Safeguarding Adults Review: Mrs AM

(Completed May 2016; Published February 2018)

Summary

Mrs AM was an 80 year old woman receiving support from Richmond health and social care agencies, who died as a result of suffocating, on 6 November 2015. The Safeguarding Adults Board (SAB) made the decision that the criteria for a Safeguarding Adults Review (SAR), under Section 44 of The Care Act 2014, were met. The SAR was completed using a Peer Review methodology. An independent reviewer, Clive Simmons led the review.

The SAR was to identify:

- If the care provided to AM was appropriate and effective
- if local systems were adequate in ensuring effective, safe and responsive care to AM
- organisations worked together effectively
- any learning and recommendations

The review was completed in May 2016 and learning shared at the SAB on 23 May 2016. The publication of this report, however, was delayed due to an ongoing police investigation. This summary report was published in February 2018.

AM – Pen Picture (Provided by Family Representatives)

Mrs AM was born in 1935 and was one of three sisters. On leaving school, Mrs AM lived in France and worked as an au pair when she returned to England she worked for the BBC in London. She worked most of her life, including in the art and history department at Kingston University. Mrs AM married in 1960 and her husband, who was an artist, died in 2008. She had a strong academic, artistic and musical background was an avid reader and a focal point in the wider family for advice. Mrs AM spent her final years (from 2012) in a local care home due to a decline in memory. A decline in mobility was noticeable from 2014 leading to Mrs AM being cared for in bed for the last months of her life when she relied on staff help for all aspects of her care, welfare and mobility.

The Background

Whilst being cared for in bed Mrs AM was not able to reposition herself and relied on staff to ensure her position was safe when left alone. Regular checks were needed to ensure Mrs AM's safety day and night. During the night of her death Mrs AM was found face down in her pillows having suffocated.

Agencies and People involved in the SAR

The following people, professionals and agencies were involved in Mrs AM's care at the time of her death and were involved in this SAR:

- Mrs AM's Daughter
- London Borough of Richmond upon Themes: Senior Social Worker, Acting Quality Assurance Manager, Community Occupational Therapists
- Central and Cecil Housing Trust: Assistant Director of Care
- Hounslow and Richmond Community Health (HRCH): Service Manager & Safeguarding Adults Professional Lead

Family members were particularly concerned that the following aspects should be looked at as part of the review:

- Could more have been done to stop the decline in Mrs AM's mobility?
- Could family members have been more involved in decision making and planning of care?
- The effect of Isolation resulting from being cared for in bed and lack of companionship as a result contributing to Mrs AM's decline in well-being?
- How effective was continuing health care, assessments and support for Mrs AM?

Key events, decisions and actions

Background to placement:

AM was a resident at A local care home, a care home in the borough of Richmond upon Thames with provision for dementia care, from November 2012. The care home is not registered for nursing care and has capacity for 24 residents, most of whom have a diagnosis of dementia. Staffing is provided on a ratio of at least 1 member of staff to 5 residents and there are 4 staff on duty during nights. The home is reliant to some degree on agency staff, although with some consistency of staffing maintained.

Increased dependency:

A significant decline in AM's mobility and transfers was evident from 2014 onwards to the point that she was no longer weight bearing. This coincided with a progression of her dementia. AM was supported with all personal care. She could express her needs, presented as content and had a positive relationship with staff.

LBRUT Adult Social Services Department:

There had not been social work input to review AM's needs, as this was a private placement, and there was no referral from partner agencies to trigger a reassessment of needs.

The care home and Community Occupational Therapy:

Significant Occupational Therapy input was provided between 21 July and 13 October 2015. An OT assessment on 21 July recommended assistance of two carers and use of a passive hoist for transfers to bed in the evenings as AM was too fatigued to manage with a standing hoist at this time. The care home carers had raised that they were experiencing increasing difficulty in providing care and a sliding sheet was provided to assist with repositioning whilst in bed. Further OT visits were completed on 23 and 30 July 2015, the latter joint with the Community Matron, and it was decided to dispense with the standing hoist completely due to AM receiving bruises to her shins from the equipment. OT visits were also undertaken on 12 and 20 August 2015, to provide a tilting armchair and to initiate a Personal Handling Plan reflecting manual handling requirements. On 26 August 2015, the The care home Manager contacted the OT and discussed a bed system (sheets to use in turning on bed). The OT agreed to The care home staff using the sheets (they had two spare sets) and considered that staff were managing manual handling competently before finishing her involvement on 27 August 2015, due to ill health and completing handover information on 5 September 2015.

There was a gap in Occupational Therapy allocation between 27 August 2015 and 6 October 2015. During this period the OT service was not contacted by to raise any concerns. A new OT was assigned on 6 October 2015 and visited The care home on 13 October 2015 to demonstrate the bed system which had subsequently been delivered to the care home. The OT recommended 4 staff to complete turning on the bed (two staff either side) and The care home raised a concern that this level of staffing was not available at night. Although not clearly recorded, the OT recalls stating that the procedure would be manageable but difficult with two staff attending instead of four. The OT discussed the use of pillows and wedges by staff in supporting AM in bed and, whilst this is considered to be acceptable practice, it was not an OT directive. The OT subsequently consulted with the previously assigned OT on using a slide sheet for moving and handling, which meant that the Personal Handling Plan was not provided, although the OT considered that staff were managing manual handling safely. The OT was due to visit AM again on 6 November 2015.

The care home and Hounslow and Richmond Community Health Care NHS Trust (HRCH):

The District Nursing service was contacted by the care home on 3 September 2015 and by the General Practitioner on 9 September 2015, to request a Continuing Health Care Assessment. The referrals were received at the HRCH single point of access. . A Community Matron completed the District Nursing element of the assessment on 10 September 2015 and emailed this to the care home Manager on the same

date, copied to District Nursing colleagues. There was a delayed response in part because the Community Matron was absent due to sickness from 14 September 2015 and subsequently left the post without a handover arrangement. The care home Manager emailed the Community Matron on 14 September 2015 to confirm that the care home element of the assessment had been completed and that the form had been forwarded to AM's daughter for her signature. This email was not seen by the Community Matron and other District Nurses were not copied into the communication. On 17 September 2015, the Care home Manager again emailed the Community Matron (not seen and not copied to other District Nurses), confirming that AM's daughter had signed and returned the assessment form. On 22 September 2015, the care home Manager emailed the Community Matron (not seen) to confirm that the General Practitioner had signed the assessment, which was now complete. One month later on 21 October 2015, the Care home Manager emailed the Community Matron (not seen), copied to AM's daughter, requesting an update on the assessment. The Care home Manager did not widen or escalate communication about the delay. There was also no follow up by the District Nursing service to ensure that assessment documents had been forwarded to the Continuing Health Care Team. The Community Matron completing the assessment did not identify a need for wider assessment or additional clinical input. On 2 November 2015, AM's daughter emailed the Community Matron (not seen), copied to the HRCH PALS service, requesting an update. AM died within a few days of this communication, before a decision on continuing health care was reached.

The care home and London Borough of Richmond upon Thames (LBRUT) Quality Assurance Team:

The Quality Assurance Team completed a light touch validation visit for compliance at the care home three months prior to AM's death. There was a delay in producing the validation report. There was also a missed opportunity as the audit did highlight a potential risk due to all care plans being updated onto electronic files, and reliance by staff on old paper care plans or incomplete files during the transition.

Circumstances of death:

The care plan for AM included a requirement for positioning on her back in bed, which appears to have been an internal care home stipulation. On 5 November 2015, AM presented to the care home staff as having a fever and remained in bed all day. There was no referral for medical assessment. She was cared for by two agency staff key workers who were familiar with AM and they made the decision, without consultation with any external agency and without recording the reason for this decision, to support AM on her side to minimise the risk of developing pressure ulcers. When the night staff came on duty, despite a visual check on AM by the Senior Care Assistant, the decision to support AM on her side was not questioned or changed. The bed system, which would have minimised the risk of rolling onto her face, was not used. It is possible that AMs arms were not positioned to prevent rolling. The responsibility for the provision of training to care home staff on bed positioning and skin integrity, as clarified by Occupational Therapy and HRCH, rests with the service provider.

The care plan for AM included a requirement that night staff at the care home would complete hourly checks and this did not happen on the night that AM died. The final check was at 21.45 on the night of 5 November 2015 and AM died at some point between then and when she was discovered at 6 am on the following morning, having apparently rolled onto her face and suffocated. It appears the record of check calls was later added to by the carer.

Recommendations & Action Plan

The attached recommendations and actions were progressed immediately following the review and were completed by August 2016.

Mrs AM

AGENCY	LEARNING POINTS	ACTIONS	EVIDENCE	LEAD OFFICER	TIMEFRAME	PROGRESS	RAG Status
SAB	Given the level of multi-agency input and concern from July 2015, there were sufficient grounds for involved agencies to trigger a multi-agency assessment, close communication and coordination in addressing high dependency care needs and risks. Agencies appeared to practice within specialist areas and largely in isolation.	Develop multi-agency trigger for reassessment of high dependency care needs and risks, via a communication protocol, and possibly using an agreed needs and risk matrix.	Development of communication protocol, briefings to staff, monitoring via SAB.	SAB	To be confirmed by SAB.	Completed. Actions taken by individual agencies including central and Cecil, HRCH and LBRUT have resulted in increased staff awareness on appropriate ways to manage complex cases. The SAB will not be undertaking individual management of the implementation of these protocols but will be monitoring through the quality assurance	Completed

AGENCY	LEARNING POINTS	ACTIONS	EVIDENCE	LEAD OFFICER	TIMEFRAME	PROGRESS	RAG Status
						framework.	
Central & Cecil Housing Trust- The care home	The care home should have requested a continuing care assessment at an earlier stage, and potential transfer to a nursing home, in view of the significant deterioration.	Clear procedure to request continuing care assessment when aware of high dependency nursing needs and difficulty in providing care.	Monitoring by Quality Assurance Team via validation visit before the end of July 2016 and then annually; also, linking with CQC inspection when arranged.	Housing Manager Care home Manager	July 2016	Completed by LBRUT Quality Assurance team in July and part of usual practices. To be evidenced	completed
Central & Cecil Housing Trust- The care home	The care home should have escalated the concern to District Nursing on the delay in completing the continuing care assessment; and to Occupational Therapy on raising concern about meeting the recommended staffing requirements at night.	The care home – clear procedure to escalate concerns about agency responses.	Monitoring by Quality Assurance Team as above.	Housing Manager Care home Manager	ASAP	Escalation procedure introduced and shared with other providers	Completed
Central & Cecil Housing Trust-	The care home should have	The care home – CCTV installed in	Monitoring by Quality Assurance	Housing Manager	Completed	All actions introduced as part	Completed

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The care home	ensured management oversight of practice standards, including that checks on residents at night were completed.	communal areas and regularly checked for compliance with caring responsibilities. Ad hoc monthly night checks by senior managers. Improved permanent staff recruitment and induction with increased emphasis on staff values. Prioritisation of supervision and appraisals. Emphasis on continuity of staff and induction of unfamiliar agency staff. Nurses call system installed in resident's rooms to record presence of carer electronically. Night staff and senior staff	Team as above.	Care home Manager		of safeguarding adult's enquiry response	

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		checklists and floor walking checklist. Senior management sign-off on night check observation					
Central & Cecil Housing Trust- The care home	The care home should have ensured that care plans, risk assessments and recording were up to date and that staff were familiar with care needs via induction, handover and communication; also, checked with external agencies on changes to the care plan regarding positioning in bed.	Monthly resident of the day and review of care plan. Review of residents' care plans to ensure that they contain current care requirements and weekly auditing of care plans – part completed. Familiarisation with care plan and any changes both on induction of new staff and during handover between day and night shifts Improved factual recording by staff.	Monitoring by Quality Assurance Team as above.	Housing Manager Care home Manager	ASAP	All actions completed as part of safeguarding adults' enquiry response, except review of care plans. Quality Assurance Team verified this care plans have all been reviewed.	Completed
Central & Cecil	The care home	Completion and	Monitoring by	Housing	Confirmation to	Confirmation by	Completed

AGENCY	LEARNING POINTS	ACTIONS	EVIDENCE	LEAD OFFICER	TIMEFRAME	PROGRESS	RAG Status
Housing Trust- The care home	should have ensured that staff are trained to an appropriate level regarding skin integrity and positioning in bed.	evidencing of training to all permanent staff.	Quality Assurance Team as above.	Manager Care home Manager	QA Team of training arrangements by July 2016	LBRUT Quality Assurance Team on staff training completed	
HRCH	The District Nursing Service should have placed an out of office message and checked the emails of the departing District Nurse, in the absence of handover capability.	Out of office and checking emails of staff leaving or absent for prolonged periods.	Evidence of procedure and briefings to staff.	Safeguarding and Operations Lead HRCH	30/06/16	A briefing has been provided to HRCH. An Email was sent on 25th July to all District Nurse Service managers with instructions to cascade to team leaders. Managers will ensure that this is embedded in practice by all responsible team leaders.	Completed
HRCH	The District Nursing Service should have monitored the progression of the continuing care assessment and addressed the delay, in liaison	Clear SAB and CCG procedure on monitoring continuing care assessments, overseen in practice by HRCH as part of continuing health	Evidence of procedure and briefings to multi-agency staff.	SAB	To be confirmed by SAB.	CCG have changed the responsibility for how continuing health care assessments are carried out and the assessment role is now being	Completed

AGENCY	LEARNING POINTS	ACTIONS	EVIDENCE	LEAD OFFICER	TIMEFRAME	PROGRESS	RAG Status
	with partner agencies.	care assessment role.				undertaken by HRCH. There is a clear mechanism for managing referrals and decisions which has been shared with all staff. This is a new arrangement which commenced in July 2016. No further action required.	