Worcestershire Safeguarding Adults Board

JOSEPH
(Pseudonym assigned by family)

A Safeguarding Adults Rapid Review Report

V7 FINAL

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Version	Date	Changes
1	16/02/2023	First draft
2	04/04/2023	following family engagement
2.1	05/04/2023	Typos corrected
V3	30/05/2023	New information Post Learning Event
V4	14/06/2023	Amends Following LE consultation
V5	20/06/2023	Amends following SC comments
V6	02/08/2023	Amends following subgroup comments and family feedback.
V7	25/09/2023	Typos and amends? following Board virtual signoff

1. INTRODUCTION

1.1. Joseph was admitted to Hospital from a Nursing Home and died the following day from aspiration pneumonia. An inquest was held, and the Coroner was concerned about the care provided issuing a Regulation 28: Report to Prevent Future Deaths[1].

1.2. The Regulation 28 report stated that:

> *Prior to Joseph's admission he had been a resident at the Nursing Home, nine days prior to his admission. He was admitted to hospital in a critical condition with erratic respiratory function and multi-organ disfunction. He was known to suffer from moderate dysphagia amongst other conditions. The aspiration pneumonia was in all probability acquired whilst he was resident at the Nursing Home.' (Redacted version)*

1.3. The Coroner listed the concerns within the report.

1.4. As a result of the Regulation 28 Report, the following action was taken:

- Quality Assurance Teams From the Integrated Care Board and the Local Authority carried out a visit; improvement plans are in place and are monitored.
- An enquiry into Organisational Abuse was undertaken into the care at The Nursing Home; the outcome of the enquiry was Partially Upheld.

1.5. A recommendation from the organisational abuse enquiry was for a SAR Referral to be made.

2. PROCESS AND SCOPE

2.1. On receipt of the referral for a SAR, scoping information was requested from involved agencies. A Rapid Review meeting assessed the information available, resulting in a decision that the criteria was met for a mandatory SAR. The learning obtained and discussed within the Rapid Review meeting suggested that there was sufficient information to be able to produce a learning report, for rapid dissemination.

2.2. The areas highlighted by the coroner were being managed through other processes and would therefore not be part of the review. How agencies worked together to safeguard and provide best care possible were however to be part of the review.

3. FAMILY INVOLVEMNT IN THE REVIEW

3.1. A key part of undertaking a SAR is to gather the views of the family and share findings with them. The Rapid Review Chair informed the family of the review following the Rapid Review Meeting. The Rapid Review Chair and the SAR subgroup chair met with a family member and a person in a support role. The views and details regarding their family member is included throughout this report where appropriate to the learning. The author is grateful for the helpful insights from them that have supported this review.

4. BACKGROUND

[1] https://www.legislation.gov.uk/ukpga/2009/25/contents

4.1. Very little information was available to the Rapid Review meeting regarding Joseph. It was known, however, that he had multiple comorbidities and that as he advanced in years, he became very frail and unwell. Joseph was having an increasing number of falls into the review period and there were concerns regarding fluctuating mental capacity and Joseph not wanting to receive appropriate care on occasions.

4.2. The meeting with the family elicited the following information about Joseph and his life. Joseph was divorced from his wife when he had young children but maintained contact with them and had regular outings with them. Joseph had his own painting and decoration business and was described by a family member as a 'jack of all trades' being able to turn his hand to most handyman jobs.

4.3. Joseph suffered from a stroke when he was only 31 years old. This had an impact on his ability to work. Following a lengthy period of rehabilitation, he recovered well but was left with a slight speech impediment and walked with a stick. He never worked again.

4.4. Joseph enjoyed spending time with his family and following the purchase of a motorised scooter, he enjoyed many outings with them. Joseph's family member described him as a practical joker and was described as thinking that he was 'The Stig' from Top Gear when on his scooter. Joseph was reported to be also stubborn and fiercely independent.

4.5. Joseph had further transient ischaemic attacks (TIAs) [2] and developed COPD[3] but managed independently in his flat for many years.

4.6. Joseph had multiple accident and emergency attendances some of which led to hospital admissions. When discussed in the Rapid Review meeting, all of these were thought to be appropriate given his level of physical health problems.

4.7. Despite being initially reluctant, Joseph had a package of home care for some time. As his needs increased, he moved into residential care 20 months prior to his passing. Following a further hospital stay Joseph moved to a care home nearer to his home to be closer to family. This was 8 months prior to his death. During that time Joseph stayed within that residential care placement and received the services of multiple teams to address his physical health needs as well as services from the GP practice. Joseph's frailty and falls were increasing, and he was struggling to manage his self-care. He was admitted to hospital after a fall, then being discharged to a discharge to assess (DTA)[4] bed. It was from here nine days later that Joseph was admitted to hospital and died the next day.

4.8. Joseph had NHS Continuing Health Care CHC assessments[5]. Initially he was admitted to the first care home under the terms of the Covid discharge process. When this was reassessed following the

[2] A **transient ischaemic attack (TIA)** or "mini stroke" is caused by a temporary disruption in the blood supply to part of the brain

[3] **Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties.** It includes:

- emphysema – damage to the air sacs in the lungs
- chronic bronchitis – long-term inflammation of the airways

[4] **DISCHARGE TO ASSESS** Where people who are medically fit for discharge and do not require an acute hospital bed but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

[5] Some people with long-term complex health needs qualify for free social care arranged and funded solely by the NHS. This is known as **NHS continuing healthcare**.

return of CHC assessment processes, Joseph was assessed as meeting the criteria for funded nursing care. A Fast Track referral was discussed but deemed not appropriate at the time. There was then a further Fast Track referral when community nurses recognised, he was approaching end of life. This was then cancelled as Joseph was admitted to hospital where, on discharge he was deemed as not for Fast Track but for referral for CHC assessment. Joseph was moved to a DTA bed in Care home 3. The final CHC assessment was not undertaken due to Joseph passing before it could be commenced.

5. FINDINGS AND LEARNING

Understanding the person; improving communication

5.1. Not all attendees at the learning event felt that they understood Joseph as well as they would like. This was particularly the case for visiting professionals who have large caseloads and are required to undertake the nursing and therapy tasks without the time that historically nurses and therapists would have had to get to know their patient. It is of note that visiting professionals do not always get to know families as they are not present at the time so do not find out about the person from them.

5.2. Care home staff do get the opportunity to know a person's history and the assessment documentation the local authority uses also contains valuable information about a person's history. Joseph was known to be fiercely independent and had struggled to come to terms with requiring a care package at home and then care in residential settings. Community staff who visited said that they took cues from photographs in Joseph's room to strike up a conversation in order to build a rapport and relationship with him as they were aware that Joseph had a general distrust of nurses. It appears that because of the efforts to engage Joseph that he did allow them to carry out dressings as required and very seldom refused care with some staff. Community visiting staff also recognised that were there were consistent carers in the care homes, that was helpful for them in finding out what a person is like and how best to approach them in terms of offering assessments and care.

5.3. When talking to professionals during learning events since the Covid pandemic, the author has heard of many issues; some of these are recorded later in this report. However, the attendees at this learning event noted many improvements as well, some as a direct result of Covid and some due to ongoing improvement in systems. Attendees were very clear that due to the need to spend as little time as possible in care homes, many community nursing teams were able to contract with care homes to provide some of the care that nurses previously would have. The community nursing teams provided additional training for care home staff to support their ability to apply basic dressings. This helped reduce the footfall of community nursing team staff attending the care homes but maintained clinical standards in wound care. This was done by using photographs and video technology so that nurses could advise on appropriate care. Community nurses have commented that this had improved their working relationship with care homes in general.

5.4. Another improvement that has had a positive impact is the use of the Frailty team as a conduit between GPs and care homes providing support managing long term conditions. The frailty team consists of advanced nurse practitioners and was in its infancy at the time that Joseph was a

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1087562/National-Framework-for-NHS-Continuing-Healthcare-and-NHS-funded-Nursing-Care-July-2022-revised.pdf

resident. This team has since been expanded and is providing an improved service more recently. There is one element though that has had a negative impact. Those residents that have known their GP for a long time or who have the generational experience of the doctor being the person who could respond appropriately to medical issues and be their prescriber, are having more difficulty accepting this newer system. Therefore, more work needs to be done to support people to understand that they do not always need to see a GP and to build faith and trust in Advanced Nurse Practitioners.

5.5. It is of note, however that there is a continuance of some barriers to communication with several IT systems in place for people such as Joseph. Whilst there have been some improvements in that staff in other agencies (notably the Health and Care NHS Trust) can have some access to the Adult Social care recording system, even after training access codes are not being gained as a sponsor is needed from the local authority which is reported to be problematic. There is now a shared care record that has been developed that staff should use; it will be important to ensure that professionals are all aware of this.

5.6. Further IT system issues noted are in terms of the change of community neighbourhood teams now recording on GP systems rather than the Health and Care NHS Trust. Whilst this has improved the communication with GP surgeries and is generally seen as a positive step, the nursing module is noted to be more akin to acute hospital nursing and does not have the fields to input that would be more relevant to community nursing teams.

Learning:

- Information that is available regarding care home residents' history is of use to visiting professionals.
- More support is needed for care home residents to understand the role of an advanced nurse practitioner.
- Systems are needed to ensure that there are ways for visiting professionals to understand the history of the person they are working with.
- People in receipt of services would benefit from communication barriers for professionals using IT systems to be resolved. This may include ensuring that all staff are up to date with current shared systems.

Assurance of quality of care in care homes

5.7. The initial referral for a SAR came as one of the recommendations from the organisational abuse enquiry into care delivered to residents in Care Home 3. During the Rapid Review meeting this was discussed at length.

5.8. The care in care home 2 was also discussed.

5.9. The meeting agreed that as there was an ongoing improvement plan and that the Care Quality Commission as regulator of the home, had been involved in the enquiry, that there was no further need for additional analysis or recommendations within this review.

5.10. There was, however, one element that had come to light which continued to cause concern, and that was the fact that there had been no registered manager in place for some time within Care Home 3. When this had been queried with CQC, it was highlighted that gaps in managers are permitted. The meeting queried where the accountability for nursing then lies particularly where the owners of a nursing home are not registered nurses. The learning event attendees discussed this, and it is apparent that there is always a need to have a nurse on shift to meet the nursing needs of residents in a nursing home. Care Home 3 stated that they now also have a senior clinical lead in place, as is good practice. This was not in place at the time that Joseph was resident; the nurse on shift when Joseph became unwell, was an agency nurse which is not ideal but does meet CQC minimum requirements.

5.11. During the learning event, it appeared that there was confusion regarding addressing quality concerns, particularly where the threshold for a s42 enquiry might not be reached. It was noted that, professionals are not always hearing about the outcome of their referral and this was thought to be due to the impact of the increase in the numbers of safeguarding concerns being reported since 2019. This led to a list of enquiries waiting to be allocated. There is now a process in place to inform the referrer of the outcome of decision making even if there is a delay in progressing an enquiry.

5.12. There are two elements here; the system of safeguarding referrals may be swamped if quality issues are all referred as safeguarding issues. On the other hand, though, there needs to be a way of ensuring that issues escalated internally within a care home and its management company are also recorded within the local authority to ensure that where there maybe multiple quality issues that they are recorded so that patterns and trends can be addressed. It was suggested that the right place to raise an issue first is with the Care Home manager. If this is not responded to appropriately then the governance/management within any umbrella care home company should be notified. At the same time the Quality Assurance Team within the local authority should be notified. Issues of concern that constitute abuse or neglect should always be referred as safeguarding issues. It was acknowledged that there are times where concerns highlighted early and dealt with promptly within a care home, that this can prevent escalation to abuse and neglect. Where issues are known to quality assurance teams (local authority or Integrated Care Board) there are processes to share information as appropriate to the level of concern and agree what action is required.

Learning:

- When concerns come to light from whatever source regarding care delivered in care homes, the care home manager and where necessary the Care Home management company should be notified.
- Where concerns are not responded to or the concern is such that it constitutes a safeguarding issue, alerts should be raised with safeguarding and the Quality Assurance Teams within the local authority and, in the case of a nursing home, with the ICB quality assurance team.
- Concerns regarding quality of care should also be raised with the CQC.
- Accountability for nursing care in a home registered for nursing care should be clarified where there is no registered manager and there is no other person in a senior nursing position.

Discharge to assess and other placements/funding for care.

5.13. On occasions Joseph was discharged to community hospital settings for further rehabilitation home. These placements appeared to be good and achieved their intended outcome.

5.14. Joseph was assessed 8 months before his death (following reinstatement of CHC following Covid) as not eligible for full NHS CHC Funding but eligible for Funded Nursing Care. This was whilst he was resident in a care home offering nursing care (Care Home 1) which was part of the discharge to assess package of care. On a further admission to hospital due to needing review and treatment for one of his medical conditions, he was discharged to Care Home (2) to be closer to family. This Care Home did not offer nursing care. At this point it was recognised by those at the learning events that Joseph's needs for nursing care were low level and could be met within a residential setting. Joseph's wish to move to a setting nearer home and his requirement for social stimulation were seen as priority needs for him at that time which is good practice.

5.15. On two occasions Joseph was discharged from hospital using the discharge to assess system. The use of discharge to assess placements has several functions. Firstly, it allows a solution to the delay in ability to discharge people from hospital who have been optimised for discharge, but the next stage of their care has not yet been organised thereby improving the flow of patients through acute hospital settings. Secondly it allows for a person to be assessed in a more suitable environment away from the acute hospital. Both of Joseph's discharges to discharge to assess beds were appropriate at the time. Linked into these placements were the referrals for which system would be used for assessing Joseph's ongoing needs.

5.16. It is of note that the system now for assessing needs following an acute hospital admission has changed, with Care home DTA only used when hospital pressures increase to Level 4[6]. On all other occasions the Intensive Assessment Rehabilitation process is now embedded, with patients being discharged to community hospitals for ongoing assessment of their needs and placements in settings that can meet those needs.

5.17. There were several discussions and apparent confusions regarding the need to use the Fast Track[7] pathway for NHS Continuing Health Care funding. Initially, 2 months prior to Joseph's last hospital admission, Care Home 2 were seeking clarity as to whether he was eligible for Fast Track. At this stage there were various discussions between nurses, social workers and the GP that suggested that Fast Track funding was not appropriate as Joseph was still mobilising and felt that his needs could still be met within the Care Home with risk assessments in place.

5.18. A week later, a community nurse reviewed Joseph and agreed that his history, increasing frailty, weight loss and very poor appetite, alongside his now refusing some care, led to the belief that Joseph was approaching end of life and a Fast Track application was completed. The nurse completing this assessment did not know about the previous fast track discussions. Joseph was then

[6] Operational Pressures Escalation Levels Framework. https://www.england.nhs.uk/wp-content/uploads/2019/02/operational-pressures-escalation-levels-framework-v2.pdf

[7] The Fast Track pathway is used for people with a rapidly deteriorating condition who may be entering a terminal phase and may require 'fast -tracking' for immediate provision of NHS continuing healthcare.
The intention of the fast-track pathway is that it should identify individuals who need to access NHS continuing healthcare quickly with:

- minimum delay
- no requirement to complete the checklist or the DST

admitted to hospital and so that application was put on hold. On a visit to the ward by the hospital social worker, ward staff stated that Joseph was not presenting as at the end of life and therefore fast track was not appropriate.

5.19. It was known that Joseph was increasingly frail, had been diagnosed with a cancer, had lost 20Kg in weight in the seven months he had been in care home 1, had multiple falls with several fractures. A later fall had caused a severe and fragmented clavicle that Joseph was not able to understand needed to be still to heal and caused excessive pain. Joseph was also at risk of aspiration. He now needed nursing care and was discharged to Care Home 3 not on a fast-track basis but for standard NHS CHC assessment. This was not completed before he passed away. The family member agreed that Joseph was becoming increasingly unwell and that he was approaching end of life; the weight loss was evident in the photographs shown when the author met with them.

5.20. During the Rapid Review meeting it was felt that albeit it had been deemed that fast track was not appropriate, it did appear that Joseph was approaching the end of his life and that with the right end of life plan in place he may have enjoyed a more peaceful end to his life. The Rapid Review meeting felt that there was no general overview from all of the professionals who had been involved. Consideration could have been given to a more robust view of all of Joseph's care needs via a multi-agency discharge meeting that included representation of Joseph's wishes and feelings or a Best interest decision if he lacked capacity, which would have included consultation with the family.

5.21. In that way it may have been that his final placement to the discharge to assess bed could have led to fast-track assessment with an appropriate end of life care plan, rather than awaiting a standard timescale CHC assessment that did not take place before he had developed aspiration pneumonia and died.

5.22. The author would suggest that the spirit of the Fast Track pathway was not applied. The Fast Track Guidance states that the only criteria for fast track are that a person has a rapidly deteriorating condition and that they MAY be entering a terminal phase. The guidance also states that strict time limits that base eligibility on a specified expected length of life remaining should not be imposed:

- 'rapidly deteriorating' should not be interpreted narrowly as only meaning an anticipated specific or short time frame of life remaining; and
- 'may be entering a terminal phase' is not intended to be restrictive to only those situations where death is imminent.

5.23. This issue was discussed within the learning event to understand from the professionals that had worked with Joseph why there had been no effective fast track application. There were several areas for learning that were highlighted. The first was that there is often confusion as to what 'Fast Track' actually refers to. In the chronology there was reference to the CHC checklist being completed in the care home. This would be for standard NHS CHC assessment and not a fast-track pathway as there is no requirement to complete a checklist for a fast-track application. This action was possibly due to the first discussions not resulting in a fast-track application.

5.24. There was also a belief that some professionals did not understand the Fast Track process, either because they are not aware of it or because they believe that there is a timeframe within which

death is expected. It was quoted at the learning event that death must be expected within the next six weeks. That is not the case and therefore leads to learning.

5.25. The learning here is borne out by a social worker who had worked elsewhere with similar issues and a specialist resource website that provides advice for those with families who need to navigate the NHS CHC funding system[8]. This would indicate that this is more of a national issue than just a local one.

Learning:

- All professionals involved in the care of a person with multiple care needs and a terminal diagnosis should have an overview as to whether end of life may be approaching.
- Whilst fast track applications are required to be made by an appropriate clinician, the views of those who know the person best, including the person and their family and carers may be consulted.
- The Fast Track Process and guidance needs to be understood by those who are likely to be caring for people who are approaching end of life.

Quality of recording and reviewing Multi-Disciplinary Team (MDT) meetings

5.26. It was noted by the GP practice, within the chronology for the Rapid Review meeting, that an MDT meeting was undertaken.

5.27. MDT meetings are an extremely good example of bringing different professionals together to discuss the needs and care of a person. What needed to happen at this point was an effective MDT that drew together all professionals to share information regarding the best ways forward with Joseph's care given the number of increasing falls and other physical health conditions.

5.28. It is not entirely clear from the information presented to the review, what the purpose of the meeting was and who was present. The recording states that Joseph had capacity to make his own decisions (see next section). If the reason for the meeting had been clear and the attendance noted with meeting recorded and minutes shared, there would have been clarity regarding the outcomes and the ability to review care robustly.

5.29. This issue has been raised in another review recently, therefore leads to learning to improve this good practice so that it is robust.

[8] Fast Track funding is not only for end of life. https://caretobedifferent.co.uk/continuing-healthcare-fast-track-assessments-how-to-get-a-quick-decision/#:~:text=Essentially%2C%20the%20Fast%20Track%20allows,authority%2C%20i.e.%20the%20care%20they

Learning:

- MDT meetings are an effective way to share information and collaborate on assessment findings and care planning.
- Effective MDTs need to be recorded to allow robust information sharing and follow up.

Mental Capacity and Cognitive impairment.

5.30. Records studied and reviewed for the Rapid Review meeting mention that there were ongoing debates regarding whether Joseph had any cognitive impairment indicating a possible dementia. In order to understand the Mental Capacity of a person to make their own decisions, it is necessary to understand if there is any cognitive impairment and to what extent that may be impacting on the person's decision making.

5.31. It was recorded over most of the period under review that Joseph often refused personal care and other nursing and care interventions. Joseph was also not able to always follow instruction regarding safely mobilising leading to some of his falls. In some people, capacity may fluctuate and that can be the case in the early stages of dementia or indeed due to medical reasons e.g., infection. Research suggests that COPD can also have an impact on cognitive functioning and that reasons are multi-faceted[9] [10]. Joseph also had a diagnosis of cancer that could have resulted in secondaries within the brain that were impacting on cognition. It was noted in his final hospital admission that that there had been a severe cognitive decline.

5.32. It is of note that some community nurses were able to encourage compliance with treatment when Joseph was in Care Home 2 by taking time to gain confidence and trust in building a rapport and distracting by talking about subjects that Joseph liked to talk about e.g. his grandchildren.

5.33. In order to understand if a person does have capacity to make a specific decision, there needs to be an assessment of that capacity based on the decision that the person is required to make.

5.34. The first mention regarding cognitive impairment was 18 months before Joseph died when he was still living at home but had been admitted to hospital. A Family member was also expressing concern regarding Joseph's cognition at this time and gave clear examples to the author of where this was evidenced.

5.35. The concerns with cognitive impairment did not go away, there were mini mental state examinations carried out on two occasions once by a doctor in a rehabilitation placement and once by an occupational therapist. Both were noted to be at low levels indicating impairment at the time of the assessment.

[9] K. J. Greenlund, Y. Liu, A. J. Deokar, A. G. Wheaton, and J. B. Croft, 'Association of chronic obstructive pulmonary disease with increased confusion or memory loss and functional limitations among adults in 21 states, 2011 behavioral risk factor surveillance system', *Prev Chronic Dis*, vol. 13, no. 1, 2016, doi: 10.5888/pcd13.150428.

[10] L. Schou, B. Østergaard, L. S. Rasmussen, S. Rydahl-Hansen, and K. Phanareth, 'Cognitive dysfunction in patients with chronic obstructive pulmonary disease - A systematic review', *Respiratory Medicine*, vol. 106, no. 8. pp. 1071–1081, Aug. 2012. doi: 10.1016/j.rmed.2012.03.013

5.36. To fully understand cognitive impairment, people showing cognitive deficits are referred to specialists working in multi-disciplinary teams within a memory clinic. No such referral was made. When this was discussed within the learning event, it was discerned that the memory service was not running at the time that Joseph was assessed. Referrals could have been made as the waiting list was open, but it is not clear if at the time that staff thought that with no appointments that referrals could not be made.

5.37. With no referral or diagnosis of or considerations of a possible impairment of the mind or brain (a prerequisite to undertake a mental capacity assessment), it appears that recorded Mental Capacity assessments were few and far between. What should have happened was that at each point that there were concerns regarding not following instructions for safe mobility, level of care packages needed or non-compliance with care, an assessment of capacity should have been undertaken given the previous concerns regarding cognitive impairment. There are various recordings regarding mental capacity. Several of these state 'has capacity'. This does not show an understanding that the assessment of mental capacity is decision specific and not a generalisation regarding having or lacking capacity. There was one occasion, when Joseph was to be discharged to a DTA bed, where a best interest decision was being discussed regarding the discharge. This can only happen if there is evidence that the person lacks capacity regarding that decision. Again, there is no record of mental capacity assessment being undertaken.

5.38. These issues have been raised in other reviews locally and will need to be addressed via the recommendations of this review. It appears that Joseph's ability to make decisions was not addressed by and understanding of his cognitive ability alongside an assessment of his capacity to make the decisions regarding keeping himself safe that he was required to make. If mental capacity assessments were being undertaken, then they were not recorded appropriately.

Learning:

- Where there are concerns regarding a person's cognitive ability, it is necessary to understand the reasons behind that concern in order that appropriate diagnostic, support services and treatment (if of treatable cause) can be provided.
- The recording of mental capacity assessments provides rationale for the reason a practitioner states or concludes that person has capacity. This is particularly important where cognitive impairment is being questioned.
- Mental Capacity assessments are decision specific and are not an overall statement regarding a person's presentation and decision-making ability.

6. Summary and Conclusion

6.1. Joseph was a gentleman who had considerable co morbidities. Practitioners found it difficult to provide care for him as his needs increased. This appeared to be due to not being able to understand Joseph's mental capacity and if he had a cognitive impairment.

6.2. Despite these difficulties there was evidence that many systems were working well, and some of those that were not, are now improved and working better to improve care for those in receipt of services.

6.3. Following a diagnosis of cancer alongside his other medical conditions, however, Joseph was not considered as approaching end of life when decisions were being made regarding DTA placements. Fast Track applications for NHS CHC funding were not deemed to be appropriate, as he was 'still up and mobile' despite the concerns of the practitioners who worked with him closely who did believe that was an appropriate assessment based on their view that he was approaching end of life.

6.4. This resulted in a routine CHC assessment having not commenced prior to his death. Joseph had the right to be nursed in an appropriate placement with a personalised end of life care plan to ensure his dignity and wishes and those of his family were respected and he enjoyed a peaceful end to his life.

7. RECOMMENDATIONS TO IMPROVE PRACTICE.

1. Understanding the person; improving communication

WSAB should ask Care Homes to make available passport style 'This is Me' document to add into a resident's room to be available to visiting professionals. Consideration should be given to uploading this to EMIS to be available for Neighbourhood Teams. (Direct work with the individual)

WSAB should ask that the ICB provides information regarding the role of the Advanced Nurse Practitioner in an easy read format that can be shared with Care Homes that they visit in order that residents have greater understanding of the role. (direct work with the individual)

WSAB should seek assurance from agencies that the use of the shared care record is promoted, and that staff are aware of and can access the system. (Interagency Team around the individual)

WSAB should seek assurance from HWHCT that those with responsibility for updates to EMIS community system templates are aware of any gaps in templates for community nurses and complete a relevant request for development. (Organisational support around the team)

2. Assurance of quality of care in care homes

WSAB should provide guidance to staff who visit care homes so that they understand the pathways for raising concerns of a quality nature where a safeguarding referral is not initially required. (Interagency Team around the individual)

3. Discharge to assess and other placements/funding for care.

WSAB should require that organisations provide clear guidance that is based on the NHS CHC framework that dispels myths to staff and any required regarding the Fast Track pathway for NHS CHC funding. Information should also be made available to the public who may require support. (Organisational support around the team)

4. Quality of recording and reviewing Multi-Disciplinary Team (MDT) meetings

Following two SAR Rapid Reviews with the same learning, WSAB should seek assurance from the ICB

that GPs are alerted to the learning from these SARs. Learning suggests that attendees and outcomes regarding MDT meetings within Primary Care Networks are recorded as a minimum. This will evidence defensible decision making. (Organisational support around the team)

5. Mental Capacity and Cognitive impairment

WSAB should publish further communication, preferable in video format, with the learning from this review regarding continuous recording of 'has capacity' with no other explanation or assessment conducted, particularly in cases where cognitive deficit has been suggested and/or compliance with care is of concern. (Direct Work with the Adult, Legal policy and financial context of adult safeguarding)

Appendix One: Terms of Reference and Scope

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

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

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and SAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

5.1. Joseph was admitted to Hospital from a Nursing Home and died the following day from aspiration pneumonia. An inquest was held, and the Coroner was concerned about the care provided issuing a Regulation 28: Report to Prevent Future Deaths[11].

5.2. The Regulation 28 report stated that:

> *Prior to Joseph's admission he had been a resident at the Nursing Home, nine days prior to his admission. He was admitted to hospital in a critical condition with erratic respiratory function and multi-organ disfunction. He was known to suffer from moderate dysphagia amongst other*

[11] The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 Report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths.

conditions. The aspiration pneumonia was in all probability acquired whilst he was resident at the Nursing Home.' (Redacted version)

5.3. The Coroner listed the concerns within the report.

5.4. As a result of the Regulation 28 Report, the following action was taken:

- Quality Assurance Teams From the Integrated Care Board and the Local Authority carried out visit; improvements plans are in place and are monitored.
- An enquiry into Organisational Abuse was undertaken into the care at The Nursing Home; the outcome of the enquiry was Partially Upheld.

5.5. A recommendation from the organisational abuse enquiry was for a SAR Referral to be made.

3. Decision to hold a Safeguarding Adults Review

3.1. The SAR referral was received in December 2022. Initial scoping information was gathered, and a Rapid Review meeting was held on 15th February 2023, chaired by an independent Rapid Review Chair. Members of the Case Review Subgroup and invited guests who had been involved with the care of Joseph attended. After hearing all of the information It was agreed that the criteria for a mandatory Safeguarding Adults Review were met. It was agreed that the information that had already been gathered was sufficient to identify multi agency learning. It was therefore agreed that a Rapid Review Report would be written. The WSAB Independent Chair endorsed that decision.

4. Scope

The review will cover key issues for learning between April 2020 to December 2021.

5. Method

5.1. The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

5.2. WSAB chose to use a methodology that uses the information gathered and discussed in the Rapid Review meeting to formulate a Rapid Review Report in order that learning could be disseminated promptly.

6. Key Lines of Enquiry to be addressed

Learning will be related to the key learning identified from the Rapid Review Meeting

6.1. Mental Capacity and Cognitive impairment

- To what extent were concerns regarding cognitive deficit followed up
- Was there clarity regarding the impact of any cognitive impairment on mental capacity.
- How was any cognitive impairment understood in terms of fluctuating capacity?
- What would have worked well regarding this issue.

6.2. Discharge to assess placements

- How were various DTA placements assessed in terms of need of Mr Joseph at the time?
- How was his increasing frailty and deteriorating physical health considered in terms of his requirement for care?
- How robust is the transfer of medical information to GPs contracted to provide medical care to care homes who are commissioned to provide discharge to assess beds.

6.3. Quality of recording and reviewing MDT meetings

- How robust is the MDT meeting process within GP practices?
- Who is invited to GP MDT meetings?
- How are decisions, actions and review recorded?.

6.4. Pandemic Impact

Following the national response to the Covid- 19 pandemic, please analyse the impact on Mr Joseph of any changes to services and/or practice.

6.5. Assurance of quality care in care homes

- How assured can the WSAB partners be regarding the quality and safety of care delivery within care homes?

6.6. Good Practice

- Ensure examples of good practice are evidenced.

7. Independent Reviewer and Chair

The named independent reviewer commissioned for this Review is **Karen Rees.**

8. Organisations involved with the review:

- County Council Adult Social Care
- Acute Hospitals NHS Trust
- Health and Care NHS Trust
- ICB for GP
- ICB CHC Team

- Care Home 1
- Care Home 2
- Care Home 3

9. Family Involvement

A key part of undertaking a Safeguarding Adults Review is to gather the views of the family and share findings with them prior to finalisation of the report. Contact is underway with Mr Joseph's daughter and arrangements will be made to include her in the review.

10. Media Reporting

WSAB will prepare a media statement which must not be varied from without the specific authorisation of the Chair of WSAB's approval. During the SAR process any enquiries from the press in relation to the SAR are to be passed to the WSAB Coordinator.

11. Publishing

It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

Reference to the adult in the report may be anonymised further prior to publishing. This will be following consultation with the adult/family and time allowed to reflect on how they would like the adult to be referred to.

The media strategy around publishing will be managed by the Community Awareness and Prevention subgroup of the WSAB and communicated to all relevant parties as appropriate

Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered, and that staff are aware in advance of the intended publishing date

Whenever appropriate an 'Easy Read' version of the report will be published.

12. Administration

It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via a secure e-mail account. Failure to do so will result in data breach.

The Board Co-ordinator will act as a conduit for all information moving between the Chair, Author and the Case Review subgroup.