Safeguarding Adults Review Systems Findings Report

Adult 'M'

The Rochdale Borough Safeguarding Adults Board
27th June 2024

Background leading to the decision to commission a SAR

In December 2022, Adult M an 83-year-old white British woman died in hospital following a recent inpatient episode at a local acute hospital, discharge to a nursing home and subsequent readmission to another acute hospital. The case was initially felt not to meet the criteria for a Safeguarding Adults Review (SAR) based on the original information received from agencies, however following a SAR screening panel meeting it became apparent that there were potentially 'system' issues that were identified as a result of further information being made available. The panel members agreed that because of the short time frame for the SAR it would be appropriate to undertake an adapted SAR model due to the smaller number of agencies involved, this approach would still allow for the identification of system barriers and ways of overcoming these.

S44 of the Care Act 2014[1] places a duty on Safeguarding Adults Boards to arrange a SAR when an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. A SAR promotes learning and identifies improvements to prevent future death or serious harm occurring again. The process is supported and agreed by all members of the Rochdale Borough Safeguarding Adults Board (RBSAB).

The Independent Reviewer made contact with the daughter whose mother is the subject of this review to offer condolences to her and her family and to outline the SAR process. The findings of this review are confidential. To protect the identity of the subject of this SAR they are referred to as Adult 'M' in agreement with her daughter.

Adult M experienced several physical health issues in the latter part of her life. She had been cared for by the nutrition and dietetics team since March 2013 when she was diagnosed with head and neck cancer and subsequently had radio therapy treatment at North Manchester General Hospital (NMGH). In February 2019 she had a radiologically inserted Gastrostomy tube[2] fitted because she was made nil by mouth (NBM). Adult M subsequently had all her nutrition and hydration via her gastrostomy tube.

Adult Social Care (ASC) were aware of Adult M via their reablement service on two separate occasions prior to the timeframe for this SAR. She was also known to the occupational therapy service who had supported Adult M to remain independent in her own home by supplying relevant adaptive equipment to meet her needs. The North West Ambulance Service (NWAS) had attended Adult M's home on 12 occasions between March 2021 and November 2022 7 of these were related to feeding tube issues. The out of hours GP service also supported Adult M and her family when there were issues with the gastrostomy tube. District Nurses (DN's) visited Adult M from April 2022 to provide care to the site of her

[1] Care Act 2014 section 44 – Legislation.gov.uk
https://www.legislation.gov.uk/ukpga/2014/23/sectipn/44/enacted [Accessed September 2023]
[2] Radiologically Inserted Gastrostomy (RIG) tube which is inserted under x-ray guidance through the skin and directly into the stomach so that a person can receive feed, fluid and medication without needing to swallow it. https://www.imperial.nhs.uk>website>imaging [Accessed January 2024]

gastrostomy tube and associated wound management. They also provided ongoing support with symptom management and palliative care[3]. She had been moved onto a palliative care pathway in June and had regular palliative care reviews. Their last visit to Adult M was on 3rd of November the day before her admission to the first hospital in this review. They were visiting to monitor pressure areas, gastrostomy tube and oral care.

In June 2022 documentation reflects there were some changes in Adult M's condition and signs of deterioration, Adult M had developed more lumps on her face and neck which the GP thought may indicate that the cancer was spreading. Following discussion with Adult M and her family, (mainly her daughter) they felt they were coping with involvement from carers and the GP. Adult M was in receipt of 4 care calls a day funded by the NHS via Continuing Health Care[4] (CHC) at the time of her admission to hospital. Her gastrostomy tube was also being overseen by an Abbott Nurse[5] throughout the period of this review.

Prior to her admission to Rochdale Infirmary there had been a short hospital admission to NMGH from October 5th to the 11th 2022 due to a fall at home possibly due to postural hypotension. There was a suggestion of bilateral pressure sores to her buttocks and progressive frailty on admission. A CT scan of head and spine were normal. Adult M was treated with intravenous antibiotics for an underlying infection. Cardio pulmonary resuscitation – do not attempt resuscitation (CPR-DNAR) was discussed with Adult M and her daughter during this admission. On discharge an action for the GP was to refer to the dieticians to review the gastrostomy tube.

Handover from the NMGH dietitians on the 12th of October documented that Adult M's weight was now 66kg, Height 1.83m, body mass index[6] (BMI) 19.7kg/m² and that she was struggling with her feeds, some had been omitted and there had been issues with hydration prior to having care support in her own home.

After this handover, Team Lead Dietitian for nutrition support B the dietetic team covering the hospital calculated there had been a 5.3kg (7.4%) weight loss since Adult M had last been weighed, this was not seen to be significant and follow up was scheduled for 3-4 months.

Her feeding regime at this time was documented as being:

FEED: Ensure Compact 125ml bottle
Via bolus
Bottles: 4/day
VOLUME: 500ml/day

[3] Palliative Care – is available when you first learn you have a life-limiting (terminal) illness https://www.nhs.uk>end-of-life-care/what-it-involves-and-when-it-starts/ [Accessed October 2023]
[4] NHS continuing healthcare is for adults, children and young people with long term complex health needs who meet the eligibility criteria. The NHS will pay for support to meet their assessed health needs. https://www.nhs.uk [Accessed October 2023]
[5] Abbott Nurse – Abbott's hone care service offers support to enterally fed people in the community https://nutrition.abbott.tools-for-patient-care [Accessed October 2023]
[6] Normal BMI range is between 18.5 to 24.9 https://www.nhs.uk/live-well-weight/bmi-calculator [Accessed October 2023]

+
FEED: Ensure Plus Fibre 200ml bottle
Via bolus
Bottles: 1/day
VOLUME: 200ml/day
Total
= 700ml
= 1500cal/day
= 65g protein/day
TIMING:
~9am Ensure Compact diluted with 125ml water. 60ml water flush prep & post
~11am 240ml water flush
~1pm Ensure Plus Fibre & Ensure Compact diluted with 125ml water. 60ml
water flush prep & post
~3pm 240ml water flush
~5pm Ensure Compact diluted with 125ml water. 60ml water flush prep & post
~7pm 240ml water flush
~9pm Ensure Compact diluted with 125ml water. 60ml water flush prep & post
FLUID:
Freshly drawn tap water / cooled boiled water
TOTAL VOLUME: ~1900ml/day - includes feed & flushes

What is a SAR Systems Findings Report?

The model used for this SAR is an adapted methodology which aims to turn around learning in a shorter timeframe, following the set-up meeting. The set-up meeting is held after the decision has been made to progress with a review. An outline of the process is set out on page 4.

The learning produced through this SAR concerns systems findings. Systems findings identify social and organisational factors that make it harder or easier for practitioners to do a good job day-to-day, within and between agencies.

Existing standardised processes and templates support an analysis of a case to identify systems findings where fewer multiagency partners are involved. The process is supported by remote meeting facilities and does not require any face-to-face contact.

The SAR in Adult M's case used the principles and tools of a full SAR model but as stated above the number of multiagency partners being small it was agreed that a practitioner learning event would not be required. Learning could be achieved through a thorough review of relevant agency records relating to Adult M's care.

Outline of the SAR process used in this circumstance:

1. Set up meeting to clarify which agencies were involved
2. Check of agency records
3. Agencies produce early analysis report to structure the report
4. Participants read report in preparation
5. Structured multi-agency discussion at panel meetings
6. Report amended based on further discussion and information
7. Systems findings report published

This Review Report

This report forms the final learning from the SAR in Adult M's case, using an adapted SAR template. It sets out the systems findings that have been identified through the process of the SAR. These findings are future oriented, this means that learning is adapted from Adult M's case to ensure that they focus on system processes and communication factors that will reduce the likelihood of the same issues affecting someone else in similar circumstances. As such, they are potentially relevant to professional networks more widely.
In order to facilitate the sharing of this wider learning, the case specific analysis is not included in this systems finding report. Similarly, an overview of the methodology and process is available separately.
Each system finding is first described. Then a short number of questions are posed to aid the SAB and partners in deciding appropriate responses.

Contact

If you have any questions or queries about this SAR, please contact the SAB Business Unit:
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Systems findings

What are the key barriers/enablers we have learnt about that make it harder/easier for good practice to flourish and that need to be tackled in order to see improvements?

The methodology used in this SAR distinguishes between case findings and systems findings. Systems findings are the underlying issues that helped or hindered in the case and are systemic rather than one-off issues. Each finding attempts to describe the systems finding barrier (or enabler) and the problems it creates. This requires that we think beyond Adult M's case, in this instance, to the wider organisational and cultural factors. It also requires that we defer at this stage from solutions or articulating what is needed, to specify first what the current reality of barriers/enablers is, that the SAR process has helped us understand.

FINDING 1: Initial care and treatment in hospital and discharge process (Rochdale Infirmary)

Systems findings

When Adult M was admitted into hospital on the 4th of November 2022 with diarrhoea and vomiting, her community feeding regime was sent into hospital with her. At her medical clerking the locum doctor did not record that she was not able to take food and fluids orally and should be NBM, IV fluids were prescribed and commenced, it was noted that she was on a palliative care pathway. Despite this omission by the doctor assessing Adult M on admission, nursing staff present were aware that Adult M was to remain NBM which was reflected in her nursing care plan.

It was not until the following day that her feeding regime provided by the community dietician was prescribed. It was then not recorded correctly on the EPMA[7] only 3 Ensure Compact boluses were prescribed (TDS) and not 4 (QDS), and no Ensure Plus Fibre bolus was prescribed. The doctor discussed the prescription with a nurse and stated their usual practice from a previous hospital was that it was prescribed TDS and a dietician would review it and change if necessary. The family of Adult M were informed by ward staff that the feeding regime was being reviewed and on one occasion were informed "there was no Ensure Plus Fibre available" *This was a missed opportunity to contact a dietician to review the prescription and correct the error.*

For the length of Adult M's hospital stay her feeding regime was never prescribed correctly on the EPMA. It was noted by a pharmacy technician on day 4 of Adult M's stay that the prescription was incorrect, that Ensure Compact should be prescribed QDS, they did not note however that the Ensure Plus Fibre should also be prescribed. A hospital pharmacist followed the locum doctor's prescription for TDS without checking the community regime and did not check with the pharmacy technician why they had advised QDS. *This was a second missed opportunity to correct the feeding regime.*

[7] EPMA – Electronic Prescription for Medicines Administration

On the same day a Community Dietician attended the ward and documented the community regime in the medical notes including the water flushes and informed both a Doctor and a Nurse on duty of the regime and that they planned to hand over to the Team Lead Dietician for nutrition support B to review. *This was a third missed opportunity to correct the feeding regime.*

Adult M was reviewed by a Doctor on a further 8 occasions while she was in hospital and the EPMA was not identified as being incorrect, therefore it was never changed. On a few occasions the hospital records show that the Ensure Compact was administered QDS by nursing staff which would not be in line with the EPMA. *These were further missed opportunities to correct the EPMA.*

Adult M had been admitted to hospital with a 4-day history of diarrhoea and vomiting, was nil by mouth (NBM} and reliant on enteral feeds for her hydration and nutrition. As part of her nursing care plan she would have required an accurate fluid balance to be recorded to allow monitoring of her fluid input and output. The recording by staff of her fluid balance during this stay in hospital was not consistent, however blood results do not demonstrate any cause for concern over her renal function while in hospital.

During Adult M's admission to hospital nursing staff noted what they believed to be deep tissue damage to the skin on her buttocks, an appropriate referral was made to the Tissue Viability Nurse (TVN) and appropriate pressure relieving measures were put in place. Photographs of the purple areas of skin were taken with the consent of Adult M. Ward staff also raised a safeguarding referral on the 7th of November 3 days after admission alleging potential neglect by the care agency staff supporting Adult M in her own home prior to admission.

This safeguarding referral was not sent to the correct area team within Adult Social Care (ASC) it was sent to a team outside Rochdale. Staff at the Trust did not receive an 'undeliverable' notification because the referral was sent to an out of area team, as a result the referral was not sent back to the hospital for submitting to the correct team. The adult safeguarding team at Northern Care Alliance (NCA) who oversee the Trust received a copy of the safeguarding referral submitted by the ward nurse which was in accordance with their procedures. The safeguarding team should have checked that the referral had gone to the correct area team within ASC, on this occasion this did not happen. The NCA panel member has made enquiries with their IT department to determine that the electronic referral process is operating correctly, and actioned with the safeguarding team why the incorrect area team was not picked up.

When reviewed by the TVN they confirmed that the damage to Adult M's skin was because of skin excoriation[8] probably made worse by the recent diarrhoea prompting the hospital admission, scratching of the skin could also have been a cause. Throughout this inpatient stay Adult M's care plan reflects that staff were carrying out regular checks on her pressure areas following her risk factor being categorised as 'amber' on the hospitals risk assessment

[8] Skin excoriation - a sore due to the superficial or partial destruction of the skin surface

tool[9]. Documentation also supports that during this inpatient episode Adult M also had her risk assessment re-evaluated as would be expected. Adult M was already known to the lead nurse for tissue viability following the District Nurses' referring to the service in the community prior to hospital admission.

Prior to discharge hospital staff noted that the skin on Adult M's sacrum, buttocks and heels was 'blanching' meaning that the skin was in a healthy condition, blood flow returned to the area when digital pressure was applied and then quickly removed. Evaluation of the records by the hospital suggest that there were some minor inconsistencies in communication and record keeping around the terminology and categories of pressure damage within Adult M's records.

Following an inpatient episode there will be a discharge planning process that is followed especially when the individual being discharged from hospital is recognised as having 'care and support needs' as in Adult M's case. In such cases other professionals such as Social Workers, Physiotherapists, Occupational Therapists and CHC staff could be involved in the co-ordination of the hospital discharge.

Ward staff were aware that Adult M had been admitted from home and that she had a care package in place funded via CHC which provided 4 care calls a day to manage her gastrostomy tube. This information was shared with the ward staff by the family of Adult M on her admission, staff also recorded that Adult M was on a palliative care pathway due to a deterioration in her oral cancer.

During her hospital stay the physiotherapy staff had recommended a period of intermediate care to attempt to improve Adult M's mobility and achieve her previous baseline prior to her admission. This could be delivered at a local unit which provided enhanced nursing and therapy care. Adult M was made aware of this option as part of early discharge planning, and it was an option both she and her family favoured to allow CHC time to commission a care provider in the community who could manage Adult M's 24-hour care needs in her own home. Being on a palliative care pathway would not have been a barrier, and it was an appropriate decision to offer a placement in this type of care setting.

From a review of the hospital documentation and the combined chronology it is evident that there were 2 other potential discharge placements for Adult M following this hospital admission. To a palliative care placement being the first option, followed by a discharge to assess placement at a local nursing home. 10 days after admission the ward staff made ASC aware that Adult M was still in hospital being medically optimised and would now need a discharge to assess[10] placement. From the documentation it appears that Adult M's physical health had not deteriorated to the extent that a palliative care placement was

[9] Purpose T is a pressure ulcer primary or secondary evaluation risk assessment tool https://www.nursingtimes.net/news/research-and-innovation/new-tool-could-transform-pressure-ulcer-care 18th Sept 2017 [Accessed October 2023]

[10] The discharge to assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they no longer require inpatient treatment. https://www.gov.uk>publications/hospital-discharge-and-community-support-guidance [Accessed October 2023]

necessary, therefore this option was discounted. Adult M appears to have changed her view and declined the intermediate placement in favour of the discharge to assess placement with a view to returning home when CHC had sourced an alternative care agency who could manage her Gastrostomy tube.

It is not clear from the records and from speaking to the daughter of Adult M why this change of discharge plan had occurred. The family were informed by the ward staff that their mother had consented to this change which the family questioned at the time as they knew she had previously expressed a wish to not go into 24-hour care in a nursing home.

On the 23rd of November the CHC team received a discharge to assess pathway from the ward staff advising them that Adult M was being discharged to a local nursing home for a period of assessment. A CHC nurse contacted the transfer of care team based at the hospital to clarify the discharge arrangements as she had also understood the Adult M's previous wishes were that she wouldn't want to go into a 24-hour care placement.

Hospital discharge was confirmed for the 23rd of November by the ward team and ASC were informed. The family of Adult M were also informed that their mother would now be going to Rakewood House (previously part of Carders Court) a local nursing home for a period of assessment and that an ambulance transfer had been booked.

On the same day a discharge to assess trusted assessment[11] carried out by a Physiotherapist when the plan was for Adult M to be discharged to a rehabilitation placement was sent to ASC for prospective placements to be sought. This document might not have reflected Adult M's nursing needs as fully if one of the transfer of care team had updated it following the change in discharge plan. There is an agreement that on receipt of the assessment any issues identified are escalated back to the assessor for clarification. In Adult M's case no issues were identified by ASC and so the assessment was shared with potential care providers. ASC's panel member reflected that they should not have been asked to source a nursing home for Adult M because she was CHC funded. For CHC funded cases the Transfer of Care Nurse would liaise with CHC but they generally source the placement themselves as opposed to sending the trusted assessor to CHC to ask them to source. As part of the additional learning following this SAR the Transfer of Care team at the hospital are working with staff in the ward areas to ensure correct processes are followed.

Rakewood House responded back that they could meet Adult M's needs and were able to accept her that day. A copy of a medical discharge summary and the feeding regime taken from the EMPA were sent with Adult M to the nursing home. Standard practice on discharge to a nursing home would be that an SBAR[12] form is completed by the ward nursing staff, one wasn't on this occasion which was an oversight in the discharge planning

[11] Many local health systems have introduced a 'trusted assessment' or 'generic assessment' where one person/team undertakes health and social care assessments on behalf of multiple teams using agreed criteria and protocols.

[12] SBAR S=Situation (a concise statement of the problem) B=Background (pertinent and brief information related to the situation) A=Assessment (analysis and considerations of options-what you found what you think) R=Recommendation (action requested/recommended – what you want) is a structured form of communication what enables information to be transferred accurately between individuals https://www.ihi.org>resouces>Pages>Tools>SBARToolkit.asp [Accessed October 2023]

process*. It is unclear whether this oversight had any impact on the nursing home staff's ability to complete a full nursing care plan.*

A scanned document on the community and dietician system suggested that Adult M was to have 2 different types of feed, Ensure Compact and Ensure Plus Fibre. 2 days after discharge a member of nutrition and dietetics team spoke with a Registered Nurse at Rakewood House who confirmed that she knew Adult M was to have Ensure Compact QDS but that she was unaware of the requirement for Adult M to have the Ensure Plus Fibre. This staff member informed the Nurse that they would send out the regime for reference via the post. It is not clear to the reviewer when the correct feeding regime was received due to a lack of availability of the nursing home records. The Nursing Home Manager stated to the CHC Nurse that they had not received the regime in the post as anticipated 12 days later, this was not followed up by the manager or staff at the nursing home which would have been normal expected practice.

Questions for the RBSAB and partners

1. Are the Northern Care Alliance (NCA) hospital managers assured that the nutrition and dietetics team have robust processes in place for checking feeding regimes prior to hospital discharges?

2. Are the RBSAB assured that there is a secure method of sharing personal information relating to people between ASC, Health and care homes which would be GDPR compliant that allows for information exchanges to take place via e-mail rather than relying on the postal service were secure e-mail addresses are not available? Do teams routinely know how to password protect a document if a secure e-mail address is unavailable?

3. Are the lapses in the care of Adult M at the hospital an unfortunate case finding, or do they indicate a wider system failing?

4. The Trust have completed a Serious Incident (SI) investigation following this inpatient episode which makes several recommendations from which an action plan has been developed. How will the Trust provide assurance to the RBSAB that all the actions from this report are complete?

Finding 2: Care at Rakewood House (previously Carders Court) the Nursing Home placement

Background to Rakewood House

This SAR report refers to ‘Rakewood House’ as the hospital discharge destination of Adult M. Rakewood House had previously been under the name of 'Carders Court' which was owned by 'Bloomcare' and was registered with CQC as a 150 bedded 'care home'. In early 2022 Bloomcare made the decision to register each 30 bedded care home separately with

CQC and the former Carders Court site was archived on 29th September 2022. made the decision to register each 30 bedded care home as separate homes with CQC. 'Carders Court' had last been assessed by CQC in 2021, the outcome of this being that the overall rating for the service was 'requires improvement'.

Following the split of the care homes managed by Bloomcare Rakewood House, the care home Adult M was discharged from hospital to in November 2022 was registered with CQC as providing legally registered 'accommodation for persons who require nursing or personal care'. In September 2022 the home was considered 'unrated' by CQC as ratings are not inherited as part of the change in provision described above. The first inspection of 'Rakewood House' was undertaken by CQC on 26th of October 2022 with report publication on the 25th of January 2023. All areas (Safe, Effective, Caring, Responsive and Well-led) were reported as 'requires improvement'.

Following the transfer of Adult M to Rakewood House on 23rd of November 2022 and it being noted by the hospital Dietician that this error had been made contact was made with the nursing home staff. The Nurse spoken to allegedly told the Dietician that they knew that Adult M should have ensure plus QDS and not TDS but they were not aware that she should also be given Ensure Plus Fibre OD. The Dietitian agreed to send out the correct regime via the post to the nursing home that day and asked them to monitor Adult M's weight.

Six days after admission to the nursing home on the 29th of November an Abbott Nurse Advisor reviewed Adult M's gastrostomy tube to provide trouble shooting advice to the home staff. The tube was known to be prone to blocking but was only partially blocked at this time. Appropriate advice was given, and it was confirmed that a spare feeding tube was available, and that staff should contact the service again if further issues arose. The details of this visit were uploaded onto a portal that the NCA dieticians can access and if further action is required this will be planned, it was not necessary on this occasion.

On the 5th of December 2022 12 days after Adult M's admission to Rakewood House a CHC nurse met with Adult M and her daughter to discuss the arrangements for Adult M's ongoing care. Adult M and her daughter were informed that while Adult M had been in hospital and at the nursing home CHC had been finding a different care agency to manage Adult M's nursing needs following her son raising his concerns on the 31st of October 2022 that the current provider was not meeting his mother's care needs. This took longer than was expected because the number of care agencies with staff trained to manage enteral feeding were limited.

The CHC nurse noted a significant deterioration in Adult M's physical health since they had last reviewed her. She identified that the wrong feeding regime was still in place, brought this to the attention of the nurse in charge and gave directions that they should be administering the correct regime to ensure Adult M received the correct amount of hydration and nutrition. Water flushes are not prescribed on a medication chart and it has not been possible to see from the nursing home records if water flushes were also being administered during Adult M's stay in line with the feeding regime.

During the same visit the CHC nurse noted that Adult M had fallen over the weekend and had also fallen over twice that morning. She was currently sitting in a chair and looked very lethargic. The CHC nurse asked the staff what measures they had in place to reduce the risk of Adult M sustaining further falls. The response was that her daughter was sitting with her so that would be sufficient. The CHC nurse pointed out that Adult M's daughter would not be with her 24/7 and that alternative measures would need to be in place to reduce the falls risk. Pressure sensor pads were available to staff but did not appear to have been utilised to alert staff to Adult M moving or attempting to stand without support.

Adult M's daughter also described her concerns to the CHC nurse that her mother was not getting the amount of fluid each day that she should be, and when she had raised her concerns with the nursing staff at the care home they had responded saying they were waiting on confirmation of the correct regime from the dietetic service. This is an unacceptable delay and should have been pursued by the care home staff more proactively if indeed they had not received the correct feeding regime through the post as had been expected. The CHC nurse advised the staff that they ring the department to seek clarification which they agreed to do.

Prior to her departure from Rakewood House the CHC nurse tried to speak to the manager however she was on a telephone call at the time and gestured that she was then about to immediately go into a meeting. On her return to the CHC office the nurse e-mailed the nursing home manager to raise her concerns about both the risk of falls and the feeding regime with a plan to visit the home again the following day. Adult M was unfortunately readmitted to hospital on the 6th of December 2022 before the follow up visit could take place.

Without access to the nursing home records relating to Adult M's care it is impossible for the independent reviewer and panel members to take a view on whether the care plan in place met the needs of Adult M, whether her weight was being recorded, fluid intake was being monitored and the correct risk assessments had been undertaken and updated following her first fall.

It is clear however that in the early hours of the 6th of December 2022 at 05:30 Adult M was found outside her bedroom after what was thought to be a further fall resulting in a bang to her head and a very small tear to the skin on her right elbow. The Nurse covering the night shift called 999 and was advised to leave Adult M on the floor but make her comfortable, no estimated time of arrival for a crew to arrive was given. At 08:30 the nursing home manager arrived and was provided with an update. Adult M was able to move all 4 limbs, was not showing any signs of being in pain and was requesting support to stand up. 3 members of staff assisted her to stand and transfer back to her bed where she was made comfortable. Adult M was advised not to attempt to get out of bed again without support and a nurse call bell was left at her side.

Approximately 10 minutes later staff reported finding Adult M sat on the floor of her room, staff checked to ensure she had no injuries and again supported her in returning to bed. A call was made to 999 to chase up a response time following the earlier call, whilst this was happening Adult M was observed to stand out of bed again and fall. The ambulance crew

then arrived and assessed her, their view was that she did not require hospital admission because her injuries were minor, Adult M's daughter was made aware and agreed that her mother should remain at the nursing home.

There is no evidence provided to the independent reviewer and the panel members to support that the nursing home staff questioned Adult M's mental capacity to understand the risk of falling and causing injury to herself if she attempted to get out of bed without the support of staff. Her recurrent falls and possible ongoing dehydration impairing her cognitive function do not appear to have been considered. It is also not clear whether consideration was given to 1:1 support to reduce the further risk of falls and whether there were enough staff on duty to allow for this.

In the afternoon of the same day Adult M was readmitted to hospital because of nursing home staff finding her unresponsive in bed. They had assumed she was sleeping but became more concerned by 2pm when she had not used her call bell or attempted to get out of bed by herself.

Questions for the RBSAB and partners

1. How robust are the procedures for transfer of patients from hospitals into nursing homes, is information and communication shared between the 2 of a standard that the findings of this report can be seen to be a case finding rather than a system finding?

2. Was the delay in following up the apparent error in the feeding regime an unfortunate event in Adult M's care, or is this an indication of a wider lack of ownership/leadership/accountability within nursing homes more generally?

3. Carders Court had last been assessed by CQC in 2021, the outcome of this being that the overall rating for the service was 'requires improvement'. Rakewood House was assessed by CQC in October 2022 with the overall rating for the service also being 'requires improvement'. Are RBSAB assured that there are appropriate measures in place to oversee the quality of care delivered in homes that have an overall CQC 'requires improvement' rating?

4. Are RBSAB assured that nursing homes commissioned via ASC's Framework[13] list have staff who are sufficiently knowledgeable and skilled in the management of Gastrostomy tubes and the standard requirements of a feeding regime given that 'water' flushes are not prescribed on a medication chart but are integral to maintaining a person's hydration and to reduce the likelihood of the Gastrostomy tube becoming blocked? If a training need is identified how will this be addressed?

[13] Framework means an agreement between one or more contracting authorities and one or more economic operators the purpose of which is to establish the terms governing contracts https://www.gov.uk>government>publications>adult-social-care-outcomes-framework-handbook-of-definitions [Accessed January 2024]

Finding 3: Readmission to hospital (Fairfield General Hospital)

Adult M was readmitted to hospital at 15:44 on the 6th of December following transfer by ambulance. On admission she was found to have a Glasgow Coma Scale[14] reading of 3 on initial assessment and acute kidney injury.

On transfer to the ward the staff completed a safeguarding adult referral to ASC because of their concerns that Adult M has suffered neglect and omissions in care while in the nursing home. It was felt by staff that Adult M had suspected widespread deep tissue injury to her buttocks and sacrum and that her gastrostomy site had been poorly managed, the site having a malodorous smell coming from it, as well as inadequate fluid being put through it resulting in dehydration. The referral was completed based on Adult M's best interest at the time as she was assessed as lacking the mental capacity to be able to consent to a safeguarding referral.

During this admission Adult M was diagnosed as having dehydration, kidney failure and was receiving intravenous fluids. A further best interest decision was made to photograph Adult M's sacrum and buttocks to evidence the damage to them by the hospital clinical photographer and to support the safeguarding enquiry.

Adult M's condition did not improve during this last inpatient episode despite referrals to the dietician, the TVN and podiatry, she developed a hospital acquired pneumonia and sadly passed away in hospital on the 23rd of December 2022.

Questions for the RBSAB and partners

It was the view of the independent author and panel members that this episode of hospital care raised no questions for the RBSAB and its partners.

Finding 4: Responses to the Adult Safeguarding Concerns

There were 3 adult safeguarding referrals made by hospital staff during the timeframe of this review relating to the last 2 hospital admissions.

The 1st Safeguarding referral was recorded by ASC but closed with no further action being required when it was confirmed by the TVN that the damage to Adult M's skin was not because of excessive lengths of time being sat or laid in one position at home following her admission to hospital in November 2022.

The 2nd Safeguarding referral was recorded by ASC on 7th December as a result of the allegation of neglect and omissions of care raised by hospital staff when Adult M was admitted from the nursing home. The 3rd safeguarding referral was made by a dietician due to their concerns about omissions and neglect; failure to provide nutrition and hydration.

[14] Glasgow Coma Scale – Provides a practical method for assessment of impairment of conscious level in response to defined stimuli a reading of 3 indicates a significant impairment https://glasgowcomascale.org.uk [Accessed October 2023]

ASC combined the 2nd and 3rd safeguarding referrals because they were relating to the same concerns by hospital staff about the management of Adult M in the nursing home. The Social Worker made appropriate contact with CHC being aware that Adult M's care was being funded by CHC and they would be best placed to undertake initial enquiries, being clinical staff rather than the social worker. This is as set out in RBSAB's policies reflecting that as S42 of the Care Act 2014 states '*the Local Authority can task others to undertake investigations to support safeguarding enquiries if it is appropriate to do so'.*

On the same day the Social Worker spoke to the Manager at the nursing home to discuss the concerns raised by the hospital about the care Adult M had received whilst in their care. The Manager informed the Social Worker that Adult M had damage to the skin on her buttocks when she was admitted to them due to what was believed to be neglect by the care agency who had been caring for Adult M in her own home before her admission to hospital at the beginning of November.

She also told the Social Worker that the same applied to the condition of Adult M's gastrostomy tube site, that it was partially blocked when Adult M was transferred to them, and that they were working with the Abbott Nurse team to review its management. The Abbott Nurse who was known to Adult M in the community prior to her hospital admission had been into the nursing home on the 29th of November to review the gastrostomy tube. She is reported to have stated that the feeding tube was partially blocked due to previous neglect and the insertion site looked better than when she had last seen it because staff had been cleaning it daily. It was reported that Adult M was reluctant to have the gastrostomy tube changed when this was discussed with her, she had been informally assessed as having the capacity to decline further Abbott Nurse input at this time. This information concurs with findings from NCA earlier in the report.

The nursing home Manager described that Adult M had an unwitnessed fall at the home on the 3rd of December, staff were unsure if Adult M had banged her head, NWAS were called and attended to review, Adult M was assisted back to bed and no serious injuries were identified. It was agreed with Adult M and her daughter that unless there was a reason for Adult M to be admitted directly to a hospital ward then she should remain at the care home. The ambulance crew were made aware of this, they made a call to the GP and arranged for the GP to come and review Adult M. The day after this fall Adult M had a bruise to her lower back, a photograph was taken of this injury and shared with ASC as part of the safeguarding enquiries.

On the 6th of December the nursing home staff told a Social Worker that they had sent a urine sample to the GP surgery which showed the Adult M had a urinary tract infection, a course of antibiotics was prescribed. Later that day Adult M was found unresponsive, clinical observations were taken and 999 called. Adult M was transferred back to hospital with possible dehydration. Staff did not have time to complete a body map noting any injuries to Adult M prior to her being transferred back to hospital. The nursing home Manager reported to a Social Worker that it was after the hospital admission that they were informed Adult M had pressure ulcers alleged to be acquired whilst in their care.

Following receipt of the safeguarding referrals a Social Worker spoke to the CHC nurse who had visited Adult M on the 6th of December, she expressed her concerns over the management of Adult M in respect of her risk of further falls and the inadequate management of her feeding regime. ASC were informed that the decision had been made that Adult M would return home after this second hospital admission because CHC had found an alternative community care provider who could manage Adult M's care on discharge in her own home now that staff had been trained in the management of gastrostomy tubes and enteral feeding. There was no further communication between the Social Worker and the CHC nurse in relation to the outcome of the safeguarding referrals made by hospital staff.

Discharge documentation from the hospital to ASC suggested that deep soft tissue injury was already present on discharge and that there were community issues with the gastrostomy tube that were carried over into her care in hospital.

ASC felt that the documentation provided by the nursing home Manager in relation to the falls had resulted in appropriate actions being taken to reduce the risk of further harm, appropriate action had also been taken after the falls including contacting the emergency services for advice and review of Adult M. It was confirmed that CHC remained in place and that Adult M would not be returning to the nursing home. The nursing home Manager was also able to evidence that the Abbott Nurse had been into the nursing home to review Adult M's gastrostomy tube.

Section 42 consideration was applied following the referrals and a decision was reached not to proceed to formal enquiry based on the information provided by the nursing home Manager and because Adult M would not be returning to the nursing home on discharge from hospital. This decision was not communicated back to the hospital safeguarding team or the CHC nurse who had been asked to provide information initially.

Since these safeguarding referrals the nursing home has been subject to quality assurance visits carried out by ASC monthly which were increased to approximately fortnightly from mid-February 2023. Prior to this quality assurance visits had taken place at the nursing home as part of the local authorities' duties under the Care Act 2014. Visits are completed in relation to a range of quality assurance monitoring required by the commissioning team and forms an overall assessment of care home services. Greater scrutiny involving the local authority, CHC and ICB is triggered if a care placement is believed to have met the multi-agency concern (MAC) threshold. A CQC rating of 'requires improvement' would not necessarily meet the need to convene a MAC meeting.

Questions for the RBSAB and partners

1. **Can ASC provide assurance to the RBSAB and partners that the safeguarding referrals were dealt with in line with RSAB's policies and procedures particularly in relation to 12.10 which *states 'If a decision is made not to proceed with a S42 enquiry the referrer must be informed of the decision in a timely way, and the reasons for it'* and if not how will this be addressed? Is this a case finding or a wider system finding?**

After the SAR's conclusion, a family representative contacted the RBSAB with further personal observations, not previously mentioned to the Independent Author, relating to Adult M's care. RBSAB responded to the individual to offer advice. The SAR report agreed by RBSAB partners has not changed.