised if necessary. The only meeting which took place was with the Care Home and it was held on 11th March 2019. The reason for this meeting was to explore gaps in information that had been submitted and to give the staff opportunity to respond to some issues raised in information from daughter 1, which would not have been captured within their simple chronology template.
	2. Stage 2.

The reviewer examined the information submitted and compiled a report.

In order to review Mrs S’s care, the reviewer used the CQC fundamental standard as a framework. Descriptive information about the standards is given under each sub heading in section 5 of the report, and further details about the standards and associated regulations can be found on the CQC website.([https://www.cqc.org.uk/guidance-providers/regulations-](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers) [enforcement/regulations-service-providers-managers](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers)).

Each standard relates to one of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

* 1. In brief, the standards cover the following themes:
		+ Person centred care.
		+ Dignity and respect.
		+ The need for consent.
		+ Safe care and treatment.
		+ Safeguarding service users from abuse and improper treatment.
		+ Meeting nutritional and hydration needs**.**
		+ Premises and equipment.
		+ Receiving and acting on complaints.
		+ Good governance.
		+ Staffing.
		+ Fit and proper persons.
		+ The duty of candour.
	2. Stage 3.

This stage relates to the action that those who commissioned the report will take following its completion, including how they will share it and the mechanisms for overseeing implementation of any recommendations. This part of the review will be led by North Yorkshire Adult Safeguarding Board and the CCG.

# INFORMATION SUBMITTED FOR REVIEW.

* 1. A list summarising the type of information submitted for the review is set out in the appendix. Information was extensive and varied in quality. Despite the written request from the CCG setting out how the template should be used, generally there was very limited indication of the appropriateness and quality of care plans, or the adequacy of risk assessments and risk management processes. As a result, the reviewer was required to use a considerable amount of professional judgement, which meant that the review process was slightly different to that which was planned.
	2. There were some 24-hour charts missing from the Care Home’s chronology and these had still not been located when the reviewer visited the Care Home in person. These related to 11th to 14th June inclusive. The daily summaries of care for those days were available and had been used to complete the chronology template. Whilst the reviewer does not consider that this gives evidence that either care was not delivered on those days or that no 24-hour charts were initially completed, it was surprising that such records of care could not be located. The nurse in charge thought that the records had been lost in the process of copying them for use by a solicitor.
	3. The information submitted by daughter 1 was extensive and very different in nature to that within the chronology templates. It included, for example, her detailed diary notes, photographs of care plans and copies of emails.

The Local Authority did not submit a chronology, instead they gave the reviewer copies of emails and meeting notes.

* 1. The nature of some of the information submitted by daughter 1 and the Local Authority was quite personal and at times, potentially defensive. This was particularly the case when copies of emails trails were submitted including names of individuals sending or receiving them.
	2. The CCG Continuing Healthcare Team had not been asked to submit a chronology. As indicated in paragraph 3.12 above, the reviewer did request information from this team. The rationale for this was that the National Framework for NHS Continuing Healthcare and NHS-funded Nursing care (revised in 2018) clarifies how CCGs ‘are responsible and accountable for system leadership for NHS Continuing Healthcare within their local health and social care economy’. It goes on to explain the expectation of the CHC case management role as being:

*As with all service contracts, commissioners are responsible for monitoring quality, access and patient experience within the context of provider performance. This is particularly important in this instance, as ultimate responsibility for arranging and monitoring the services required to meet the assessed needs of those who qualify for NHS Continuing Healthcare rests with the CCG.*

* 1. Infact, as no direct contact apparently took place between the CHC team and Mrs S during this period, the team liaised with the reviewer via email rather than completing a chronology template

# ANALYSIS OF INFORMATION.

* 1. The analysis of information against the CQC fundamental standards is set out below. The scope of the review was clear that information pertaining to care outside the agreed time period, should not be considered by the reviewer.

Therefore, the amount of information to consider against each standard varied, and for some standards there was none.

# Person Centred Care:

This CQC standard concerns how care provided reflects the preferences of the patient, in collaboration with the ‘relevant person’, should the patient lack capacity. It also considers whether the care and treatment given is appropriate and meets the patient’s needs.

* 1. Within the Care Home, there was evidence of several care or support plans for Mrs S. Those which the reviewer had sight of were written in a person-centred way, clearly setting out Mrs S’s needs and preferences. The reviewer was made aware of plans for nutrition and hydration, dysphagia, aspiration and choking, skin integrity, massage routine, T-roll usage, hand care, mental health and well-being, activities of daily living, sleep, end of life, pain, management of epilepsy, vascular dementia.
	2. However, it was not clear how the development of these engaged daughter 1. When this was discussed with the Care Home manager, she explained that daughter 1 had seen them and had copies of most of them. The latter was evidenced by the copies of some of the care plans submitted by daughter 1 to the reviewer. This does not necessarily reflect collaborative development of the plans or her engagement in understanding what the options were associated with her mother’s care.
	3. Daughter 1 appeared not to be happy with some of the care plans, or the way they were implemented. For example, she documented concern about the fact that Mrs S was nursed in bed on a pressure relieving mattress. She felt that this engendered isolation as Mrs S remained in her room. However, the senior nurse explained that this decision had been made as a result of an assessment by a physiotherapist who indicated that postural seating was not adequate for Mrs S in the light of her contractures and incontinence. The fact that her skin remained intact, and she had no pressure sores, demonstrated that the pressure relieving mattress and the repositioning and personal care delivered by staff, effectively met her care needs.
	4. There is evidence from the Deprivation of Liberty Standard Authorisation dated 6th March 2018, of conditions which included a requirement for a care plan documenting social activity for Mrs S to prevent social isolation. These seemed to be covered by her

activity plan and mental health and wellbeing plan. They led to evidence of visits from the ‘activity co-ordinator’ in the Care Home chronology. Activities recorded included chatting to Mrs S and trimming her nails. An aromatherapist is also recorded as visiting to carry out massage to her arms and legs. There were some occasions when thes e staff visited when Mrs S was asleep, and they did not wake her to carry out planned activities. This approach would seem acceptable as it would not be kind to wake her up for their convenience. Private therapy sessions are also recorded, presumably arranged by daughter 1, such as a reiki healer. A ‘companion dog’ was kept on her bed as part of Mrs S’s mental health and wellbeing plan, as she apparently loved dogs. Daughter 1 was concerned that this dog was sometimes out of her mother’s reach, which may demonstrate that the care staff could improve their attention to detail, but would not equate with inadequate care.

* 1. Daughter 1 documents dissatisfaction as she believed that the nutrition plan was not followed by staff during the period under review, as Mrs S was not routinely fed three meals and was not always given a warm drink in the evening. However, when interviewed, the senior nurse was clear that if Mrs S was sleeping, they would not force her to eat or drink as this would compromise her dignity. Their aim would be to ensure that there had been a minimum fluid intake in the day and that she was not losing weight. When confident that those two criteria were met, the staff apparently would not worry if she missed meals or drinks. (More detail about this is set out in the section on ‘meeting nutritional and hydration needs’ in paragraph 5.49). This does seem to be a reasonable approach to take, but it is not clear whether it was reflected in the care plan and discussed with daughter 1.
	2. Regarding Mrs S’s sleep care plan, this focused on making sure that despite being in bed, she had verbal stimulation during the day, through staff visits, visitors and the TV, and subdued lighting and a more peaceful environment at night. According to daughter 1, Mrs S also liked a hot drink in the evening and to watch her favourite TV programmes. However, daughter 1 commented that on many occasions the TV was not turned on, and she regularly was not given a hot drink, so this care plan was not routinely implemented. As the care plans were not kept in the patients’ rooms, it would be interesting to know how familiar all the care staff were with their contents, and what arrangements were in place to ensure all staff understood the importance of implementing them. Whilst it is not possible to draw any conclusions about how frequently care was not provided in line with the plan, thus the impact this had on the quality of care, there does seem to be some evidence of inconsistencies in attention to detail with respect to care plan implementation.
	3. There was evidence that the GP had signed a ‘Do Not Resuscitate’ (DNR CPR) form for Mrs S, indicating that she considered that the outcome of resuscitation would not be of overall benefit to Mrs S. The form indicated that this decision had been discussed and agreed with daughter 1. This reflects sound person-centred treatment planning.
	4. There were a number of emails submitted about discharge planning when Mrs S was in hospital, and allegations were made by daughter 1 that the Care Home had, in effect, evicted her mother during her hospitalisation, in spite of evidence submitted that the CCG continued to pay for the Care Home bed under NHS Continuing Healthcare funding. Allegations were made following a reported statement by the Care Home manager that Mrs S could not return, and an observation by daughter 1 that her mother’s ‘special bed’ had apparently been removed from her room whilst she was in hospital. However, there are emails showing that the Continuing Healthcare team

liaised with daughter 1 regarding a Best Interest meeting which was to be held before hospital discharge, to look at the best place for her mother to be discharged to. This meeting would consider whether Mrs S’s care needs were different to those that she had prior to admission, and thus agree where her current needs could best be met. In the end, this meeting was cancelled due to the deterioration of Mrs S’s health and an acknowledgement that she was not fit for discharge. This sensitive approach to discharge planning, giving full consideration of Mrs S’s needs was good practice. Regardless of the ongoing conflict between daughter 1 and the Care Home, the CCG continued to pay for her placement and would have been able to discharge her there, should that have been in her best interest.

* 1. The care provided by the hospital appeared to be person-centred. For example, daughter 1 was present during the process of medical clerking on 14th June, giving her the opportunity to explain care needs and provide background information about her mother. The nursing admission assessment documented the fact that Mrs S needed the assistance of 2 people and that she was unable to express her needs. During her time in hospital she was frequently reassessed by clinicians as her clinical needs changed, to make sure that the most appropriate treatment plans were in place. These included the Care of the Elderly Senior House Officer, a Speech and language therapist, a Neurologist.
	2. The hospital chronology describes how Mrs S was observed very carefully in order to reassess her needs. For example, on the night of 27th June she was apparently groaning, so the staff commenced a syringe driver for pain relief and gave her anti- epilepsy drugs through this route. At that point she was assessed as needing palliative care so a full discussion took place with daughter 1 concerning the fact that the hospice might now be the best place for her. This reflects sensitive, person-centred care.

# Dignity and Respect:

This CQC standard looks at the extent to which the patient is treated with dignity and respect and in a manner that is caring and compassionate. This includes the level of privacy, and the extent to which the patient is supported in maintaining relationships. It also looks at whether the level of surveillance is in the patient’s best interest.

* 1. Mrs S had privacy in her own room at the Care Home. However, being next to a staff office, the carers were able to easily monitor her. The Care Home chronology seems to demonstrate care that gave dignity and showed respect. Examples of this include her hair care routine, her nail care and aromatherapy. She was also doubly incontinent and there was frequent care given by staff to attend to her continence needs. Evidence of staff allowing her to sleep when they attended for aspects of care which were not essential, demonstrated a caring and compassionate approach, yet daughter 1’s notes interpret this as negligent.
	2. There are a couple of examples given by daughter 1 that potentially compromise dignity and respect during this period. One example is when a soiled pad was apparently left on the bedside table in Mrs S’s room on 7th June. This is clearly not acceptable but is likely to be an oversight on behalf of a carer rather than a demonstration of enduring deficits in compassionate care. Secondly, daughter 1 submitted a copy of the contracture care plan requiring T-roll support, and support for Mrs S’s hand. Photographs were also submitted demonstrating times when T-roll support was not adequately implemented, resulting in potentially painful positions for Mrs S. Although this does not demonstrate good care, there is no clarity regarding the

length of time or frequency with which she was left in a sub-optimal position. As Mrs S received general care on a 2-hourly basis, this may have been a very rare and transient problem. The fact that her skin remained intact would lead one to believe that this was a transient rather than an enduring issue, but there was no information submitted regarding her flexion deformities and their progression. This information would have been useful as an indication of how effectively her T-roll support and hand positioning care plans were implemented.

* 1. The Care Home demonstrated a strong commitment to supporting Mrs S’s family relationships, including with daughter 1 who visited daily and was given protected time with Mrs S on her own.
	2. The hospital chronology covers an acute episode of care and a gradual worsening of Mrs S’s state of health such that dignity and respect are difficult to assess. However, it is noteworthy that the nursing admission assessment notes that Mrs S needs the assistance of two and is unable to express her needs. There are examples during this period when the hospital staff clearly engage the daughter or son in updates or to seek specific information. For example, on 15th June, after the nursing assessment, daughter 1 was included in the ward round to give some background information to support plans for care and treatment. This demonstrates a commitment to provide the most appropriate care for Mrs S.

# Need for Consent.

This CQC standard examines whether information on care is provided in an understandable way over a period. It looks at whether, should consent be withdrawn by a patient or someone acting on their behalf, that this is appropriately respected. It also explores whether, should a patient lack capacity to consent, that those providing care act in line with the Mental Capacity Act.

* 1. In the Care Home chronology, there is mention of the ‘Complete Care Homes Consent Form’ listing a range of care needs that Mrs S was consenting to. Although the chronology indicates that this form had been signed, it is apparently unclear who signed it on behalf of Mrs S who was assessed as lacking capacity. The form is apparently dated 23rd March 2018 and because this predates the time period under investigation, this was not explored further. When visiting the Care Home, the senior nurse did explain how Mrs S’s care was ‘sanctioned by the Court of Protection’. There is clearly a separate issue about how information on care provided was fully understood by Mrs S’s ‘relevant person’, which is just as significant as having court sanction for the care. There is limited evidence in the information submitted to demonstrate this latter point, but that may be due to the short time period under review, rather than a failure to fully discuss planned care with daughter 1 or other relatives.
	2. The ‘Do Not Resuscitate’ agreement apparently dated back to 24th June 2013. However, daughter 1 reports that when her mother became acutely ill, the staff at the Care Home did try to resuscitate her. When interviewed, this was refuted by the Care Home manager who had been on duty at that time. She explained that she had undertaken a Heimlich manoeuvre to stop Mrs S’s choking and was holding Mrs S in a way to unblock her airways. It may be that there was a misunderstanding between the care staff and daughter 1 regarding the actions taking place demonstrating a communication issue rather than evidence of failure to respect an advanced decision.
	3. There is indication that the Care Home acted in line with the requirements of the Court of Protection on such issues as:
		+ Instigating a care plan which sets out which social activities Mrs S engages in.
		+ Considering whether an epilepsy sensor would be beneficial with respect to Mrs S’s seizures.
	4. When making the decision to convey Mrs S to hospital on 14th June the paramedics undertook a mental capacity assessment and concluded that due to her decreased level of consciousness, Mrs S did not have capacity at the time. They documented that they conveyed her to hospital considering it to be in her best interest, since daughter 1 apparently shared concerns that the Care Home staff were not monitoring Mrs S sufficiently. This assessment and documentation demonstrate good practice in spite of the fact that the Care Home describe their level of monitoring as good.
	5. During her hospital chronology, there is no formal consent information set out. However, there is evidence that the hospital, treating daughter 1 as next of kin, engaged her in discussions about Mrs S’s care. Examples of this include:
		+ through participation in the ward round on 15th June,
		+ participation in the speech and language therapy assessment on 19th June,
		+ discussion about Mrs S’s atrial fibrillation and commencement on new medication for this on 20th June,
		+ discussion on 24th June regarding treatment for pneumonia,
		+ discussion regarding her deterioration and palliative care on 27th June.

This all signifies good practice and a commitment to engage Mrs S’s next of kin at every point in her care and treatment so that she fully understands the treatment provided and the rationale for it.

# Safe Care and Treatment.

This CQC standard looks at the extent to which risk assessment is involved in care planning, balancing needs and safety with preferences of the patient. It looks at how risks are mitigated and how timely carers respond to meet needs. It considers how incidents are reported internally and externally and whether policies are in place to raise concerns regarding care. Arrangements for clinical emergencies are also considered.

* 1. There are numerous examples of risk assessment in relation to Mrs S’s Care Home care plans. These include risk assessments for nutrition and eating which show how Mrs S had a risk rating of 9, reducing to 6 when the care plan was put in place. This meant that she had a high risk of poor nutrition and hydration without the care plan. The plan required mitigating actions including for Mrs S to be positioned upright, have pureed food, to have close monitoring of her food and fluid intake etc. It reflected well on the Care Home that Mrs S’s routine blood tests apparently always showed that she was well hydrated. Also, she apparently was not underweight.
	2. A support plan for dysphagia, aspiration and choking was in place which was regularly evaluated. It took a risk mitigation approach by describing what actions to take if Mrs S starts to cough or splutter when she is drinking or eating.
	3. A skin integrity risk assessment indicated that Mrs S was nursed in bed, had dysphagia, had suffered a stroke resulting in contractures of her left leg and right hand and was incontinent. She was identified as having a risk of pressure ulcers and deterioration of flexion deformities. The risk rating was assessed as high (9) reducing to medium (6) following the mitigating actions. The level of risk was reassessed

monthly and the care plan was evaluated. The last review apparently took place on 31st May 2018.

* 1. Daughter 1 had concerns about the epilepsy care plan and the fact that it identified symptoms that could demonstrate increased likelihood of a seizure, but not how to escalate this. Daughter 1 apparently thought that she had witnessed these symptoms in the week leading up to the choking episode but did not know what to do about it as this was not made clear in the care plan. As she was not permitted to speak directly to the staff, she had seemingly left a message in a ‘communications diary’ concerning this, but the staff apparently did not respond to her message. She felt that if this had been acknowledged, the seizure and choking leading to hospitalisation could have perhaps been prevented. When speaking to the Care Home manager, a message in the diary had not been noticed at the time. Care Home staff reported that ‘all cares were normal’ between 1st and 14th June and did not note any changes in Mrs S’s appearance and behaviour. It is therefore not possible to form a view concerning whether there were any signs of an imminent seizure nor whether the seizure and associated choking could have been prevented. However, it is very clear that when communication between the relevant person and carers is restricted, and relationships have broken down, tensions and misunderstandings are inevitable.
	2. In terms of response time, the care was exceptional, with the nurse and carer attending Mrs S as soon as the call was raised by daughter 1, as they were apparently in the next room. The ambulance took only 3 minutes to arrive at the Care Home. This was coded as a category 1 call for which the response time standard is 7 minutes
	3. When considering reporting routes for incidents and policies setting out how to escalate concerns, it should be noted that specific information on this was not requested from organisations. However, one observation is that escalation of clinical concerns such as with the epilepsy care plan, seemed to be unclear and daughter 1 submitted evidence that this was eventually discussed at a Local Authority multi- agency meeting, rather than directly within the line of accountability for clinical care.
	4. During the hospital stay, there were numerous examples of risk assessment, albeit through implication rather than giving evidence of a detailed process. Decisions about how to progress Mrs S’s care was based on such assessments. For example:
		+ Nurses decided that she needed 2 people to move and care for her
		+ Decisions to catheterise due to urinary retention and to commence antibiotics due to aspiration pneumonia.
		+ Decisions to commence IV fluids due to haematuria and possible pain on 16th

June

* + - Decisions to commence on medication to reduce atrial fibrillation on 19th June. 5.41) **Safeguarding service users from abuse and improper treatment**

This CQC standard looks at how well people who use services are safeguarded from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005. This requires organisations to have the appropriate policies and procedures in place and to take action where abuse or improper treatment is reported.

* 1. It is difficult to comment on this standard when reviewing such a short period of care and treatment. However, it would seem clear that the Care Home staff were aware of

safeguarding procedures because they initiated a safeguarding alert regarding the choking episode that led to Mrs S’s admission to hospital. This related to the period of time that Mrs S and daughter 1 were alone, before the alarm was raised to obtain help with Mrs S’s choking episode. However, since the home’s experience of daughter 1 to date was as a provider of intense and well-intentioned care, and of having very high expectations of the care that the home could deliver, this seemed to be a strange use of the safeguarding referral process. Safeguarding concerns usually build up over time and may involve some triangulation with evidence or anecdote from other sources.

* 1. Whilst Mrs S was in the Care Home, there was seemingly a history of complaints and safeguarding referrals submitted by daughter 1, setting out concerns about the care provided by the home. It therefore appeared that the safeguarding referral process was potentially being used defensively rather than appropriately. Once the referral had been made, the Local Authority discussed it with daughter 1 but did not take it any further.
	2. There is no evidence of unrecognised safeguarding issues at the Care Home, and apart from the time when an incontinence pad was allegedly left on Mrs S’s bedside table, there is no evidence of degrading care. The need for bed rest was challenged by daughter 1, but the reasons for this and justification for it are set out above in paragraphs 5.14. The Care Home had also demonstrated that steps had been taken to ensure that bed rest did not result in social isolation for Mrs S, through her activities and mental health and wellbeing plans.
	3. It would appear that Mrs S was safeguarded as an adult at risk by both the ambulance service and the hospital. There is mention in the ambulance service’s chronology of the paramedic’s assessment of Mrs S’s mental capacity and rationale for conveying her to hospital to act in her best interest. Likewise, the hospital was working with the Continuing Healthcare Co-ordinator to plan a Best Interest meeting where Mrs S’s most appropriate discharge location would be decided.
	4. Information about availability of safeguarding procedures to staff, and board level training was not sought as part of this review.

# Meeting nutritional and hydration needs.

The intention of this regulation is to make sure that people who use services have adequate nutrition and hydration to sustain life and good health and reduce the risks of malnutrition and dehydration. This involves assessing their needs and ensuring they are met in the most appropriate way.

* 1. The Care Home had a care plan in place for how Mrs S should be fed and the frequency and consistency of the food she should be given. Advice had been sought from a speech and language therapist on this. There was also a plan in place for her fluid intake, and both food and fluid intake were monitored and recorded on a chart.
	2. As set out above in paragraph 5.16, when the Care Home’s senior nurse was interviewed, she explained that, on days when Mrs S was sleepy and unresponsive at meal and drink times, the staff would not routinely wake her. She described their ‘rule of thumb’ as being that only if Mrs S’s fluid intake fell below 700 mls a day, or her routine blood tests revealed she was dehydrated, would she be woken to ‘push fluids’. The senior nurse described how Mrs S had become quite obese and the Care Home staff had some concerns about this, particularly due to the increased risk of pressure sores associated with her weight gain. Because of this they did not wake her to make

her eat. They also understood that daughter 1 gave Mrs S high calorie drinks and desserts when she visited.

* 1. Daughter 1, however, had concerns about the fluid and food intake of her mother. She documented in her personal notes that between 2nd and 13th June Mrs S had no lunch on 4 days and a very small breakfast on 2 days. On the 12 days leading up to hospitalisation, her notes state that only once did her mother have all 3 meals. She documented that over the 12 days prior to hospital admission, her average fluid intake between 8.30am and 5pm was 480mls and fluids were not given between 6pm and 9am. This included no warm evening drink, as required by her care plan.
	2. Daughter 1’s record of fluid intake was not the same as that of a service manager from adult social services whose notes about fluid intake were submitted to the reviewer. She documented that Mrs S’s daily record sheets showed from 7th to 10th June 2018, fluid intake varied between 1230 and 1530mls a day, which is a good intake. There were no daily record sheets for 11th to 14th June 2018 as noted above in paragraph 4.11.
	3. It is therefore difficult to comment on daughter 1’s concerns. There may have been days when some of Mrs S’s drinks were not recorded on her chart until after daughter 1 had visited. If her fluid intake really was as low as 480mls a day, her blood tests would have been unlikely to consistently show she was well hydrated.
	4. Again, the breakdown of relationship and communication between daughter 1 and Care Home staff posed a considerable problem here. Had daughter 1 been fully engaged in development and delivery of the care plan, the fluid chart could have been completed collaboratively so that everyone understood what fluids she had taken and whether more should be given on any day.
	5. When in hospital, a speech and language assessment was carried out on 19thJune. This stated that pureed food could be given, and sips from a cup, and this was incorporated into Mrs S’s care plan. IV fluids were commenced on 23rd June when her condition deteriorated and then this was discontinued when a decision was made that she should commence palliative care on 26th June. These decisions appeared to have been made sensitively, engaging relevant clinical experts, and involved discussion with daughter 1. The hospital staff therefore appeared to assess and reassess her nutrition and hydration needs and sought to meet them in the most appropriate way during her brief hospital stay.

# Premises and equipment

The intention of this regulation is to make sure that the premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located, and that the equipment that is used to deliver care and treatment is clean, suitable for the intended purpose, maintained, stored securely and used properly.

* 1. In the evidence submitted, there is no detail of anything that would suggest that the premises and equipment were unclean, insecure or inadequately maintained. The only minor issue here relates to the Care Home suction machine. When interviewed, the Care Home manager who was the qualified member of staff on duty when Mrs S had the seizure and choking episode, explained how she did not know how to use it. As part of the emergency response to Mrs S’s choking, it could have been used to clear

her airways. However, the Care Home manager managed to do this without suction, and the paramedics then used suction when they arrived.

* 1. It should also be noted, that in relation to Mrs S, her dysphagia, aspiration and choking care plan apparently did not mention the need to use the portable suction machine or the need to have such equipment located in Mrs S’s room.

# Receiving and acting on complaints

To meet this CQC standard, providers must have an effective and accessible system for identifying, receiving, handling and responding to complaints from people using the service, people acting on their behalf or other stakeholders. All complaints must be investigated thoroughly, and any necessary action taken where failures have been identified.

* 1. There was no documentary evidence of complaints submitted during the time period under review, therefore it is not possible to examine this standard.

# Good governance.

* 1. To meet this CQC standard; providers must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. In addition, providers must securely maintain accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity.
	2. Within the Care Home chronology, there is no evidence of audits being carried out during the period under review, which is perhaps unsurprising due to its short duration. However, where there were concerns expressed by daughter 1 about her mother’s care, it would have been useful for the Care Home to have this type of information to examine and to use to frame a response to her. For example, audits of compliance with various care plans would have provided a focus for discussions concerning her dissatisfaction regarding their implementation. Either an audit would demonstrate full compliance with a care plan, or it would indicate improvement actions that could be put in place and shared with daughter 1. Instead the only clear route of escalation evidenced in the information submitted was to Local Authority led multi-agency meetings, which seemed not to take a focused, evidence-based response to her concerns about care and treatment.
	3. It is clear that the Care Home staff were struggling with managing an adversarial relationship, and senior clinical, rather than managerial support from the Care Home Group, or the CHC case manager, could perhaps have supported the staff in taking a more objective and evidence-based approach to responding to concerns regarding Mrs S’s care. This would be an appropriate role for the CHC case manager whose responsibilities include *monitoring the quality of the individual’s care and support arrangements and responding to any difficulties/concerns about these in a timely manner* (The National Framework for NHS Continuing Healthcare and NHS-funded Nursing care (revised in 2018)
	4. Moreover, during the period under review, there was no evidence that the CHC team monitored the quality of Mrs S’s care in the Care Home. Recognising that the time period under review was a short one, the reviewer asked the CHC team when the most recent quality review had taken place. The team had apparently agreed with the Local Authority that any reported quality concerns would be taken via the Local Authority safeguarding route, ‘to ensure that a clear record is kept, and a thorough investigation takes place’. It therefore appeared that multi-agency safeguarding meetings were being used as a substitute for proactive, quality monitoring, to provide routine assurance about the quality of care and treatment commissioned.
	5. The other issue relating the Care Home governance, which is evidenced in the documents submitted, was missing daily records charts. It is not clear what processes were in place for storage or records and what actions had been taken regarding this loss of confidential information.

# Staffing

To meet this regulation, providers must have sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times. Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practise

* 1. It was not clear from the information submitted whether there were sufficient staff at any one time in any of the settings, but when interviewed the Care Home senior nurse explained that staffing is tight but commensurate with most other care homes, and she did not feel that the home was understaffed. Two members of Care Home staff responded very quickly to the emergency bell when Mrs S was choking, which does not give the impression of sub-optimal levels of staffing.
	2. There was no evidence of any staffing problems within the ambulance service or the hospital and indeed, the paramedics arrived very promptly to the Care Home and the hospital demonstrated a commitment to providing two members of staff to provide routine care for Mrs S. A variety of consultants were available to assess her treatment needs at different times including neurology, cardiology, palliative care.

# Fit and proper persons

To meet this regulation, providers must operate robust recruitment procedures, including undertaking any relevant checks. They must have a procedure for ongoing monitoring of staff to make sure they remain able to meet the requirements, and they must have appropriate arrangements in place to deal with staff who are no longer fit to carry out the duties required of them.

* 1. No information was submitted on this in the documents for review. 5.71) **Duty of Candour.**

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment,

including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

5.72) It is only possible to comment on the general level of transparency and openness as reflected in chronologies and documents submitted. This appears to be very good in the hospital, with numerous examples of information being shared with family members including daughter 1. In the Care Home, whilst communication did occur, led by the senior Care Home manager, there is also evidence of misunderstanding between the staff and daughter 1 about significant issues such as the epilepsy care plan and the actions taken by Care Home staff during the choking episode. These misunderstandings could have been reduced if open discussions took place, including perhaps a ‘debrief’ led by the Care Home, after the choking episode.

# CONCLUSIONS.

* 1. This review was a challenging one to conduct due to the variations in, and volume of, information submitted to the reviewer, and the complex history of adversarial relationships between daughter 1 and the Care Home.
	2. There are examples of very good care set out in chronologies and other information including:
		+ The person-centred care plans produced by the Care Home
		+ The fact that Mrs S’s skin remained intact despite having such a high risk of pressure ulcers
		+ The prompt, effective response from paramedics on 14th June who took full responsibility for assessing and documenting Mrs S’s mental capacity before conveying her to hospital.
		+ The treatment provided in hospital that effectively assessed and responded to complex and changing health needs in a person-centred way
	3. The issue that appeared to compromise care in the Care Home, was the difficult relationship with daughter 1, which limited communication between her and care staff and made it very difficult for them to be truly person-centred and open in the care they delivered. It also appeared that there may have been some minor inconsistencies in the implementation of care plans in the Care Home, as set out in the section above on ‘person centred care’.
	4. Information submitted demonstrated that in the brief period under review, the Care Home staff received limited clinical support from leaders in the Care Home Group or from the commissioners of Mrs S’s care package, the CCG CHC team. Such support may have helped them to more effectively address concerns about the quality of her care through audit and other quality assurance processes.

# RECOMMENDATIONS

1. **The senior management of the Care Home may wish to consider how the home routinely engages relatives of those who lack capacity, in the development and monitoring of care plans.**
2. **The senior management of the Care Home may wish to consider how it ensures that all carers are equally and consistently informed of the detail of care plans and leads the support and monitoring of their implementation.**
3. **The CCG CHC team may wish to review how it routinely monitors and supports the quality of care delivered within commissioned care packages, in line with the National Framework for Continuing Healthcare**
4. **The CCG and Adult Safeguarding Board may wish to clarify the difference between multi-agency safeguarding processes and routine clinical quality assurance processes and ensure that there are clear and different escalation routes for each.**

**APPENDIX**

# INFORMATION SUBMITTED FOR REVIEW.

A summary of information submitted for the review is set out below:

# Care Home.

A chronology for the required time period using the template provided by the CCG. This chronology also gave information about the care plans in place.

To augment this information, a visit to the nursing home took place on 11th March 2019 where the nurse in charge was interviewed, followed by a meeting and interview with the manager who was on duty at the time of Mrs S’s acute episode of illness.

# The GP Surgery

Print out of DS’s patient record demonstrating no direct contact during the period under investigation.

# The Hospital

A chronology for the required time period using the template provided by the CCG

# The Ambulance Service

A chronology for the required time period using the template provided by the CCG.

# The Local Authority

Email print outs of dialogues between the LA and hospital discharge liaison nurse about Mrs S’s current state of health. These took place on 25th June 2018

Notes of a meeting which took place between the LA and daughter 1 on 2nd August 2019 at which the details of the acute episode leading to hospitalisation was discussed.

A brief note highlighting reason for Mrs S’s admission to hospital and a summary of what happened from 14th June until her death? who wrote it.

Email print outs of a dialogue that took place in August between the LA and the Care Home and continuing care manager about a safeguarding alert and any evidence they could find concerning what exactly happened leading up to the acute episode and during it.

A copy of an email from Mrs S’s daughter to the LA about the acute episode leading up to her mother’s hospital admission.

# The CCG Continuing Care Team

Email response to my specific request for information concerning how the team assesses and reviews the quality of care it commissions on behalf of the CCG.

# Mrs S’s Daughter (daughter1)

Personal diary notes about her mother’s care during the period under review

Photos of care plan for ‘feeding’, the care home’s communication diary, a notice for staff regarding skin care, of Mrs S’s contractures,

Copy of care home care plans for sleep and epilepsy, the safeguarding alert submitted by the care home on 18th June 2018, a general information sheet from the care Home about T-Roll support for contractures and one about hand care.

LA meeting notes including:

* where the care plan for epilepsy was discussed on 2.8.18,
* a meeting after the death of Mrs S at which her acute illness and admission to hospital were discussed,
* where the cancellation of the Best Interest meeting was discussed. Print outs of emails including:
* from the CCG CHC team regarding Mrs S’s discharge and the planned ‘Best Interest’ meeting which was originally due to take place on 26th June 2018.
* A trail with names and organisations redacted about the role of the RPR.
* Regarding whether Mrs S had in effect been ‘evicted’ from the Care Home when she was in hospital.

Some information about recording decisions about CPR.

A letter she received from the Local Authority dated 6th September 2018 in response to complaints raised on 17th and 22nd August 2018

The court of protection order dated 6th February 2018

A letter she received from the CQC dates 20th Nov 2018 about her concerns regarding a potential decision by the Care Home not to take Mrs S back should she have been discharged from hospital