EXECUTIVE SUMMARY OF A SERIOUS CASE REVIEW REGARDING MR AA

Sections 1 & 2
Reasons for and purpose, terms of reference and methodology of the review

This section sets out in broad terms the circumstances leading up to the decision to hold a serious case review and the main purpose for it. This being, to enable lessons to be learned from serious injury or death of an “adult at risk”, and for those lessons to be learned widely and thoroughly and to reach an understanding of what needs to change to reduce the risk of further such incidents.

The terms of reference were set out as:

Information Gathering - explore the background
- To establish a chronology about the series of events prior to Mr AA’s first admission to hospital during early January 2013 up to and following his death on 13 June 2013.
- To examine the roles, responsibilities and involvement of professionals and key agencies involved or in contact with Mr AA during this period.

Review - the SCR will consider, review and analyse
- Whether there are lessons to be learned and/or improvements to be made with regards to the way in which the professionals and agencies involved with Mr AA’s care worked together in meeting his health and social care needs.
- How professionals and agencies involved shared and acted upon information and communicated with each other in relation to Mr AA’s needs and the care provided.
- If this case highlights any general difficulties and concerns in relation to policies and processes around information sharing and communication between different professionals and agencies.
- Whether there are any gaps in protocol which impacted on the safe discharge/transfer of service users between hospital and care homes.
• The communication and sharing of information between different professionals and agencies involved in relation to Mr AA’s changing and complex health and social care needs.

**In Specific the SCR will analyse**

• The circumstances around each episode of care. This is in relation to discharge planning and reasons for re-admission.
• The care received by Mr AA during hospital admissions.
• The care received at Lennox Hose in the periods between discharge from hospital and re-admission to hospital and how Mr AA’s increasing care needs were addressed.
• The care Mr AA received while at Highgate Nursing Home.
• The end of life care received by Mr AA. The period both prior to and after his death should be considered and the care in each of the different settings.
• The GP care provided to Mr AA.
• Whether the care provided by all professionals and agencies was consistent with expected professional standards.

This section goes on to set out the membership of the Panel and the methodology used including a list of agencies that were asked to provide Individual Management Reviews.

**Sections 3 & 4**

**Background of Mr AA and the narrative chronology of key events**

This sets out a brief description of Mr AA’s circumstance and family connections prior to his needing to enter residential care in 2008, when dementia inhibited his ability to care for himself sufficiently. For many years before his admission to residential care Mr & Mrs O, who he considered as his next of kins, supported Mr AA. Mr & Mrs O attempted to maintain that relationship throughout his time in care homes including the period under review.

A long section describes the events that took place from January 2013 until shortly after Mr AA’s death in June 2013. It is drawn from each of the Individual Management Reviews (IMRs) and some additional information provided by Mr & Mrs O. It starts with deterioration in his physical health that led to 3 acute hospital admissions, 2 discharges back to his original care home where his place was funded by the Local Authority and a final discharge to a registered nursing home funded by the NHS through continuing health care. On his first admission he acquired a grade 3/4 pressure ulcer and as a consequence received some community health services between in-patient episodes.
In both homes, Mr AA was registered with the GP practices that were contracted to provide additional services to care homes to improve the physical, mental and social care of service users resident in residential and nursing homes in the Borough. This is over and above the levels contracted through their GMS/PMS$^1$ Contract (which specifies levels of service to any or all patients registered with the Practice).

Mr AA had some serious, and at times, life threatening infections during his 3 hospital admissions. This included periods in intensive care from which he recovered. Prior to his last discharge, a colostomy was undertaken to assist with the management of his pressure ulcer and reduce the risk of further re-infections. Although, given his age and frailty, this was a risky intervention its longer-term aspiration was to improve his general health and comfort. Following his recovery from surgery Mr AA was discharged to a nursing home where he died 15 days later.

**Section 5**

*Analyses the information in the narrative section*

This considers the information against the specific requests as set out in the terms of reference. It concludes the following (described in the same order as the ToR):

- Hospital discharge planning on the first 2 occasions was poor and probably contributed significantly to the re-admissions.
- The safeguarding considerations relating to serious pressure ulcers were not considered despite a number of opportunities by a wide range of professionals, for the first 4 weeks of Mr AA having been found to have a grade 3/4 pressure ulcer.
- Use of the Mental Capacity Act by a range of staff involved in Mr AA’s care was patchy at best, despite his advanced dementia and a whole range of physical interventions.
- Some of the basic nursing care whilst in hospital was poor and despite complaints from next of kin and the care home were unaddressed.
- The residential care home was unable to meet Mr AA’s increasing needs but did not recognise that.
- The serious risks involved in the failure to meet the increasing dependency and needs was not recognised by other professionals in a timely way.
- Communication between the Care Home and GPs also failed to identify the mismatch in care given to care needed, as decisions were based on the home’s inappropriate and inadequate assessment of Mr AA’s condition.
- The nursing home where Mr AA was discharged to on the last occasion, did not pay adequate attention to the discharge information.

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$^1$ GMS= General Medical Services, PMS=Personal Medical Services, the 2 most frequently used contracts between the HNS and General Practitioners
when drawing up a care plan or utilise the knowledge of the next of kin to personalise the care plan.

- The implementation and/or recordings of the implementation of the care plan that was made were inadequate.
- Mr AA was not afforded the care and dignity at the end of his life or in his death that most would want for their friends and family.
- Neither GP practices involved in this review used the Mental Capacity Act at appropriate times despite Mr AA’s known dementia.
- Neither practice sought to involve the next of kin in decision making even when considering “Do not attempt resuscitation” decisions.
- Neither practice appeared to demonstrate that in Mr AA’s case at least, they were fulfilling the responsibilities set out in the enhanced service specification to which both were contracted in particular the elements covering: Providing a proactive, preventative service. Minimise the risk and complications within this vulnerable group, which includes patients with highly complex needs by providing and monitoring a comprehensive programme of care. Fulfill the minimum requirements set out in the NSF Older People, 2001, Standards for Better Health, 2004, End of Life Care Strategy, 2008, End of Life Care LCS and Gold Standards Framework. To provide proactive care in managing chronic disease and medicines including care planning especially around discharge and end of life care.

This section also identifies further areas for improvement/to be learned from that were not identified in the ToR, these were:

- The responsible safeguarding team attempted to implement safeguarding procedures when alerts were raised. They did not however, suit well the situations that caused the concerns and did not therefore achieve the purposes they identified.
- GP engagement in all parts of the process (from safeguarding investigations to serious case review) has not been good.
- If there had been social work involvement in Mr AA’s first 2 hospital discharges it should have improved his situation and the potential risks that emerged following discharge.
- A way needs to be sought to better identify those discharges that would significantly benefit from Social Work involvement.
- Application and understanding of the Mental Capacity Act has been a problem in most of the situations analysed.
- Appropriate identification of palliative care and end of life care and implementation of their appropriate pathways was confused.

Section 6
Recommendations

This section sets out the actions/improvements identified by each agency in their IMRs (where any were identified). It also sets out any additional recommendations for each agency arising from the Serious Case Review. It further sets out recommendations for agencies not directly involved in Mr AA’s
care and finally some further recommendations for the Safeguarding Adults’ Partnership Board to consider. The latter 3 categories are set out below:

**Lennox House**
- Review weekend management support to enable decisions with a pecuniary implication to be made if needed.
- Improve knowledge and understanding of the Mental Capacity Act at a minimum of manager and deputy levels.
- Review with the Archway Medical Centre what and how information is given and evaluated at the regular planned GP visits.

**Archway Medical Centre**
- GPs to undertake Mental Capacity Act training (or refresher training as appropriate).
- When an individual lacks capacity, ensure decisions re DNAR are taken with the appropriate relative/carer/designated next of kin where known.
- Review with Lennox House, together with the CCG’s clinical lead for residential care, how “ward rounds” are undertaken to improve the exchange of information and provide better informed assessments of individual resident’s circumstances.
- Review, with the CCG, the Practice’s implementation of the Locally Commissioned Service Specification in respect of Care Homes.

**Whittington Health – the Hospital**
- Identify an auditable way of recording discharge decisions at patient level.
- All clinical staff to be made aware of their responsibilities in relation to safeguarding and pressure ulcers.
- Improve the reach of Mental Capacity Act training to relevant inpatient staff.

**Whittington Health Tissue Viability**
- Ensure all tissue viability nurses are familiar with the Pan London Safeguarding Adults Policy, in particular the London Borough of Islington Appendix to the: “Appendix N: Pressure Ulcer Policy”.

**London Borough of Islington**
- Review thresholds for “acceptable risk” in care settings and disseminate/train accordingly.
- Work with Wittington Hospital to optimise social work input to hospital discharges.

**Highgate Nursing Home**
- Audit the implementation and effectiveness of actions identified in the IMR.
- Identify what percentage of staff should be trained in basic dementia care and then action.
- Identify what percentage of staff require Mental Capacity Act training and then action.
- Review care planning processes to improve personalisation of care plans.
- Ensure and evidence accuracy of care plans linked to discharge and other available information, particularly medication, dietary needs and pain management.
- Senior management of Bupa to consider how it supports its homes involved in Serious Case Reviews to nurture a culture of transparency, openness and learning.
- Senior Management of Bupa to ensure all staff at Highgate Nursing Home reflect on the issues raised in this report.

**Northern Medical Centre**
- During admission assessments, identify relevant relative/next of kin/carer and enter into clinical notes.
- GPs to undertake Mental Capacity Act training (or refresher training as appropriate).
- Review with HNH and the CCG clinical lead for residential care how “ward rounds” are undertaken to improve the exchange of all relevant information and provide better informed assessments of individual residents’ circumstances.
- Review, with the CCG, the Practice’s implementation of the Locally Commissioned Service specification in respect of Care Homes. Particular attention to be paid to end of life care.

**Clinical Commissioning Group**
- Review the implementation of the Locally Commissioned Service Specification for GP cover to Residential, Nursing and Intermediate Care Homes, with the Archway Medical Centre and Northern Medical Centre.
- Sample other GP practices with the Locally Commissioned Service Specification to ensure practice is compliant with the same specification.
**NHS England (London)**

- Issue very clear written advice to all GPs about their responsibilities in respect of the full spectrum of safeguarding from alerts to Serious Case Reviews/ safeguarding Adults Reviews (SARs).²
- Consider making available an advisory/support service for GPs when involved in Safeguarding investigations and serious case reviews, to enable timely and informative contributions to keeping people at risk safe and/or mutual learning.

**Islington Safeguarding Adults’ Partnership Board**

- Consider establishing a mechanism for identifying learning and improvements across agencies that arise from safeguarding incidents when safeguarding procedures are no longer required.
- Review the SCR process in preparation for Safeguarding Adults Reviews (SARs).
- Take action to improve the understanding of the Mental Capacity Act and its role in the care of some adults at risk across the range of health and social care organisations in its area, from all sectors.
- In the context of increasing levels of frailty on hospital discharge, review the thresholds for risk of harm across all agencies.
- Seek assurance from the agencies involved that actions identified in IMRs have been implemented and their effectiveness scheduled for audit/audited.
- Agree a mechanism for monitoring progress against the action plan.

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²SCRs become known as Safeguarding Adults Reviews under the Care Act 2014