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Executive Summary of a Safeguarding Adults Review into the death of Mrs MX while a resident at a care home in Peterborough

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1. About the review

This review has been commissioned by Peterborough Safeguarding Adults Board: and compiled by Prof Hilary Brown, Emeritus Professor of Social Care, Canterbury Christ Church University, scrutinised by a Panel of senior managers representing the key agencies involved in the provision of health and social care to older people in Peterborough. The Panel has been chaired by Russell Wate, who is chair of the Safeguarding Children's Board and of the Safeguarding Adults Board, for the partnership of agencies involved in safeguarding adults and building safer services in the area. Agencies who were involved in Mrs MX's care submitted Internal Management Reviews to the Panel and sent delegates to meetings of the review panel.

The status of the review

The purpose of the review, that has been shared with all the contributing agencies, is *not* to reinvestigate or apportion blame but

- To establish whether there are lessons to be learnt from the circumstances of the case and the way in which local professionals and agencies work together to safeguard adults at risk of abuse
- To review the effectiveness of procedures
- To inform and improve local inter-agency practice
- To improve practice by acting on case-based learning

The review follows a process of investigation and shared decision-making conducted under the guidance of the Peterborough Safeguarding Adults Board. The goal of safeguarding work is not only to hold individuals and agencies to account but to prevent abuse and neglect in future.

1.1 Analysing difficulties at different levels

The panel looked at the issues from different perspectives, exploring the standards of nursing care, the way that different health professionals worked together in relation to this case, and more structural issues about hospital discharge and the differing interface between primary care teams and nursing and residential homes, Most lapses in acceptable care are not the sole responsibility of individuals but occur at the junction of both organisational and individual pressures. Even where it looks as if there has been an error of judgment or less than optimal care on the part of one or

more *individuals* that we could think of as "active failures", it may also be the case that a service has failed to provide an appropriate skill mix or adequate training and support for their staff and that these "latent factors" have created the context that affected the person's decision-making and/or exacerbated their stress.

The Panel has also explored how this matter was brought to the attention of the Home itself and subsequently of the Adult Social Care (ASC) department within Peterborough Council. We have looked at the boundary between a complaint and a safeguarding alert and at whether the inquiries that were made were appropriately robust and independent. We have also looked at the experience of the family at the heart of this case and of how they have been supported throughout this process.

Our deliberations have led to a number of recommendations, some of which are discrete and specific to this situation while others have more general application and/or are more systemic in nature. In this case there has been no suggestion that actions or omissions were motivated by malice but still we have to reach a view about whether the care provided in this service was "good-enough." The Safeguarding investigation reached a finding of neglect and the panel have endorsed this: using current policies and clinical guidelines as a reference point against which to make this judgment.

1.2 The role of statutory services in supporting residential and nursing homes

Health and Social Care agencies are supposed to work together to provide a seamless service when a person is discharged from an acute ward into residential or nursing home care. The hospital ward is supposed to signal that a person is ready to leave the hospital in order to trigger the search for a suitable placement or package of care at home,- this is then followed by a discharge summary detailing their medical conditions and nursing requirements. ASC, who manage the placement process and secure funding are supposed to summarise these arrangements in a care plan that goes with the person into the home informing staff who then create a detailed care plan to address each area of need that has been outlined.

The ward staff of local hospitals refer patients who are being discharged into *residential* care back to their GP and any nursing needs to community teams and district nurses while it is expected that those going into *nursing*

home beds will be cared for directly by the nurses employed in the home. This distinction caused confusion in Mrs MX 's case because although she was assessed as needing a residential home bed, she was actually placed into a nursing bed in the home as a stop-gap measure because they did not have a place in the residential section of the home. When she was later transferred back into the residential bed for which she was funded, it was as if her transfer suggested she was getting "better" when in fact her nursing needs had intensified

1.3 The loss/removal of records

One of the most troubling aspects of this case is that at some point between Mrs MX 's death and the formal safeguarding adults review, about half of her records "went missing." One of the Directors of the company managing the home explained to the Panel that after a death, records are usually dispatched to the company's head office where they are archived. On retrieval of Mrs MX 's records it was found that the file was incomplete. Although no-one could be sure about how this documentation went missing, he acknowledged that there were grounds for thinking that the missing papers might have been deliberately removed. The matter could have been investigated with a view to prosecution as an offence of "perverting the course of justice" and/or of "obstructing the coroner in the execution of his duties." These are serious offences.

In the absence of these papers the review has had to proceed using what records remained, supplemented by interviews carried out by the Director of the Company which were inevitably hampered by the passage of time as they took place 18 months after Mrs MX 's death. The records that do exist are poor; they show inconsistencies and misunderstandings.

2. About Mrs MX

2.1 Mrs MX 's history and medical conditions

Mrs MX had been living independently despite several chronic conditions that she was managing well. She was admitted to Peterborough Hospital, Emergency Short Stay Ward, as a result of a fall in August 2012. This led to a long hospital stay after which she was due to be discharged in October but unfortunately suffered a pulmonary embolism while she was there and was

readmitted to the acute ward of Peterborough City Hospital on 3/11/12 where she was stabilised on Warfarin and eventually discharged to The Home at the centre of this review in November.

The outpatient clinic staff responsible for managing her Warfarin were in direct contact with The Home at this time about Mrs MX 's medication, and asked the home to monitor her blood pressure which they did irregularly, and to take measurements designed to inform her prescribed doses of Warfarin which the staff did but only after a short delay. It was noted that she suffered from a number of co-morbid conditions including

- ⇒ Diabetes controlled by medication and diet
- ⇒ Asthma and possibly Chronic Obstructive Pulmonary Disease (COPD)[1]
- ⇒ Diabetic retinopathy
- ⇒ Suspected glaucoma
- ⇒ Bilateral cataracts
- ⇒ Diverticular disease and chronic diarrhoea
- ⇒ Hypertension (that is high blood pressure)
- ⇒ Osteopenia (that is the early signs of loss of bone density that can lead to osteoporosis)
- ⇒ Pernicious anaemia
- ⇒ Pressure ulcers
- ⇒ Pulmonary embolism as diagnosed through a CT pulmonary angiography scan (CTPA) for which she was taking Warfarin which has to be closely monitored

She was also discharged from hospital with a urinary catheter according to the PSHFT IMR.

But although this is a long list it is not untypical of older people leaving hospital and her care needs were not considered complex or extreme.

2.2 Mrs MX 's discharge from hospital and placement

Mrs MX was placed in The Home during November 2012 on her discharge from hospital. She had been assessed as needing residential, as opposed to nursing home care, but they did not have a bed in the residential part of the home so she was admitted to the nursing home floor as an interim measure.

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1 This diagnosis was disputed, her GP said that she did not have this condition, but the hospital staff noted it.

This complicated the discharge arrangements somewhat in that the ward staff made a referral to the district nurses attached to the primary care team in relation to a potential pressure ulcer, thinking that Mrs MX was going into residential care and that she would be receiving her nursing care from the community nurses. As it was, she was discharged into this nursing home bed as an interim measure and this meant that she received nursing care from the home's own nursing staff. She had been discharged with a catheter and possible pressure ulcer as well as her chronic conditions of diabetes and COPD but without a discharge summary, which is regarded as an essential aid to good practice.

3 Mrs MX's placement at the home

3.1 Care plans not in place

Within The Home, despite the missing documentation, care plans were in place for care in relation to Mrs MX 's plaster cast and for her catheter care but not for the other issues that were critical in relation to her nursing care including pressure ulcers, her food intake, her diabetes and the potential for her to have a hypoglycaemic episode, her Warfarin and her blood pressure. The lack of a proper, live record is strongly suggestive of a service that was not reliably collecting the kind of detailed information that underpins good nursing care. Safeguarding enquiries do not look for records that have been kept as a formality but for documentation that is being used on a day-to-day basis. The home's manager acknowledged in hindsight that the recording had been *"erratic"*.

There was an additional problem in that neither Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT), nor Peterborough Adult Social Care (ASC) had completed their own paperwork properly. These are important omissions and the supervisory systems that allowed this discharge to go ahead without this minimal sharing of information should be rectified. Quality assurance should be on-going and systematic. There are key points that trigger reviews and these systems should be monitored and supported within ASC and NHS provider agencies and their efficacy scrutinised by the Safeguarding Adults Board. It is vital that they do not fall into disuse.

3.2 Management of potential pressure ulcers

Mrs MX had a lesion on her back that was alternately referred to as a *"red mark"*, *"a cyst"* or a "*pressure sore*" but there was no wound care assessment or plan. Pressure ulcers are usually graded according to the depth of the tissue breakdown but this had not been assessed in these terms. Skin integrity is a particular risk for people with diabetes, as they do not heal as easily as others, therefore one would have expected this to have been attended to with extra care. The ulcer deteriorated while Mrs MX was in hospital and at the point where she was discharged it was said to be open, which is why she was referred by the ward nursing staff to the district nurses but they did not visit because Mrs MX was in a nursing bed. Nursing staff at The Home should have picked this up and produced a detailed care plan in relation to her pressure areas.

3.3 Management of diabetes

Mrs MX was a "tablet controlled" diabetic and she took Metformin[2], 500mg twice a day which tended to make her nauseous so she sometimes refused to take her medication. On November 29th 2012 the Nurse Prescriber from the GP practice spoke to the staff of the nursing home regarding Mrs MX 's nausea and recommended changing the form of her medication from tablets to a solution but maintaining the dosage at 500mg twice per day and she asked for blood sugar levels to be monitored and for the surgery to be informed of the results. Mrs MX 's GP again specifically asked for the home to monitor her blood sugar levels over a one-week period and they were measured the following day but then not again for a week and not again after that. The reason given for this failure to follow the GP's instructions was that there was a malfunction / error message on the machine. The home did not seem to have any contingency plans for dealing with this other than to keep trying, so no-one tried to replace the machine or get it re-calibrated or to find another machine that could be used in the interim. Given the crucial role that blood sugar testing had in the care of Mrs MX and has in relation to other residents with diabetes, including in acute episodes, this is an extraordinary omission and failure of decision-making.

[2] http://www.drugs.com/metformin.html

3.4 Monitoring food intake and bowel care

Mrs MX did not have any special diet noted on her records even though she was diabetic. Her notes said that she should have a "normal" diet, which referred to its consistency (ie whether it was liquidised) not its content. Diabetes obviously presents particular challenges if a person is unable to maintain a regular intake of food, which is what happened to Mrs MX, partly, we infer, as a result of nausea induced by her medication. The standard procedure in a nursing home would be for food intake to be assessed on admission and regularly monitored using a standardised tool such as MUST (Malnutrition Universal Screening Tool)[3] but there is no evidence as to whether this practice was followed at The Home.

Another routine aspect of good care is to maintain accurate bowel charts and the fact that Mrs MX was constipated only came to light during the safeguarding investigation when her son passed this information on to the independent investigator. Apparently Mrs MX had not opened her bowels for 8 days, which her son considered must have been extremely uncomfortable for her. Her GP visited on 17th December 2012 confirming the diagnosis of constipation and prescribing a laxative and enema. Three enemas were given to Mrs MX on 17th December 2012.

Staff were unable to throw any light on why there was no care plan for diabetes, no food chart and no bowel chart.

3.5 Blood testing related to Warfarin

Warfarin thins the blood and is absorbed differently by each individual so it has to be regularly assessed and the dosage adjusted accordingly. The INR result is the time in seconds that is required for the blood to clot. INR stands for International Normalized Ratio. The higher your MX - INR is, the longer it takes your blood to clot. The most common INR target range for someone on warfarin is around 2.0. INRs of 5 or more are typically avoided because they are indicative of an increased risk of bleeding. Mrs MX 's readings had been taken on the following dates 15/11/2012 (2.00), 20/11/2012 (2.5), 4/12/2012 (1.6), 10/12/2012 (2.6), 19/12/2012 (4.4). There is no record as to whether this high reading (4.4) led to any remedial action. The hospital had asked for these tests to be conducted by the nursing home staff after Mrs MX 's admission for her embolism. Good practice

[3] http://www.bapen.org.uk/pdfs/must/must_full.pdf

would have been for her to have had an anti-coagulation booklet stating what her optimum INR range should be as this could have acted as a running record of her INR readings and Warfarin dosages. None of the staff mention such a booklet and it is not in Mrs MX 's file.

The home manager explained that on December 29th 2012, Mrs MX 's INR had been 6.9, which is considerably above this safe limit; the target was for her to register at 2-3. Her next test had been due on December 31st and the home manager, unable to get a District Nurse to attend to take the blood, took her to the City Clinic, regarding it as essential that this test, by now 5 days overdue, was carried out. Mrs MX 's relative complained about this visit, saying that his mother was already unwell when she was taken on this "outing" perhaps not realizing the importance of this particular medical appointment. Obviously this was a difficult judgment call.

3.6 Management of medication

Several issues arose in the way that Mrs MX's medication was managed including a short delay when one medicine that was making her nauseous was substituted with another but the care home staff did abide by national guidance in asking for written confirmation of this change.

On occasions Mrs MX refused to take her medication: we have no evidence as to how this was managed at the time, for example whether a staff person routinely carried out a mental capacity assessment each time and/or the extent to which they spelt out the potential consequences of not taking her medication or sought to persuade her to be compliant with the regime suggested by her GP. the GP had also asked for regular blood pressure checks but these were done irregularly.

3.7 Mrs MX's last hours

On their return from the clinic Mrs MX became very unwell and her blood sugar levels fell dangerously low. Staff did follow instructions by giving her Hypostop (a fast acting glucose gel) but the level did not return to normal. One staff person took readings of her blood sugar level on 5 occasions during her shift that finished at 10pm and another took 2 further readings after 2am. The normal range for this reading is between 4-7, anything below 4 is considered low and should trigger corrective action and/or referral to emergency services. This Home staff did not call emergency services when Mrs MX 's blood sugar level was 1.4 although Mrs MX 's

blood sugar levels took a long time to stabilise and it was not until approximately 04.00 am, that they rang 999. They reported that Mrs MX was by then conscious but breathing abnormally, that she was diabetic and had cold clammy fingertips and was blue. A second call was placed at 04.12am saying that she had stopped breathing and that the nurse had commenced CPR. The Home did not have a defibrillator available. The first ambulance crew arrived at 04.09 having experienced difficulty locating the home as their records had not been updated to show it had a new name. A cardiac arrest crew were dispatched at 04.13am in response to the second call and they arrived at 04.20. Mrs MX was confirmed dead at 04.40am following 28 minutes of CPR.

The home had not discussed the issue of active resuscitation with Mrs MX or her family when she was admitted or in the intervening period. Her relatives were understood to want proactive care and there was no advanced directive or "Do not attempt resuscitation" (DNAR) notice in place but this had not been the focus of any sensitive exploration with her family. This is a difficult area of care but it is one that nursing homes should be skilled at managing.

Nursing homes usually have experience of, and protocols for, the management of expected deaths but Mrs MX's death was not expected and the signs,that she was dying, were not registered by the staff in a timely way. It is as if the staff were on two pathways, one of which was to calmly watch over her while noticing that her vital signs were failing and the other that they were in an "emergency" situation and that they were monitoring her to see when /whether they should call an ambulance. They could not do both, and in the event they ended up doing neither.

Notwithstanding this, the Panel reached a consensus that even if Mrs MX 's care during the evening prior to her death and in the early hours of the next day, had been more coherent, her death may not have been preventable. It would seem that emergency services should have been called shortly after she registered a blood sugar level of 1.4 at around 6pm on Jan 2nd 2013 but it is possible even then that her admission to hospital would not have prevented her death but had the staff recognised how ill Mrs MX was, they would have called an ambulance. The *possibility* that Mrs MX could die should certainly have been registered by the time the shift ended at 10pm when her relatives should have been informed of this.

At what point during this trajectory should a trained and experienced nurse have been able to predict that this was a woman in her last hours? The ASC safeguarding investigator discussed this with Mrs MX 's GP who was clear that the combination of a low blood sugar, low blood pressure, nausea, vomiting and feeling unwell in an older person would signify that a person was very ill and yet the staff at The Home do not seem to have registered this in their internal communications and/or by talking to Mrs MX 's relatives. Staff continued to see her as a patient who was ill rather than as someone who was dying, despite the many signals that she was extremely unwell.

3.8 What was learned about the overall standard of care at The Home?

From the interviews conducted by the Director with members of The Home's staff it is clear that some of the omissions that occurred in relation to the basic nursing care provided to Mrs MX were indicative of wider failures. They speak to a staff group who seemed demoralised and were not surprised that records were absent or that care was haphazard. Information was sometimes recorded on the daily logs but not in individual patient files so that it was not reliably passed on to all staff. Important things were not captured at all including information about food intake and bowel care. Care plans had not been put in place to address Mrs MX 's diabetes or her pressure sore.

It would be simplistic to "blame" poor record-keeping in isolation from other factors. Nursing homes are busy places and we cannot, from this distance, know what else was going on, how many other residents were in need of intensive support and /or how many experienced staff were available to provide this care. But the lack of proper, live record-keeping is strongly suggestive of a service that was not reliably collecting the kind of detailed information that underpins good nursing care. Safeguarding enquiries do not look for one-off records that have been kept as a formality but for documentation that is being used on a day-to-day basis.

4. Addressing neglect when it occurs

4.1 How the matter was raised

Concerns about Mrs MX 's care in the weeks leading up to her death, were first raised by her son in a phone call four months after she had passed away. He said in this call that he was going to make a complaint but it was not clear why it had taken the family this length of time to formulate their concerns, especially given the seriousness of the allegations. There was a further delay while the home seemingly waited for him to put his concerns into writing but it is clear from his later correspondence that he felt he had actually already made a complaint by making this phone call and that he had been awaiting a response. The home's manager had mentioned this once to one of the Directors of the company but neither had proactively followed it up, for example by seeking an early meeting with Mrs MX 's son or other family members.

The Director of the company sought advice from a senior nurse from local services but it is unclear on what basis she became involved,- she did not seem to be giving advice from her formal position and this meant that she was not working within a formal remit either to ensure a prompt referral to the safeguarding adults system or to oversee any disciplinary actions or professional scrutiny of nursing practices.

According to the CQC report following the inspection carried out in December 2011, the home did have adequate safeguarding procedures in place but these were either not robust enough and/or had not been applied properly in relation to these concerns. So turning away from feedback from Mrs MX's family about the way that she had been treated was both insensitive and poor practice.

Care homes must be managed on the basis of sound values, good clinical care and respect for service users. Directors should *want* to know if there are problems and *actively* seek out feedback about the quality of care that is being delivered. The home failed in its responsibilities to inform ASC that a serious safeguarding matter had been raised.

Had the referral been passed to ASC in a timely manner the Panel would expect to have seen a concerted multi-agency investigation with distinct but

coordinated strands driven by a formally constituted professionals' meeting, and including:

- Consideration, as a matter of routine, as to whether there were grounds for a referral to the Health and Safety Executive to explore whether the home had breached their duty of care
- Investigation to see whether the company had been negligent in any way
- A possible criminal investigation to determine who had removed documents from the file as this constituted a potential criminal offence of perverting the cause of justice and/or obstructing the coroner in the course of her or his duty
- Scoping of the evidence to see whether a breach of Section 44 of the 2005 Mental Capacity Act had been breached during any times when Mrs MX seemed to lack capacity
- A formal inquiry into the clinical practice of nursing staff to see if there was a need to make a referral to the NMC regarding their clinical practice
- The possibility for an unannounced inspection by CQC to determine whether the gaps in recording and lapses in good practice were departures from the home's usual standards or an indication that poor standards were the norm in this establishment and if the latter how far inadequacies had been remedied.

Raising these questions as a matter of routine in professionals' meetings does not imply that all cases, or this case in particular ,warrants these interventions but that each should be considered at the early stages of an enquiry. It is important that organisations as well as individuals are held to account through these mechanisms. An action plan could then have been drawn up and managed from that initial investigation. As it is a number of these issues remain unaddressed and the Panel have asked that they be attended to now.

4.2 Safeguarding Adults

The Home was not the only agency that was unclear about the boundary between a complaint and an allegation of neglect because when the concerns of Mrs MX 's family were passed to Peterborough Council as a complaint (instead of being referred to Adult Social Care as a safeguarding issue) they also sought to resolve matters within their complaints policy without alerting adult safeguarding. The Council complaints department

does sometimes refer complaints to the safeguarding team within the ASC department but in this case declined to do so.

One of the clearest indicators that a matter is best worked with as a safeguarding issue as opposed to within the complaints policies, is where several agencies and professionals have had difficulty in working together. Where problems occur in the communications and working practices *between* agencies, as opposed to *within* a single agency, then a safeguarding enquiry allows those fault lines to be explored. In this case there had been a breakdown in communication between the nursing staff of the home, PSHFT's staff, district nurses and Mrs MX 's GP. The placement had been made in the context of discharge from an acute hospital bed as is often the case. Peterborough ASC had placed Mrs MX temporarily in the nursing home section of this dual registered home, but subsequently in the residential part of the service and this transfer created somewhat of a hiatus which unfortunately coincided with a deterioration in Mrs MX 's health.

The safeguarding adults investigation reached the conclusion that the care offered to Mrs MX ***had*** been neglectful due to

- Poor and inadequate record keeping at the home
- Failing to monitor BSL, INR, BP in a consistent manner
- Staff not following the advice of medical professionals
- Inadequate bowel care??
- Inappropriately taking Mrs MX out when she was feeling unwell
- Delay in seeking medical attention and poor clinical decision-making.

and the review panel concurred with those findings.

5. What can be learned?

Using a form of "root cause analysis" we have traced areas of practice that could have been better and tried to track the points at which different decisions and actions could have made a difference.

5.1 What went wrong in the lead up to Mrs MX 's experience of poor care?

- There was no routine training specifically addressing treatment of diabetes given to nursing or care staff in this home despite the fact that there is a high prevalence of people with the condition entering into nursing homes making this a core aspect of their practice, their skills should include how to take and record blood sugar levels, how to use blood testing machines and how to manage a hypoglycaemic episode
- The home's manager had been expected to be the clinical liaison lead in relation to pressure ulcers and diabetes as well as managing the home; work was not delegated or spread across senior staff
- Mrs MX did not have a food chart, which meant that her erratic eating went un-noted and this may have contributed to her unstable blood sugar levels in the weeks leading up to her death
- Mrs MX did not have a bowel chart and this allowed her to become constipated without staff noticing or taking action
- Nursing staff did not seem to be sufficiently skilled at taking blood sugar levels (BSL's)
- Mrs MX sometimes refused her medication and staff did not have a routine way of managing this, including conducting a mental capacity test to determine whether they should over-ride her wishes in her best interests
- Nursing staff were not able to obtain readings using Mrs MX 's blood sugar level testing equipment but did not take swift action to replace or recalibrate it
- No chart was put in place for recording Mrs MX 's blood sugar levels until she had been in the nursing home part of the home for one month
- Mrs MX did not have a care plan in relation to her diabetes or how to proceed if she had a hypoglycaemic episode
- Mrs MX did not have a care plan addressing wound care of the cyst or pressure ulcer on her back
- Mrs MX 's GP was not asked to examine Mrs MX in relation to her cough
- At the point where Mrs MX transferred from the nursing floor to the residential floor of the home there seems not to have been

    - A formal handover internally
    - A clear contract and formal transfer of aspects of her to District Nurses
    - Any reassessment by Adult Social Care who were funding her placement

- Mrs MX was taken to the clinic to have her INR tests taken even though she was feeling unwell
- Staff person 6 gave an account of her reasons for taking Mrs MX to the clinic when she was feeling unwell that seems not to have been corroborated by Mrs MX 's GP
- The day before she died Mrs MX had very low blood pressure and the staff were advised by her GP that this was a cause for concern despite which no further measures of her blood pressure were taken throughout the ensuing day.
- The home's manager had not followed procedures, or accepted best practice by calling 999 as soon as it became clear that Mrs MX 's low blood sugar reading (1.4) was not quickly returning to normal after she had been given hypostop.
- On the night in which Mrs MX was dying no-one recognised that her condition was rapidly deteriorating or named the fact that she might die, as a result of this her relatives were not called
- The handover process on the evening before Mrs MX died seemed insufficiently detailed, given the severity of Mrs MX 's condition at that point
- The Panel have not seen guidance on how dying and death were managed in the home and have been unable to ascertain whether this could have prompted staff to call emergency services, Mrs MX 's GP and /or relatives sooner
- As soon as Mrs MX died her files should have been secured.
- The lead nurse at the service as not supervised by a clinician with whom she could have discussed difficult cases and/or sought advice about agreed best practice

5.2 What went wrong in the immediate response to Mrs MX 's experience of poor care?

- Phone calls made by Mrs MX 's son were not followed up, either in person or in writing, by the home's manager or by the Director of the company
- Papers went missing from Mrs MX 's file which have hampered subsequent enquiries and which suggest that someone knowingly and dishonestly removed these documents
- The Director did not routinely follow up a death at the home or carry out any form of routine debriefing to establish the cause of death and/or whether anything more could have been done
- The Director of the company treated the concerns as a complaint and not as an allegation of neglect that should have warranted a referral to the adult safeguarding system
- The senior nurse brought in to provide a clinical perspective on the complaint did not recognise these concerns as an allegation of neglect and refer it in to the safeguarding system
- Social Services also persisted in framing these concerns as a complaint about quality of care rather than as an allegation about very poor practice and/or neglect.

5.3 What went wrong in offering some remediation after the poor care Mrs MX experienced?

- Delay in responding to the verbal concerns expressed by Mrs MX 's son may have caused additional stress and conveyed a message that no one cared about his mother's death
- No opportunity was offered to Mrs MX 's relatives for debriefing or counselling, nor were they signposted to other sources of support or advice
- There was no consideration of a referral to the Health and Safety Executive to explore whether the home had been culpable in relation to Mrs MX's death under Health and Safety legislation – I thought this was to be removed

- No police investigation was instigated to determine whether documents had been removed from Mrs MX 's file, and if so by whom, even though this would have constituted an offence of perverting the course of justice if it could have been proven.
- No formal proceedings were instigated to explore whether the clinical practice of Staff person 6 met the standards of her professional body
- Medication policies and practice at the home were not the subject of sustained improvement with the result that the home had still not achieved compliance with this part of the CQC inspection carried out in July 2014 .

6. Recommendations for change

This multi-agency review suggests improvements in the way that all agencies can work together under the auspices of the Safeguarding Adults Board. These will be translated into comprehensive action plans by each agency that will be implemented with support and oversight from the Safeguarding Adults Board.

1. All residential and nursing home providers must provide secure systems for storing records to which only designated individuals have access; any removal or destruction of records should be treated as a disciplinary offence.

2. Residential and Nursing Home owners and managers must be reminded that they have a duty to retain all files for at least three years. Detailed guidance from the Department of Health specifies how long particular medical records should be kept and these should also be adhered to.

3. Safeguarding guidance and training should in future include a focus on record keeping, setting out

- ***That when there are no proper records any disciplinary proceedings will be based on a presumption that none have been made, this should act as a deterrent to any future loss or removal of important evidence***
- ***That Directors and Home Managers of residential services will be held responsible for lost records and will be expected to set up safe storage and archiving facilities***
- ***That Directors will be expected to secure files as a first step when a safeguarding enquiry is initiated.***

4. When a person receiving care is moved from a nursing home bed to a residential bed or visa versa, whether or not this is prompted by a change in their funding, and at any point where their formal funding does change for example from self-funding to Continuing Health Care (CHC) or Funded Nursing Care (FNC), this should always prompt a review and a revised care plan to ensure that the new configuration of services if properly coordinated.

5. All patients leaving hospital for a residential or nursing home placement should be accompanied by an appropriate discharge summary.

6. All placements supported by Peterborough ASC should be governed by a properly detailed care plan

7. All initial care plans should be signed off by team managers within Adult Social Care and subsequent care plans, that are developed by the residential or nursing home, should be scrutinised by the home manager and quality assured through regular audit of a sample of current care plans (10%) in a systematic way.

8. MUST, which is a universally accepted screening tool that assesses the risk of malnutrition and informs care planning; should be used at all care homes and district nurses should facilitate its introduction into any residential home which is unaware of its benefits. Nursing home staff should be familiar with the tool and its use and owners/managers must make time for their registered nursing staff to undertake appropriate training in its use as part of their regular Continuing Professional Development (CPD) and clinical updating.

9. Medication management should be improved at this and all care homes in line with national guidance; registered nurses should be competent to manage the dispensing and recording of medication; they should also be given clear instructions as to how to record, and what to do, when a resident refuses prescribed medication.

10. Local GP practices should be reminded that they must set up proper systems for the written prescription of medications to patients in nursing homes subject to proper recording practices as outlined in national guidance

11.Residential and nursing homes should have clear signage indicating to ambulance crews and other health professionals how to access their buildings, including after hours when there are no reception staff about.

12. All nursing homes should have a defibrillator available for those patients who might need to be resuscitated

13. All care homes should be skilled at initiating specific discussions about end-of-life care with relatives when a person is admitted to a

home and/or at their regular reviews: they should ensure that relatives have an opportunity to say how they would want these issues to be managed, and clear about options such as advanced directives and DNAR statements

14. Nursing staff should be able to hand over care of all patients but particularly those who are very ill, smoothly and efficiently so that essential observations, medication, pain relief, liaison with family members and appropriate care can be managed seamlessly.

15. If a person, assessed as needing residential care, is placed into a nursing home bed as an interim measure in order to expedite hospital discharge, the home should arrange a reassessment at the point where the nursing support is stepped down: this should be used to draw up a new care plan and allocate responsibilities to a different team of health care professionals accordingly. ASC could delegate this re-assessment to residential or nursing home staff but they should oversee such reviews and ensure that primary care services are appropriately engaged.

16. All care homes should revisit their procedure and see that it is explicitly linked and cross-referenced to the safeguarding adults policy in relation to any allegations of abuse and/or neglect. These should always be referred into ASC for investigation under the safeguarding adults protocol.

17.The SAB should work with the CCG to identify how nursing homes can access independent clinical advice and support when referring matters of concern to professional bodies such as the NMC and/or when determining whether to refer a concern to ASC as a safeguarding matter or as a complaint.

18. The SAB should seek assurance that all agencies with responsibility for quality assurance and training routinely explore issues of neglect, alongside more overt forms of abuse, when evaluating the safeguarding competencies of services and of individual professionals.

19. In all cases where a safeguarding inquiry has involved concerns about the practice of a registered professional, the strategy meeting charged with investigating the allegations should ensure that the

employer prepares a submission to the NMC or other professional body, detailing the person's conduct and clinical decision making.

20. All homes should have a complaints policy that clearly sets out, with case examples, the criteria and thresholds signalling that a matter should be referred into the safeguarding adults process and that indicates when a matter is too serious to be dealt with internally, without recourse to the safeguarding adults system.

21.The Safeguarding Adults Board, working with all partner agencies, should draw up a protocol and a flowchart to show when a matter can be dealt with using a complaints procedure as opposed to being referred into the safeguarding system

22. The owner as well as the manager of the home should regularly review whether appropriate care plans are in place especially

- ***At the point where a resident is moved from the nursing part of the dually registered home to the residential part as this is the point at which community health care professionals take over some tasks from internal nursing home staff***
- ***Where a patient enters the home with a potential pressure ulcer or lesion requiring specific nursing care***
- ***Where a patient has diabetes***
- ***Where a person is likely to be constipated as a result of opiate pain relief***
- ***Where a person has been prescribed Warfarin or other drugs that require consistent monitoring.***

23. At the point at which a person moves from a residential to a nursing placement, whether in the same or a different home, their nursing and care needs must be reviewed and a specific agreement drawn up with the primary care team specifying who is responsible for which elements of the person's care.

24. All homes should develop shared guidelines for managing diabetes, setting out which staff will take responsibility for this area of care, including professional development, clinical updating, standard clinical pathways, the maintenance of equipment and the oversight of unqualified staff, so that they work together for the prevention of acute episodes and long-term complications. The person

who takes on this role should see that each patient with diabetes has an individual diabetes care plan within this overarching framework.

7. Concluding remarks

This report has addressed the terms of reference set out in Appendix C and identified where practice fell short of expected standards. Recommendations have been drawn out of the report and are indicated throughout the text. These will be turned into concrete and measurable action plans that will be implemented by partner agencies under the oversight of the Peterborough Safeguarding Adults Board. The learning from this case will also be used in training and, where appropriate, shared with other nursing homes in the borough.

The observations of staff and of the professional network suggests a staff team that were not uncaring in their interactions with service users but that lacked the resources, skills and perhaps the clinical leadership to maintain systems that could *support* and *enable* good care. It is not good enough just to show a caring attitude if a service user is suffering the discomfort of constipation, or if their haphazard eating puts them at risk of going into a diabetic coma, you also have to be responsibly informed and make clinically sound decisions. The paperwork that should have been in place in this service functions to structure the skilled input of nursing and care staff. Good records are kept not as a chore, or as a "back-covering" exercise, but because they are the means by which consistent individually tailored care can be delivered.

The Panel hopes that by strengthening the systems and record-keeping in this home, the staff will feel motivated and supported to provide more consistent, individually tailored and clinically sound care.