NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD

Serious Case Review Executive Summary

Adult C

A report prepared for the

Nottinghamshire Safeguarding Adults Board

January 2011

Contents

1. Introduction

Adult C was a 55 year old woman who had been living with early-onset dementia since diagnosis in 2005. In November 2006 Adult C was discharged from hospital to a Nursing Home in Liverpool. By April 2008, she required help with all tasks of daily living including personal care. Adult C's son and daughter were, understandably, wishing to visit her more frequently and at this time her son expressed a wish to have his mother living closer to himself and his sister in Nottinghamshire. Following some discussion with Liverpool Social Services, the transfer of Adult C's care to a care home in Nottinghamshire was arranged. She remained there until her death seven months later.

The Nottinghamshire Safeguarding Adults Board would like to offer their sincere condolences to Adult C's family, their thanks also goes to Adult C's son for his support throughout the investigation process.

2. The reason for the Serious Case Review

Following the report of Adult C's death to the Coroner for Nottinghamshire, an inquest into her death recorded a verdict of death by natural causes; however, the Coroner heard sufficient evidence of deficiencies in the care provided to be sharply critical in his closing remarks.

2.1 The aim of the Serious Case Review

The aim of the Serious Case Review was to establish whether there are lessons to be learnt from the circumstances of the case where local professionals and agencies have worked together to safeguard vulnerable adults.

This is the summary of a serious case overview report commissioned by the Nottinghamshire Safeguarding Adults Board (NSAB). This report is based on information provided by the agencies, which has been analysed by the independent author. The conclusions and recommendations are based on the analysis of the information provided.

3. Agencies involved in the Review

- Care Home
- Care Home Owners

- East Midlands Ambulance Service
- Liverpool City Council
- NHS Nottinghamshire County
- Nottinghamshire Community Health Trust
- Nottinghamshire County Council
- Nottinghamshire Police
- Sherwood Forest Hospital Trust

4. The Scope of the Review

The period covered in the review is from July 2008 when a decision was reached that Adult C would move to Nottinghamshire until the date of her death in April 2009.

Following the terms of reference, the main issues considered were:

- Were the transfer arrangements from care home A to care home B in line with best practice?
- What was the involvement of Adult C and her family?
- Was the information given on transfer sufficient to effectively manage Adult C's care?
- Did actions accord with assessments and decisions made?
- Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- Were care plans in place that were appropriate, in line with best practice, documented, communicated and, monitored?
- Were there communication and documentation failures which resulted in the prescribing of penicillin despite Adult C having a known allergy to this medication?
- Were appropriate actions taken by responsible agencies following the safeguarding referral of Adult C to include a period of three months after her death?
- Was the communication between all agencies involved in Adult C's care effective to safeguard Adult C as a vulnerable adult?

5. Key Findings

- Prior to Adult C's transfer to Nottinghamshire, her care appears to have been satisfactory.

- The decision to negotiate a change in the venue of Adult C's care was instigated by her family. There is no evidence that Adult C herself was able to participate in these discussions and no documentary record of a formal test of her capacity to contribute to decision-making.

- There is no record of information gathering from other professionals involved in her care who might have been consulted on the basis of expert opinion with particular reference to her clinical condition and any adverse effect of the proposed move.

- In preparation for the move, Adult C was assessed. Adult C was normally nursed in bed, only occasionally sitting out in a chair. With this in mind, it is difficult to understand how the decision to affect Adult C's transfer by wheelchair taxi was arrived at. Considering the length of the journey and the known vulnerability of Adult C's pressure areas, the chosen mode of transportation was, at the very least, potentially harmful.

- There is no nationally accepted guidance or protocol that governs the transfer of care arrangements for vulnerable adults. In commissioning care in Nottinghamshire there is little evidence to suggest the clear and detailed communication of clinically relevant information between the homes involved in the transfer of Adult C's care. There was no formal transfer letter and the details of multidisciplinary involvement with Adult C in Liverpool were not transmitted otherwise.

- Adult C was assessed by a manager prior to transfer, but no member of staff from the receiving care home was involved with this assessment. The Care Quality Commission (CQC) standards state that;

  "…a resident should not go into a home without a full assessment having been made, except in the case of an emergency. The proprietor/manager and relevant professional staff within the home should be party to that full assessment and only

accept a new resident if they feel the home can adequately meet the needs of the prospective resident as determined through that assessment." (CQC Care Home Regulations 2003)

- Communication between the Nottinghamshire care home and visiting home professionals fell below acceptable standards at times, resulting in insufficient coordination of Adult C's care. There were laudable attempts to provide good care to Adult C but these efforts were hampered by a disjointed multidisciplinary team, lacking in overall senior oversight and direction.

- The care provided to Adult C fell substantially short of good practice. Staff at Care Home made efforts to engage specialist help through the Tissue Viability Service and other professionals. However, the resulting strategies were not well recorded and their application was subsequently unsuccessful in preventing the deterioration in Adult C's health. In particular, there was little evidence of medical oversight or leadership from the primary care team. Communication between visiting clinicians and staff at Care Home was generally inadequate and there were no discernible lines of responsibility or accountability for monitoring the overall health of Adult C.

- The reported allergy to penicillin was included in the transfer documents. This annotation is reproduced in all Medication Administration (MAR) Sheets other than that which was in use immediately prior to her final admission to hospital. The primary care physician who prescribed penicillin for Adult C was in possession of a summary record when visiting Care Home. This record did include information regarding her reported allergy to penicillin. The professional concerned was unable to explain the prescribing error.

6. Independent Authors Recommendations

Recommendation 1

As far as possible, the care of care home residents should be the responsibility of a single group practice of primary care physicians. A multidisciplinary approach should be encouraged through shared records (held within the care home) and a regular programme of team meetings comprising all relevant members of the primary care team.

Primary care responsibilities;

1 - All new residents of care homes should have a comprehensive primary care clinical assessment as early as possible after arrival, ideally within 2 days or at the next routine weekly visit in line with criteria in the Good Practice Guidance.

2 - To respond to request from care homes for advice on the same day. Response may be advice only, GP visit or arrangement of care from other Health Care Professionals.

3 - Ensure care homes medication charts are updated with current medication and signed. Contribute to maintaining up to date care home records.

Recommendation 2

Multidisciplinary teams caring for patients with dementia should demonstrate that they have carefully considered the need for specialist mental health advice and support through a documented assessment process.

Recommendation 3

The Tissue Viability Primary Care Service must demonstrate clinical leadership in the management of skin integrity in care homes. Care home managers should retain responsibility for standards of care. Concerns about tissue viability should be reported inline with local procedures.

Recommendation 4

All agencies review their processes in respect of the application of the Mental Capacity Act. There should be closer liaison with receiving authorities when placing service users out of county. The responsibility to check that best interest assessments have been undertaken should remain the responsibility of the care home managers. Good practice would suggest that this should be included in the regular quality assurance review which will aid an appropriate and consistent approach throughout.

Recommendation 5

The CQC should continue to examine pre-admission assessment procedures in care homes as part of their regulatory function. There should also be agreed protocols within the county regarding what information should be shared.

Recommendation 6

The Local Authority should undertake a rigorous evaluation when considering placements outside of their statutory area. This should include an assessment of appropriateness and best interests in the context of the individual concerned. The placing authority should obtain information from the hosting authority and the CQC regarding the suitability of the proposed receiving home.

Recommendation 7

In arranging transfer of care of all vulnerable adults, Local Authorities must give adequate consideration to the suitability of transportation. Good practice would suggest that this should be included in any multidisciplinary assessment made prior to such transfers of care.

Recommendation 8

Local Authorities, Healthcare organisations and the CQC should develop clear information sharing mechanisms with regard to the assessed standards of care in residential and nursing homes. In particular, where there is evidence of poor care, the communication of this information between these organisations should be mandatory.

Recommendation 9

This Serious Case review recommends that all organisations ensure that their provision of training in the area of Safeguarding Adults and Mental Capacity Act meets national standards.

Recommendation 10

In planning future Serious case Reviews, the Chair of NSAB must give serious consideration to the potential time and resources required such that future SCRs may be completed within 6 months of the events under review.