Bedford Borough and Central Bedfordshire Safeguarding Adults Board

Report of the Serious Case Review Panel into SCR 3 (Mrs B)

1 Background

1.1 Mrs B was admitted to Bedford Hospital on 10 May 201, with a suspected stroke. Examinations revealed that she was suffering from advanced stage cancer and given a poor prognosis, it was decided that she would be provided with palliative care. It was arranged that this would be provided in a local nursing home, where her husband had been admitted when Mrs B was taken into hospital. She had been his carer, as he suffered from dementia. She was admitted to the same care home on 1 June 2011 and died there on 4 June 2011.

1.2 The family and some professionals, raised concerns about the care that Mrs B had received and a safeguarding investigation was commenced on 8 June 2011. The local procedures identify four possible outcomes to a safeguarding investigation and these are

- Not substantiated
- Not determined/inconclusive
- Partially substantiated
- Substantiated

The outcome of the safeguarding investigation in Mrs B's case, was 'not determined/inconclusive' and a recommendation was made to the Safeguarding Vulnerable Adults Board, that they consider commissioning a Serious Case Review, in order to give further consideration to the circumstances of Mrs B's care. Having considered the findings of this investigation, the Safeguarding Vulnerable Adults Board (SOVA) decided that the concerns were sufficient to meet the criteria for a Serious Case Review, as defined in the Bedford Borough and Central Bedfordshire Safeguarding Adults Board multiagency policies and procedures, in particular that Mrs B may have experienced

- Sustained serious and permanent impairment of health or development through abuse, maltreatment or neglect, and
- The case gives rise to concerns about the way in which local professional and services work together to safeguard and promote the welfare of adults at risk

The Board therefore decided that a Serious Case Review (SCR) should be undertaken and it was commissioned in November 2011. This report provides the summary findings from that Serious Case Review.

1.3 The purpose of the Serious Case Review is not to investigate how Mrs B died, nor to identify a culpable individual. The SCR is a learning process and is intended to

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of adults at risk
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result, and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of adults at risk

2 Conclusions

2.1 Mrs B was terminally ill and in the end stage of her life. This SCR has not therefore been considering whether her death was avoidable. The matter for consideration has been whether she was provided with appropriate care at the end of her life. This has been discussed in detail, using the framework of the questions posed by the SOVA Board.

2.2 Whilst there was a common view that responsibility for providing the information that would inform the care arrangements after Mrs B's discharge and also the responsibility for making the discharge arrangements lay with the hospital, there was not complete clarity about the overall leadership and accountability for the detailed elements and this led to some differences in expectations. Consequently, it was not clear who had the overall lead responsibility for taking the overview of the forward arrangements for Mrs B's care and their successful implementation, although in practice, the Discharge Coordinator took the lead in making the practical arrangements for Mrs B's discharge from hospital.

2.3 There was no shortage of activity and communication in this case, much of it done on a one to one basis and by telephone. However, feedback to key parties was not always provided and conversations were not always well documented, well coordinated or subject to the same understanding by all concerned. Consequently the various activities and communications were not effectively consolidated into a common view.

2.4 Recording was not always consistent within and across the agencies. Some important documents were not provided, not available at the time that would have been of most benefit, or were incomplete. There were also differing expectations within and across agencies, as to whether colleagues form other agencies should make entries into each other's ongoing records.

2.5 Mrs B was in the end stages of her life and despite the anticipated decline, there was no multidisciplinary care planning meeting involving all the relevant agencies

outside the hospital and linked disciplines, and no documented and anticipatory care plan (whether LCP or otherwise) including no documented anticipatory pain management plan, either before or after her discharge from hospital. The responses to her care were reactively rather than proactively managed.

2.6 All the agencies were sympathetic to the family preference of accommodating Mrs B and Mr B close to each other in Mrs B's final stage of life; they worked to this end and it became the priority factor in arranging Mrs B's care.

2.7 The agencies did consider the needs of both Mrs B and Mr B as individuals, but less attention was paid to their combined needs as a couple, when determining the care options.

2.8 Placement options were limited, given lack of available, suitable places and the wish to place Mrs B close to her husband.

2.9 Mrs B and her family were able to express their preferences and were engaged in some aspects of the decision processes. They were not fully engaged in the preparatory discussions about the compromises that would have to be made, in order for Mrs B to be placed in the same care home as her husband.

2.10 The various health professionals concerned and the Nursing Home themselves, all acknowledged that the Nursing Home was not experienced in palliative care. This did not translate into a common understanding of the nature or timing of any external support that would be required to overcome this inexperience.

Additional Note

2.11 In November 2011, the National Institute for Health and Clinical Excellence (NICE), issued quality standards for end of life care, that would apply to both health and social care agencies. These standards were not in play at the time that Mrs B was receiving her end of life care, so the agencies cannot be held to account for their practice against these specific standards in this instance. The standards do now provide, however, a valuable reference point to aid local commissioners in reviewing the local end of life strategy and practice.

3 Recommendations

As a result of the serious case review, the safeguarding board adopted an action plan which included the following recommendations. These actions are being monitored through the safeguarding board on a quarterly basis and the individual named agencies are responsible for reporting on their respective actions.

1 NHS Bedfordshire and Central Bedfordshire Council review the market supply of, and their joint commissioning strategy for, the local provision of care homes, including for provision of end of life palliative care.

2 NHS Bedfordshire and Central Bedfordshire Council review their use of standard and specialist contractual terms used for care homes and how appropriate support is assured when non-specialist or inexperienced facilities are used to provide the more specialist aspects of end of life palliative care.

3 NHS Bedfordshire and Central Bedfordshire Council clarify with local providers, the leadership and accountabilities for developing and monitoring the implementation of palliative care plans.

4 NHS Bedfordshire should clarify whether comments associated with approving CHC funding are for consideration or are requirements of the funding being made available and communicate this to providers accordingly.

2 NHS Bedfordshire and Central Bedfordshire Council satisfy themselves that the understanding and application of Gold Standard Framework and Liverpool Care Pathway is now sufficiently comprehensive across the area.

6 NHS Bedfordshire and Central Bedfordshire Council satisfy themselves that the need for multidisciplinary and proactively framed palliative care plans, including pain management plans, is embedded into local practice of health and social care providers and that families are appropriately engaged in the process.

7 NHS Bedfordshire lead a review, with representatives of the care homes sector and the GP services as to whether or not there is a way to facilitate early communication with GPs, for newly admitted care home residents, who need to be newly registered with a GP practice.

8 NHS Bedfordshire and local acute hospital providers investigate the benefits of all patients being discharged from the hospital to care homes, being given their own copy of the Dr's transfer letter.

9 Bedford Hospital NHS Trust, review the consistency of the content of the nurse led transfer summaries, to ensure that any forward care and medication requirements are clearly stated, where appropriate.

10 Bedford Hospital Trust and representatives of the local care home providers, consider a consistent protocol for care home staff making entries into hospital's patient records.

11 NHS Bedfordshire and Central Bedfordshire Council, in partnership with representatives from the local hospitals and care homes sectors, review the requirements for the nature and content of documentation that should accompany medication sent from hospitals to care homes.

12 South Essex Partnership Trust Community Health Services Bedfordshire, NHS Bedfordshire (via clinical governance processes) and representatives from the care homes sector, review the recording protocols across the agencies, for recording the administration of medication to care home residents and also reach common agreement about what and when colleagues are expected to make entries into or countersign each other's records, consulting with CQC if appropriate to ensure regulatory compliance for each agency.

13 NHS Bedfordshire and Central Bedfordshire Council review the findings of this SCR, against the terms of reference and practice of the recently commenced PEPS service for people with palliative care needs. This should include assurance that the

thresholds for involving PEPS and the Macmillan service are clear and communicated to relevant partners.

14 In the light of recommendations above, NHS Bedfordshire and Central Bedfordshire Council should identify any training needs for joint working between South Essex Partnership Trust Community Health Services Bedfordshire, Macmillan and local care homes together with any specific training needs for the care homes sector.

12 NHS Bedfordshire and Central Bedfordshire Council, satisfy themselves that the local 'end of life' strategy and practice is compliant with the NICE quality standards issued in November 2011.

16 Central Bedfordshire Council and NHS Bedfordshire should prioritise a review of their contractual arrangements with and expectations of the Nursing Home, ahead of the wider system reviews recommended, to clarify the care groups for whom the Nursing Home will be expected to provide care in the future, assure all parties that the Nursing Home has the appropriate skill and resource base to provide that care, and associated with that, ensure confidence in admission procedures and assure themselves that there are robust internal processes for quality assurance, care practices and medicines management.

17 The SOVA Board receives confirmation that the recommendation made by individual agencies in their IMR reports and also the ones listed in 1 to 16 above, have been appropriately implemented.

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