

Safeguarding Adult Review

in respect of

“Mrs. A”

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The report is anonymised

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## Safeguarding Adults Review – Mrs. A

# Purpose of the Safeguarding Adults Review

The subject of the Review is Mrs. A, an 88-year-old lady who died on 4 June 2015. She had been cared for in hospital and at home prior to her death and had refused treatment for a fractured distal end of the femur (above the knee).

This Review looks at the actions of the agencies who were supporting her and whether they had acted appropriately in their dealings with her in order to inform learning for the future and where possible prevent circumstances occurring again.

This Review covers the period between 9 March 2015 and 4 June 2015 and the various agencies responses and actions, which occurred up until June 2016. Its purpose is for the multi-agency teams who supported Mrs. A to engage in an analysis of events leading to her death and to reflect on whether the revisions made to date have effected change. It is also to enable senior leaders on the Safeguarding Adults Board (SAB) to consider whether any further changes are required and to promote effective learning by the members of the SAB in order to ensure the highest quality of care is available to the service users of the area.

Following Mrs. A’s death, Airedale NHS Foundation Trust undertook an investigation using the Serious Incident Framework and produced a report dated 9 November 2015. A Multi-agency Safeguarding investigation was also conducted which concluded in a ‘lessons learned’ meeting on 17 May 2016.

The learning from both these processes had been included in this Review at the appropriate section

The statutory basis for the Review is as follows -

*Under the Care Act (2014) A Section 42 enquiry must take place if there is reason to believe that abuse or neglect is taking place or is at risk of taking place, and the local authority believes that an enquiry is needed to help it to decide what action to take to support and protect the person in question. The particular circumstances of each individual case will determine the scope of each enquiry, as well as who leads it and the form it takes.*

*The local authority may decide that another organisation should carry out the enquiry, but the local authority will retain overall accountability. The local authority must satisfy itself that the organisation will meet agreed timescales and follow-up actions. Whatever form the enquiry takes, the following must be recorded:*

* + *details of the safeguarding concern and who raised it*
  + *the views and wishes of the adult affected, at the beginning and over time, and where appropriate the views of their family*
  + *any immediate action agreed with the adult or their representative*
  + *the reasons for all actions and decisions*
  + *details of who else is consulted or the concern is discussed with*
  + *any timescales agreed for actions*
  + *sign-off from a line manager and/or the local safeguarding lead or designated adult safeguarding manager.*

Taken from the Care Act 2014, Department of Health

# Executive Summary

Mrs A was an 88-year old lady who died in June 2015 of septicaemia. She had received domiciliary care four times a day since 2010 and despite some physical frailty, she socialised with friends and was described as having an ‘iron constitution, sharp views and a strong mind’ by her family.

In March 2015, she broke her femur whilst being assisted with her personal care and due to difficulties with communication between professionals, the team looking after her in the community weren’t aware of this and her support plan was not amended to reflect her changed needs. Subsequently the complications of this injury led to septicaemia and Mrs A refused treatment for this condition. She had two admissions to hospital between in the three month leading up to her death and passed away in June 2015.

A Coroner’s inquest was held in June 2016 where a Regulation 28 notice was issued to two of the organisations supporting her.

A Safeguarding Adults Review was commenced in April 2017 and concluded in December of that year. The Hospital where she received care, Health and Adult Services and the Clinical Commission Group responsible for commissioning community services participated in the Review as did the home care agency who had provided care.

Key lessons from the Review were the issue of communication from the Hospital to Community Services and also communication between the different agencies involved in Mrs. A’s care. Recommendations were made for strengthening communication and considering which agency should be responsible for facilitating multi-agency discussions.

Working with individuals who have capacity but who nonetheless make decisions that could be viewed as unwise can be challenging to professionals.

Recommendations include working with individuals in a person centred way and using the learning included in ‘Making Safeguarding Personal’ to ensure that wishes are respected but agencies are acting responsibly.

Mrs A made her own decisions and the agencies involved could not have prevented her death from occurring. However, they could have ensured that her family were included in discussions and that the was a clearer understanding about the care plan and thus avoided some of the tension and misunderstandings that existed during that time.

# Definition of a Safeguarding Adults Review (SAR) and Principles

### Definition of a SAR

* + A SAR is a multi-agency review process, which seeks to determine what relevant agencies and individuals involved could have done differently which may have prevented harm or a death from taking place.
  + The purpose of a SAR is to promote effective learning and improvement action in order to prevent future deaths or serious harm occurring again.

## 3.1 The SAR will:

* Establish whether there are lessons to be learnt from the circumstances of the case about the way local professionals and agencies work together to protect adults with care and support needs;
* If so, to use the review of the case as a learning process to trigger recommendations that specifically identify where systems, procedures and practices might be improved to contribute to more effective individual and inter-agency working and to better outcomes for adults with care and support needs;
* Ensure that any urgent issues that require immediate actions are dealt with as soon as they are identified; and
* Prepare or commission an Overview Report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

A SAR is not an inquiry into how an adult died or suffered injury or who may be culpable. It is not a reinvestigation of the case, and a SAR does not seek to apportion blame or hold individuals or agencies to account. There are other processes that exist for these purposes, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and regarded as safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs then their response will be defensive and their participation guarded, partial and potentially incomplete.

An important starting position is that all agencies should have their own internal/statutory review procedures to investigate serious incidents. Agencies may also have their own mechanisms for reflective practice. The SAR protocol is not intended to duplicate or replace these. Such review/investigation procedures and /or reflective practice can be used alongside, to contribute to a SAR and can be considered as an alternative option for reviewing a case should a request for a SAR fail to meet the criteria.

### Principles of a SAR (taken from North Yorkshire Safeguarding Adults Review Policy 2016)

* SARs should reflect the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability. SARs should both consider and reflect the Making Safeguarding Personal approach.
* North Yorkshire Safeguarding Adults Board should also apply the following principles to all reviews:
  + There should be 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;
  + The approach taken to reviews must be proportionate according to the scale and level of complexity of the issues being examined;
  + SARs will be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
  + Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
  + The adult with care and support needs should be supported to be involved with a SAR and advocacy arranged if required;
  + Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively; and
  + The North Yorkshire Safeguarding Adults Board (NYSAB) is responsible for the SAR and must ensure that it takes place within a specified timescale and seek assurance of the completion of the appropriate Action Plan, including any monitoring arrangements.

# Terms of Reference of the Safeguarding Adults Review (SAR)

The Terms of Reference were ratified by the SAR Panel and, following amendment, agreed with Mrs. A’s family on the 30 May 2017. The Terms of Reference are as follows -

## Working with Mrs. A and her family

* + 1. Were Care Plans personalised and agreed with Mrs. A to maximise concordance?
    2. Were options for treatment/care (including e.g. pain management) and reasons for lack of concordance appropriately explored with Mrs. A? (appropriate problem solving with Mrs. A).
    3. Were Mrs. A’s and her family’s wishes around her care (e.g. not wanting pureed diet) communicated and consistently respected?
    4. Were there missed opportunities to agree and document advanced care planning with Mrs. A?
    5. Were palliative care arrangements effective and in partnership with Mrs. A?
    6. The handling of Mr. B’s complaint including any delays and any areas of the complaint, which remain outstanding at the present time.
    7. Was there a delay in the investigation, which led to the 2016 case conferences?
    8. Did North Yorkshire County Council (NYCC) provide an appropriate level of service to Mr. and Mrs. B in dealing with them throughout the period of March 2015 to the present time?

## Communication

* + 1. Communication of clinical risks and care plans, between different agencies and staff.
    2. What factors led to practitioners and agencies not being aware, or taking account, of known medical needs (fracture)?
    3. Opportunities for improving documentation and communication through IT systems

## Safeguarding process

* + 1. The appropriateness of the multi-agency safeguarding enquiries and whether these were in line with statutory and local policies and procedures. This will include the decision taken by North Yorkshire County Council (NYCC) not to progress the initial safeguarding alert further through the safeguarding process when it was made and consider whether the safeguarding investigation was conducted appropriately.
    2. Interaction of safeguarding enquiries with other processes, including for example, complaints, employer disciplinary investigations and the NHS Serious Incident Framework.

## Coroner’s process

* + 1. Clarification of the process to be followed by the Coroner.

## Discharge from the hospital

* + 1. Were discharge arrangements properly considered and implemented, with all appropriate needs and care plans being communicated to teams/agencies?
    2. Were fast track arrangements timely and used effectively (were they triggered and early enough)?
    3. Opportunities for the District Nurse team to support arrangements for the agency to prompt pain control (Oramorph)

## Maintaining Mrs. A at home

* + 1. Were Moving and Handling assessments undertaken/reviewed appropriately and communicated upon discharge, considering the known fracture?
    2. Assessment and planning, particularly around moving and handling assessments.

## Commissioning issues

* + 1. Did NYCC fail to acknowledge or respond to two letters sent to them by Mr. B (14/12/15 and 20/2/16) questioning what action they were planning to take in relation to the Home Care Agency?
    2. Should NYCC have kept Mr. B up to date in relation to any action it may have taken against the home care agency?
    3. Did NYCC follow their protocols when they became aware of the first Safeguarding alert and the shortcomings in relation to the home care agency?

# The Review Process

* 1. Mrs. A passed away on 4 June 2015, following this there was the beginning of an investigation by Airedale NHS Foundation Trust (ANHSFT), which was initially understood to be a multi-agency review by ANHSFT, but this was not

believed to be the case by the other organisations involved. There was also a Safeguarding Review led by NYCC. A case conference was held on the 17 May 2016 and the Coroner’s Inquest was held on the 23 May 2016.

* 1. The author was approached in April 2017 to undertake the role of Independent Author of the SAR and to agree the method to be used was root cause review, analysis and Challenge Panel with Individual Management Reviews (IMRs) being completed by NYCC, ANHSFT and Airedale, Wharfedale and Craven Clinical Commissioning Group (AWCCCG).
  2. The author is independent of any Officer within the remit of this SAR. She is a freelance Consultant with thirty years’ experience working within the Health and Social Care sector. She is a registered Social Worker, has a Master’s degree in Business Administration and until 2015, was Chief Officer for Social Work for Leeds Adult Social Care.
  3. There was a considerable time delay from the date of Mrs. A’s death to the commencement of the SAR. Although this presented with some difficulties, it also meant that a large number of lessons to be learned had been identified and changes made. These will be identified in Section 10.
  4. The members of the Challenge Panel were

|  |  |
| --- | --- |
| **Name** | **Organisation** |
| Victoria Pilkington (Chair) | NHS Partnership Commissioning  Unit |
| Michele Tynan | Independent Author |
| Matt O’Connor | Airedale Wharfedale Craven  CCG |
| Elaine Andrews | Airedale NHS Foundation Trust |
| Tina Simpson | NYCC – Health and Adult  Services (HAS) |

* 1. The responsibility of chairing the Panel transferred to Carrie Wollerton, Executive Nurse, Scarborough and Ryedale Clinical Commissioning Group

on the 7 August 2017 as a consequence of Victoria Pilkington changing her role.

* 1. The Challenge Panel met on 19 May 2017 to agree the Terms of Reference (ToR) and discuss the issues going forward. It met as a Panel with the IMR authors/representatives on 4 July 2017 to discuss and review the submitted IMRs.

# Family involvement

* 1. Mrs. A’s son, Mr. B was contacted for his agreement to the ToR on 2 May 2017 and he subsequently requested some amendments. The ToR were amended to reflect these changes and Mr. B agreed them on the 30 May 2017.
  2. Mr. B felt some frustration with the events leading up to his mother’s death; he had a number of complaints, which he had raised during the time she was alive and following her death. He had been involved in the Safeguarding enquiry which took place in 2016 but still felt there were questions and complaints he had raised which weren’t addressed.
  3. The broad theme of the issues he raised with the Independent Author have been included in this SAR, however the purpose of this review is to consider what went well and what didn’t and to learn from this. It is not the appropriate place to consider complaints. To this end, Health and Social Care (HAS) have contacted Mr B separately to respond to the issues he has raised.
  4. This Review was shared in draft form with Mr. B on the 21 September 2017 for comment on matters of factual accuracy. He responded on the 19 October 2017 stating that he had been unable to review the document and would appreciate a copy of the final version of the Report.

## Pen picture of Mrs. A

* + 1. “My mother was a farmer's wife with an iron constitution, strong views and a sharp mind. She had lived in the same village since 1962 and was very settled and happy there. Prior to having mobility problems she was very independent. She had a small circle of old very close friends who she valued and spent time with.
    2. Before she became ill, she had a settled routine, which included going to church, and going out with her friends, and doing needlework. She very much did things her way and was happy and independent.
    3. She had a very dry sense of humour, a sense of fun and before she became ill, she never shied away from telling people exactly what she thought. Her comfort zone was familiarity and she didn't like change. She was a real one off in many ways.
    4. She was 88 when she died of septicemia, and although she was immobile for several years before the end of her life she was 100% on the ball mentally until the hoist incident in March 2015.
    5. She was fiercely independent, proud and private. Her home was everything. She also disliked people who she saw as authority types and felt her privacy was being invaded when she had to deal with social services and hospital staff. She did not like hospitals- not least because on a previous inpatient stay at Airedale she had contracted MRSA and had remained in hospital for many months.
    6. As a result of her no longer having her independence, she became deeply anxious.
    7. Because of my mum's fiercely independent lifestyle prior to her getting ill, her dependence on these services were very hard for her and sadly made her very unhappy."

### Received from Mr. B on 29th August 2017.

# Chronology of events

* 1. Mrs. A had lived alone in her two-storey house since 2007. She registered at her GP’s surgery in 2007 and first met her GP, Dr. D in 2010. During 2010 she experienced significant problems with her mobility and repeated falls, one of which resulted in a fracture of her right ankle, which required surgery and a five-month admission to Airedale General Hospital. By the end of that year she was unable to weight bear and was transferred between her chair, toilet and bed by hoist.
  2. In December 2010 HAS commissioned a home care agency to provide care to Mrs. A. Two carers made 4 half hour visits daily in the morning, lunch, tea and evening and continued to provide support until her death. The agency had a small number of care workers and care was provided from this group therefore it wasn’t always the same two carers who visited Mrs. A at home. This was agreed and accepted by Mrs. A and her family.
  3. From 2011 to 2015 the District Nursing team visited Mrs. A to dress persistent leg ulcers on her right leg.
  4. On 3rd March 2015, the home care agency (the agency) requested a visit from the GP due to observing an open sore on Mrs. A’s right ankle.
  5. On the 4th March 2015 the District Nursing team visited her to review a small wound to her right outer anklebone. At this time a previous care plan from 2013 related to Mrs. A’s left leg was incorrectly re-started and not amended to reflect her right ankle
  6. On the 7th March she was prescribed antibiotics by an out of hours GP when she was diagnosed with cellulitis of her right leg.
  7. On 9th March 2015 only one carer from the Agency arrived at teatime instead of the agreed two workers. She had received a telephone call from her colleague saying she would be late. Whilst only one carer was present, Mrs. A needed to use the commode and insisted the carer who was present should hoist her, which she did. The carer then left Mrs. A alone to afford

her some privacy, as was the agreed practice. A few minutes later the carer heard Mrs. A call out, ran into the room and saw that she had fallen forwards off the commode. The carer assisted Mrs. A back onto the commode and left her again. Mrs. A complained of a slight pain in her left leg. The second carer did not attend for this visit although the first carer signed her in as being present.

* 1. On 10th March, different carers from the agency noticed that Mrs. A screamed in pain whilst being hoisted. When asked what had happened she eventually said that she had banged her knee when she had fallen but refused to say how she had come to fall.
  2. The carers requested a visit from the GP on the same day and they recorded that – *‘right leg swollen bad, toes black’*. Dr. D visited Mrs. A on 10th March and found her to be alert, lucid and oriented in time, person and place. Her right foot and leg were swollen and Dr. D was concerned about the risk of a deep vein thrombosis. A blood test was advised, Mrs. A stated she did not want to go into hospital under any circumstances. Dr. D assessed her capacity and considered she had capacity to make this decision and agreed to keep things under review. Dr D did not check her left leg as she was not aware of any problems with this leg and therefore did not examine it.
  3. Later the same day Mrs. A spoke to her son, who reported that she seemed confused. Her carers telephoned him that evening to say she was not well and her speech was slurred; they had called paramedics to try to get her to hospital. Mrs. A refused to go, despite her son’s efforts to persuade her. She also declined a visit by the out of hours GP who also noted ‘clearly has capacity to make decision’.
  4. On 11th March 2015, a carer informed Mrs. A’s son and that she was not very well and her right leg was swollen but less painful.
  5. On 12th March, Dr. D spoke to Mrs. A following an episode of slurred speech and contact with the out of hours GP. She suspected that she had suffered a Transient Ischaemic Attack. Mrs. A did not mention any injury to her left knee in this conversation.
  6. On 13th March, the owner of the Agency (the owner) visited Mrs. A to assist with her care and noticed a bruise on her left leg and asked her about it. Mrs. A said she had dropped something into her lap and told the owner to stop fussing and that the bruise didn’t hurt. The second carer on this visit was the individual who had hoisted Mrs. A on the 9th March.
  7. On 14th March the owner again visited Mrs. A and again asked her how she had got the bruise. Mrs. A replied: “I’ve told you.” The second carer then informed the owner of the incident on the 9th March.
  8. The owner made a Safeguarding Alert via email to HAS on Sunday15th March, contacted the GP and suspended the two carers involved in the incident on 9th March (the carer who had hoisted and the carer who had not attended the visit). She lifted the suspension on the 19 March after an investigation and following disciplinary action in line with their internal disciplinary process.
  9. On Monday 16th March, the owner telephoned Dr. D to request her to visit Mrs. A, as she was concerned about bruising to Mrs. A’s left thigh and the link with the hoist incident. She reported that Mrs. A had fallen forwards on the hoist and as she did so, her thigh had caught on it. She described considerable bruising to the left thigh but said Mrs. A denied pain and was handling normally when hoisted.
  10. Dr. D said that she had seen Mrs. A on 10th March following the incident and the District Nurses would be visiting on Wednesday18th March and would see it then. Dr. D said that she would telephone Mrs. A, which she did. Mrs. A told Dr. D that her knee had slammed against the zimmer frame but that it had settled and she wasn’t in any discomfort. Dr. D sent a message to the District Nurses asking them to check her left knee when they visited on 18th March and report back to her if there were any issues.
  11. Unfortunately this visit from the District Nurses never occurred, the message was received from the GP but wasn’t picked up and actioned by the District Nursing service.
  12. The Safeguarding Alert was closed as ‘no further action’ on 18th March by HAS by the Designated Safeguarding Manager following a Safeguarding adults risk assessment (SARA). The notes record that ‘*disciplinary action*

*was to be taken by the agency and an annual reassessment of care needs was to be initiated’.*

* 1. Dr. D visited Mrs. A on 23rd March as the carers had reported that she had slurred speech again. Dr. D examined Mrs. A’s left knee and thigh and concluded that a fracture was likely. However, Mrs. A declined any intervention and did not want to go to hospital.
  2. Dr. D visited again on 24th and 25th March. Again Mrs. A declined to go to hospital. After a long conversation, Dr. D believed that Mrs. A had the capacity to make these decisions following discussion with the District Nursing team. She documents in her notes the impact of Mrs. A’s long stay in hospital in 2010 and the negative impact this had on her. Mrs. A agreed to a prescription of iron for anemia but declined discussion with Safeguarding Adults team.
  3. On 26th March 2015 Mrs. A agreed to be admitted to Airedale General Hospital with concerns that she had suffered a stroke. The carers had called for an ambulance and her temperature was found to be low on arrival in A&E where a Consultant in Emergency Medicine saw her. She had a facial droop, slurred speech, her left leg was swollen, but she did not complain of any pain. She was diagnosed with a fractured left femur but refused treatment. Her refusal of treatment raised concerns about her capacity but Mrs. A was adamant she did not want any treatment. After a short time she ceased to be hypothermic and the Consultant informed her son that he believed she had capacity: she was able to understand what he told her, retain it, process it and tell him “in no uncertain terms” what she wanted. The Consultant recorded in the notes that Mr. B agreed with this view. Another doctor in the emergency department said that Mrs. A was very clear as to what she did and did not want. Mrs. A was discharged the same day.
  4. The GP sent a message to the District Nursing team the evening Mrs. A returned home on 26th March to inform them she had a fractured distal end of femur. This message was picked up by a Healthcare Support Worker (HCSW) the following day but it wasn’t communicated to the rest of the District Nursing team supporting Mrs. A.
  5. On the same day, Yorkshire Ambulance Service (YAS) made a Safeguarding Alert due to concerns that Mrs. A was hypothermic and the conditions in the house were cold and unclean. Mrs. A had refused to have the central heating on in the house and the YAS was concerned about the risk to her health.
  6. On 27th March, a social care assessor spoke with the Agency about the conditions in the house. The owner of the Agency stated that Mrs. A did refuse to have the heating on although she would use portable heaters and also that Mrs. A did have a cleaner. The owner had spoken with Mr. B and he had advised that the carers should turn on the heating to prevent the situation happening again.
  7. On 30th March, Mr. B contacted social care requesting an increase in care – from 30 minutes per visit to 60 minutes to assist with eating. It was agreed that visits could ‘run over’ by an extra 15 minutes to commence from that day. It was agreed on the telephone that a reassessment was needed by social care and would be actioned.
  8. On 1st April the District Nursing team visited to manage the wounds present to both her right inner and outer anklebones.
  9. On 2nd April, Mr. B rang the GP surgery to state that he felt his mother didn’t have capacity to make decisions; he was informed that Mrs. A had instructed that she did not want her medical records discussed with him. Nutritional supplements were prescribed and message left for Dr. D to contact him.
  10. On 4th April, Mr. B raised his concerns with the Agency around his mother’s diet. She had been eating fish and chips when he believed she was on a pureed diet. There was some discussion between Mr. B and the owner around Mrs. A’s capacity to make this decision; the owner believed she did have capacity and Mr. B felt she did not.
  11. Mr. B contacted the GP on 7th April to express his concerns about his mother’s capacity and Dr. D agreed to visit her at home.
  12. Mr. B and his wife were present during this visit and capacity was discussed, as was consideration of admission to a nursing home; it was felt by Mr. B

and Dr. D. at this point that she did not have capacity to make decisions around care. Dr. D then contacted Mr. C (social care assessor) to request an urgent respite admission as she considered that the carers were ill equipped to support Mrs. A. A social care assessor spoke with the District Nursing Team to request additional visits. Later that day Mrs. A was admitted to Airedale General Hospital due to concerns about her deteriorating health and concerns that she had had another stroke.

* 1. On 16th April a formal capacity assessment by a hospital Consultant concluded that Mrs. A had the capacity to decide what care she wanted on discharge. She wanted to go home with the existing care package. Mr. B questioned whether his mother had capacity and thought she would be at risk at home. A Nurse Case manager assessed Mrs. A’s capacity again and considered that she had made her views clear about not wanting her son *‘interfering’* in her care package and that she did not want a social care assessment before discharge. The nurse did consider that Mrs. A would be at risk of harm due to her high care needs but had no concerns about her decision-making ability. Mrs. A fully understood the implications of her decision and reaffirmed her decision to return home.
  2. The hospital doctor conducted another capacity assessment on 20th April; the conclusion was Mrs. A had capacity to decide whether she wished to be discharged. The ward Consultant spoke with Mrs. A around the risks of aspirating food and the advice to eat only a soft diet and notes Mrs. A disagreed with this. He also explained to Mrs. A that although he considered it was a bad decision to return home, she had the capacity to make it and ‘*things could always be reviewed should it not work out there’.*
  3. A Moving and Handling assessment was undertaken whilst Mrs A was a patient on the ward but this does not mention the fractured distal end of left femur. Reference is made to *‘an old fracture’.* She was discharged from hospital on 23rd April following a 28 day stay.
  4. The Speech and Language Therapist had assessed Mrs. A during her admission in hospital and advised that she should only drink whilst someone is present and that additional time should be allocated whilst eating and drinking a soft diet.
  5. On 24th April, the social care assessor Mr. C assessed Mrs. A’s capacity at her home. He concluded that at that time she was able to understand and retain information and to make informed decisions about her care. It is stated in the notes that ‘for the avoidance of any doubt, the purpose of *‘Mr. C’s visit was to assess Mrs. A’s capacity at that time, not to review other people’s earlier assessments’.*
  6. On 26th April, a District Nurse, whilst dressing a wound on Mrs. A’s right ankle, noticed a weeping wound on Mrs. A’s left knee and dressed it; she was unaware of the fracture. She was later told Mrs. A had an old fracture, and looked at the GP’s notes about the current fracture following the visit. A note from this visit states ‘ *leaking wound noted left knee, noted knee swollen, longstanding from surgery, however this knee has been operated on – no pain’* . The source of this information is unclear
  7. A new Moving and Handling risk assessment was completed on 27th April 2015 by a nurse in the community team, but again there was no mention of a fracture above Mrs. A’s left knee as the nurse later attests that she was still unaware of it at that stage. Another District Nurse dressed the wound on 28th April and again on 1st May. She too had been informed that this was an old fracture. She noticed that the wound had increased in size and telephoned the GP on the same day.
  8. Dr. D visited her at home on 1st May and discussed concerns about the fracture and her swallowing. Mrs. A was able to describe the risks to Dr. D who notes that ‘she either did not share or was in denial of, our concerns about her ability to swallow’.
  9. On 4th May 2015 (a bank holiday Monday) a District Nurse visited Mrs. A and observed the bone protruding from the wound. On questioning, Mrs. A reported that *‘she may have knocked it yesterday’*. As the GP was due to visit the next day, the nurse did not contact the GP.
  10. On 5th May, Dr. D visited with a District Nurse. She noted the sinus on the left leg now measured 4.5 x 2cm and that the underlying bone was visible, it was discharging pus-stained fluid and the skin margin was inflamed. The clinical diagnosis of osteomyelitis and open fracture was explained to Mrs. A

and, after extensive discussion she eventually agreed to hospital admission for an orthopedic opinion. She was admitted that day.

* 1. Whilst in hospital, Mrs. A was informed that the only treatment was amputation, which she refused. She was informed that without surgery she would be likely to become septic which would result in rapid deterioration of her health and her death. Dr. D also notes that the probability of a good outcome and medium term survival after surgery for a frail 88 year old lady with Mrs. A’s history are slim and this was discussed with Mrs. A and her son on the 6 May. She was assessed as having capacity to refuse the operation.
  2. On 8th May, the Orthopedic Consultant discussed the options with Mrs. A, he explained the seriousness of the situation and that the infection would worsen and there would be *‘pain, sepsis and death’* if not treated. He went on to inform her that the best surgical option would be amputation but that this also carried a risk. He gave Mrs. A an Abbreviated Mental Test Score of 9/10 which indicated she had capacity and noted that he was happy that the patient was competent to make this decision and that he had discussed with son ‘*who is aware of the decisions made and the rationale behind them’* and concluded that he would discuss this with the GP.
  3. He discussed with Mrs. A the risks and benefits of having thickened fluids and discussed the risk of aspiration and pneumonia. She was keen to stop thickened fluids and understood the risks and benefits. He returned to the discussion the next day and records that ‘*the patient recalled discussion and still feels she does not want to have them thickened’.*
  4. Mrs. A was discharged on ‘fast track’ arrangements (a process where palliative care is provided speedily to patients who are near the end of life) on 11th May. Her GP was informed that she had an open infected distal end of fracture, with a discharging wound.
  5. A nurse on the ward reviewed the handling risk assessment.
  6. Following discharge, there were noted concerns about Mrs. A's refusal to take pain medication, the condition of her skin and her refusal to eat or drink. She was now receiving input from the Palliative Care Team.
  7. On 15th May, there was some debate around whether the Agency was able to prompt the taking of the Oramorph pain medication; they considered that as it was a controlled drug they were unable to do this. Their role in terms of the medication was to pour the correct amount into a measuring cup and offer it to her. After discussion with the telehealth hub and Collaborative Care team, it was agreed that the carers could prompt the Oramorph.
  8. The Agency spoke with their nominated Officer in the Quality and Monitoring Team at HAS as they were keen to ensure they were able to do this within their contract; it was explained that they were already prompting the taking of controlled drugs to other clients but the agency hadn’t recognised this was the case. They received support to amend their medication policy from the HAS team to ensure it covered the storage and prompting of controlled drugs. Following this, they began to prompt Mrs. A to take the Oramorph.
  9. Mr. B was reported to be unhappy with the care that Mrs. A was receiving from some members of the Care Agency and, on 15th May, requested that these staff should not support Mrs A in the future. A bottle of Oramorph was reported missing to the police by Mr. B at this point; no further action was taken as it was discovered in the fridge the following day.
  10. On 19th May the Agency gave notice it would cease providing care to Mrs. A; the relationship between the Agency and Mr. B had become strained and therefore the NHS’s Craven Collaborative Care Team (CCCT) took over on 23rd May 2015. In the interim, the hoist broke on 23rd May and Mrs. A was nursed in bed following this.
  11. A nurse in the CCCT on her first visit was very concerned about the lack of a robust moving and handling plan and requested an urgent physiotherapy assessment of the situation. A Physiotherapist from the CCCT assessed Mrs. A on 26th May and recorded his serious concern that continued hoisting had opened the fracture and made it worse. He contacted Mr. C to express his concern and questions why it hadn’t been done previously and to question whether the hoist incident had caused the fracture. Mr. C contacted the Safeguarding lead at Airedale General Hospital who stated that he believed that the fracture on the left femur was related to a previous fracture.
  12. Discussions took place with a Registrar at the hospital with reference to the broken hoist and the impact on the fracture moving forwards. He believed that if Mrs. A was keen to be hoisted and had capacity to agree then she should be hoisted. However the GP took a different view saying that ‘*if hoisting is actively causing harm, we cannot do this without explicit consent and understanding by patient. Capacity would have to be absolutely clear to actively do harm. I suspect her capacity may not fulfil this. Should also explain that worsening wound is likely to mean increasing pain and advise this may be avoided by nursing her in bed’*. Mrs. A was nursed in bed from this point.
  13. Mrs. A was discharged from hospital on 11th May and died on 4th June 2015. The cause of death was septicaemia due to, or as a consequence of, the infected compound osteoporotic fracture of the left femur.
  14. A Coroner’s Inquest was held on 26th May 2016, which issued a narrative verdict and a cause of death as septaceamia. He issued a Regulation 28 notice to ANHSFT and the GP’s practice.

# Analysis

# Working with Mrs. A and her family

### Were Care Plans personalised and agreed with Mrs. A to maximise concordance?

### Were options for treatment/care (including e.g. pain management) and reasons for lack of concordance appropriately explored with her? (appropriate problem solving with Mrs. A).

### Were wishes around Mrs. A’s care (e.g. not wanting pureed diet) communicated and consistently respected?

* + 1. The specific areas in relation to Care Plans, pain relief and diet will be dealt with in detail in other sections of this Report, namely 7.2 Communication and

7.5 Discharge from Hospital. I shall not deal with them here but I will respond to the ‘theme’ within the three areas outlined in 7.1 a – c.

* + 1. Mrs. A made decisions around her health and wellbeing that were not in the best interests of her health and prolonging her life. As such, her wishes caused considerable upset to her family and presented the professionals with difficulty. She was assessed under the Mental Capacity Act on numerous occasions in order to determine her ability to make these decisions and was deemed to have capacity. The professionals involved spent considerable time and effort in determining her ability and wishes. However, there were occasions when Mrs. A was not enabled together with her family, to attempt to reach consensus about her care and support. An example of this is the Safeguarding Alerts, which were not discussed with her.
    2. Similarly, although Mrs A agreed with the Consultant Ortho-Geriatrician that, despite the risks, she would pursue a normal rather than a pureed diet, this was not effectively communicated to other agencies or reflected in her care plans upon discharge from hospital on the 11th May.
    3. Mrs. A was a strong-minded lady who was very clear in terms of her views and expressed them in a forthright manner. She did not like taking painkillers as she did not like the effect of them and informed her care team of this. Similarly with her diet as she wanted to carry on eating the food she enjoyed, despite the risks being explained to her. Her wishes around analgesia, treatment and medical investigations were very fixed and the confines of what would have been acceptable to her dictated and often limited the quality of life she experienced. It is possible, based on the evidence available, that had she accepted early investigation and treatment of her fracture, she may have lived longer than she did. However the Mental Capacity Act allows individuals to make decisions that other people may consider unwise. It is very possible that Mrs. A’s previous experience of her right ankle fracture influenced her decision to refuse active treatment for her fracture and that she considered this to be the wisest decision given her circumstances.
    4. Where it appears that there could have been room for improvement is working with the team around her and her family, an attempt could have been made in exploring and documenting Care Plans, with Mrs. A and her family, that set out potential risks but respected Mrs. A’s wishes and clearly set out the care and treatment options acceptable to her.

### Were there missed opportunities to agree and document advanced care planning (ACP) with Mrs. A?

* + 1. *ACP is a process that supports adults at any stage of health in understanding and sharing their personal values, life goals and preferences regarding future medical care. The goal of ACP is to help ensure that people receive medical care that is consistent with their values goals and preferences during serious and chronic illness. (International consensus definition of ACP taken from ANHSFT IMR)*
    2. Mrs. A was consistently clear about her wishes. She was made aware of the effect of refusing the amputation of her leg and it is recorded that the Consultant Orthopaedic surgeon discussed the likely serious impact of the decision. Equally there were risks attached to the procedure, which Mrs. A

was made aware of. Despite this she was clear that she wanted to return home and did not wish to remain in hospital and undergo the amputation.

* + 1. Documenting these decisions as part of a multi-agency approach would have helped everybody involved understanding and, hopefully, agreeing with the plan. It would have been good practice to have a written ACP in place that was agreed by all agencies involved in Mrs. A’s care.

### Were Palliative care arrangements effective and in partnership with Mrs. A?

* + 1. When Mrs. A was discharged from hospital on 11 May 2015, she became a ‘fast track patient’ and eligible for palliative care from the Craven Collaborative Care Team. She received a good level of service from the team with the involvement of a Physiotherapist and detailed Moving and Handling assessments. The team appeared to work with her and her family and respected her wish to be nursed and to die at home.

### The handling of Mr. B’s complaint including any delays and any areas of the complaint which remain outstanding at the present time.

* + 1. Mr. B wrote to HAS on 5 June 2015 raising a formal complaint and asking for copies of the ‘*Safeguarding file’* in relation to his mother. This letter was responded to on the 11 June 2015 to inform him that the complaint could not be responded to until the Coroner had completed his investigation, in line with the Complaints Policy. He wrote with more information on the 15 June 2015 and received an acknowledgement on the 18 June 2015. He was written to on the 14 August 2015 and the 24 August 2015 to advise him that he wouldn’t receive a complete response until the results of the Safeguarding investigation were known. He received a full response on the 23 December 2015 and an apology for the delay. The delay in response was overly long and frustrating for Mr. B given the death of his mother and a number of unresolved issues he raised. The Officers involved were trying to manage the complaints issue alongside the Coroners and Safeguarding process, which caused delay.
    2. In the letter to Mr. B in December 2016, the Council’s response dealt with two issues – the absence of a Safeguarding file and the issue of redacted minutes, which Mr. B had received, from the Case Conference he attended. He had asked for an unredacted copy of the minutes but this request was refused, as Mr. B was not entitled to the information within the minutes. There was an apology for the delay in the response to dealing with this issue which was dealt with as a Subject Access Request.
    3. On 13 April 2017 Mr. B was provided with full details of the Safeguarding information, which was held on Mrs. A’s file. The source of the redacted information was given to Mr. B should he wish to contact the source directly to ask for the information. Again, an apology was given to Mr. B for the delay in response.
    4. The Regulations covering complaints for Local Authorities are *‘The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009’*. They require that an acknowledgement of the receipt of a complaint should be made within 3 working days but do not specify a response timescale for responding to a complaint, other than complaints should be completed within 6 months or a longer period agreed between the Council and complainant.
    5. Mr. B wrote to the Local Government Ombudsman on the 26 February 2016 detailing his complaints; they referred the matter back to the Council, as it had not been completed through the statutory social care complaints process. The Council wrote back to the Local Government Ombudsman on the 19 October 2016 informing them that it intended to complete an independent review of the Council’s response to the safeguarding concerns raised by Mr. B in his complaints. As a result of an initial review of the situation, the Council made a referral to the Safeguarding Adults Board that a Safeguarding Adults Review be commenced.
    6. Mr. B also wrote to the Director of Social Services on the 14 December 2015 outlining his concerns around the Agency’s involvement in Mrs. A’s care. He did not receive a response. He followed up this letter on 20 February 2016, to date he has still not received a response. The Directorate has been unable to find a record of either of these letters having been received, and therefore no response was made. It acknowledges that a third letter from Mr B to the

Chief Executive was passed onto the Complaints and Quality Assurance Team, but was not responded to.

* + 1. The delays in responding to Mr. B’s complaints were unacceptable, however the December 2015 letter was comprehensive and contained the information requested.
    2. Mr. B had contacted the Information Commissioner in relation to his request for unredacted minutes and, following their involvement, HAS reviewed their practice in relation to responding to requests for information. This has resulted in updated procedures and guidance for staff, a rolling programme of training for staff and a new process for the Council to log and monitor requests, overseen by a team that staff can contact for advice.

### Was there a delay in the investigation, which led to the 2016 Case Conferences?

* + 1. Mrs. A passed away on 4 June 2015 and a number of Case Conferences were held in April and May 2016. The Coroner’s Inquest into her death was held on 26 May 2016; the Safeguarding Review process should have taken place in a timely manner in order to inform the Coroner of the findings of the Review and provide evidence of actions taken and lessons learned (if appropriate).
    2. In the 2009 operational guidance, which was in use at the time, the timescales for holding a Case Conference should be detailed using a ‘Safeguarding Assessment Strategy’. There is no evidence that this was conducted at the time and if used, it could have set a timescale and ensured that all involved were aware and working within this.

### 8.1.h). Did North Yorkshire County Council provide an appropriate level of service to Mr. B and Mrs. A in dealing with them throughout the period of March 2015 to the present time?

* + 1. This covers the time period from the incident on 9th March to the date of commencing the SAR as there were a number of complaints raised by Mr. B following Mrs. A’s death. At the point of the Safeguarding alerts being classed as ‘no further action’ from HAS in March 2015, Mr. B did not receive an

appropriate level of service. He made representations around the standard of care from the Agency as well as the Safeguarding process from April to June of 2015.

* + 1. Although Mr. C from HAS had spent time explaining the rationale behind HAS’s position and was responsive to Mr. B, it is clear from the notes that Mr. B remained unhappy with the Safeguarding response, even asking if he could ‘appeal’ the decision at one stage.
    2. As referred to in Section 7.1.f, there was also considerable delay in responding to his letters of complaint and there remains one area of correspondence that is yet to be resolved. NYCC has apologised to Mr B for the delay in responding to his complaints, and that he did not receive a response to his letters in December 2015 and February 2016.
    3. The standard of customer service provided to Mr. B and Mrs. A fell short of expected practice and is being addressed by NYCC through increased staffing in the Complaints and Quality Assurance Team, and introduction of more rigorous processes for monitoring responses.

# Communication

### 8.2.a) Communication of clinical risks and Care Plans, between different agencies and staff

### 8.2.b What factors led to practitioners and agencies not being aware or taking account of known medical needs (fracture)?

* + 1. The Doctor in the Emergency Department had a telephone conversation with the GP who documented the fractured femur. Mrs. A was then discharged from the Emergency Department at Airedale General Hospital on the 26th March 2015, a letter was sent to the GP Surgery on 27th March 2015 by the Hospital. This gave a diagnosis of *‘likely stroke, hypothermia and fractured l finger’*, which was a typing error. However the coding of the injury was correctly recorded as fracture of the distal end of the femur. The outcome was GP follow up.
    2. The ‘task’ for follow up of this was logged on SystmOne by the GP for the attention of the District Nurses accurately saying that Mrs. A had a femoral fracture and that the GP would visit the following day. It appears this was picked up by a HCSW in the District Nursing team but wasn’t communicated to the District Nurse or passed on as a task to them. This resulted in the fractured left femur not being recognised and managed by the District Nurses, also that Mrs. A continued to be hoisted after the fracture was diagnosed. This was a missed opportunity. On the 26th April 2015 a member of the team noticed a weeping wound on Mrs. A's left leg and dressed it, she was unaware of the fracture and was informed by colleagues that it was an old injury. A District Nurse completed a Moving and Handling assessment on 27th April 2015 but again there was no mention of a fracture as the Nurse states she was still unaware of this at this stage. The wound was dressed on 28th April 2015 and 1st May 2015, the nurse at this stage believed it was a sinus at the site of an old fracture however she noticed that the wound had increased in size and telephoned the GP who prescribed antibiotics. At this point, Mrs. A had been admitted to hospital twice and her fractured distal end of femur had been identified on both occasions but the District Nursing team members delivering the care were still unaware of it.
    3. The District Nursing team should have been made aware of the fracture to the left femur on the 26th March 2015 and formulated a Care Plan around this. A Moving and Handling assessment was conducted on the 27th April 2015 but the fracture was not known and therefore not factored into the assessment.
    4. On 4th May a member of the District Nursing Team visited Mrs. A and observed the bone protruding from the wound. As the GP was due to visit the next day, they did not contact the GP. At the point that the wound on her left leg appeared and worsened thus necessitating the use of a stoma bag (to collect the volume of exudate/oozing fluid) further investigation as to the cause of the wound did not take place. Nursing guidance would indicate that a call to the GP for an urgent visit should have been made immediately.
    5. Mrs. A. was seen by the GP and admitted to hospital on 5th May 2015. She was then reviewed by a Consultant Orthopaedic surgeon and informed the only treatment was amputation, which she declined and she was assessed as having capacity to make this decision. She was discharged on 11th May for palliative care at home and became a Fast Track patient.
    6. There was a missed opportunity to undertake a Moving and Handling assessment on the 12th May visit following Mrs. A’s discharge from hospital by the District Nursing sister. This is despite recording ‘*there is an open left fracture and Care Plans were in place for wound management of right ankle and left knee*’. This should have been the trigger for ensuring that a Moving and Handling assessment was in place and it was remiss that this did not happen.
    7. The CCCT took over from the District Nursing team on 25th May 2015 and it was at this point that a nurse on her first visit was concerned at the lack of a robust Moving and Handling plan due to the fracture and requested an urgent physiotherapy assessment of the situation. The CCCT Physiotherapist assessed Mrs. A on the 26th May 2015 and recorded his serious concern that continued hoisting had opened the fracture and made it worse. There was some discussion around whether to continue hoisting and it was thought it more appropriate to nurse her in bed from that time.
    8. The Physiotherapist logged the continued hoisting and lack of Moving and Handling assessment as an Incident within the Trust and the Trust then logged this as a serious incident requiring investigation.
    9. The process where the GP would allocate a ‘task’ to the District Nurses to visit and attend to the patient broke down. The GP responded correctly but although there is evidence that a ‘task’ was picked up on SystmOne, it was not communicated to the team looking after Mrs. A. and they weren’t aware of the diagnosis of fractured left femur. Since this time, the GPs had put in place a system where tasks are routinely followed up by telephone calls to the relevant team for follow up, however this has proved to be burdensome to the practice due to the numbers of calls having to be made. The system has recently been changed to only phone calls for tasks that are complex and urgent.
    10. Whilst there is evidence of communication between GP and District Nurses it is not evident that this was effective, since the District Nurses did not review the Moving and Handling plan to take account of the fracture from the date of it becoming known on the 26th March 2015 until the 12th May 2015. The Executive Nurse (Airedale, Wharfedale and Craven Clinical Commissioning Group) who led the Safeguarding review logged her concern about the lack of a Moving and Handling assessment and the fact that the fracture became a compound fracture as a Safeguarding incident.
    11. Within the District Nursing Team, it is established practice that a Registered Nurse undertakes every third visit; this did not happen in Mrs. A’s case as she received the majority of her visits from unregistered staff who may be less likely to recognise the symptoms of a fracture in her leg. This fell short of established practice.
    12. The Coroner raised his concerns in a Regulation 28 notice dated 3 June 2016:
        1. *Following Mrs. A’s discharge from hospital there was no communication from the Emergency Department to the community nursing teams, that Mrs. A has a fractured distal end of femur.*
        2. *Although the GP was informed of the fracture and left a message for the District Nursing Team which was picked up, there appears to have been no further communication to the District Nursing Teams who attended Mrs. A*
        3. *As a consequence nobody involved in the care of this lady was aware of the fracture and she continued to be hoisted without any review of the arrangements for moving her and the potential injury this may have caused.*
    13. Airedale NHS Foundation Trust did not dispute the conclusions of the Inquest and a response to the Regulation 28 notice is detailed in Section 7.4 of this report.
    14. As a point of good practice, CCCT responded promptly on their initial visit to Mrs. A by requesting an urgent Physiotherapy assessment, which was completed the next day. The Physiotherapist involved raised concern within the Trust, which led to further investigation. They should be commended for their timely response to this matter.
    15. A list of the changes made as a result of the issues identified is detailed in Section 9.

### Care plan – pureed diet.

* + 1. During the hospital stay on 24th April 2015, there were documented concerns about Mrs. A’s ability to eat and drink on discharge. The notes record that ‘*discharge advice re eating and drinking placed in front of nursing notes’. Information also given that carers or family can re-refer to Speech and Language therapy if further assessment required’*.
    2. On the 8th and 9th May 2015 again whilst in hospital, there are notes around discussions with Mrs. A and the Orthogeriatric Consultant around her ability to swallow and the use of thickened fluids. Mrs. A consistently objected to taking thickened fluids. The notes observe ‘*patient has poor oral intake as thickened fluids make her sick. Agreed can stop thickened fluids and have*

*normal diet as tolerated. Discussed with patient risks and benefits of not having thickened fluids, discussed risk of aspiration pneumonia’*

* + 1. On 9th May 2015 it is noted by the Consultant that *‘patient recalled discussion of previous day and told me this may result in death’.*
    2. This was later to become a source of tension when Mrs. A was discharged back home as Mr. B was under the impression, following the 24th April 2015 advice, that his mother should not take solid food as the risk was too great. Following discharge on the 23rd April 2015, Mr. B arranged for pureed meals to be delivered to his mother and was upset to find that she had been eating fish and chips instead.
    3. Despite the advice being given and the risks explained, it is clear that Mrs. A didn’t wish to abide by this and had expressed this whilst in hospital. Mrs. A was not involved in discussing what the options may be and was not helped to explore what may be acceptable. An agreed eating plan wasn’t put in place in conjunction with Mrs. A; information was recorded on her case notes. It is clear that Mrs. A did not agree to only take thickened fluids and she was assessed as having capacity to make this decision.
    4. A co-ordinated approach to discussing the risks and agreeing a plan of action that respected Mrs. A’s stated wishes and noted her son’s concerns should have been put in place as it was acknowledged by the Orthogeriatric Consultant on the 9th May 2015 that she could have a normal diet. A more person centred approach to Mrs. A’s wishes may have facilitated this.
    5. The absence of such an approach led to tensions between Mr. B and the Agency supporting Mrs. A that could have been avoided, or at least mitigated. Mrs. A appeared determined to obtain the food she wanted and despite Mr. B arranging for pureed foods to be delivered and the nursing team encouraging a soft diet, she insisted on sending out for fish and chips via the agency carers after attempting to get them delivered by a taxi. The Carers felt they were put in a difficult position as they believed her to have the mental capacity to make her own choices, that she didn’t have anything enjoyable remaining to her and that she chewed rather than swallowed the food.
    6. An assessment of needs before discharge could have facilitated communication and helped to achieve some consensus in this area.

### The District Nursing Team work to established practice that a Registered Nurse should undertake every third visit and all new patients have a full assessment resulting in appropriate Care Plans.

* + 1. During the period from initial referral on 4th March 2015 to admission to hospital on 7th March 2015 (four days) Mrs. A was visited by the Craven District Nursing Team five times, once by an experienced bank staff nurse and four times by HCSWs. This was following a referral from the GP as Mrs. A required wound management to her right ankle. The initial visit was undertaken by a HCSW and occurred prior to the incident involving the hoist. Following the fracture, she did not receive a full assessment of her care in a timely manner. Subsequent visits were scheduled by the resurrection of a previous Care Plan on SystmOne dated 2013. The practice of resurrecting old Care Plans in order to schedule a visit no longer occurs as ANHSFT has now rolled out a mobile SystmOne unit and this has been supported by staff training.
    2. Although there is evidence that her case was discussed with a Registered Nurse who co-ordinated her care on 2nd April 2015, ANHSFT did not follow established practice at this time in relation to visits by registered staff which may have enabled them to identify the injury sooner.

### The other area for consideration is the use of Multi-disciplinary Team Meetings (MDT’s) to discuss cases where there are a number of agencies involved.

* + 1. The GP visited Mrs. A regularly as she had complex needs whose case presented challenges. The GP’s surgery had started to initiate MDT’s in June 2015, this wasn’t specifically in relation to Mrs. A but a new initiative for the surgery; the MDTs anticipated attendance from Health colleagues but didn’t routinely invite social care staff to attend.
    2. Whilst acknowledging the difficulties in including all professionals involved in a patient’s care, these meetings provide an opportunity to double-check and improve communication with all agencies. It may be worth giving consideration to how all agencies involved in a patient’s care could be included in them.
    3. Existing MDTs were in place for patients on the palliative care pathway on a 3 month cycle but Mrs. A had not come up in these for discussion by the time of her death. Mrs. A’s case was complex with a number of agencies and individuals involved and some debates around the appropriate care package; a MDT would have been useful in helping to facilitate discussion around these.

### Opportunities for improving documentation and communication through IT systems

* + 1. The Reviewer has been informed that the SystmOne IT system has been changed to make it more able to communicate information such as the ‘task’ to the District Nurses and training has been put in place to ensure all staff are familiar with the system. In summary, as part of the roll out of the Community SystmOne module used by the District Nursing Team, training was provided to enable them to use SystemOne more effectively.

*See Coroner’s response from Airedale in Section 7(4) for fuller explanation of the changes.*

# Safeguarding process

### The appropriateness of the multi-agency safeguarding enquiries and whether these were in line with statutory and local policies and procedures. This will include the decision taken by HAS not to progress the initial safeguarding alert further through the safeguarding process at that time and consider whether the Safeguarding investigation was conducted appropriately.

* + 1. The first safeguarding alert was made on 15th March 2015 by the Agency to report the hoist incident. This was recorded as *'no further action' on the system with a note that ‘disciplinary action was to be taken by the agency and an annual assessment of needs was to be initiated’.*
    2. The second alert was raised on 26th March 2015 by YAS to Health and Adult Services *- ‘Safeguarding alert details have been provided by the safeguarding alert form as follows " crew were called out by carers of patient as they thought patient was having a CVA, crew believes that patient’s behaviour will lead to self-neglect. Patient refuses any medications or help. Patient is supposed to be taking antibiotics but won’t, she refused to go to hospital today although she was hypothermic; she took a lot of convincing to*

*go. House is also unkempt. Has carers 4x daily.’*

* + 1. At this stage, Mrs. A’s case was open to HAS but not actively care managed. She was admitted to Airedale General Hospital on 7th April 2015.
    2. The case was then opened and allocated to Mr. C, a qualified Social Worker, on 10th April 2015 to undertake an assessment of need and make arrangements for Mrs. A’s care following her discharge from hospital. Mr. B rang Mr. C on the same day to explain his concerns and the risk of harm he believed his mother would face if discharged home. Mr. B outlined his concerns around the home care agency and the hoist incident; he also raised the issue of his mother eating food he said she shouldn’t have i.e. fish and chips and the incident where his mother was admitted to hospital with hypothermia. Mr. C didn’t raise these as Safeguarding Alerts this time. It was agreed with Mr. B that Mr. C would undertake an assessment of her needs once his mother was fit for discharge.
    3. On 13th April 2015 the owner of the Agency contacted Mr. C to discuss some of the safeguarding issues they were dealing with in relation to medication and food. Again he didn’t raise these as Alerts.
    4. On 16th April 2015 a Nurse on the ward rang Mr. C to advise that Mrs. A is now fit for discharge and will be discharged to her home, Health and Adult Services had responsibility at this point in ensuring that an assessment was undertaken to ensure she had the right level of support at home. It is acknowledged that Mrs. A had said she didn’t wish to be assessed but social care had a duty to identify if her needs could be met at home in a sensitive manner; this did not happen.
    5. On 17th April 2015 the Designated Safeguarding Manager recorded the following safeguarding decision in relation to 26 March 2015 YAS alert *– ‘Mrs. A has full mental capacity and can assertively express her wishes. At times she may be reluctant to accept help, which others may regard as an unwise choice. She is supported by a POC (package of care) 4 times daily, which will be monitored and reviewed when she returns home. Her needs are already being actively case managed, and there would be no benefit to Mrs. A from using the safeguarding procedures’.*
    6. This fell short of HAS guidance that a decision should have been made within 24 hours of receipt nor was there any attempt to discuss this with Mrs. A. There was also no notification sent to the Quality and Monitoring Team at HAS, which should happen when there is a Safeguarding Alert involving a Registered Provider. On 19th May 2015 during an email exchange between Mr. C and Mr. B, he explained that as Mrs. A was deemed to have mental capacity to take the decision about raising a Safeguarding Alert and she did not want to progress this, no further action was taken by the Council.
    7. A more pro-active approach to the situation would have been indicated; clearly Mrs. A was said to have capacity but good social work practice will seek to try and build a relationship and work with people to ensure that their wellbeing is maintained. This can on occasions be achieved by liaising with the individuals who have a more established relationship with the person and can take some time. There was clearly a role for a Social Worker to co-

ordinate the various strands of her care and ensure that she was safeguarded.

* + 1. On 21st April 2015 Mr. B emailed Mr. C to express his concerns around safe discharge and Mr. C returned the email on 22nd April explaining that Mrs. A didn’t wish him to assess her prior to discharge and that she had the capacity to make this decision. He shared the concern about the length of visits not being sufficient and s agreed that these can ‘overrun’ if required. This was not recorded as a change of support on the Care Plan.
    2. Following the withdrawal of the agency, a Physiotherapist within the Collaborative Care Team reviewed Mrs. A on 26th May 2015. He raised the possible link between the knee injury and the hoist incident when he was asked to undertake a Moving and Handling assessment by a colleague in the team. He informed Mr. C who phoned the Safeguarding Team at the hospital to ask why a Moving and Handling assessment hadn’t been undertaken and to query the link between the hoist incident and the fracture. No new Safeguarding Alert was made following this discussion however the Physiotherapist escalated the incident to the Assistant Director of Patient Safety within ANHSFT, which led to an investigation.
    3. Throughout this period of time, there were numerous conversations in relation to Mrs. A’s capacity to make decisions; these are outlined in section 8. It is relevant to add at this stage that the presumption of capacity appeared to be used to justify a lack of intervention by HAS. Case note by Mr. C dated 24th April 2015 states *‘ District Nurse contacted me to raise her concerns regarding Mrs. A’s discharge. I explained that I shared her concerns and explained the discussions around discharge and that Mrs. A has declined any increase in care, has declined a reassessment, CHC referral and it has been assessed consistently that she has the mental capacity to make these decisions’.* Whilst Mr. C respected Mrs. A’s autonomy to make these decisions, a more robust approach in working with her may have been more productive. There should have been more attempts to speak with Mrs. A by HAS and a multi-agency meeting would have been helpful.
    4. In conclusion, Safeguarding practice did not follow the HAS procedures in a number of areas –
       - *The initial decision to close down the safeguarding concern on 18 March 2015 related to the hoist incident*
       - *No consultation with Mrs. A about the Safeguarding incident took place*
       - *No response when the referral on 10 April 2015 was made or after the conversation with Mr. B when he details his concerns.*
       - *The practice standards and timescales within HAS are that a safeguarding risk assessment should be used to inform the safeguarding decision and should include the wishes of the adult at risk unless to do so would increase risk to them.*
       - *A safeguarding decision should be made within 24 hours of receipt unless there are exceptional circumstances that are documented*
       - *A strategy meeting should take place in 7 days*
    5. Mr. C appropriately documented the direction from his line manager (who was the Designated Safeguarding manager) and there is a record of the key decision recorded by him. However these give no indication of the rationale for the decisions. There was no attempt made to discuss the issues with Mrs. A, which should be done routinely unless this was likely to increase the risk to an individual. A safeguarding risk assessment (SARA) should be used to evidence decision-making about the safeguarding concern in a timely way – usually within 24 hours of receipt. The 26th March 2015 alert was documented three weeks after it was reported.
    6. It is equally of concern that no assessment of need was undertaken; no support plan was in place for Mrs. A from HAS. According to HAS guidance, a reassessment of social care need is indicated when there is –
       - *A change in circumstances*
       - *An increase or decrease in support needs*
       - *A hospital discharge*
       - *A safeguarding concern*
       - *At request from the adult or their representative.*
    7. All of these triggers took place and yet no assessment was undertaken. This was a complex case with a number of agencies involved and a MDT should

have taken place to explore how to work with Mrs. A to best meet her needs whilst acknowledging her wishes.

* + 1. Timescales were not always met and a number of safeguarding concerns were not progressed appropriately or in a timely manner. The multi-agency safeguarding approach could have been an appropriate response to engage all partners to consider risk and develop a joined up approach to Mrs. A’s care but this was not implemented.
    2. On 11th May 2015 Mrs. A was referred for consideration for Fast track funding, she was transferred to this on 13th May 2015 and Mr. C records that from that point HAS ceased to be the lead agency and documented that their input ceased.
    3. Upon discharge from hospital, the District Nursing Team and CCCT undertook appropriate assessments, delivery of care and onward referral to relevant specialist services.
    4. In conclusion, there were numerous opportunities to progress to a multi- agency Strategy meeting and explore views, concerns, risk management approaches and these were not acted upon. There should have been a shared discussion about Mental Capacity and a full assessment of Mrs. A’s needs should have taken place.
    5. The last recorded assessment by Health and Adult Services on file of Mrs. A is dated 20th December 2010; a telephone review took place on 30th January 2014. The notes made by the Designated Safeguarding Manager on 18th March 2015 indicate that an annual assessment of needs was to be initiated, this didn’t happen. The homecare Support Plan was reviewed on 5th May 2015 but this did not appear to involve the adult at risk and just details the support being provided to her in terms of the commissioned contract.
    6. In conclusion, HAS fell short of their own guidance and expectations in relation to safeguarding practice; although the Care Act 2014 didn’t come into force until 1st April 2015 the provisions for responding to Safeguarding concerns as detailed in Section 1 (Purpose of the review) were not adhered to.

### Interaction of safeguarding enquiries with other processes, including

### e.g. complaints, employer disciplinary investigations and the NHS Serious Incident Framework.

* + 1. Following the reporting of the hoist incident on 14th March 2015, the owner of the Agency suspended the two carers on 15th March 2015. She allowed the carer who was working to finish off her shifts for that night; she should have suspended her immediately given the safeguarding concerns but states that the carer had scheduled visits and she didn’t feel she could cover these at such short notice.
    2. There is some ambiguity in the reports as the owner was initially told to dismiss both workers by a HR agency she had contracted with for advice. In the end, this didn’t happen and both carers were given final written warnings. They also undertook additional training.

1. Mr. B made numerous phone calls and written letters/emails during this time outlining his dissatisfaction with the way his mother’s care was handled. These are dealt with in section 7.1 – Working with Mrs. A and her family.
2. The main thrust of the Safeguarding Adults Review is to explore the events leading up to Mrs. A’s death, however it is appropriate to consider the events following her death to understand the main agencies’ responses
   * 1. Following her death, ANHSFT initiated an investigation under the Multi- Agency Serious Incident Requiring Investigation national framework. As there were a number of agencies involved, it is unclear whether the Executive Nurse ever agreed this with the other agencies. Airedale NHSFT appointed a lead investigator and held their investigation meeting on 1st October 2015. This resulted in a report dated 9th November 2015. This report was

ANHSFT’s internal response to be contributed to what was expected to be a multi-agency report and it includes details of the incidents to be considered:

* + - * ***Section 1:*** *- Community involvement in patients care on 9th March 2015 when alleged hoist incident occurred - particularly moving and handling assessments/care.*
      * ***Section 2:*** *- Community involvement in patient’s care from the 9th March 2015 until the 26th March 2015 - particularly moving and handling assessments/care.*
      * ***Section 3:*** *- Admission to A&E on 26th March 2015, discharge plan, communication to GP, community teams re untreated fracture; Community involvement in patients care from 26th March 2015 until 7th April 2015 - particularly moving and handling assessments/care.*
      * ***Section 4:*** *- Hospital involvement from 7th April until 23rd April when discharged home, particularly moving and handling assessments/care.*
      * ***Section 5:*** *- Community involvement in patients care from the 23rd April 2015 until the 5th May 2015 - particularly moving and handling assessments/care, wound assessments and sinus on left knee and open fracture appearing.*
      * ***Section 6:*** *- Hospital involvement from 5th May 2015 until discharge on 9th May 2015.*
      * ***Section 7****: - Community involvement thereafter until death.*
    1. ANHSFT’s completed Serious Incident Report is comprehensive and includes detail around lessons learned and contains a full Action Plan in relation to ANHSFT.
    2. On 6th November 2015 a multi-agency Strategy meeting took place under the Adult Safeguarding procedures. A decision was taken to transfer the process into Adult Safeguarding; ANHSFT had then concluded their Serious Investigation requiring Investigation process. This decision was taken by the

Executive Nurse, as a number of Safeguarding incidents had become apparent.

* + 1. The Procedures used to investigate matters were the Safeguarding Procedures used at the time - The North Yorkshire Safeguarding Adults Multi-agency Policy & Procedures - Version 1.0 - May 2009
    2. In these it states that the purpose of a Strategy meeting is to formulate a multi-agency plan for investigating, assessing risk and addressing any protection needs. The outcome of a strategy meeting should be that the vulnerable adult is offered protection and risk minimised.
    3. In 2015, HAS did not have a separate policy for reviewing safeguarding incidents when the person dies. It was their practice to use the Safeguarding Policy and Procedures mentioned above. This procedure doesn’t lend itself well to the situation where the subject is a person who has died and it is currently being revised.
    4. However, the Executive Nurse Airedale, Wharfedale and Craven CCG and Safeguarding assessor from HAS were tasked with leading the Safeguarding review. A Case Conference/lessons learned meeting was held on 17th May 2016 but the Chair didn’t approve the minutes until 25th August 2016. In these there is reference to the ongoing actions being taken forward by a ‘Collective Care Process’ of which a meeting was due to be held in June 2016.
    5. A number of issues were raised as part of the 2016 Safeguarding review, which led to discussion as to whether abuse was substantiated or unproven. It is not within my remit to re-investigate this issue, however there was challenge to the conclusions of the Review. The Safeguarding process following Mrs. A’s death was comprehensive and thorough, however the methodology used requires review as it does not follow Care Act principles in that ‘*professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith’* ***Care Act section 14.167***

Under the revised guidance following the implementation of the Care Act, a different methodology would be used.

Six safeguarding incidents were considered during the review -

* + - * *Fall from hoist – Neglect and Acts of omission - substantiated.*
      * *Food/risk of choking/aspiration – Neglect and Acts of omission - substantiated.*
      * *Inappropriate heating – unsubstantiated*
      * *Hospital discharge/moving and handling – inconclusive*
      * *Controlled drugs/medication – Neglect and Acts of omission – substantiated.*
      * *Consent form/shouting by staff – Psychological and emotional abuse - substantiated*
    1. Clearly a review of the incidents leading up to Mrs. A’s death was required. Ideally this should have happened prior to the Coroner’s Inquest in May 2016 in order that these could be used in evidence, and to outline to the Coroner actions that had been put in place to prevent future deaths and provide assurance to the wider public.
    2. What is important is that a Review process should be agreed between all agencies to be implemented when there is a serious incident that requires further investigation. It appears that in Mrs. A’s case, there was confusion and a lack of leadership in agreeing an appropriate response between all agencies and this is demonstrated by the initiation of both a multi-agency SIRI process and a Safeguarding Review. Both processes were appropriate and serve different purposes; the breakdown in communication at this stage was that ANHSFT believed that a multi-agency SIRI was taking place, whereas HAS don’t appear to have realised they had been asked to contribute to this.
    3. There is now a Safeguarding Adults Review procedure in place following the implementation of the Care Act in 2015 and a more robust understanding by the Safeguarding Adults Board of the Review process, however this only applies where death or serious injury has occurred or where there was a ‘near miss’. It would be helpful for the Board to agree how it routinely reviews incidents where there are a number of agencies involved to facilitate learning.

# Coroner’s Process

* + 1. On 23rd May 2016 the Assistant Coroner for North Yorkshire, Western Area held an inquest into the death of Mrs. A. Her death was recorded as a narrative verdict; this definition is used when a death is more complex than a single cause of death and cannot be classified under the ‘single cause of death’ used more usually at the conclusion of an Inquest.
    2. Paragraph 7, of Schedule 5 to the Coroners and Justice Act 2009 provides Coroners with the duty to make reports to a person; organisation, Local Authority or Government department or agency where the Coroner believes that action should be taken to prevent future deaths (Regulation 28 notice).
    3. A Regulation 28 notice was issued on 3rd June 2016 with actions required from ANHSFT and the GP’s surgery; it was copied to Airedale NHS Foundation Trust, Airedale, Wharfedale and Craven CCG, the GP surgery, Mr. B and The Chief Coroner.
    4. The Coroner’s concerns were *‘that during the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. The matter of concern raised although not directly linked to the death are matters which I believe in the circumstances needs raising’.*

*The matters of concern are –*

*‘Following Mrs. A’s discharge from hospital there was no communication from the Emergency Department to the community nursing teams that Mrs. A had a fractured distal end of femur.*

*Although the GP was informed of the fracture and left a message for the District Nursing Team, which was picked up, there appears to have been no further communication to the District Nursing Teams who attended Mrs. A*

*As a consequence nobody involved in the care of this lady was aware of the fracture and she continued to be hoisted without any review of the arrangements for moving her and the potential for injury this may have caused’.*

* + 1. The Coroner requested that responses from ANHSFT and the GP to his report should be submitted to him by 29th July 2016 although the Coroner could extend the period of time if requested. The response was asked to include details of any action proposed or taken, setting out a timetable for action.

### Responses

* + 1. The GP surgery sent a response to the Regulation 28 report from Dr. D on the 8th July 2016 and within the timescale set.
    2. In relation to Concerns 1 and 2, Dr. D notes that she discussed her clinical concern re the possibility of a fracture with a member of the District Nursing team on 25th March 2015 prior to Mrs. A’s attendance at the Emergency Department on 26th March 2015. Following Dr. D’s telephone discussion with the Emergency Department Consultant regarding the fracture, she sent a SystmOne task (a notification of an action) to the DN team to inform them that Mrs. A had been formally diagnosed with a femoral fracture of the distal end (knee) and a left hemiparesis (weakness down her left side) and had been sent home as she had declined any intervention. The task was picked up by a HCSW but apparently not communicated further within the District Nurse Team. Dr. D states that she first learnt of this in November 2015 when the Team Leader for the District Nurse Team wrote to the surgery to express her concern that a task alone was not sufficient to communicate urgent clinical information. The GP’s discussed this at a practice meeting on 1st December 2015 and agreed that in future, urgent and important information would be communicated to the District Nursing Team by telephone with immediate effect. She attached the minute of the Practice meeting minutes detailing this.
    3. In relation to the issue of the Moving and Handling assessment, the GP notes that this is not within the remit of a GP. However she noted that as GPs *‘we*

*should be aware of the implications of hoisting a patient with a fracture and if they had concerns, to ask the District Nursing team to review the needs of the patient’*. This was identified as a learning point for primary care and disseminated to all local practices in a newsletter.

* + 1. In relation to ANHSFT, a report detailing ANHSFT’s actions was sent to the Coroner detailing the following actions on 25 July 2016.

### Concern 1: Following Mrs. A’s discharge from hospital there was no communication from the Emergency Department to the community nursing teams, that HR had a fractured femur.

On 24th November 2015, a formal review was commenced of the Emergency Department discharge process for all patients in a community care setting or where care was being undertaken by a care agency or professional within the patient’s home environment. The Matron, Urgent Care, led this review.

The review identified a discharge letter template already in use in the department; however it had not been used for this particularly patient’s discharge. Further immediate actions taken at this stage were; reinforcing the use of the discharge letter at the nursing safety briefs at each shift handover, and the Matron, Urgent Care undertook a baseline audit to determine usage.

The learning from the incident investigation was shared by the Matron, Urgent Care at the Emergency Department Sisters Meeting on the 26th November 2015, and the Joint Sister’s Operational Meeting on 26th November 2015.

The outcome of the audit in January 2016 indicated further actions were required, one of which included a review of the accessibility to the forms in a busy environment, and the forms are now readily available in each patient cubicle.

The Matron, Urgent Care, subsequently worked alongside the Trust’s Clinical Audit Team to agree a methodology to monitor the discharge process, via an on-going audit process and it was further discussed at the Emergency Department Governance Meeting on 18th May 2016.

The data is now collected electronically and measured against key performance indicators (KPI). Two key standards have been identified:

*‘Standard 4: Documented that patient discharge letter completed and sent with patient/carer’.*

*‘Standard 5 Copy of discharge letter filed with patient notes’.*

These KPI’s are accessible on the Trust’s intranet for staff in the department to view and learn from the information. A further long term solution is the Emergency Department Electronic Patient Record (EPR), which is planned for implementation September 2016. This will facilitate a permanent electronic discharge template, for all patients, which must be completed prior to any electronic discharge from the Emergency Department onto SystmOne, which is the electronic system used in the Trust and GP practices holding patients health records), it will also have a printable facility to enable a copy to be taken home with the patient for other care agencies.

**Concern 2: Although the GP was informed of the fracture, and left a message for the District Nursing Team which was picked up, there appears to have been no further communication to the District Nursing Teams who attended Mrs. A**

A risk assessment was undertaken by the Trust’s Community Manager identifying the issues relating to the use of SystmOne, which is used to support caseload management for the Trust’s community teams. The Trust’s IT System’s Manager and the Community Manager attended the Bradford Integrated Care, Adults Programme Board for the Integrated Care Records Work stream Project Group on 26th November 2015. This is chaired by a GP provider/Clinical IT Lead, where the risks were formally raised. On 11th December 2015 the risks were also discussed at the Trusts internal Digital Futures Programme Board. Immediate solutions were identified and actioned, including SystmOne refresher sessions for staff, IT staff one to one support for Community teams, and regular monthly training sessions thereafter.

The risk assessment has since been reviewed by the Community Manager and all actions have been addressed, and the risk assessment removed from the Trust’s Community local risk register. The Trust’s Community Teams continue to hold SystmOne meetings to discuss any identified issues or risks, and the teams will raise any risks as per Trust process via their monthly Governance Quality and Safety meetings.

AWC CCG undertook action for GP’s improving processes in relation to urgent messages being passed as a ‘Task’ on the electronic system to the Community Teams. The Trust’s Community Manager has provided assurance that urgent referrals from GP’s is a well embedded process and are consistently being received by the Teams, this is being monitored by the ongoing work around SystmOne.

### Concern 3: As a consequence nobody involved in the care of this lady was aware of the fracture and she continued to be hoisted without any review of the arrangements for moving her and the potential injury this may have caused:

A full system review was undertaken with all Trust’s District Nurses and Case Holders by the Community Team Leader, this included the following:

Initial patient visits require new referral and District Nurse to complete full holistic assessment, which includes the following;

New personalised care plans added to SystmOne and linked to a new referral; Completion of manual handling assessments including awareness of care provider’s provisions;

Following a discharge from hospital and prior to a visit, SystmOne must be read, alongside the discharge letter;

Daily handover’s for each team.

Internal management systems for sharing information received by the Community Teams were reviewed and Safety Briefs were developed for the teams and are being utilised.

The Trust has also incorporated the learning into the mandatory training for moving and handling so all staff fully understand the consequences of moving a patient with an untreated fracture, and the need to seek specialised physiotherapy input for moving a patient in such incidences.

The Trust’s monthly Quality and Safety newsletter, December 2015 edition, reinforced the requirement to communicate all patients’ needs on discharge to relevant teams and/or care agencies.

The Executive Medical Director on 8th July 2016 reinforced to all staff via the Trust’s communication brief, the importance of communicating a patient’s needs on discharge, and that all health professionals have a moral and professional responsibility to do so.

* + 1. In conclusion, the Coroner received appropriate responses to his request for details of action to be taken and timescales for this. The Coroner didn’t request any further information or action.

# Discharge from the hospital

### Were discharge arrangements properly considered and implemented, with all appropriate needs and Care Plans being communicated to teams/agencies?

* + 1. This section has been dealt with under Section 7.2 Communication

### Were fast track arrangements timely and used effectively (were they triggered and early enough)?

* + 1. Fast Track arrangements were triggered on Mrs. A’s discharge from hospital on 11th May 2015 and the Collaborative Care Team took over her care at home on 23rd May 2015 at the point where the agency terminated their services.
    2. The arrangements were timely and in line with Airedale NHS Foundation Trust guidance in accessing NHS Continuing Care.

### Opportunities for NHS teams to support arrangements for the Agency to administer pain control (oramorph)

* + 1. Following Mrs. A’s discharge on 11th May 2015, she was sent home with anticipatory pain medication, which included Oramorph. The Agency was not notified about this nor were they given instruction on how it should be used. They contacted the Telemedicine Hub on 14th May 2015 to express concerns that she was not eating or taking analgesia (oral dihydrocodeine and Oramorph). The Collaborative Care Team visited out of hours and administered pain relief by injection.
    2. The Agency telephoned the Telemedicine Hub again on 16th and 17th May 2015 as they felt they were unable to administer Oramorph. Their confusion was that they believed they were not able to administer a ‘*controlled drug’*. After discussion with the telemedicine hub and Collaborative Care team, it was agreed that the carers could administer the Oramorph.
    3. The agency then spoke with their nominated Officer in the Quality and Monitoring Team at HAS as they were keen to ensure they were able to do this within their contract; it was explained that they were already administering controlled drugs to other clients but weren’t aware of it. They received support to amend their medication policy from the HAS team to ensure it covered the storage and administration of controlled drugs. Following this, they began to administer the Oramorph.
    4. On 18th May 2015 opiate patches were prescribed by the GP and commenced. The Agency gave notice to terminate the service on 19th May 2015 and the Collaborative Care Team took over on the 23rd May 2015. It is clear from the Case Conference notes of 10th May 2016 that there was confusion around the administration of pain control – dihydrocodeine and particularly, Oramorph. The District Nurses thought the Agency were prompting Oramorph and the Agency thought it wasn’t allowed to as it was a controlled drug and they believed they were prohibited from prompting controlled drugs.
    5. The Agency found themselves in a difficult position on 11th May, as Mrs. A had previously not taken prescribed medication prior to her hospital admission. She was discharged home with medication, which included a controlled drug, with no prior notification from the hospital around the use of medication. They were then facing a situation they were unprepared for. The carers working in the home didn’t notify the owner of this until the 14 May 2015; she then attempted to get assistance by ringing the Telemedicine hub on the 14th, 16th and 17th May 2015. The District Nurses administered Oramorph on one occasion only.
    6. The Trust’s policy is that the administration of medications prescribed within the hospital should be communicated to any carers supporting individuals in the community. If there is are health professionals involved in the care, advice should be sought from these individuals to understand the medication and possible side effects. It appears that in this case, the agency carers had not sought advice from the District Nursing team until 16th May 2015.
    7. The Agency contacted the Quality and Monitoring Team to seek their assistance on 18th May 2015 and they were given support and guidance. An

opiate patch was prescribed by the GP on the same day therefore the Oramorph was no longer used.

* + 1. It is unfortunate there was a delay in ensuring that Mrs. A was offered pain relief through lack of communication and confusion. Improved communication between acute and community services may have helped to bridge the gap in this area. The Agency received support from HAS’s Quality and Monitoring team, which they found helpful and were then able to give the Oramorph.
    2. Improved communication between all parties, and internally within the Agency, would have lessened the chance of this confusion occurring.
    3. There has also been an issue raised in relation to the issue of an alleged missing bottle of Oramorph, which re-appeared in the fridge the day after being reported to the police. The police considered this incident at the time, no further action was taken and it is beyond the scope of this Review.

# Maintaining Mrs. A at home

### Were handling and moving assessments undertaken/reviewed appropriately and communicated upon discharge, considering the known fracture?

### Assessment and planning, particularly around moving and handling assessments.

8.6.1 These issues have been dealt with under Section 7.2 Communication

# Commissioning issues

### Did North Yorkshire County Council fail to acknowledge or respond to two letters sent to them by Mr. B (14 December 2015 and 20 February 2016) questioning what action they were planning to take in relation to the Home Care Agency?

* + 1. NYCC has not been able to locate the two letters coming into the Department nor any response to them from NYCC.

### Should North Yorkshire County Council have kept Mr. B up to date in relation to any action it may have taken against the Home Care Agency?

* + 1. Under the Data Protection Act, NYCC would not divulge information to third parties in relation to their contractual relationship with provider organisations. However, it would give a factual response if an interested party requested information on a providers performance, e.g. ‘*there has been some concerns but the provider is working with the local authority to move forward’*. The only other time information is shared is when a provider is suspended or partially suspended (phased lifting) and this information is on the Council’s website. If any action were being taken with the provider solely in relation to the individual family member this information would be shared through the care management process.

### Did North Yorkshire County Council follow their own protocols when they became aware of the first Safeguarding alert and the shortcomings in relation to the Home Care Agency?

* + 1. The Procedure in 2015 was that safeguarding referrals would come to HAS through two different routes; they could go through the Customer Service Centre who would then forward information to the relevant social care team, or they could go directly to the locality team. However, the Quality and Monitoring Team was not always notified when an alert concerning a provider was made. The social care team would review the alert and based on the information provided, determine what further action to take, if any.
    2. In the Procedures issued to staff in 2009, and still in operation during 2015, it states that

*‘CQC will be informed of Alerts from registered services and from other services as appropriate.*

*The Contracts Unit/Section should be informed of allegations relating to care settings where consideration may need to be given to suspension of placements.’*

* + 1. The Quality and Monitoring team would not necessarily get involved at the stage where HAS was investigating or where the police were involved. However having knowledge about a provider in one unit allows a Local Authority to have an overview of complaints in order to inform its monitoring process and take action should a provider be under-performing.
    2. The system in place was that the Quality & Monitoring team receiving a Safeguarding Alert would document these on a spreadsheet. However, the Designated Safeguarding Manager did not always notify the team when an alert was received.
    3. In this instance, the Quality and Monitoring Team were not made aware of the alerts.
    4. The Quality and Monitoring Team is the only unit in NYCC that has an overview of all the Providers. It is possible that practitioners could be experiencing concerns around a Provider that they think are ‘one offs’ and, unless they are reported, will not be seen as part of the ‘bigger picture’.
    5. It is unlikely that the failure to report concerns would have made any difference to the outcome of Mrs. A. However it should be established that a robust system is in place to ensure Alerts are raised with the Quality and Monitoring team and that these are routinely considered by and risk assessed in terms of standards of care to safeguard vulnerable service users.

# The Mental Capacity Act 2005 and the Code of Practice 2007

### Although not specifically included in the Terms of Reference of the Review, it is clear that the issue of Mrs. A’s ability to make her own decisions and thus demonstrate Capacity, was central to the events leading to her death and worthy of consideration in this Review.

* + 1. During the period under review there were many Capacity Assessments of Mrs. A undertaken by the various agencies involved using the framework of the Mental Capacity Act 2005.
    2. As an overview these were conducted as follows, where it is indicated that the assessment was undertaken around a specific issue I have indicated this.

12/3/15 Dr. D assesses capacity. 18/3/15 Care agency assesses capacity

25/3/15 Dr. D and District Nurse assess capacity

26/3/15 Emergency Department Consultant assess capacity

2/4/15 Mr. B feels she doesn’t have capacity and raises this with Dr.

D

7/4/15 Home visit with Dr. D plus Mr. B. Mrs. They believe Mrs. A doesn’t have capacity to decide whether to be admitted to hospital or residential care. Dr. D deemed she could retain and communicate but her ability to weigh up information was more difficult to assess. Informed Mr. C. However, Mrs. A agrees to admission to hospital.

16/4/15 Hospital Consultant, formal capacity assessment undertaken, deemed had capacity to make decision about returning home but noted difficulty communicating, decision is to be discharged home.

17/4/15 Mr. B feels she does not have capacity to agree to discharge, nurse case manager WH agrees to reassess, no concerns about decision-making ability,

20/4/15 Assessed on hospital ward and is deemed to have capacity to agree to discharge. Discussion with ward staff and Mr. B, notes say ‘*assessed capacity several times, can’t force a capacitous patient to do something against her wishes’*.

Medical notes list 3 MCA assessments completed by Doctors on the ward.

24/4/15 District Nurse concerned about discharge and capacity.

24/4/15 Mr. C assesses and agrees Mrs. A has capacity to make decisions around accepting or declining care interventions.

8/5/17 Discussion around thickened fluids by Dr. on ward (not formally recorded as MCA assessment) returned to discussion next day and agreed able to recall decision and has capacity to make decisions around what she eats.

* + 1. There was an awareness of the need to establish capacity and test out whether Mrs. A was able to make life-changing decisions around treatment and the care provided to her. There was also challenge from Mr. B and, at times, from individuals who deemed that her capacity did fluctuate around 2nd to 7th April 2015.

### The Mental Capacity Act 2005 has at its core five principles in relation to capacity:

* + - *Presumption of capacity*
    - *All practicable steps must be taken to enable Individuals being supported to make a decision*
    - *An unwise decision doesn’t mean a person doesn’t have capacity*
    - *Anything done for or on behalf of a person without capacity must be in their best interests*
    - *The least restrictive option should be chosen for a person lacking capacity.*
    1. Without wishing to reproduce the Mental Capacity Act 2005, it is helpful to highlight the key issues in relation to this case. Section 2(1) of the Act states:

*‘For the purposes of this Act, a person lacks capacity in relation to a matter if, at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.’*

This means that a person lacks capacity if:

* *they have an impairment or disturbance (for example, a disability, condition or trauma) that affects the way their mind or brain works, and*
* *the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.*
  + 1. An assessment of a person’s capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. Section 3 of the Act defines what it means to be unable to make a decision.
    2. Section 2(2) of the Code of Practice states that the impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:
       - *the loss of capacity is partial*
       - *the loss of capacity is temporary*
       - *their capacity changes over time.*

A person may also lack capacity to make a decision about one issue but not about others.

* + 1. To help determine if a person lacks capacity to make particular decisions, the Act sets out a two-stage test of capacity. The first stage is questioning whether the person has an impairment of, or a disturbance in the functioning of, their mind or brain. Evidence is required that the person has an impairment of the mind or brain, or some sort of or disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Act. Some examples of impairment or disturbance are quoted as – conditions associated with some form of dementia, significant learning disabilities or physical or medical conditions that cause confusion.
    2. The Mental Capacity Act 2005 goes on to say that a person is unable to make a decision if they cannot understand information about the decision to be made, retain that information in their mind, use or weigh that information as part of the decision making process and communicate their decision (using non-verbal methods if appropriate)
    3. Capacity assessments should be related to a specific decision, however there may be people with a condition that affects their ability to make certain decisions or that may affect other decisions in their life. Because of this, it is important to review capacity from time to time as the ability to make decisions may change.
    4. The Code of Practice to the Mental Capacity Act 2005 states (Section 4.30) that it is important to acknowledge the difference between unwise decisions, which the person has a right to make, and decisions based on a lack of understanding of risks or inability to weigh up the information about a decision.

### From reading the Individual Management Reviews and case

### documentation, the professionals’ assessments of Mrs. A record her as being able to make the decision to remain at home and not accept medical intervention around the fractured left femur. There is one occasion where Dr. D and Mr. B believe Mrs. A doesn’t have capacity; Mr. B raised concerns about the decisions his mother was taking and the impact these would have on her wellbeing. It appears that Mrs. A’s capacity did fluctuate at times due to her physical frailty and illness.

* + 1. There is overall agreement that Mrs. A had, for the most part, the ability to take the decision around refusing medical intervention, wishing to return to her home and also choosing to eat a non-liquid diet. Dr. D who had a fairly long-standing relationship with Mrs. A considered her decision was partly based on the five month stay in Airedale General Hospital in 2010, which she did not want to repeat. Dr. D records on the 24/3/15 that ‘*she had a long stay in hospital a few years ago and does not want to go back’*. She was also a lady of 88 years of age, not in good health and there was a general feeling that she wished to end her days in her own home. There is evidence that the professionals respected and supported her in this decision. Situations such as these are difficult to deal with, clearly the professionals were aware that Mrs. A was shortening her life by making the decisions she made; they allowed her to do so whilst listening to her son’s concerns and attempting to support her.
    2. Recording of capacity should be recorded and be specific. Any staff involved in the care of a person who lacks capacity should make sure a record of the process is kept on the person’s file, setting out –
* *How the decision was reached;*
* *What the reasons were;*
* *Who was consulted; and*
* *What factors were taken into account.*

#### Mental Capacity Act 2005 Code of Practice

### Mrs. A refused an assessment of her needs before she was discharged from the hospital stay on 24 April 2015. Mr. C (social worker) visited the ward on the 22 April 2015 having been allocated on 10 April 2015, he reviewed the records of the capacity assessments undertaken on the ward by medical professionals but did not meet Mrs. A. as she had stated to the Nurse Case Manager that she did not want an assessment of need.

* + 1. On 24th April 2015, Mr. C was contacted by the District Nurse who raised her concerns about Mrs. A’s decision to decline an assessment of needs; Mr. C explains that ‘*I have not met her as she declined an (re) assessment of needs but I am trusting the medical professionals who have completed the capacity assessments’.* The Nurse said she would speak to the GP, she also advised Mr. C that Mrs. A has a Grade 4 pressure ulcer and they discussed the possibility of raising this as a safeguarding concern, although this did not happen.
    2. Mr. C visited Mrs. A at home on 24th April 2015 and assessed her capacity, which he concluded she had in ‘*all areas of decision making’*. Mr. C clearly undertook a thorough assessment and checked back with Mrs. A later in the visit whether she had retained information; it was a critical decision Mrs. A was making. Mr. B had contacted Mr. C with his concerns, the Agency was finding the situation difficult to maintain and there were unresolved safeguarding complaints. She was admitted to hospital again on 5th May 2015 and discharged on 11th May 2015; Mr. C didn’t re-visit the care package at this point.
    3. Given that any professional can organise a MDT, this duty doesn’t just rest with the Social Worker, however they could have arranged a meeting of professionals to facilitate communication around the presenting issues. This was a complex and multi-faceted situation with a number of agencies involved and a family member who was expressing his concern about the circumstances, Safeguarding issues that had been closed and there was a need for advance care planning. Although there appears to be a consensus that Mrs. A was able to make and take her own decisions, it does not follow that these were not discussed or debated as to how to make the best of this decision by the team around her. A MDT approach may have enabled the individuals supporting her to continue to review them.
    4. A Social Care Institute for Excellence (SCIE) briefing in March 2015 on self- neglect which, although not directly relevant to Mrs. A, has a range of key learning points which are useful to reflect on in relation to these issues. The research identified five themes that featured most strongly as being effective in working with people who declined interventions. These were:
       - *the importance of relationships*
       - *finding the person*
       - *legal literacy*
       - *creative interventions*
       - *effective multi-agency working.*

*The theme that emerged most consistently was the importance of relationships in securing engagement and achieving interventions that could make a difference.*

* + 1. The independent author is not seeking to suggest that a more involved approach would have made any difference to Mrs. A’s decision to decline medical intervention and return home; however it may have made the last six to eight weeks of her life less strained and painful with a better understanding between those concerned including her son.
    2. The independent author is aware that time constraints are always an issue when dealing with caseload issues and as the SCIE research indicates –

*‘There was some agreement between the practitioners and managers interviewed that self-neglect practice, because of its reliance on building relationships and engaging in long, slow negotiations, often does not fit with organisational expectations about timescales. Limits to the amount of time allocated to any one case and pressure not to keep cases open were thought to belong with care management models that assumed a neat and predictable relationship between assessment, service provision and closure, and did not rely on longer- term engagement. In some cases, it was necessary to adapt workflows in order to allow the ongoing involvement that would lead to positive outcomes, or to put aside temporarily the normal expectations of timely case closure’.*

* + 1. Good practice was evidenced in professionals supporting Mrs. A in her wish to remain in her home and by using the Mental Capacity Act to support her decision-making. Having capacity doesn’t negate the need to continue to support individuals to make the best of a situation and to ensure the team around the person is helped to work together to provide the best quality care.

# Evidence of good practice and lessons learned

As detailed in the Report, there are a number of areas where there was good practice was identified and also those where practice could be improved.

These are identified below.

Over two years have passed since Mrs. A’s death. A number of changes have been initiated and improvements made during that time running in conjunction with the Review. This has demonstrated good practice and improved service quality.

### Airedale NHS Foundation Trust

### Key learning points for ANHSFT

1. There is a need to review systems and processes to support caseload management, clinical care and communication/handover in order to facilitate multi-disciplinary working
2. Current established practice related to numbers of visits (every third visit being a registered nurse) is presently being reviewed in light of HCSWs’ ongoing professional development.
3. There is a need to address the risks and issues relating to the use of SystmOne related to caseload management to ensure that we have reliable processes.
4. Mrs. A’s case should have been communicated to the Community Team upon discharge from ED so that further assessment was undertaken.
5. Upon discharge from her inpatient stay information should have been provided to the Community Team so that an assessment and review of plans of care were undertaken.
6. There is a need to improve processes for internal management systems and the sharing of information across Primary and secondary care Community Teams.
7. There is a need for staff to seek advice from a Physiotherapist when a patient requires complex moving and handling techniques.
8. There is a need for staff to promote proactive communication between agencies involved in care (MDT meetings).
9. There is a need for staff to promote sharing of good practice in relation to prompting of analgesia.
10. There is a need to review clinical processes for wound investigation and management. This will be in accordance with best evidence and practice to ensure that holistic care is promoted.
11. There is a need to review the processes when a patient is being discharged home for end of life care regarding medication administration to ensure all staff are aware of their roles and responsibilities. This needs to include clear communication with domiciliary care agencies to ensure the package of care being agreed reflects the patient’s needs and the agency’s ability to deliver any relevant treatments and interventions.
12. There is a need to review of the process within community teams to ensure care plans for End of Life/Fast-Track patients in order to ensure that all involved are aware of their role (for example administering medication)
13. Ensure that Speech and Language therapy is undertaken in conjunction with the individual concerned to attempt to achieve agreement.

### Areas where good practice was observed

1. Craven Collaborative Care Team immediately recognised a Moving and Handling assessment was required and a Physiotherapist attended the next day to undertake this.
2. Upon discharge from hospital the District Nursing team and CCCT undertook appropriate assessments, delivery of care and made onward referrals to relevant specialist services i.e. specialist palliative care nurse and specialist Tissue viability services.
3. Practice was considered to be good when delivered under the Palliative Care pathway
4. Mrs. A was informed of the risks/benefits of treatment, time spent with both her and Mr. B when explaining the options and consequences.

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| **Areas where practice fell short** | **What has changed?** |
| Referral should have been made to out of hours GP when bone discovered protruding from wound on 4 May 2015 | Existing Guidance reinforced |
| Emergency Department didn’t request Moving and Handling assessment before Discharge | Systems reviewed and reinforced |
| Task wasn’t picked up from SystmOne re Mrs A’s fractured distal end of femur | Training on the “management of tasks” on SystmOne is provided. Task Management is now embedded in daily  practice. |
| No Moving and Handling advice sought from Physiotherapist | Guidance reinforced |
| Mrs. A wasn’t visited by a Registered nurse every three visits as per standard | Guidance reinforced, practice under review in light of the developing role of Health Care Support Workers |

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| Lack of communication with care agency with regard to pain medication | New Guidance issued |

### Health and Adult Services (HAS)

### Key learning points for HAS (as identified from the IMR)

1. Involving and evidencing the direct involvement of the adult in all aspects of their care and support including Making Safeguarding Personal.
2. Ensuring that social work practice is not fragmented and encompasses all aspects of practice to deliver the individual’s outcomes in a Person Centred manner.
3. Ensuring that the approach to safeguarding practice meets best practice and that the culture of HAS and the support to staff procedurally in terms of practice and through supervisions and management balances the agenda of self-determination and effective risk assessment and management.
4. Ensuring that training and competencies are refreshed and updated to meet best practice throughout workers and not seen as a ‘one off’ opportunity.
5. A robust organisational approach is needed to learn from experience and to share lessons learned in a timely and effective way across HAS.
6. There should be opportunities for all partners to learn from experience and sharing any lessons learned from serious incidents.
7. Clearer policy and guidance should be shared with all staff in terms of what should be considered a safeguarding concern.

### Areas where good practice was observed

1. Staff attempted to follow Mrs. A’s wishes around staying at home, not wishing to be admitted to hospital and used the Mental Capacity Act 2005 to support decisions which were complex and potentially life-shortening.
2. Mr. C diligently engaged with Mr. B explaining decisions and the rationale behind them.

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| **Areas where practice fell short** | **What has changed?** |
| No Assessment of Mrs. A undertaken by HAS | Guidance reinforced with staff |
| Safeguarding concerns not discussed with Mrs. A and didn’t involve her in discussing care | Training delivered including Making Safeguarding Personal |
| Risk assessment and balance of self- determination needs reinforcing | Guidance reinforced |
| Despite Mr. B’s concerns, safeguarding alerts not made by HAS staff | Guidance and training |
| Delay in dealing with the 26th March  2015 Safeguarding alert | Guidance and training |
| Safeguarding alert closed without any appropriate follow up | Guidance and training |
| Reliance on other professionals’ Mental Capacity Act assessments | Role of Social Care Assessor reinforced |
| Failure to attempt to pursue a constructive dialogue with Mrs A | Training delivered |
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| Mr B did not receive a timely response to letters, he also did not receive a  response to two letters sent. | Systems for receiving and handling of complaints reviewed and additional  staffing allocated to the team |
| Case transferred to Health when fast track funding in place, still a role for HAS due to ongoing safeguarding  concerns. | Guidance reinforced |

### GP’s surgery

### 10.3.1 Key learning points for GP Practice (as identified from the IMR)

* + 1. Review of the GP practice concluded that the surgery showed good practice in relation to care.
    2. The surgery have reviewed and implemented a change to communicating with the District Nursing team. Initially all ‘tasks’ were phoned through but now it is urgent tasks only. Staff have been instructed in the new system.
    3. GP’s should be aware of the implications of hoisting a patient with a fracture and if they have concerns, to ask the District Nursing team to review the needs and wishes of the patient. This was identified as a learning point for primary care and disseminated to all local practices in a newsletter.

### Areas where good practice was observed

* + 1. Mrs. A’s GP visited her at home on a regular basis and was responsive to calls to support her. She supported her to remain at home and was mindful of her capacity, questioning when she thought it was lacking.
    2. Mrs. A received a good level of care from the GP surgery.
    3. Following Mrs. A’s death, the GP surgery put in place a system where they asked for acknowledgement of any urgent or important tasks or referrals they communicated via SystmOne. This proved too time intensive for the surgery and this practice has now been discontinued. It should be established what arrangements are now in place.

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| **Areas where practice fell short** | **What has changed?** |
| The task actioned on SystmOne wasn’t picked up by the Community team.  Although this wasn’t a fault of the GP surgery, action should be to strengthen the system for allocating urgent tasks. | Practice was changed to ensure all urgent tasks were followed up to confirm they had been actioned |

### Care Agency

### Key learning points for Care Agency (as identified from IMR)

* + - 1. The IMR process related to the Agency had to be undertaken in a different way from the other organisations involved in this SAR. The agency involved is small in scale with an owner and manager who are involved in all aspects of the care provided. As IMRs are undertaken by somebody who has not been involved in the events which led to the IMR, the Panel took the decision that the Independent Author would interview the managers to identify and extract the information required. This has led to discussions within the Panel of how the SAR process is effectively applied to small agencies to ensure they have both the skills and the support to contribute in a meaningful manner and in a way that doesn’t necessarily put them in a disadvantaged position.
      2. A reflection from the agency that better communication including face to face meetings between Mr. B and the owner/manager and other

agencies may have been conducive to dealing with problems as they arose.

### Areas where good practice was observed

* + - 1. Good practice centred around the owner of the agency doubling up with staff at times to view standards of care for herself.

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| **Areas where practice fell short** | **What has changed?** |
| Only one carer attended Mrs. A rather than the two commissioned | Staff now ring duty officer if one carer doesn’t turn up or is late |
| Hoist incident not reported until the following week | Guidance revised |
| Lack of clarity around prompting medication | Medication policy revised |
| Failure of carers to draw issues around medication to managers’ attention | Guidance and induction reinforced |
| Human Resource procedures not implemented appropriately | Procedures reinforced |

### 10.5 All agencies

### Key lessons learned (from IMR)

10.5.1 The need to ensure that multi-agency meetings are held to share and discuss concerns and develop plans where an individual has complex needs and a number of agencies involved in their care. These should involve relatives as appropriate. It should be established who has the responsibility to facilitate such meetings.

# Recommendations requiring further and ongoing consideration by the Safeguarding Adult’s Board

There are a number of specific areas where I would recommend that the Safeguarding Adults Board (SAB) reviews to ensure that appropriate lessons have been learned. These include –

* 1. Ensuring that the ‘Making Safeguarding Personal’ guidance is embedded in all practice, including Social Work practice – we need to ensure that the person is at the ‘heart’ of the process.
  2. Review whether a person’s right to decline assessments under the Care Act 2014 and exercise their autonomy is weighed sufficiently, fully and carefully against professional standards in Health and Social Care.
  3. Explicitly reinforce the need to record mental capacity in terms of being both decision and time specific; it is not enough to record that a person has, or may have previously had, ‘capacity’.
  4. Ensuring that all practitioners undergo a rolling programme of Safeguarding training that is relevant and appropriate to their job role and function.
  5. Take action to validate and ensure that the system where the GP notifies the District Nursing team of urgent tasks is both operational and functions safely. This should include a system for checking that urgent tasks have been received and confirmation back of actions taken. In doing so, is the Board confident and assured that this would help to avoid the communication issues identified within this SAR? (see key lessons GP’s surgery).
  6. Each organisation should have an appropriate mechanism for escalation of concerns in relation to quality and safety. There must be a clearly understood process for managing and co-ordinating responses to incidents and concerns, which is endorsed by the SAB and is compliant with both the Care Act 2014 principles and the national Strategic Information reporting system (STEIS) for NHS Providers. The SAB should agree how the organisational processes feed into each other to ensure that intelligence and actions are jointly owned.
  7. There must be a common and clear understanding of who the lead agency is when there are a number of agencies involved in a person’s care. This would clarify who is responsible for initiating a Multi-disciplinary meeting, and is particularly important when working with people where capacity may be an issue, and there is dispute around aspects of care and advice.
  8. Consideration should be given to the level of support offered to smaller agencies to enable them to engage more effectively with future Safeguarding Adult Reviews (SAR’s).
  9. All agencies contracted to provide care should be aware of safeguarding policy and procedure and of their role and what support may be available to them when a Safeguarding Adults Review or Lessons Learned is held.

10.10 There must be a clear understanding by all staff of how customer interactions, such as responding to complaints, will be handled while safeguarding processes are being carried out.

* 1. To improve the functionality of SystmOne in order to support

frontline staff thus benefitting the patient. This will ensure the links with

other agencies in the MDT are robust and aid effective communication about the patient’s care needs.

* 1. Promote a holistic approach to patient assessment and care planning against best practice and ensure it is personalised to the individual for example speech and language therapy (SALT) plans should be adapted to personal wishes and needs. It is also important that care plans are personalised to reflect decisions of the patient with mental capacity including when this is contrary to medical advice.
  2. Record keeping should be reviewed to make sure essential communications are recorded and acted upon when transferring care between agencies including hospital discharge (following inpatient stays or attendance at accident and emergency departments) to community nursing and homecare and care home teams, to ensure any changes in practice have been noted and effected. This should include relevant discharge information.
  3. There should be clear local arrangements and responsibilities for undertaking moving and handling assessments in the community, including where risks have been identified during hospital stays or Accident and Emergency Department attendance.
  4. There should be a review of arrangements to support advanced care planning during ‘fast track’ pathways, to ensure they are timely, clear and effective. This would include where the person makes a valid decision to refuse treatment, care and support or professional advice.

# References

Care Act – Department of Health 2014

Making Safeguarding Personal – Local Government Association/ADASS 2013 Mental Capacity Act – Department of Health 2005

Code of practice – Department of Health 2005

Self-neglect policy and practice: key research messages. Social Care Institute of Excellence 2015

North Yorkshire Safeguarding Adults Multi Agency Policy & Procedures - Version 1.0 - May 2009

North Yorkshire Safeguarding Adults Board Safeguarding Adults Review Policy - May 2015

# Glossary

ANHSFT – Airedale NHS Foundation Trust. Provides hospital and community nursing services.

CCCT - Craven Collaborative Care Team provides cover for the district nursing service and intermediate care to patients within the Craven area. Their role is to prevent unnecessary hospital admission where this is safe and appropriate and to facilitate early discharge from hospital. It is a multi-disciplinary team.

CCG – Clinical Commissioning group

District Nursing Service – visits patients in their own homes or in residential care homes during working hours.

Fast Track - this is a fast assessment for people who are at the end of their life or in a period of rapid deterioration. It ensures that NHS funding is in place as quickly as possible.

HAS - Health and Adult Services Team, North Yorkshire County Council

Regulation 28 Notice - The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths Report

SCIE - Social Care Institute of Excellence

Telemedicine - a service provided by ANHSFT, it is remote delivery of healthcare service such as health assessments or consultations via telephone or computers.