Safeguarding is everybody's business

A serious case review into the response to concerns about the safety and quality of care at Wyton Abbey Care Home

Overview report by Jonathan Phillips, independent author

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Executive summary of findings and recommendations

What is a serious case review?

It is a method of carefully looking at what led up to an event that caused concern. Its purpose is to identify good practice and draw out lessons that agencies can learn for the future. It is not a disciplinary investigation – that is the task of each agency. It is also not an investigation into the cause of death or serious injury- that is the task of the Coroner's Office and the investigation agencies – the police and social services.

Why was this review undertaken?

From July to November 2012 placements were suspended at Wyton Abbey Care Home, owned by Prime Life. This serious case review was arranged because the East Riding Safeguarding Adults Board decided that:

a Wyton Abbey had not responded appropriately to a number of incidents including two deaths
b There was no evidence of improvement in the care provided following several interventions over a seven-month period
c The Coroner's narrative verdict concerning one of the people who died said that earlier intervention might have postponed the time of his death
d A number of statutory partners were involved with Wyton Abbey over the period in question
e There would be an opportunity for learning for all the agencies involved.

The review focuses on the care offered between May 2011 and November 2012 to three people, two of whom died. The third person continues to live at Wyton Abbey. The circumstances were thought to be significant enough for a serious case review because of the medical condition of the residents and the range and depth of concerns about the safety of the home identified by both the Care Quality Commission (CQC) and East Riding of Yorkshire Council's (ERYC) contracting unit and safeguarding team. The Coroner's report on one of the residents concluded that he might not have died if he had received more timely medical help.

It was also thought important to bring to the attention of a wider audience the issues identified in this report. As increasing numbers of people fund and organise their own care they will have direct dealings with care homes with

little reference to local councils. All care homes are regulated by the CQC but the maintenance of quality and safety cannot be laid solely at the regulator's door. It is important that registered managers and providers take full responsibility for the quality of the care that they provide and that residents and families are aware of what they can expect and what they can do if they have concerns.

The findings of this report can be summarised under the following headings:

- providing high quality services for people living in care homes
- identifying problems
- promoting improvement

Providing high quality services

Every care home must have a registered manager and be owned by a registered provider who is registered with CQC. It is the registered manager and provider's duty to ensure that the home complies with all regulations and as a result the people living there are safe, content and well cared for.

One of the key audiences for this report is, therefore, those managers and providers.

One key finding is the importance of records. The report contains many examples of where failure to keep good records has made it difficult to understand what really happened. Good records are not just a chronological record of events. What was often missing was a record of decisions: both decisions to do things, like contact relatives, and decisions not to do things, like call a doctor.

There were also examples of decisions made and then not carried out, such as ringing the doctor, or making a safeguarding referral. It is vital that homes have a system that ensures decisions are made, acted on and properly recorded.

During the period of the review the home was unable to demonstrate, until the appointment of a new manager in September 2012, that it was reviewing people's progress against well thought out care plans. Although the registered provider, Prime Life, expected that each resident would have a key worker, none of those whose care we looked at had one. This meant no-one had an overall picture of their health and welfare. It also meant families did not have a single point of contact amongst the staff team with whom they had a relationship.

The impression is, therefore, given of a culture where staff members were responding on a daily basis to events, with little opportunity for reflection and consideration of the implications of what was happening.

There was a notable improvement once the new manager was appointed. This demonstrates how much the quality and skills of managers are vital to the effectiveness of care homes. Registered managers should ensure that families and residents know who they are. They have a clear responsibility to make sure that people using their service know what to expect. This enhances the role of families in promoting the quality of care for their relatives.

There were also some problems in the wider services offered to residents by the statutory services. There was a clear need for a falls service which helps care homes prevent residents having falls. The offer available for residents of Wyton Abbey was fragmented and confused – there is a clear need for improvement. There appeared to be some misunderstandings about the respective roles of district nurses and doctors, which needs clarification. The approach to palliative care was not well joined up between the GP practice and the care home and requires further review. There is a need to make sure that the expectations of care homes without nursing in the administration of Haloperidol and other anti-psychotic drugs is clear and reasonable.

There were plenty of examples of health assessments not being joined up: such as falls and speech therapy assessments. These were the result of fragmented recording systems, which were not linked, and differing views about what information can be shared with whom.

Identifying problems

The first worries about the quality of care were as a result of concerns expressed by relatives following the death of their father. There was nothing to indicate there were problems from the contact his social worker had with either the home or the resident himself. He had mental capacity so involvement of relatives was not required to establish his best interests and where this is the case there would only be contact with relatives if specifically agreed by the resident. In cases where the resident does not have capacity then there would be regular contact with the nearest relative or person acting on their behalf. It is the responsibility of registered managers as well as funding authorities where they are involved to regularly review residents and include their relatives where necessary. It must be recognised that over 50

per cent of care and nursing home residents are self-funded and would not be under any supervision by the local authority.

There were a number of examples of when the reporting of safeguarding concerns were either delayed or not made at all. Some of this was down to the limitations of old fashioned technology which has now been addressed, but there was also an unacceptable delay of two weeks by a GP. Some visiting professionals also had anxieties but did not convert their concerns into action. There are some important messages here about professional responsibility. However once the local authority's safeguarding teams and business management unit, which handles contracts, were involved there was a thorough response.

There were occasions when reviews did not pick up inadequacies in recording and care planning. These were potential missed opportunities in picking deficiencies in the quality of care.

The CQC were closely involved in addressing concerns and carried out a number of inspections, which both identified serious problems and provided evidence of improvement.

When placements were suspended in July 2012, key professionals such as GPs were not informed. This meant their knowledge of the home, which may have been valuable source of evidence, was unavailable during the period the home was under additional scrutiny.

Promoting improvement

Once concerns were identified, the agencies worked well together. CQC carried out a number of inspections and the council's business management unit monitored improvement on a regular basis. However, as already mentioned, improvement was slow until the appointment of a new manager at Wyton Abbey.

The need to be more systematic in setting out the required evidence of improvement for homes has been identified by the agencies involved. This will help homes to prioritise their actions and also enable stronger enforcement if timescales and milestones are not met.

One of the concerns raised at the start of this review was whether the decision to reinstate placements was timely and thorough. There was the potential to wait until a further CQC inspection had been carried out. However, this needed to be balanced against the acknowledgement that Wyton Abbey

needed new placements to secure its future. It seems unlikely that waiting for another inspection would have changed the decision to reinstate placements. However, if more people had been aware of the decision to suspend placements in the first place then there may have been more evidence to weigh up in the decision on whether or not they should be reinstated.

An important part of promoting improvement is ensuring that there is a robust approach to investigating potential criminal offences including corporate manslaughter and the Mental Capacity Act 2005 with reference to the role of registered managers and providers. The information available to this review suggests there is scope to enhance police officers' understanding of this difficult but important area of the law.

Conclusions

The 23 recommendations are designed to address the main findings highlighted here plus more detailed issues. It is important the review is publicised widely so that all those involved in providing residential care for people who may be vulnerable, as well as families and friends, can be more informed about the critical factors that underpin high quality care and keep people safe.

By assuring itself that these recommendations have been implemented, East Riding Safeguarding Adults Board will be able to enhance the quality of residential care in its area.

Reading the report

The report describes in detail the care that each of the three residents received drawing out key learning points from each person's experience.

It goes on to look at the way the key partners responded to the issues.

Summary of Recommendations

Recommendation 1: ERYC should make it a requirement that families are contacted at the time of an initial post placement visit as well as all reviews if the service user wishes for them to be involved.

Recommendation 2: Prime Life and other care homes should be able to demonstrate that they have ensured key family members understand how bedroom doors operate, why they might be locked and explain the potential risks.

Recommendation 3: East Riding CCG should remind all GPs they should always take into account the difference between care homes with and without nursing when making decisions on how to advise on and manage treatment.

Recommendation 4: Prime Life and all care homes should be able to provide evidence that there is a single member of staff, known to families and professionals, for each resident who is clearly responsible for following any medical advice provided.

Recommendation 5: Hull and East Yorkshire Hospital NHS Trust should be able to provide evidence that staff can identify possible safeguarding risk factors prior to discharge and take the necessary action

Recommendation 6: NHS England (North Yorkshire and the Humber) should issue advice to GP practices that care homes should be involved in palliative care multi-disciplinary team discussions.

Recommendation 7: East Riding Safeguarding Adults Board should ensure the lessons of this serious case review are widely circulated to local care homes so they can take the necessary action. Homes should be asked to evidence their approach to keeping records, monitoring health, managing falls, seeking medical attention and establishing clear accountability to residents and families. This should be reported as part of routine contract monitoring. ERYC should report back in six months from the publication of the report as to any further action that is required as a result of the exercise.

Recommendation 8: The East Riding CCG should:

- **lead the development of a health passport which should be available for all residents in care homes and should be checked at review**
- **develop a course or information pack for care home staff that identifies when they should seek medical advice.**

Recommendation 9: The East Riding CCG should issue to care homes and other partner agencies a joint statement clarifying the respective roles of nurses and doctors.

Recommendation 10: The East Riding CCG should recommend to GPs that when prescribing haloperidol or other anti-psychotic drugs "as required" for people living in care homes, they should indicate an upper limit.

Recommendation 11: Whilst recognising national constraints, the East Riding CCG should ensure local health agencies identify opportunities to optimise their use of electronic recording, referrals and communication and report improvements to the East Riding Safeguarding Adults Board.

Recommendation 12: The East Riding Safeguarding Adults Board should routinely include the experience of people who use services and their carers in their audits of service and include the findings in their annual report.

Recommendation 13: ERYC should ensure reviewing staff know what to look for in care home files and always use them for reviewing purposes, confirm the necessary pre-assessment information is in place and follow up any omissions.

Recommendation 14: Prime Life and all registered managers in the East Riding of Yorkshire Council area should be able to provide evidence that they have used this report to highlight the importance of good recording and the timely seeking of medical assistance, pointing out that poor recording can endanger lives.

Recommendation 15: NHS England (North Yorkshire and Humberside Area Team) should monitor the quantity, quality and timeliness of safeguarding referrals from GPs and report the outcome to the East Riding Safeguarding Adults Board.

Recommendation 16: The CQC along with the Information Commissioner and other partners should issue guidance on legally compliant processes for the sharing of information to ensure any relevant information is accessed at all times to make certain the needs of the person who uses services may continue to be met.

Recommendation 17: The East Riding Safeguarding Adults Board should carry out a wider review of the adherence to Outcome 6 of CQC Essential Standards of Quality and Safety, which starts from the experience of all those receiving residential care in the area.

Recommendation 18: ERYC should review the council's business management unit's involvement in safeguarding investigations of care homes with a view to its role being more central to the process and clear to all agencies.

Recommendation 19: ERYC's procedure for suspending placements should require that a joint decision with CQC should be made on the most effective use of CQC's inspections in achieving the required evidence of improvement. CQC should then apply this learning nationally.

Recommendation 20: ERYC should ensure that when placements are suspended, providers should be given clear timescales for the improvement milestones expected and evidence that will be required.

Recommendation 21: When ERYC suspends placements a strategy meeting should decide which key professional visitors to the home should be made aware of the reasons and their support elicited. This should be reflected in safeguarding policy and procedures.

Recommendation 22: The East Riding CCG should commission a NICE compliant falls service with very clear pathways that make it easy for care homes to receive assistance with frequent fallers.

Recommendation 23: Humberside Police should provide evidence to the East Riding Safeguarding Adults Board that investigating officers have a good understanding about what can reasonably be expected of registered managers and providers to underpin decisions relating to their prosecution.

Overview report

Serious case review into the response to concerns about the safety and quality of care at Wyton Abbey care home

Purpose of a serious case review (SCR)

East Riding Safeguarding Adults Board (ERSAB) commissioned this SCR in January 2013. It was requested because serious concerns had been expressed about the condition of one resident at the time of their death. The Coroner reported that: "It is probable that had medical attention been sought earlier this would have led to an intervention which could have led to a different outcome". There were also worries about the care of two other people, one who died and one who continues to live at the home. The concerns related to the home's failure over a 15-month period to:

- seek medical assistance in response to falls and deteriorating health
- keep up-to-date records and care plans
- maintain adequate staffing levels
- meet cleanliness and infection control requirements
- respond to safeguarding procedures
- and improve quickly and sustainably when problems were highlighted.

These issues gave rise to anxiety about the quality of care the residents had received whilst living at Wyton Abbey. Questions were also raised about whether the various agencies that had been supporting the residents, or working with the care home, had properly noticed and acted upon any concerns.

What is a serious case review?

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How was the review carried out?

The ERSAB appointed an independent author who chaired the serious case review panel and wrote this report. The independent author is Jonathan Phillips. He is a former director of adult social services for Calderdale Council from 2007 until his retirement in 2011. Prior to that he was a national director of the Commission for Social Care Inspection and was a regional director for the Social Services Inspectorate. He currently chairs two safeguarding adults boards – in North Yorkshire and Bradford. He recently served on the National Commission on Schizophrenia established by Rethink, a large mental health charity. In June 2012 he was awarded an OBE for services to social care.

The SCR panel had the following membership:

- East Riding of Yorkshire Council [ERYC]
  - adult services
  - business management unit [BMU]
- Humber NHS Foundation Trust [HFT]
- Hull and East Yorkshire Hospitals NHS Trust [HEY]
- NHS East Riding of Yorkshire Clinical Commissioning Group [CCG]
- Prime Life Ltd
- Yorkshire Ambulance Service NHS Trust [YAS]
- Humberside Police
- Care Quality Commission [CQC]

Each agency was asked to submit an independent management review (IMR) about their agency's involvement with the three residents and Wyton Abbey. They each provided a rigorous analysis of the activities of their staff and the policies and procedures used and provided a chronology of events. A simplified timeline is available at Appendix 1

The SCR panel also received Coroner's reports on the two people who died.

An officer from ERYC interviewed the families of the three people involved and provided to the SCR a written report, approved by the family members concerned. The families of all the current residents were notified and invited to contact the review. None did. However, Mr A's family believe that by only focussing on the care their father received at Wyton Abbey wider learning opportunities have been missed.

The SCR panel first met on 30 January 2013 when the terms of reference were agreed and IMRs were commissioned. It met again on 23 May 2013 to

consider the IMRs and the family views on what had happened. Further work was requested on some IMRs. The panel next met on 4 July 2013 to consider the first draft and again on 5 August 2013.

The independent chair of the SCR met the families of Mr A and Mr B to discuss the findings of the review and asked for their comments prior to publication. They made a number of points about the report and the breadth of the investigation and welcomed the recommendations.

Term of Reference

These were agreed as follows:

a) What information was available and to whom in relation to the care being provided to the three principle subjects at the residential home between 1 September 2011 and 30 November 2012 and what if any action was taken. For Mr A only start from 31 May 2011.

b) Identify agencies in contact with the home and the principle subjects of the review during the relevant period; review the mechanism that each organisation had in place to monitor the care being provided to the principle subjects and report any concerns they had in relation to the care they observed as being provided to them at that time.

c) Identify if the pre-admission assessment and on-going care planning carried out by the residential home and any commissioning agencies had any impact on the outcomes for the principle subjects identified in the review and were there any opportunities for agencies to have intervened.

d) Following receipt of the initial safeguarding alert how did the multi-agency partners respond over the period under review in terms of timeliness, decision-making, rationale and adherence to multi-agency procedures and could any of the subsequent incidents have been avoided.

e) What actions were taken by agencies/organisations following the initial alerts in relation to the care of other residents and were they effective?

f) Following the initial alert consider organisation/agency actions in relation to the staff involved in that and subsequent alerts.

g) Consider the decision to suspend and reinstate placements (or not to do so) and report on timeliness, rationale and proportionality.

h) Establish how well agencies/organisations worked together and to identify how inter-agency practice could be strengthened to improve the safeguarding of vulnerable adults.

i) Consider whether the regulatory and legal powers available were used effectively and whether they offered the principle subjects concerned sufficient protection.

Note: for Mr.A the start date was subsequently moved to 31 May 2011.

Structure of this report

The report will be in two parts. Part one will examine the care and experience of each person and draw out lessons for agencies.

Part two will then look at the overall agency responses to the issues raised and make recommendations for the whole system.

The names of the individuals have been changed in order to preserve the confidentiality of the families concerned.

Part One

All the information presented in part one is drawn from the IMRs and chronologies provided by each agency, interviews with the relatives of each man and the Coroner's letter.

Mr A

Mr A died aged 65 on 11 September 2011. He had lived at Wyton Abbey since 18 May 2011. He had a complex history of serious medical conditions, which affected his independence - this included Parkinson's disease. He had previously lived in another care home, but following a stay in hospital in May 2011 decided to move to Wyton Abbey. He was assessed as having the capacity to make this decision under the Mental Capacity Act 2005.

Unusually, although he had capacity, he had a corporate appointee to support him in managing his financial affairs, as there had been some difficulties in the past. Although the family accepted Mr A's decision to move to a new care home, Wyton Abbey's location made it more difficult for them to visit him.

According to ERYC records, he had a support plan which identified that he had a risk of falls, sometimes chose to eat biscuits even though he knew they might make him choke, chose to be non-mobile and could neglect himself. His family said he ate biscuits because they dissolved in his mouth which he found easy to manage.

Within days of his admission to Wyton Abbey there are reports in the home's notes of "challenging behaviour" with Mr A throwing punches at staff members and trying to leave the care home unattended. It is not clear from the notes provided by Wyton Abbey on what basis the staff were concerned about him leaving the home given that he was assessed as having capacity. He also

asked staff to contact his GP, who he had known for a long time, to request stronger sleeping medication. His dose of Zoplicone was increased.

Humber NHS Foundation Trust were quickly involved with visits from the speech therapist, who advised that he needed blended food, and the district nurse who carried out a tissue viability assessment and applied dressing to pressure sores.

The occupational therapist saw Mr A on 11 July 2011 and 14 July 2011. She identified that the door was locked but according to the HFT IMR did not highlight it to her managers. It is unfortunate that this member of staff did not highlight this as a concern at the time. This was also mentioned by Mr A's family who were also concerned. It is not possible to identify the date when these concerns were identified.

Mr A's daughter visited him after a few weeks and was concerned about his condition. She cannot recall the date and there is no record of her visit at Wyton Abbey. She reports that his food was not being pureed and his medication was left in a pot, which he couldn't manage. He said he wasn't getting enough to drink but Wyton Abbey was unable to produce a record of his intake of food and liquid. She says he was unhappy at being locked in a room all the time which he found oppressive and he could not reach his buzzer. She reports that she sometimes had to wait for 15 minutes before being allowed into her father's room.

Mr A's daughter says she could not find out who the social worker was and that Hedon customer service centre could not tell her either. She contacted his GP who assured her that he was alright. It would not appear that she considered discussing her concerns with the registered manager.

On 3 July 2011, Wyton Abbey records indicate there was a change in his mental state and he had started to have hallucinations. However, the CCG report says he had an unusual form of Parkinson's since 1984, the symptoms of which included hallucinations.

On 4 July 2011, nearly two months after his admission, the ERYC assessment officer responsible for supporting Mr A with his move visited him for the first time. She reported that he said he was well and had settled in well. There appears to have been no mention of the unsettled start and certainly no mention of any concerns about the locked room. It was apparently confirmed that he was enjoying a wholesome diet, which was blended with some finger foods. She did not look at the case notes and so did not pick up any warning signs that the home may be finding it difficult to support him. She did not look at the risk plans or pre-assessment documents. She also assumed the family was visiting regularly and had not raised concerns. She did not contact the family. The ERYC IMR identifies this as a key missed opportunity to identify some of the challenges in providing support for Mr A.

According to ERYC policy, Mr A should have been reviewed three months after admission – which would have been August 2011. This was postponed and was not held before he died. It was planned for 19 September 2011.

However, there was nothing to suggest at the time that Mr A was at risk or that the review should have been prioritised.

On 11 July 2011, according to the HFT chronology, a Parkinson's specialist nurse assessed him. There is nothing in the details extracted from Wyton Abbey's notes by Prime Life that suggests they were aware of the outcome of this assessment and used it to guide their support of Mr A. It should have been available.

On 14 July 2011, HFT initiated contact with Mr A and the occupational therapist visited on 14 July to assess his seating position and feeding.

The next time ERYC had contact with Wyton Abbey was on 2 August 2011 when an assessment officer visited Mr A to discuss his tenancy and check on his welfare. There is no evidence this was used as an opportunity to take a wider look at his care plan. According to the record, no issues were raised by either Mr A or the care home manager.

Two days later, on 4 August 2011, there is a record at Wyton Abbey that Mr A's amitriptyline had arrived. This was routine medication.

For the rest of August there appear to be no reports of any significance about Mr. A's health or welfare

On 30 August 2011, Wyton Abbey contacted the GP to ask for a visit because Mr. A had pain when passing urine. The GP did not visit but rang to prescribe antibiotics.

The following day there was a telephone review with the speech and language therapist. There appears to be no record of this review on the Wyton Abbey records.

On 4 September 2011, five days after contacting the GP, Mr A was again reported as being unwell with hallucinations and vomiting and on 5 September a GP visit was requested. There was an unsuccessful attempt by the home to contact the family. The GP visited and recorded that Mr A smelled strongly of urine and thought he had a urinary tract infection so prescribed a different course of antibiotics. He advised that the GP should be called again if there was no improvement within 48 hours or if he deteriorated.

On 7 September 2011, Wyton Abbey records indicate the GP needed to be contacted again as there was no improvement. A call was not made until 8 September when, according to the GP records, a diagnosis over the phone of constipation was made.

There is some confusion in the care records at this point as there are two entries on 6 and 7 September 2011 recording small opening of the bowels, but on 8 September the daily living profile says he had not opened his bowels since 4 September. This is a good example of where a key worker with some oversight of his care might have noticed the discrepancy and taken action,

A laxative, Macrogel, was delivered by pharmacy on 8 September and Wyton Abbey record that a nurse gave them advice on the dosage over the phone.

Also on 8 September 2011, a nurse visited to administer an enema – according to Wyton Abbey records, but one was not available. Wyton Abbey staff said they would chase it up. This is unfortunate as, if the enema had gone ahead, a nurse would at least have seen Mr A at this point.

On 9 September 2011, Wyton Abbey report that they made contact with Mr A's son and daughter. The source of this information is an interview with Wyton Abbey staff rather than formal records; however Mr A's daughter confirms it.

That afternoon Mr A's.daughter visited and was shocked by his condition and rang the surgery herself. She had the impression that the GP was reluctant to visit and she recalls having to insist on a visit. However, the GP is adamant that they were trying to assess whether the visit could wait until after surgery had finished. This resulted in an urgent visit from the GP. The CCG IMR states the following:

> On attendance the patient was in bed but was agitated with his arms moving. He had a dry oral mucosa, with sunken eyes and cheeks (signifying significant dehydration). Care staff reported no oral intake within the past two days. His temperature was 36.1 (normal). His abdomen was soft (normal). He was faecally loaded (stool in rectum) and had a pulse of 100bpm. The GP diagnosed dehydration and hallucinations. It was recorded in the GP notes that the family were insistent on admission to hospital. It was also recorded that it was not clear why home didn't contact GP surgery earlier. The visiting GP referred the patient to the bed bureau at the local acute hospital, initially requesting transfer within one hour but upgrading whilst on phone to an emergency (999) response. The GP reported the patient was comfortable and was pain-free on review prior to the GP leaving the care home.
>
> The next entry is at 4.55pm when the daughter rang to say the ambulance had not arrived. The daughter had dialled 999 but was told no ambulance had been booked. The surgery thought the bed bureau had arranged the ambulance but it would appear the bed bureau thought that the GP was making the arrangements.

The report from Wyton Abbey indicates the reason for upgrading the referral to a 999 call was that Mr A was experiencing severe chest pains. Mr A's daughter is adamant that it was her who upgraded the call to 999 because of her father's distress.

The ambulance report indicates there was a further episode of chest pain in the ambulance however, Mr A's ECG was normal and he did not meet the criteria for referral for the cardiac pathway in place at Castle Hill Hospital. They reported he was generally unwell, not eating, taking little fluids and had severe weight loss. He may have a urinary tract infection and may be dehydrated. He was also constipated. During the journey his blood pressure

dropped so he was given intravenous fluids. There was no GP letter with the patient. The ambulance service raised no safeguarding concerns about the condition in which they found Mr A.

There had been a significant delay in the arrival of the ambulance because the GP had assumed the bed bureau would book it whilst they expected the GP to do so. However, the Coroner did not think this had any effect on Mr A's overall condition.

He was seen in A&E on 9th September 2011 at 17.54. The hospital's records indicate Mr A received a full medical review and a treatment plan, including commencing IV fluids. Wyton Abbey sent a copy of the medication chart, some patient passport information and an escort. According to the notes, the daughter attended with her father. The initial diagnosis was constipation and dehydration and he was transferred to the acute assessment unit at 22.30 for overnight observation and continued treatment.

On 10 September 2011 at 11.05, the hospital record indicates he had been incontinent of faeces overnight and was now fit to return to Wyton Abbey. As the home couldn't be contacted he was transferred to a base ward with a diagnosis of constipation and dehydration.

During the afternoon, the family spoke to nursing staff about their concerns about their father's care at Wyton Abbey and they contacted the medical social worker who visited at 15.30 that day. According to the ERYC case notes, the social worker raised a query about whether Mr A had capacity to make decisions. It was decided that Mr A would require reassessment for continuing health care and nursing care. The nursing staff referred him to the hospital dietician.

According to Wyton Abbey records, they were contacted by a hospital social worker who said that a dietician was assessing him and they would be contacted the following day.

It does not appear therefore that, on the morning of 10 September, he was expected to die so imminently

Also on the same day Mr A's daughter contacted the emergency duty team (time not specified in the chronology) to raise concerns about the care her father had received at Wyton Abbey and to raise a safeguarding alert. She was aware the hospital was considering returning him to Wyton Abbey and said she did not want this to happen. This was the first time anyone had raised any concerns about Mr A's care with ERYC.

At 17.35 his condition had deteriorated. His blood pressure was low and his respiratory rate increased indicating possible pneumonia. He was still constipated and a manual evacuation was performed.

At 22.00, he had deteriorated further and a do not attempt cardio-pulmonary resuscitation (DNACPR) order was put in place and agreed amongst the professionals based on his clinical condition. This was discussed with the

family by the ward doctor and senior registrar at 01.05 11/09/11. The family disagreed with this decision and was concerned it had been discussed within their father's hearing. Mr A continued to receive treatment but it became apparent he was not responding. The hospital records indicate the procedures for initiating a DNACPR order and communication with the family were properly followed and taken in the patients' best interests based on his condition and co-morbidities and was an example of good practice despite the family disagreeing with the order. However, the family continues to have reservations about how they were dealt which were raised during this review rather than with the provider. The trust is now considering these issues outside this review.

Mr A died at 02.16 on 11 September 2011.

The hospital post mortem, requested by the family, concluded he had died of:

- bronchopneumonia
- chronic Intestinal obstruction
- Parkinson's disease.

On 12 September 2011, the police decided with the safeguarding adults team that there were no concerns regarding criminality and they would not investigate further. However, they became involved a week later following a request for statements from the Coroner. It is surprising that this decision was taken so quickly especially given the concerns that emerged in preparing for the Coroner's hearing.

The Coroner's report confirmed the cause of death. It said that dehydration and constipation contributed to Mr A's inability to resist infection. It did not say whether it thought the dehydration was caused by a lack of fluids or a by-product of the chest infection, but thought it was probably the latter.

During the course of this review, Mr A's family raised a number of detailed concerns about the quality of the care he received from the hospital and the GP. These have been referred to the NHS agencies concerned and they have been asked to consider them and respond directly to the family, outside this review process.

Key Learning Points

Initial post admission visits

When the placement has been organised and funded with the support of the council it is important that the initial visit to the resident confirms that all the key components of the care package are in place. They should ensure the home has the necessary information, any missing elements are filled in and the family and key carers are engaged. It is important to make sure there is an effective person-centred care plan in place. If this had happened then there would have been an increased chance that any concerns, such as the family's worries and the issue of Mr A being locked in his room might have been

addressed in a more timely manner. It would also have identified any deficits in the pre admission planning

Reviews

It was regrettable that the initial review was planned for September rather than the August due date, as it would have been an opportunity to create a whole picture of Mr A's care drawing on the views of all the professionals involved. Occasional postponements are unavoidable. If it had been held when due, there is some reason to suppose the family's concerns about Mr A's welfare may have emerged and a detailed look at the care home's files might have revealed some of the problems they were experiencing in providing and recording his care. If the review had taken place and the families' concerns acted on then Mr A's rapid decline could perhaps have been avoided.

Action Taken: ERYC is undertaking a review of the reviewing process. This will improve the way in which reviewing is carried out in order to address these issues. Joint reviews between agencies already take place but this review will also look at harmonising the documentation.

Recommendation: 1 ERYC should make it a requirement that families are contacted at the time of an initial post placement visit as well as all reviews if the service user wishes for them to be involved.

Recordkeeping in residential care

There was no overall personalised record of Mr A's care. Whilst there was a daily continuous record, the Prime Life IMR draws on a variety of different sources and makes the point that it was hard to piece together what happened. There did not appear to be any evidence that Wyton Abbey itself carried out any on-going reviews of care. There is no evidence that they sought out the views of the family or Mr A about how the placement was going. For most of August there is no evidence of any record of his care apart from the need for him to temporarily move rooms because of some maintenance work. When the police seized his records after his death, they noted that they were in various different places within the home.

The number of people involved in his care increased the need to make sure that there was a co-ordinated approach. It is does not appear from the records available that he had a key worker who took an overall responsibility for what was happening. This would have helped to keep a clear focus on his health and welfare.

Action taken: Prime Life, the owners of Wyton Abbey, report that they have completed a comprehensive review of all individual resident care plans to ensure that they were all complete, recorded, stored and structured in line with Prime Life requirements. This has been independently verified by both ERYC's business management unit and the Care Quality Commission (CQC)

The locked room

It has been explained to the SCR that the doors at Wyton Abbey are like hotel room doors. They are locked from the outside when closed but can be opened from the inside by the occupant. As Mr A had capacity to make decisions he was free to decide whether he wanted it open or closed. A personal emergency evacuation plan was in place. Yet there was something about the way it was managed, perhaps linked to whether staff had quick access to keys, which raised both the family and a visiting professional's concerns. HFT have recognised in their IMR that staff need to be alert to deprivation of liberty issues and take the necessary action if they have concerns. It is important that care home managers make it clear to families and friends what the door arrangements are and what the potential risks might be.

Recommendation 2: Prime Life and other care homes should be able to demonstrate that they have ensured key family members understand how bedroom doors operate, why they might be locked and explain the potential risks.

The delayed ambulance

The confusion over ambulance booking indicated a clear need to clarify policy and procedures in order to ensure that ambulance attendance is not subject to avoidable delays. At the time it was the bed bureau's responsibility to order the ambulance but this has now been changed to the GP.

Action taken: The clinical commissioning group has issued clear guidance saying it is always the GPs responsibility to book an ambulance when they have identified a need for it.

Mr A's final days

Mr A was reported as unwell on 30 August 2011 but then improved until 4 September. Many different staff members were involved with his care. Although concerns were noted on 4 September 2011, a GP visit was not requested and made until 5 September 2011. This reinforces the importance of keeping good records and keeping a potentially changing situation under review. There was a day's delay between recognising the need for a doctor and contacting the GP. The GP advised recontacting if no improvement in 48 hours but the home actually waited 72 hours until 8 September 2011. It is important that a care home, especially one without nursing, follows medical instructions regarding seeking further advice.

On 8 September 2011, a telephone diagnosis of constipation was made. It was the following day that Mr A's family, not having seen him for some time raised the alarm and contacted the GP.

It is unclear from the IMR why the GP decided not to visit Mr A on 8 September 2011. The review has established that the GP understood that Wyton Abbey is a care home without nursing but there remains a concern that

there was too much reliance on the competence of the staff to deal with the situation. This links to the management of Mr C.

It is also of some concern that the hospital were actively considering his return to Wyton Abbey and this was only avoided by their inability to contact the home. It was after this that his family expressed their worries about his return. It is important that hospital staff should consider all the elements of care and what led to the patient's condition prior to arranging discharge including raising a safeguarding concern, if needed and discussing fully with the family.

Whilst Prime Life maintain they operate a key worker system across all their homes they have not been able to establish who the key workers were for any of the three people involved in this review.

It emerged during this review that Mr A had been placed on a palliative care register and had been the subject of a multi-disciplinary team meeting. This came as a surprise to some of the other agencies involved in his care including Wyton Abbey. The family also did not know. Under the NHS quality improvement framework (known as the QOF) practices are required to have three-monthly multi-disciplinary meetings. The rationale for this is to:

- ensure all aspects of the patient's care have been considered (this should then be documented in the patients notes)
- improve communication within the team and with other organisations (e.g. care home, hospital, community nurse specialist) and particularly improve handover of information to out of hours services
- co-ordinate each patient's management plan ensuring the most appropriate member of the team takes any action, avoiding duplication
- ensure patients are sensitively enabled to express their preferences and priorities for care, including preferred place of care
- ensure the information and support needs of carers are discussed, anticipated and addressed where ever reasonably possible.

It would appear that a number of these outcomes were not realised in this case. It would therefore be advisable for the NHS locally to review the experience of patients who have been placed on registers, particularly those who are in care homes.

Recommendation 3: East Riding CCG should remind all GPs that they should always take into account the difference between care homes with and without nursing when making decisions on how to advise on and manage treatment.

Recommendation 4: Prime Life and all care homes should be able to provide evidence that there is a single member of staff, known to families and professionals, for each resident who is clearly responsible for following any medical advice provided.

Recommendation 5: Hull and East Yorkshire Hospital NHS Trust should be able to provide evidence that staff can identify possible safeguarding risk factors prior to discharge and take the necessary action.

Recommendation 6: NHS England (North Yorkshire and the Humber) should issue advice to GP practices that care homes should be involved in palliative care multi-disciplinary team discussions.

Mr B

Mr B died on 1 July 2012. He was 72-years-old. It was Mr B's death, which resulted in the decision to hold a serious case review. This is because there were serious concerns about his condition when he was admitted to hospital and the Coroner concluded that he might not have died when he did if he had received more timely medical intervention. During the period of this review Mr B did not have capacity but had not been the subject of a mental capacity assessment. His family was fully involved in the decision making about his placement.

Mr B had received support from ERYC because of his dementia since 2009. He started having regular short breaks at Wyton Abbey in June 2011, usually of one or two days duration, funded by ERYC. He also had some aids and adaptations to his home and a sitting service was also provided.

He was allocated one to two days per fortnight, up to a maximum of six weeks. His first admission was on 16 June 2011. On 1 September 2011, he stayed for two nights. The first night it is reported that he did not go to bed. There is no other information available about this stay.

There were then two stays, for one night and then five nights. There is no information available in the chronology from Wyton Abbey about what happened during the stays because nothing exceptional was recorded.

He was admitted again for two nights on 19 October 2011. He had an unwitnessed fall with a graze to his eye and nose. It appears that no-one was informed. His wife remembers him returning on one occasion with an unexplained carpet burn on his face, which may have been this occasion. She was happy with his care until June 2012. Indeed she informed ERYC that she wanted him to be admitted to Wyton Abbey if she were to die.

Between October 2011 and June 2012, he had 10 stays at Wyton Abbey of mainly one or two nights. There are no concerns reported. He was reviewed by ERYC on 18 November 2011 and according to their records no concerns were expressed. There were no concerns raised about the quality of the care records or plans. It does not appear that the fall from a month earlier was mentioned.

On 2 June 2012, he was admitted as an emergency to A&E following a fall at his home. He did not have any fractures and was discharged home.

Mr and Mrs B were planning a holiday to France but she decided that he couldn't manage this and so arranged for him to have a two-week stay at Wyton Abbey starting on 16 June 2012.

Wyton Abbey records indicate he was fine for the first three nights but then on the nights of 19 and 20 June 2012, he did not sleep all night.

He was then reported as "fine" until 23 June 2012, the seventh day of his stay. He had a fall that was unwitnessed by staff in the dining room after supper. Staff observed a graze and a skin flap to which they applied first aid. The accident report notes that residents reported that he just fell. This is identified as a missed opportunity to contact a district nurse in Wyton Abbey's IMR. It should be routine practice to consider seeking medical advice when there is an unwitnessed fall that may have caused internal injury or a head injury, which should have resulted in contacting the GP. The decision on whether to contact the GP should be recorded.

Wyton Abbey report that on 24 June 2012 there is an unsigned report that he scraped his elbow on a wall as he was sitting down. He then fell again. There is some question as to whether he had been pushed by another resident, but it was unwitnessed. There were no apparent injuries. However he had refused breakfast and was walking around rubbing his legs and refused to sit down. He did not eat for the rest of the day and his knees appeared to be hurting him. That night he was reported to be awake at 23.00 and 01.00 hours.

Wyton Abbey reports that a safeguarding alert form was completed because another resident said he had pushed Mr B. This form is unsigned. It does not appear to have resulted in any action and the safeguarding team was not contacted. This was a serious error.

On 25 June 2012, he continued to eat very little but the pain in his knees appeared to have subsided.

On 26 June 2012, although active, he again ate and drank very little.

On 27 June 2012, he was reported as quiet, had drunk a bit more. The report also says he was moved to another room because he had been disturbing another resident. There does not appear to be any recognition that it might have an impact on him.

By now Mr B's behaviour had significantly changed for four days but no medical assistance had been sought.

On 28 June 2012, Wyton Abbey found an entry in the handover sheet that says the district nurse attended to dress his left elbow. HFT appears to have no record of this. There is no reference to Mr B's deterioration. He then fell again during the evening, grazing his shoulder and back.

29 June 2012 was a key moment in Mr B's care. The home asked a district nurse who was visiting another patient to have a look at his forehead and nose as she was leaving. She quickly checked it and reports that she advised

them to contact the GP if there were further concerns and to monitor for head injury. It does not appear that the staff explained that he had had a number of falls and had virtually stopped eating and drinking. Wyton Abbey attributed much more significance to that contact than it deserved.

The contact between Mr B and the district nurse was so transient that it is only by deduction that it has been concluded that it was Mr B she saw.

On 30 June 2012, following a disturbed night he was quiet all day, had "deep and shallow" breathing and was taking very little food or drink. He was also in some pain and holding his side and had a large bruise on his hip. The home's records make it difficult to determine when his breathing changed.

There was therefore, a week when Mr.B's health deteriorated and there was one safeguarding concern but the home failed to call any medical assistance. The Wyton Abbey IMR identifies this day as the key missed opportunity in contacting the emergency services or seeking medical assistance. There appear to have been nine different staff members who recorded events relating to Mr B plus some that were not signed. It appears that no single person was responsible for his care. Once more the lack of an assigned key worker was significant.

According to Mr B's wife, a number of friends and relatives had visited him during the two weeks. They expressed concern about his condition and noted that he wasn't drinking or very lively. When they brought this to staff's attention they said he was fretting for his wife. There was no mention of any falls or the deterioration in his health. It may have been that the assumption that he was fretting for his wife might have obscured the real reason for his declining health.

The series of falls was not mentioned and there was only one reference to the visitors. There is no evidence from the records provided by Wyton Abbey that they had responded to the concerns of the various visitors to Mr B.

On 1 July 2012, which was the day his wife was due to pick him up, the home called an ambulance. It appears they checked with his wife before doing that.

A rapid responder arrived at 07.47 and an ambulance arrived at 7.51. They described him as critically ill with what they believed to be aspiration pneumonia. He appeared to be neglected. He had a strong odour and his bedding needed changing. They identified a dislocated hip, however the post mortem suggested this might have been linked to an ongoing condition. They thought that weight bearing had exacerbated his condition.

Yorkshire Ambulance Service (YAS) has identified that the paramedics should have made a safeguarding alert. However, the lack of availability of a fax machine and problems with getting through to social services' emergency duty team who were engaged meant that this did not happen. YAS also report that they were told by the hospital that they would also be raising a safeguarding alert – this does not appear to have happened.

Action Taken: YAS have now removed the identified barriers to making safeguarding referrals out of office hours

The ambulance staff also expressed concern that none of the care staff were able to provide a coherent history and they said they had little information about Mr B. They were unable to provide a health passport, which should have basic information about medication and on-going health conditions.

Ambulance staff spoke with Mr B's wife at the hospital regarding his care and treatment. She expressed her frustration and anger regarding his condition.

He was admitted to Hull Royal Infirmary at 08.27 and died three-and-a-half hours later. Ward staff said he was in a critical condition and a do not attempt CPR (cardiopulmonary resuscitation) order was agreed.

The Coroner issued a narrative verdict. "Following a fall at Wyton Abbey on 23 June 2012, his condition began to deteriorate. He suffered further falls at the home.
"Death was due to aspiration pneumonitis. It is probable that had medical attention been sought earlier this would have led to an intervention which could have led to different outcomes."

Key learning points

Failure to seek medical attention

The Coroner's verdict makes it clear that had Mr B had received medical attention earlier during the second week of his stay, he may not have died when he did. It is therefore vital that lessons are learned that will reduce the risk of this happening again. The home did not appear to understand the seriousness of his condition and failed to respond on a number of different counts.

Apart from the transient contact with a district nurse there was no involvement of any medical professional before his admission to hospital. This review is therefore entirely reliant on the records at Wyton Abbey to understand what happened. However, as they only record events, they shed no light on the decision making process behind the failure to decide to seek medical help.

Medical help was not sought until his wife had returned from her holiday and the home had contact with her. There could have been some confusion as to whose responsibility it was to seek medical intervention. Given his poor state it should have been the home's responsibility.

It appears that the key contributors to Mr B's untimely death were:

- the lack of any formal documented decision process about when to seek medical assistance
- the failure to recognise key indicators of rapidly declining health

- the failure to assign a named key worker who may have taken action in relation to the deterioration
- the failure to take the necessary safeguarding action
- waiting to contact Mrs B before seeking treatment

Action taken: The Prime Life IMR recognises the importance of record keeping and identified that the simplified care plan used for someone on respite was inadequate and failed to provide the structure and analysis that is required. They have improved both the files and compliance.

Prime Life proposes that it would be helpful for each home to have a section within each person's care plan where a visiting professional can record the action taken and any recommendations. This would reduce the risk of misunderstanding. This is discussed later in relation to **Recommendation 16.**

The East Riding CCG IMR makes a recommendation that there should be a course developed which raises awareness of common medical conditions and the associated warning signs.

Recommendation 7: East Riding Safeguarding Adults Board should ensure the lessons of this SCR are widely circulated to local care homes so they can take the necessary action. Homes should be asked to evidence their approach to keeping records, monitoring health, managing falls, seeking medical attention and establishing clear accountability to residents and families. This should be reported as part of routine contract monitoring. ERYC should report back in six months from the publication of the report as to any further action that is required as a result of the exercise.

Recommendation 8: The East Riding CCG should:

- **lead the development of a health passport which should be available for all residents in care homes and should be checked at review**
- **develop a course or information pack for care home staff that identifies when they should seek medical advice.**

Medical or nursing assistance

Central to the failure to manage Mr B's health effectively was the over reliance the care staff placed on a transient intervention by a district nurse. The distinction between the role of a nurse and a doctor is obvious to people within the medical profession but is not so clear to those outside it. Busy district nursing staff need to be alert to the risk of their intervention being seen as medical rather than nursing assistance thus providing inappropriate reassurance to a care home.

Recommendation 9: The East Riding CCG should issue to care homes and other partner agencies a joint statement clarifying the respective roles of nurses and doctors.

Mr C

Mr C continues to reside at Wyton Abbey. He is 91-years-old. He has dementia and received respite care at Wyton Abbey until July 2011 when he moved in permanently as his condition became too demanding for his wife to continue to manage him at home.

Mrs C was surprised to learn his care has been included in this serious case review. She continues to be happy with the care he receives and is positive about the skill and attitudes of staff. She does have some issues with how Mr C's case has been managed.

Mr C was assessed as not having capacity to decide that long-term care was in his best interests so a best interests assessment under the Mental Capacity Act 2005 was carried out to make the decision. This was good practice and fully involved the family members who shared lasting power of attorney. His care is funded by ERYC.

On 6 September 2011, there is mention in the home's records of a discussion with his GP about Haloperidol, which is an anti-psychotic drug sometimes used for people with dementia who are in an agitated state.

On 19 September 2011, he had his first review. This was within acceptable timescales. No problems were identified and his wife was happy with his care. However, Wyton Abbey's support plan was not available. It is not clear from ERYC records whether the file was looked at and whether pre-admission documentation was checked to ensure the right care was in place.

On 24 September 2011, records from the home indicate he was up in the night.

On 29 September 2011, a GP visit was arranged because he had a sore eye. It is not clear from either the GP or the home's records whether this took place.

From 3 October to 15 October 2011, there are frequent reports of Mr.C being unsettled at night.

The home records and GP records indicate a medication review by telephone took place on 19 October 2011. There were clearly some problems with the accurate recording of events. The outcome of the review was to maintain current levels of medication with no medication prescribed to help with sleeping.

For the rest of October Wyton Abbey records indicate most nights were unsettled. This pattern continued with reports of him up and down the stairs during November. On 15 November, he was reported as being aggressive to other residents and staff.

On 22 November 2011, he was very agitated and violent to staff. The out-of-hours doctor was called and prescribed Haloperidol. His GP visited later in the

day to advise on the administration of Haloperidol and according to the home records suggested a urine test to rule out a urine infection. There is no mention of this in the notes provided by the East Riding CCG IMR.

According to Wyton Abbey records, the aggression continued and on 27 November 2011, he was reported to be aggressive and throwing objects. His wife was called to assist. The out-of-hours GP service was called (it was a Sunday) and prescribed Haloperidol again and advised he should see his own GP. The home records indicate a conversation with the GP on 28 November 2011, who confirmed that Haloperidol should be used as required. Between then and March 2012 he was not formally seen but the GP was in regular contact with his wife and reviewed his medication.

It is surprising at this point that Wyton Abbey did not seek more help. Mr C appeared to be a risk to both himself and others. There may well have been grounds for a safeguarding alert. This would have provided the opportunity to consider a range of options to help manage his aggressive behaviour.

On 4 December 2011, the home records describe “sexually dis-inhibited behaviour towards a female member of staff”. There is no follow up to this.

There were ongoing references to Mr C not sleeping at all or having unsettled nights. His wife noticed a scratch on his ankle. The handover book indicates that the district nurse should be asked to examine it and on 9 December 2011, there is a reference to the need to ask the district nurse to examine his leg. Neither of these requests appears to have taken place. It is important that such requests are always followed up.

Following further unsettled nights, he was reported to have a cold on 20 December 2011. A GP request was indicated but there is no evidence that the request was made.

On 26 December 2011, there is reference to a graze on the left elbow but no reason or subsequent action is recorded.

Mr. C’s son asked HFT for the minutes of the September review, which according to the Trust, were not available. A further review was fixed for 23 January 2012.

ERYC then held a routine review on 14 January 2012, when Mr C was seen. This was combined with a care programme approach review, which is good practice. No issues were raised by Wyton Abbey or other agencies despite the concerns about his aggression and his difficulties with sleeping, though the risk of falls was identified.

On 27 January 2012, ERYC business management unit visited and examined Mr C’s files. They concluded that the care plan was incomplete and inaccurate. It did not have the necessary risk assessments, key information and history.

It is of concern that the review on 14 January 2012, involving key staff, residential, social care and nursing failed to identify deficiencies in Mr C's care plan.

On 18 and 28 February 2012, there were further examples of aggression as well as on 5 March 2012 there was an unwitnessed incident between Mr. Conway and a female resident. He sustained a small cut under his nose. No action was taken in relation to any of these events. The final one may well have warranted a safeguarding alert.

On 20 March 2012, the GP has a record of a telephone consultation requesting a prescription for incontinence pads. This may have been a routine request. However, the HFT record describes it as an assessment for incontinence. This appears somewhat ambiguous.

On 23 March 2012, Mr C was found on his knees on the bottom step of the stairs. He had a skin tear on a finger. The district nurse dressed it the following day. She was due to review it on 26 March 2012, but this does not appear to have happened. However, a continence assessment was carried out.

On the same day, the GP records describe an Alzheimer's annual review which was undertaken by phone. The fall was mentioned. He was described as confused. The GP record also reports that Wyton Abbey staff also said his wife had requested that he should be listed as not for cardio pulmonary resuscitation. There is no record of this in the IMR provided by Wyton Abbey. It is unclear what the GP was going to do with this information. It does not appear to have been connected to the previous review.

On 1 April 2012, Mr C's daughter pointed out to staff that he was dragging his left leg and unable to raise his left arm very high. It appears there was a worrying four day delay in contacting the GP regarding symptoms that may have indicated a stroke. The GP visited on 4 April, 2012. The examination was normal.

On 14 April 2012, early in the morning he was seen to fall by care staff and given first aid for his hand.

A visiting district nurse was asked to check the hand on 17 April 2012, but was told the injury was due to his watch being too tight. She advised they should contact the GP if there was no change. His hand was redressed on 20 April 2012, and reported to have healed by 24 April 2012. This injury was effectively dealt with.

He fell again on 30 April 2012; there was no visible injury.

Between 7 and 10 May 2012 he refused to eat, was aggressive to another resident and was undoing his trousers while walking around. His family was informed. This was a further falls hazard, as well as raising issues of dignity and risk.

He fell again on both 14 and 20 May 2012, no injuries were noted. During May and early June there are references to him eating small amounts. It is not possible to conclude from the information provided whether his overall condition was stable or deteriorating. Information has been drawn from both Wyton Abbey's handover reports and the continuous report.

He fell again, his fifth fall, on 19 June 2012, early in the morning. He had a graze to his hand and redness to his eye. The sixth fall was on 21 June 2012. He cut his eye, grazed his head and cut his right hand.

The GP visited the following day. The record says he had a bruised left eye and an eye infection. Wyton Abbey records say the "GP requires that he no longer wears his glasses". This is a good example of how the same situation can be interpreted very differently and demonstrates the need for more joined up records. Not wearing glasses could increase the risk of falls and also disorientate someone with dementia. The GP record states that care staff were worried about his falls and planned to move him to a downstairs room.

On 26 June 2012, the home had installed a pressure sensor mat so they knew whether he was moving around his room. The same morning he fell again; the seventh fall. Later the same day he fell again and cut his right eye. According to Wyton Abbey records his wife did not want him to go to A&E. The GP was called and carried out a telephone consultation and noted he would benefit from a referral to the falls service. There was no home visit and no record of a falls referral being initiated. The Wyton Abbey records indicate they requested a falls assessment. The cut to the eye was dressed by the district nurse.

On 27 June 2012, the district nurse carried out a falls assessment. A range of risks was identified.

Wyton Abbey requested a GP visit on 26 June 2012. According to the GP, an error was made at the surgery and the visit was missed. Wyton Abbey did not chase this up until 3 July 2012. The GP carried out a further telephone consultation as Mr.C's left hand was swollen. She said she would prescribe antibiotics and ask the district nurse to visit, which she did. Though there is no record of this on HFT's records

On 4 July 2012, the GP visited Mr C. A referral to the falls team was sent on 6 July 2012. It would appear the GP did not have the result of the falls assessment carried out by the district nurse on 27 June 2012. The GP registered a safeguarding concern at the practice because the home had left it seven days to chase up the missed visit on 26 June 2012 which they concluded was a failure to act in the patient's best interests.

On 9 July 2012, an ERYC care co-ordinator visited after a colleague had raised concerns that Mr C had some injuries following a fall. She checked he had received medial attention and the sensor mat was in place and whether the family was aware. She also raised concerns about his weight loss and advised Wyton Abbey to contact the GP. She made a safeguarding referral.

On 11 and 12 July 2012, there was further aggression reported and Mr C was walking with his trousers round his ankles.

On 12 July 2012, six days after the GP made a referral, a paper referral arrived at the Beverley falls service, run by HFT. This built a week's delay into the system.

On 17 July 2012, the falls service visited. It appears that no new strategies were suggested though moving him to a downstairs room was discussed. The record from the home raises questions about whether they realised this visit was from the falls service. They thought she was an occupational therapist but she was a falls physiotherapist. This added to the confusion around the falls service.

Also on 17 July 2012, the GP made a safeguarding referral to ERYC following the visit on 4 July 2012 when multiple bruises were noted. The GP practice maintains this was because they were concerned the home did not alert them to the missed visit on 4 July 2012 and it demonstrated a lack of vigilance. However, according to the ERYC records there was mention of bruises rather than the missed appointment. The reason for the delay in making a safeguarding referral was that the issue was discussed at the practice's next safeguarding meeting. There was a period of time, therefore, when at least one GP, and possibly more at the practice, had a safeguarding concern which they did not act on.

The safeguarding team visited in response to this referral on 24 July 2012. They noted the weight loss and recommended an urgent move to a room on the ground floor. It was decided a best interests meeting was needed to consider this. There were concerns about poor recording of weight as well as diet and injuries.

Consideration was given to safety gates but these were thought to increase rather than decrease risk. A decision was taken to move him urgently to a downstairs room. This was done the following day, with his wife's involvement, prior to the best interests meeting, which took place on 30 July 2012.

Mr C's wife has expressed concerns about how this was handled. She felt she was not in control and had been bulldozed into the decision. She did not disagree with it but wanted to be part of it and was unhappy about how the way it was handled made her feel. She reported that the safeguarding officer said that emotional welfare was not their concern, only physical wellbeing. If this were the case it would be contrary to national expectations about good practice in adult safeguarding.

From July to December 2012, a similar pattern of falls and minor injures continued. There appears to have been an improvement in the speed with which medical assistance was sought both for fall and for health problems. He acquired a pressure sore which appears to have been appropriately dealt with and it healed.

There were a couple of issues of note. There was a safeguarding alert on the night of 25 September 2012, following an incident where Mr C was hit by another resident whose room he had entered. Paramedics were called. Mrs C did not want Mr C to be conveyed to A&E. In consultation with care home staff it was agreed that Mr C would remain at Wyton Abbey with half hourly checks taking place. Instructions were given to care home staff to call 999 should they have any concerns. This incident was investigated by police who decided that both those involved were vulnerable and no further action was needed. Wyton Abbey appears to have acted promptly and appropriately.

On 26 September 2012, a senior assessment officer from ERYC visited to check that Wyton Abbey had taken actions following the previous day's incident. There is reference to safeguarding measures being put in place. This was followed up by ERYC on 1 October and 4 October 2012, when it was confirmed that the necessary actions had been put in place.

However, on the same day ERYC's business management unit visited and reported that Mr C's plan was still being updated and identified poor recording which did not reflect current need and led to confusion. In particular medication signings were missing.

In mid-October there were some concerns about which members of the family had power of attorney to make welfare decisions. It was decided to hold a best interests meeting but the family resolved their disagreement before it was called.

On 25 October 2012, Wyton Abbey staff found substantial bruising on his hip. Mrs C agreed to take him to hospital to be checked up. Nothing serious was found. Mrs C thinks this was an unnecessary visit and could have been dealt with by a GP visit or going to the local practice rather than hospital.

The final event within the timescales of this review happened on 27-28 November 2012. Mr C fell again. The ambulance was called as was Mrs C. She was reluctant for him to go to hospital. Paramedics thought he should, but appropriately passed clinical responsibility onto the out-of-hours GP service. It appears that Wyton Abbey responded appropriately. They contacted ERYC the following day saying they thought he needed a reassessment. The district nurse said she would carry out a full falls assessment.

Key learning points

Use of Haloperidol to manage aggression

The management of Mr C's dementia has been confirmed by the East Riding CCG as NICE compliant. Treatment included the involvement of a community psychiatric nurse (CPN) to support behavioural strategies and Haloperidol was prescribed for extreme agitation. One issue of concern was that there was no upper dosage limit. The prescribing advice for older people is 0.5–

1.5 mg once or twice daily. It would seem advisable to indicate an upper limit particularly when prescribing for someone in a care home without nursing.

Recommendation 10: The East Riding CCG should recommend to GPs that when prescribing Haloperidol or other anti-psychotic drugs, as required, for people living in care homes they should indicate an upper limit.

Joining up services

There were a number of examples of services not communicating effectively and working on different systems. The HFT IMR identified three different recording systems being used. District nurses and the Beverley falls service both carried out falls assessments but they did not seem to connect with each other. The GP did not seem to be aware of the one carried out by the district nurse.

There were examples of referrals being delayed because they were sent in paper form rather than electronically

Recommendation 11: Whilst recognising national constraints, the East Riding CCG should ensure local health agencies identify opportunities to optimise their use of electronic recording, referrals and communication and report improvements to the East Riding Safeguarding Adults Board.

Balancing urgency and involvement

The safeguarding response to Mr C's fall on 24 July 2012, highlights the importance of proportionality in safeguarding. Lord Justice Munby in his review of social care legislation said "What good is it making someone safer if it merely makes them miserable?"

It is interesting that Mrs C reports that a safeguarding team worker said they were just interested in physical safety and not emotional welfare. This was not the safeguarding worker's intention, who is clear that this would not be the case and both are important. Whilst it was clearly important to reduce the risks to Mr C it appears that the approach taken alienated a key member of his circle of support. This may have been unavoidable, however, this example shows how important it is to find out routinely how people have experienced safeguarding interventions. This may not have come to light without a serious case review.

Recommendation 12: The East Riding Safeguarding Adults Board should routinely include the experience of people who use services and their carers in their audits of service and include the findings in the annual report.

Keeping good records

The difficulties in keeping up with the frequency of falls and changing behaviour brings into sharp focus the importance of keeping good records in care homes which don't just record events but focus on the individual's needs and outcomes. The failure to use records was not just a problem for Wyton Abbey. Two reviews failed to pick up the inadequacy of records and this meant that Mr C's aggression was not picked up early and considered strategically.

Recommendation 13: ERYC should ensure reviewing staff know what to look for in care home files and always use them for reviewing purposes, confirm the necessary pre-assessment information is in place and follow up any omissions.

Recommendation 14: Prime Life and all registered managers in the East Riding of Yorkshire Council area should be able to provide evidence that they have used this report to highlight the importance of good recording and the timely seeking of medical assistance, pointing out that poor recording can endanger lives.

Speedy safeguarding referrals

The delay in the GP making a safeguarding referral is clearly of concern, as the referral was not made before it was discussed at the practice safeguarding meeting. It was also not brought out as an issue in the East Riding CCG IMR. It would be useful for the CCG and NHS England to work with ERYC's safeguarding team to identify whether referrals from GP's is a wider issue. Local GP's need to be made aware of this learning point so they are clear that each has an individual responsibility to make timely safeguarding referrals which should not be delayed by internal processes.

Action Taken: East Riding CCG has agreed to give protected training time on adult safeguarding to GP's.

Recommendation 15: NHS England (North Yorkshire and Humberside area team) should assess whether the speed of safeguarding referrals from GP's is an on-going issue and issue advice and guidance based on this experience.

PART TWO

Agency responses and how they worked together

Co-operation between providers

Outcome 6 of the Essential Standards of Quality and Safety published by the CQC is all about how regulated providers should co-operate with others. It emphasises that where the care, treatment or support is provided by more than one service, or the responsibility for the delivery of care is transferred from one service to another, all those involved in the care, treatment and

support of the person should have all the relevant information about the person who uses services available, especially where it has a direct bearing on the quality and safety of the care, treatment and support being delivered.

There are many examples of this standard not being met. There were times when Wyton Abbey had either not recorded or not known about assessments done by other professionals. There was one example of a delay in making a safeguarding referral. There were delays in requesting medical assistance. There was lack of awareness of a palliative care plan. There appeared to be uncertainty about who was taking the lead in managing people's care.

Prime Life have proposed there could be a more open way of sharing information including medical information for people who are residents in care homes

Yet it is interesting to note that compliance with Outcome 6 did not feature in the regulatory concerns about Wyton Abbey. This may be because these issues could be less likely to emerge when looking at one agency.

This is also vital because it has a real bearing on people who are self-funding who have a much greater reliance than funded residents on the ability of the various providers to co-operate with each other.

There are clearly obstacles to information sharing such as confidentiality but a risk that these can be overestimated. There is a real opportunity both locally and nationally to take a whole systems approach to how well providers are co-operating, co-ordinating and sharing relevant information.

Recommendation 16: The CQC along with the Information Commissioner and other partners should issue guidance on legally compliant processes for the sharing of information to ensure that any relevant information is accessed at all times to make certain the needs of the person who uses services may continue to be met.

Recommendation 17: The East Riding Safeguarding Adults Board should carry out a wider review of the adherence to Outcome 6 of CQC Essential Standards of Quality and Safety that starts from the experience of all those receiving residential care in the area.

The response to Mr A's death

Concerns about the quality of care first came to light on 12 September 2011, when Mr Ashton's children expressed concerns about their father returning to Wyton Abbey.

Their first action was to contact the CQC, which is the regulator for residential care homes. CQC informed ERYC safeguarding team on 13 September 2011. It is worth noting that CQC did not pro-actively follow up that referral and had no further involvement until they were informed of the outcome of the investigation in January 2012.

Also on 12 September 2011, the local authority assessment officer at Hull Royal Infirmary, having picked up concerns from Mr A's family, alerted the safeguarding adults team. The system worked effectively in responding to those first concerns

On 12 September 2011, it was decided jointly with the police that there was no need for police involvement and ERYC safeguarding adults team would investigate alone. The police seized documents relating to him. This decision was reversed on 19 September 2011 after the police had been requested by the Coroner to prepare a report. The safeguarding adults team and the police then planned the investigation together and they visited the family on 18 October 2011.

In the meantime on the 30 September 2011, the Holderness care management team received a contact from the son of another resident at Wyton Abbey setting out his concerns about his father's care. They emailed this information to the ERYC business management unit the same day. This appears to be the first time that the business management unit was involved. According to the chronology, they were not informed by the safeguarding adults team of safeguarding concerns until a routine update on 16 October 2011. There is also no evidence in the chronology of any contact between the safeguarding adults team and the Holderness care management team in relation to this contact.

It is surprising that the business management unit, who would have already been involved with Wyton Abbey and would have a lot of information about the home, was not formally included in the investigation. There was subsequently a decision that the business management unit would not visit the home until the safeguarding investigation had been completed. This does not appear to be an effective use of the available resources. Although it has now been agreed the business management unit can visit homes whilst an investigation is on-going there is a wider issue of what its role should be, as the contractor, in leading or co-ordinating safeguarding investigations of care homes.

Recommendation 18: ERYC should review the business management unit's involvement in safeguarding investigations of care homes with a view to its role being more central to the process and clear to all agencies.

CQC did a responsive inspection on 24 January 2012. They were unable to look at Mr A's files as the police had seized them. They identified minor concerns relating to care and welfare and notifications of incidents and moderate concerns about safeguarding. Records were thought to be compliant with regulations but could be improved. The methodology used at the time meant that each outcome was looked at individually and so the risk was identified as minor. CQC did not sufficiently take into account new information from ERYC about staffing levels. They have concluded that a further inspection should have taken place in February/ March 2012.

Action taken: CQC have now overhauled their methodology and from April 2012 there was a revised judgement framework, which looks at outcomes in the round.

There is also a concern about whether CQC should have done a responsive inspection following the decision to suspend placements. CQC made their own decision not to – it was not discussed at the professionals meeting.

Recommendation 19: ERYC's procedure for suspending placements should require that a joint decision with CQC should be made on the most effective use of CQC's inspections in achieving the required evidence of improvement. **CQC should then apply this learning nationally.**

Recommendation 20: ERYC should ensure that when placements are suspended, providers should be given clear timescales for the improvement milestones expected and evidence that will be required.

The response to Mr B's death

The serious concerns raised by the condition of Mr B when he died appear to have been well managed. The business management unit and the safeguarding adults team worked well together to identify concerns. CQC were involved and used their powers to request certain documents in order to assess the quality of care. The quality of these was used to focus further inspections and enforcement decisions.

A meeting of professionals on 13 July 2012, decided to suspend placements because of concerns about Mr B's condition linked to delays in seeking medical assistance, combined with poor hygiene, poor care planning and inadequate staffing. This decision making included the key partners including a neighbouring council, which had also arranged placements at Wyton Abbey. It does not appear that any specific actions were taken in relation to how to secure prompt medical assistance. It would have been helpful to involve HFT and the GP in this issue.

Placements were suspended by senior management on 16 July 2012. A detailed plan was agreed but the IMRs have identified a failure to set clear timescales for improvement. This had some effect on the decision making process for reinstating placements and perhaps failed to inject the required urgency into the improvement process.

One issue of note is that the meeting concluded that no other residents were at risk. This was at exactly the same time that concerns were increasing about Mr C. If the GP had made a timelier safeguarding referral, the 13 July 2012 meeting would have known there was, in fact, a concern about another resident. Although this did not affect the outcome of the decision, it is a striking example of the importance of responding speedily to concerns.

Sharing Concerns

There is no evidence from any of the IMRs, that health colleagues were aware placements had been suspended and there were on-going concerns about the quality of care in the home. In fact, GPs were only aware of the suspension when they were informed it has been lifted. It is important that regular professional visitors to the home are provided with such information. Their assessment of what is happening can provide valuable additional information. It also heightens their sensitivity to the risk of further problems.

Recommendation 21: When ERYC suspends placements a strategy meeting should decide which key professional visitors to the home should be made aware of the reasons and their support elicited. This should be reflected in safeguarding policy and procedures.

The decision to reinstate placements

Placements were reinstated on 2 November 2012. There are a number of questions about the timing of the decision. It has already been mentioned the lack of a clear timescale for improvement may have blurred the decision making. There is strong evidence from the business management unit that care at the home had markedly improved. Concerns about the sustainability of change had been reduced following the appointment of a new manager in September 2012

A CQC inspection on 19 September 2012, focused on the warning notice that has been issued and confirmed that Outcome 8 relating to infection control and hygiene was now met. However the other two outcomes, which were the subject of compliance notices relating to care and safeguarding, were not inspected on that date as the timescales for improvement were different. The suspension decision was therefore not based on CQC's independent assessment of improvement across the range of key concerns. It is not clear whether CQC knew their inspection was key to the decision to lift the suspension. Decision making is based on a range of factors and the CQC position is crucial. The decision would have been more robust if their visit on 19 September had looked at all three outcomes where non- compliance had been identified or ERYC delayed their decision until after the final inspection took place.

In the event, the decision was also taken two weeks before CQC carried out a full inspection on 12 November 2012. On 14 November 2012, the report from the Coroner concluded that Mr B's death was influenced by the delay in seeking medical attention. Whilst it would have been prudent to wait until these reports were available, these two events would probably not have affected the decision to lift the suspension.

The falls service

The SCR has been informed that for the period of this review the falls service available was not NICE compliant. It is probable that this led to the confusion over whether Mr C had been referred to the falls service and who was doing the falls assessment and intervention. The home received some advice and assistance from a physiotherapist, but there does not seem to have been a referral to the consultant led acute falls service at Hull and East Riding Hospitals. There is a clear need to ensure that there is an easily accessible, comprehensive falls service for East Riding.

Recommendation 22: The East Riding of Yorkshire CCG should commission a NICE compliant falls service with very clear pathways that make it easy for care homes to receive assistance with frequent fallers.

The police decision not to prosecute in the wake of Mr B's death

The decision not to investigate further was made by the police on 17 November 2012 after the Coroner had reported that Mr B might not have died if he had received medical attention earlier.

The IMR states the police decided there was insufficient evidence of corporate manslaughter which they defined as: An organisation is guilty of an offence if the way in which its activities are managed or organised:

- causes a person's death
- amounts to a gross breach of relevant duty of care owed by the organisation to the deceased.

They also considered whether an offence had been committed under Section 44 of the Mental Capacity Act 2005, which relates to wilful neglect.

The death of Mr B was reported to Humberside Police and referred to the public protection unit for the East Riding.

A detective inspector considered the circumstances of the death with oversight from a detective chief inspector; they were also discussed with an accredited senior investigating officer (SIO). It was determined there was no evidence criminal offences had contributed to the death of Mr B and therefore a criminal investigation did not proceed. Humberside Police did undertake an investigation, on behalf of the Coroner, into the circumstances of the death. This investigation was undertaken by a very experienced public protection detective constable and was subject to supervisory scrutiny.

During the course of the serious case review the initial police decision making around the death of Mr B has been discussed by three further SIOs, two of whom are trained as review officers. They are in agreement with the initial decision making and concur that the threshold for criminal investigation and prosecution was not met.

The Crown Prosecution Guidance on wilful neglect (CPS 2009) identifies the following behaviours as being examples of wilful neglect:

- ignoring medical or physical care needs
- failure to provide access to appropriate health services
- withholding medication
- adequate nutrition or heating
- unmet physical needs such as bedding or clothing soaked in urine or faeces, decaying teeth, overgrown nails.

Some concern has been voiced by partners as to whether the police made the right decision or had sufficient evidence to do so at the time. The concern hinges on the conclusion they drew that Wyton Abbey sought medical advice when he was cursorily examined by a district nurse who had her coat on as she was leaving the building. This issue relates to the earlier discussion about the importance of people outside the NHS being clear about the distinction between medical and nursing assistance. Mr B's health had clearly declined over a period of time when no medical assistance was sought.

Whilst it is not now appropriate to reconsider that decision, it reinforces the importance of addressing **Recommendation 9.**

Recommendation 23: Humberside Police should provide evidence to the East Riding Safeguarding Adults Board that investigating officers have a good understanding about what can reasonably be expected of registered managers and providers to underpin decisions relating to their prosecution.

Timeline **Appendix 1**

2011	May	Mr A admitted
	June	Mr B starts short term breaks
	July	Mr C admitted Mr A change of mental state Mr A first assessment officer visit
	August	Mr A review cancelled
	September	Mr A dies Mr A safeguarding investgation starts CQC notified Mr C review – OK
	October	Mr C not sleeping Mr B falls – no notification
	November	Mr C – 1st report of aggression
	December	
2012	January	Mr A safeguarding investigation ends Mr C reviews – OK CQC responsive inspection – some concern BMU visit – Mr C's records poor
	February	
	March	
	April	
	May	CQC inspection – concerns about cleanliness
	June	Mr C starts 2 weeks stay
	July	Mr B dies Suspension of placements Mr C GP raises safeguarding concerns Mr C assessment officer raises safeguarding concerns Mr C moves to downstairs room
	August	CQC inspection warnings and compliance action
	September	CQC inspection – focus on cleanliness only New Manager at Wyton Abbey
	October	BMU notes considerable improvement
	November	Placement suspension lifted Coroner report on Mr B CQC inspection – compliant
	December	Serious case review commissioned