Islington Safeguarding Adults Board

Safeguarding Adults Review in respect of the care and support of two adults

Ms BB and Ms CC

Ms BB died on 1st October 2015

Abridged Report

Safeguarding Adults Review Chair: Detective Chief Inspector Paul Cheadle
Safeguarding Adults Review report author: Jane Lawson
This Overview report is based on information taken from Individual Management Reviews (IMR) and chronologies completed by each of the organisations involved. There is a presumption that when an organisation completed an Individual Management Review, all relevant people were consulted with.

The findings expressed in the report are those of the report’s author and the Safeguarding Adults Review Panel.

Names have been anonymised throughout this report.

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The following abbreviations are used in the report:

ASS  Adult Social Services (provided by London Borough of Islington)
BARTS Barts Health NHS Trust
CANDI Camden and Islington NHS Foundation Trust (Mental Health)
CHC Continuing Healthcare
CMC Coordinate my Care
DNAR Do not attempt resuscitation
DNACPR Do not attempt cardiopulmonary resuscitation
DoLS Deprivation of Liberty Safeguards
IMR Individual Management Review
INC Integrated Network Coordination
IQCM Integrated Quality Care Meeting
LBI London Borough of Islington Council
MCA Mental Capacity Act 2005
OT Occupational Therapist
SAB Safeguarding Adults Board
SAR Safeguarding Adults Review
SALT Speech and Language Therapist
RLH Royal London Hospital
TVN Tissue Viability Nurse
UCLH University College London Hospital NHS Foundation Trust
UTI Urinary Tract Infection

SP1: Senior Practitioner (1)
SP2: Senior Practitioner (2)
SW1: Social Worker 1 (main social worker allocated to Ms BB)
SW2: Social Worker 2 (main social worker allocated to Ms CC)
1 Introduction & the circumstances that led to a Safeguarding Adult Review (SAR) being undertaken in this case

Ms BB died on 1 October 2015 in circumstances that give rise to concerns about the way in which professionals and agencies worked together with Ms BB and Ms CC. The cause of death was dehydration and infection secondary to a grade 4 pressure ulcer.

Ms BB died in hospital having been admitted on 18 September 2015 with a Urinary Tract Infection (UTI); hypotensive; malnourished and dehydrated. She had an infected pressure ulcer. She was admitted to hospital along with Ms CC. Ms BB and Ms CC had been receiving 24 hour care following Ms BB’s discharge from hospital on 20 August 2015.

Under section 44 of the Care Act 2014, the Local Safeguarding Adult Board (SAB) must arrange a Safeguarding Adult Review “when an adult in its area 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”. The purpose of a Safeguarding Adult Review is primarily to:

- provide useful insights into how organisations are working together to prevent and reduce abuse and neglect of adults
- promote effective learning and improvement action to prevent future deaths or serious harm occurring
- identify lessons and examples of good practice where this might be applied in future situations

“Safeguarding Adult Reviews should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that...” It is emphasised that this process is not about blame.

In November 2015, the Islington Safeguarding Adults Board received a request to consider whether to commence a Safeguarding Adults Review in relation to the death of Ms BB and which would also consider the care provided to Ms CC. The Safeguarding Adult Review sub-group of the Safeguarding Adults Board made the decision that the care received by Ms BB and Ms CC had met the criteria for their case to be progressed to a Safeguarding Adult Review under Section 44 of the Care Act. The criteria set out in section 1 are met.
Ms BB and Ms CC

Ms BB was born on 9 March 1924 and died 1 October 2015. Ms CC was born on 1 August 1930 and currently lives in a nursing home. They lived together in Islington for over 40 years. Their home was a second floor two bedroom flat. The tenancy of the flat was initially in the name of Ms BB’s brother, Mr XX. On his death (1981) it transferred to Ms BB. At this time Ms CC was recorded as a friend and member of the household. On 20 August 1990 the tenancy transferred to a joint tenancy of Ms BB and Ms CC.

Both Ms BB and Ms CC had strong and supportive family relationships. Their families enjoyed spending time with them over the years. They received substantial support from both of their families when their care needs increased. Ms BB’s younger brother lives in Potters Bar and offered significant support to Ms BB and Ms CC throughout the period under review. Ms CC’s sister also offered significant support and lives in Kent. They visited at weekends carrying out numerous practical tasks and making sure money was available to carers for necessities.

Ms BB’s brother described Ms BB and Ms CC as “the most caring couple of ladies you could wish to meet”. He said that they were previously always spotlessly clean and they all enjoyed spending time together over the years. He said that “we feel like something is really missing now [Ms BB] is gone and they, [Ms BB and Ms CC] are not together”.

The two families (of Ms BB and Ms CC) remain close and Ms BB’s brother said that he and his wife and Ms CC’s sister had arranged to visit Ms CC together the following Sunday (after this conversation for the review took place )and that Ms BB’s brother was to visit Ms CC that same day. Ms CC lives in a nursing home in Potters Bar.

Similar characteristics were conveyed by the GP who had primary responsibility for Ms BB and Ms CC. He said they were: caring, both within their own relationship and towards others; kind; independent; private; mutually supportive; spotlessly clean; well organised. The report provided by the GP gives insight into the life of Ms BB and Ms CC before their independence began to be eroded due to their increasing support needs. It stated: “They always consulted together never separately. They were 'model patients' in so much as they always attended the practice for their six monthly blood pressure check and annual blood tests. They didn’t require a reminder letter. This was the main reason for them attending the surgery, prior to 2013. They usually walked round to the surgery but in the latter years Ms CC drove them both in their car. At Christmas time they would bake mince pies and bring some to the surgery to give to Dr A. Neither called nor consulted over minor self-limiting illnesses".
The GP reported: “They … had met while both working 'at the print' [reference to working together in a print factory when they first met] over 40 years ago and had lived together a similar length of time. They came across as very caring towards each other and shared a home, working as a team”.
Prior to July 2014 they lived largely independently. Ms BB had received professional support around mobility and an assessment from Services for Ageing and Mental Health (SAMH) when a likely diagnosis of vascular dementia was made.

2 Purpose of the Safeguarding Adult Review; methodology and Terms of Reference

The Islington Safeguarding Adult Board Safeguarding Adults Review subgroup has identified the purpose of this Safeguarding Adults Review as to understand what happened and to learn from the way local agencies and staff worked together including what did and did not work well. It has made a commitment to agree how this learning will be acted on and what is expected to change as a result. It is intended that through developing practice as highlighted in this review, adults who may be in need of safeguarding support will be better safeguarded from significant harm.

Methodology and Terms of Reference
The Safeguarding Adult Review (SAR) was commissioned by the Safeguarding Adults Board and the Panel convened for this SAR met to agree terms of reference.

The Independent Chair of the Panel, panel members and independent report writer were determined as follows:

- **Paul Cheadle (PC)** Chair- Detective Chief Inspector, Metropolitan Police
- **Jane Lawson (JL)** Independent Safeguarding Adult Review Author
- **Elaine Oxle (EO)** Head of Safeguarding Adults and Mental Capacity Act, London Borough of Islington
- **Jo Holloway (JH)** Safeguarding Adults Policy and Practice Officer, London Borough of Islington
- **Andy Murphy (AM)** Chief Executive Officer, Age UK Islington
- **Deborah Wright (DW)** Head of Social work and Social care, Camden and Islington
- **Emma Whitby (EW)** Chief Officer, Healthwatch
- **Liz Rutherford (LR)** Chief Executive Officer, Single Homeless Project
- **Jenab Yousuf (JY)** Designated Safeguarding Lead, Clinical Commissioning Group
- **Sobia Masood (SM)** Safeguarding Adults Board Administrator, London Borough of Islington

This review considers the period from May 2013 until the death of Ms BB in October 2015 and the time when Ms CC was admitted to a nursing home.
Alongside this report an executive summary will be produced. The Safeguarding Adult Review subgroup of the Islington Safeguarding Adults Board will set out how the learning will be acted upon and what is expected to change as a result.

The independent Safeguarding Adult Review author contacted the brother of Ms BB and the sister of Ms CC to advise that this Safeguarding Adult Review is taking place and to seek their views of the care and support offered to Ms BB and Ms CC. These views were represented at the panel discussion.

The organisations involved with Ms BB and Ms CC were asked to produce individual management review reports providing exhaustive chronologies of their involvement and bringing together overall learning from the involvement of their organisation with Ms BB and Ms CC (to cover at least the period from May 2013 to 1 October 2015).

These reports were presented to a Safeguarding Adult Review Panel meeting on 14 April 2016. Panel members asked further questions and requested further information. The Panel then identified themes that required particular exploration in the Safeguarding Adult Review report.

The overview report collates and analyses the information contained in the Individual Management Reviews and any other reports and information presented to the Safeguarding Adult Review Panel with reference to relevant research and guidance. It highlights lessons learned and draws overall conclusions in terms of key issues for the safeguarding partnership. It makes recommendations on what actions the safeguarding partnership should take following the Safeguarding Adult Review. The final Safeguarding Adult Review report is taken to Islington Safeguarding Adults Board in October 2016.

Individual Management Reviews were commissioned from:

Allied Healthcare Group (Care Agency)
Aquaflo Care Ltd (Care Agency)
Barts Health NHS Trust
Camden and Islington NHS Foundation Trust
GP Practice
London Borough of Islington Adult Social Services
London Borough of Islington Commissioning Department
London Borough of Islington Housing Department
London Ambulance Service
Metropolitan Police
Palliative Care Team (Central and North West London NHS Foundation Trust)
Whittington Health NHS Trust
University College London Hospital NHS Foundation Trust

(These Individual Management Reviews included chronologies of involvements with and in respect of Ms BB and Ms CC):

The emphasis in this review is on the lessons and implications for multiagency working. Individual Management Review reports have been prepared by all agencies involved with Ms BB and Ms CC and deal in detail with the actions required
within each individual agency. The Safeguarding Adults Board will provide a scrutiny role in relation to single agency action plans but those individual actions and recommendations will only be included in the Safeguarding Adult Review overview report recommendations:

- where they have significant implications across agencies
- where they underline highly pertinent matters which may have received tepid attention in the Individual Management Review recommendations - and the Safeguarding Adults Board needs to be alert to them.

The Safeguarding Adult Review panel (and by extension, Individual Management Review authors) agreed to consider and reflect on the following:

- whether there are lessons to be learned and improvements to be made with regards to the way in which the professionals and agencies involved with Ms BB and Ms CC’s care worked together in meeting their health and social care needs.
- how professionals and agencies involved shared and acted upon information and communicated with each other in relation to Ms BB and Ms CC’s needs and the care provided.
- whether this case highlights any general difficulties and concerns in relation to policies and processes around information sharing and communication between different professionals and agencies. A focus on the review, monitoring and quality assurance mechanisms each agency had in place; the robustness of these in monitoring the care being provided to/ the welfare of Ms BB and Ms CC and responding to any deterioration, change in circumstances, increased risk or concerns.
- any specific concerns regarding health or social care service delivery issues at the time, which may have impacted on this case

Specific areas for enquiry were identified as:

- whether Ms CC’s needs and views as a carer were adequately considered.
- involvement of Ms BB and Ms CC in decision-making.
- involvement of care staff who knew them well in decision making.
- whether Ms CC’s care needs were fully assessed during Ms BB’s hospital admission. This is in relation to her physical health, mental health and care needs.
- whether Mental Capacity Act 2005 was considered throughout and used appropriately and at key times.
- to consider the safeguarding concerns raised, the outcomes from the safeguarding process and the extent to which the risks were reduced. To also consider whether there were other points where safeguarding concerns occurred and were missed.
- when the Integrated Quality Care Meeting Panel considered least restrictive care options, were issues of risk in relation to complexity and previous history appropriately considered? How the views of Ms BB and Ms CC and their families were reflected in best interest decision making and in the Panel decision making process.
- the communication between agencies and the assessment of the impact Ms CC had on the care received by Ms BB.
• in relation to the pressure ulcer, was this appropriately reported on, assessed, monitored and managed both within the hospital and community?
• the role of the multi-disciplinary team in terms of discharge planning and information sharing prior to discharge of Ms BB from Mile End Hospital.
• consideration of care planning and risk assessments completed including by the care agencies when they took on the care package. Exploration of how the care agencies involved monitored the care provided by their carers.
• consideration of the impact of commissioning and procurement arrangements and practice for contracting care services including the contractual arrangements when a care agency wishes to withdraw from providing care.
• consideration of the events which occurred at home prior to the hospital admission on 18 September 2015.
• whether the care provided by all professionals/organisations was consistent with expected professional standards and in line with existing policies/procedures including: safeguarding adults, Mental Capacity Act 2005, Do Not Attempt Resuscitation, assessment and management of risk; hospital discharge, pressure ulcer care; working with individuals who do not engage with services/support.
• whether there are any concerns in respect of protocol which impacted on the safe discharge and transfer of service users between hospital and home.

The Safeguarding Adults Board is charged with seeking assurance that safeguarding adults in Islington is effective. The Care and Support Statutory Guidance sets out 6 key principles that must be at the heart of effective adult safeguarding practice: empowerment; prevention; proportionality; protection; partnership; accountability. The conclusion to this report will include reference to the extent to which these six principles were a) reflected in working with Ms BB and Ms CC and b) are central to the learning and practice development required.

Panel members are very aware that being in a position where it is possible to view all of the records and information together and with hindsight gives obvious advantage and is very different from the situation in which practitioners or professionals find themselves. It is often clearer with the benefit of hindsight than would have been evident at the time that a particular decision or response is required in particular circumstances. This overview that the Panel is able to achieve is necessary for the identification of strengths and gaps in service responses and the learning that must result. The complexity in health and social care and the challenges faced by professionals and their organisations is recognised as context to the events and practice outlined.

2.2.12 All agencies will have their own internal and statutory review procedures to investigate serious incidents. Agencies may also have their own mechanisms for reflective practice. This Safeguarding Adult Review protocol is not intended to duplicate or replace these.
3  Summary of key issues emerging from the chronology of involvement with Ms BB and Ms CC

The panel scrutinised a lengthy integrated chronology (109 pages), bringing together the range of chronologies from involved organisations. This section summarises key issues as they unfolded during five distinct stages of the chronology. The panel scrutinised the chronology in detail in order to draw out these aspects of practice.

This review considers the period from May 2013 until the death of Ms BB in October 2015.
There were five distinct periods within this:
- the period before and during Ms BB’s hospital admission on 15 July 2014
- the period between Ms BB’s discharge from hospital on 24 July 2014 and her readmission on 22 March 2015
- the period during which Ms BB was again a hospital inpatient from 22 March 2015 until 20 August 2015
- the period following Ms BB’s discharge from hospital on 20 August 2015 up to the admission of both Ms BB and Ms CC on 18 September 2015
- this period in hospital for both Ms BB and Ms CC from 18 September until Ms BB’s death on 1 October and Ms CC’s move into a nursing home.

3.1 The period before Ms BB’s hospital admission on 15 July 2014 and during that admission

London Borough of Islington Adult Social Services was involved with Ms BB from April 2013 after a referral from her GP following an incident of collapse after a bath. There was involvement with Ms CC from July 2014 as a result of a referral regarding a falls assessment.

Ongoing involvement with Ms BB and Ms CC began in June 2014. During 2014 there was involvement from a range of professionals including from: GP practice; palliative care team; University College London Hospital NHS Foundation Trust; London Borough of Islington Adult Social Services; care agency (Aquaflo); district nursing service; Camden and Islington NHS Foundation Trust (CANDI); Barts Health NHS Trust; London Borough of Islington Housing Department; London Ambulance Service; Metropolitan Police.
On 15 July Ms BB was reluctantly admitted to hospital with Bradycardia and a Urinary Tract Infection (UTI).

During this admission to hospital Ms BB was resistant to the idea of care at home but Ms CC accepted the need for this.

There was social work and enablement team involvement during hospitalisation and the following issues were raised (as set out in the chronology provided):

- patient needs a capacity assessment and services
- patient requires personal care as this is needed on the ward and...
• “friend/next of kin (friend Ms CC)...stated she can no longer manage Ms BB with washing her - states she wants a carer to come in daily”
• “patient remains declining services despite previous attempts at broaching”
• “concerns in regards to lacking insight and awareness of risk of discharge without a package of care”
• “occupational therapist to inform medical team that patient cannot be discharged until seen by [social worker] SW - as discharge without package of care unsafe”

**Issues emerging from this period:**

There is a clear message that Ms BB and Ms CC wished to remain together at home and to avoid hospital admission. This is recorded in Coordinate my Care (CMC) record as... preferred place of care (and death) “home”.

There is good practice from the GP and palliative care nurse in initiating a conversation about future plans. Ms BB and Ms CC are told that their accountable GP is Dr A.

There are comments in the records about mental capacity but no formal assessment of capacity in respect of decisions being discussed or made. Indeed this is not followed up until November 2014.

Lack of insight into the risk associated with a hospital discharge without a package of care in place is noted. Such a discharge was noted as being unsafe.

Ms CC is described as a room-housemate to Ms BB. There is no evidence in the records that the nature of the relationship is pursued across organisations so that this can be taken into account on planning care and support.

Reluctance to accept care emerges as a theme very early on.

3.2 The period between Ms BB’s discharge from hospital on 24 July 2014 and her readmission on 23 March 2015

3.2.1 24 July to 30 September 2014
Ms BB was discharged from hospital on 24 July 2014 with a package of care in place. This package of care was described as “3 times daily (7 days a week) single handed care put in place with input from occupational therapist, patient and friend Ms CC – to provide personal care, help with medication prompting and meal set-up. Ms CC agreeable to continue to help with cooking, cleaning, and shopping”
Within days of Ms BB being discharged from hospital it was recorded that a review needed to be brought forward because the patient wanted to cancel the package of care. It was recognised that there were risks to both Ms BB and Ms CC if care was refused.

Throughout August and ongoing there were recurrent occasions where Ms CC and / or Ms BB did not allow carers in or to carry out their role and where concerns and information were exchanged between social worker, care agency, GP practice, and district nurses.

**Issues reflected during this period**

There is significant information exchange and actions by a range of professionals but **no meeting across professionals to join up that information to facilitate a shared understanding of the relevant information and formulate a shared action plan.**

There is no joined up risk assessment. **No clear strategy outlined/agreed to address the non-engagement of Ms BB and Ms CC.** No reference to any guidance or protocol, for such circumstances.

**No assessment of Ms CC’s needs and wishes in her own right or as a carer.**

There is **no timely assessment of capacity** in respect of problematic decision making around acceptance of care.

**Review of decisions emerges as a weak aspect of practice.** The care is reduced at the request of Ms BB and Ms CC with an intention to review how this is working. The review does not take place and the changed arrangement is simply formalised administratively. Similarly there is no formal review agreed between the GP and district nurse when the medication is withdrawn on 2 September. An agreement does however exist that this is being monitored and the district nurse would inform the GP of any issues.

**The family are not proactively engaged with** as part of a plan to manage the risks, to help them understand the various roles of those involved and who to contact.

**A safeguarding referral** by the district nurses (because they were concerned that Ms BB’s needs were being neglected due to lack of access allowed by Ms CC) **is closed down.** The risk remains and there is no robust plan in place to reduce this. There is an absence of proactive coordinated involvement on the presenting issues. Even the plans recorded are not carried out to the full extent.
A summary recorded by the GP on 11 September includes some significant information. This is good practice. However what is required is a shared understanding across professionals of the admission avoidance care plan and the “for attempted cardiopulmonary resuscitation (CDPR)” agreement.

The GP explained during this review process that the inconsistency in expressed Do Not Attempt Resuscitation (DNAR) decisions expressed by Ms BB is as a result of Ms CC wanting her to have cardiopulmonary resuscitation and Ms BB acceding at times to her wishes. This needed to be formally resolved.

3.2.2 October 2014 to December 2014

In October Ms BB and Ms CC requested a further reduction in care from two visits to one each day (1 hour in the morning and half an hour in the afternoon to 2 hours in the morning). This was still being discussed in the records on 20 October where it says “1.5 hours morning only is being requested”. By 27 October the social worker was still recording two calls per day. This appears to be left not concluded. During October there were further instances of denial of access to carers.

In November an assessment by a consultant psychiatrist from the Memory Assessment and Treatment Service (MATS) is recorded: “Diagnosis of dementia (most likely Alzheimer’s disease). Ms CC had no insight into her impairment (believes nothing wrong with her mentally or physically – therefore reticent re accepting carers and support)”.

Issues reflected during this period

The request by Ms BB and Ms CC to reduce care visits from two to one daily was left not formally concluded throughout October. This lack of clarity about what care exactly was being provided and when and by whom was a recurrent theme in this review (later on Aquaflo Care Ltd continued to provide care (August and September 2015 when Allied Healthcare had instead been commissioned to provide 24 hour care).

In October when Ms BB’s sister in law approached professionals several times and then again in December the opportunity was not taken to engage with her on all of the presenting issues and possible actions or support. Adult Social Services dealt with the presenting issue on each occasion rather than assessing and putting in place contingency plans and actions to mitigate risk.

Professionals had been focusing on the need to assess capacity. In November there is a clear assessment that Ms BB lacks capacity (and insight) to decide on healthcare and medication issues and that decisions are likely to be required in
their best interests. It was stated that it would be unlikely that they would regain capacity. The records do not reflect that any one took a lead on following up on this, sharing it and acting upon it by facilitating a multiagency discussion on the question of “whether essential care should be provided assertively if deemed to be in Ms CC’s best interests” (Individual Management Review author, Camden and Islington NHS Foundation Trust)
The available information and assessment on capacity does not appear to be accessible to or accessed by all involved.

The case was closed to active social work on 27 October by the social worker despite ongoing risk and concerns from the family. The case does however remain open to the London Borough of Islington Adult Social Services department. The service manager at the Individual Management Review meeting of the Panel said that care coordination does not necessarily need to be carried out by a social worker who may allocate tasks / actions to others before closing a case to active social work. However the care co-ordination was not put in place ahead of the case being closed.

3.2.3 January 2015 to 22 March 2015

7 January: The case was allocated to social worker (SW1) “for exploration of financial management issues”. This is following a further call from a family member about this. The social worker SW1 undertook an initial assessment. Within this assessment there is reference to the possibility of a nursing home placement for Ms BB and Ms CC.

8 January: The GP explained to the family the diagnosis in relation to Ms CC following the psychiatrist’s assessment in mid-November (they had not been advised of this hitherto). He suggested they seek advice on arranging power of attorney.

During February the GP, the care agency and the social worker all spoke with Ms BB’s sister in law and these conversations along with assessments and records of professionals indicate accumulating concerns and a general consensus that the situation needed to be reappraised with a view to increased support and support for Ms CC in her own right.

27 February: Ms CC is allocated a social worker (SW2). This is apparent from a record of a conversation social worker SW1 had with a family member on 25 March. However, there are no entries in the records by SW2 between 27 February and the admission of Ms BB to hospital on 22 March.

9 March: The district nurse had advised the dementia navigator that the carer was not with Ms BB and Ms CC for the correct time.
22 March: Ms BB fell getting out of bed and was taken to the Royal London hospital by ambulance. She was described as follows by London Ambulance Service staff:

“On examination Ms BB was sitting in bed alert, there were no obvious injuries, Ms BB denied having any pain, was incontinent x 1, breathless on exertion. Ms BB had difficulty mobilising and weight bearing”.

It is recorded later on (in the Barts Health NHS Trust Root Cause Analysis (RCA) in respect of the sacral pressure ulcer) that Ms BB was admitted having been found on the floor and was agitated. This is inconsistent with this contemporaneous London Ambulance Service record. Given the London Ambulance Service description of Ms BB and the agreement in place to avoid hospital admission it is unclear as to why Ms BB was admitted. The analysis of the Coordinate my Care record does show that London Ambulance Service consulted Coordinate my Care on this occasion.

The hospital record at this time indicated delirium and a chest infection as the reason for Ms BB’s admission to Royal London Hospital.

**Issues reflected during this period**

During this period there is a reference to what seem to be marked **visual issues for Ms BB**. This is not referred to again or acknowledged by other professionals as a significant issue.

The re-allocation of the case of Ms BB to a social worker is for exploration of financial management issues probably in response to concerns raised by a family member. It is surprising that this is the precipitating factor when issues surrounding the earlier safeguarding referral were never resolved and the **issues of risk to both Ms BB and Ms CC are persistent and escalating**.

**The possibility of nursing home care** for both Ms BB and Ms CC is noted in the first assessment carried out by the social worker SW1 in January 2015. This narrative gathers pace as it is repeated in the records across agencies (GP; psychiatrist; dementia navigator) throughout this period as well as being discussed as a possibility with a family member. Whilst the social worker on 9 March subsequently tells the dementia navigator that having discussed this with her manager “he advised that they need to increase the service and review it before making plans for any placement”, this is not clarified more widely with a range of professionals.

In February further **contacts from Ms BB’s family should have elicited a greater level of engagement** with them in planning for / addressing the care and support needs of Ms BB and Ms CC.

**The multi-disciplinary GP practice meeting** covers health and social care issues
and the possibility of a residential care placement is a dominant theme even though it is not more than an idea of one social worker at present. These meetings might benefit from social work input or update.

**Risk of falls** had been an issue for Ms BB since at least July/August 2013 when a referral to a “staying steady through falls” group was made. It is acknowledged that Ms BB did not wish to engage with being proactive on this issue but there is no continuing risk assessment of this nor mitigating measures being put in place across the multidisciplinary team. No active review of this issue.

The **hospital admission** occurred despite an “avoid unplanned admissions” agreement put in place by the GP. It is unclear whether, had the GP been communicated with, this admission could have been avoided.

There is discussion of the need for **Ms CC to be assessed in her own right** over some considerable time (from the initial assessment on 15 January). Social worker SW1 referred Ms CC for a social worker of her own through the Access team. By the time Ms BB is admitted to hospital on 22 March although it appears that Ms CC was allocated a social worker on 27 February there are no records made by the SW2 ahead of the hospital admission on 22 March. It is unclear as to why a separate social worker was allocated. Again this rationale is not recorded. It appears contrary to best practice for two people who live together in a caring relationship not to be supported by one social worker. This arrangement appears problematic as the chronology of involvement unfolds.

The family is informed by the GP of the diagnosis for Ms CC of vascular dementia on 8 January when the diagnosis was made back in mid-November. This makes it difficult for the family to plan or to offer appropriate support.

### 3.3 Period of Ms BB’s hospital inpatient episode 22 March to 20 August 2015

Further issues regarding reason for admission emerged in the records as: fast heart rate; chest infection; slurred speech. At first a stroke was queried but it was then ascertained that Ms BB had a slight bleeding in the brain due to the fall. (This is taken from a record of a call to social worker (SW1) from Royal London Hospital doctor on 1 April).

On 1 April the social worker, SW1, communicated concerns to a senior practitioner outlining urgent support needs of Ms CC. She stated that carers were at present continuing to visit to support Ms CC whilst Ms BB was in hospital. SW1 was asked to communicate advice to Ms CC’s social worker (a capacity assessment was indicated).

20 April: it is recorded that Ms BB had been transferred to Mile End hospital for rehabilitation (the move had taken place on 16 April). The family stated their wish
that Ms BB move closer to them in Potters Bar on discharge. This is reiterated again on 28 April.

15 July: The social worker (SW1) outlined the situation in considerable detail for two senior practitioners SP1 and SP2. She underlined the decline in Ms BB both physically and mentally whilst in hospital but that the hospital now felt she had reached her baseline and could be discharged. SW1 stated that the Panel decision was to turn down the request for 24 hour care. She underlined the risk for Ms BB and Ms CC without adequate support and repeated the request for 24 hour support at home. A Service Manager approved 24 hour care at home for one week to facilitate discharge and monitor the situation.

During July the hospital recorded a grade 3 pressure ulcer to Ms BB’s sacrum. This was referred to the tissue viability nurse. Ms BB became unwell and was diagnosed with hospital acquired pneumonia.

12 August: The Adult Social Services Panel decision was for: “Trial 24hrs care at home from a joint care package for both Ms BB and Ms CC 12 hrs each. Social worker to provide Aquaflo agency with keys. Case to be reviewed in 4 weeks.”

**Note that care package is joint (12 hours each).** This fact is not acknowledged by anyone from this point. For example during the meeting where Allied Healthcare presented their Individual Management Review they stated that “in this instance, the risk was Ms CC who was not a client of Allied so was beyond their control.” Allied Healthcare did however escalate concerns about that risk to Islington councils Adult Social Services department.

13 August: Ms BB was deemed medically fit for discharge. However the social worker (SW1) was concerned at the depth of the pressure ulcer and that there was discharge from it. Nursing staff reassured her that there would be tissue viability nurse involvement. Two hourly turning would be required and Ms BB would not be able to sit for long. The social worker recorded her concerns in the hospital communication book.

A discharge date of 20 August was agreed. Health and social care and support were put in place.
Issues reflected during this period

Ms BB and Ms CC had in place with their GP an agreement that unplanned hospital admissions would be avoided in the context of them wanting to stay at home as far as possible. This should therefore have been a consideration at the point of admission of Ms BB to hospital. This hospital admission is a pivotal point for Ms BB and Ms CC. It brings into focus the need for: local discussion of initiatives that support alternatives to hospital admission; robust contingency planning and development of clear personalised pathways for the support of those with progressive illness; clear communication and available information across organisations.

The issue of Do Not Attempt Resuscitation (DNAR) presented again. There is a DNAR in place in the hospital which was not discussed according to available guidelines with the family until a month later (entry 21 April, narrative chronology).

The arrangement whereby Ms BB and Ms CC have two separate social workers emerged as flawed in this period. There is little on record from Ms CC’s social worker, blurred boundaries and confusion as to the care being discussed at Panel. This is reflected in the recording of SW1’s communication with the senior practitioner for example on 1 April. “I am only allocated to Ms BB [but] the issues need to be urgently addressed to support Ms CC”.

It is unclear who is getting which care from which agency. The Panel decision is clearly recorded as 12 hours for Ms CC and 12 hours for Ms BB when Ms BB is discharged from hospital. It later emerges that there has been an oversight and Aquaflo Care is still providing care for Ms CC. Confusion is again apparent in the social worker’s (SW1) communication of 22 April with the senior practitioner. On 4 June SW1’s record in response to questions from the Panel again indicates the difficulties inherent in this arrangement “it is possible for both to be placed together but Ms CC’s social worker would need to look into the option”.

Communication about the hospital admission is slow and lacks accurate/consistent detail. Similarly with the transfer of Ms BB to Mile End Hospital.

The challenges around service refusal are clear. The social worker for Ms CC articulates these on 1 April in communication with her senior practitioner and again on 22 April. The dilemma as to capacity and consent/choice is a key issue. What level of support was offered by managers and what guidance exists to support practitioners on this dilemma?

There are a range of confused messages and manifestations of flaws in practice.
and understanding in respect of the Mental Capacity Act 2005 in this period. Quality of Mental Capacity Act assessment in terms of, for example, how the decision was reached (e.g. 23 April undertaken in respect of Ms BB by psychiatrist in hospital).

A lack of clarity as to responsibilities for (Continuing Healthcare) assessment and a lack of following due process and review when circumstances change. There was a clear issue about pressure of numbers of such assessments required to be completed at the time (identified in the chronology on 20 May by discharge coordinator).

Hospital discharge procedures National guidance suggests that best practice ensures discharge planning begins on admission; is multiagency in nature and engages with family and carers. This aspect of practice was inadequate. The GP record on 21 August passes comment on the poor quality of discharge planning. Reports were requested early on by the social worker and were not forthcoming over a period of months. The discharge coordinator was asked for these on 13 May. They were still not forthcoming on 23 July. The escalation of health issues close to the date of discharge caused the social worker to request a review of the Decision Support Tool and health needs assessment. This was never carried out.

In view of the possibility of Ms CC obstructing care and health professionals a risk assessment and contingency plans were certainly called for. There was inadequate engagement with family members who had significant concerns and who were ill informed as to the options and considerations that might to be explored. The discharge coordinator’s conversation with the family just before discharge and which led them to cancel a proposed meeting with social workers to discuss what would be in the best interests of Ms BB and Ms CC was at best made on the basis of an incomplete understanding of the challenges and risks. It offered incomplete information and outlined undertakings that the coordinator could not be sure would be carried out. Accountability was placed in the court of the social workers.

Lack of risk assessment and early contingency planning: the discharge of Ms BB from hospital began to falter on the first day. Only then is any contingency put in place. There is no analysis of patterns of concern and accumulating risk. Instead professionals respond to the ebb and flow of concerns.

The Adult Social Services Panel process: the lack of personal presentation of the issues by the social worker leads to delays and misunderstandings. This is exacerbated by the fact that there were 2 social workers for one household. It is exacerbated by an inconsistent panel.
Assessments requested repeatedly by the social worker were not forthcoming including the Continuing Healthcare assessment. This information would have been valuable for the Panel application in informing the decision.

The role of commissioning in circumstances where a care provider is failing to provide the service specified. The social worker states that she has contacted the contracts officer on 17 June but there is no record of any response.

Commissioning and block contract issue. This was clearly not the best idea for the care organisation to be changed from familiar to unfamiliar at time of stress and anxiety.

Safeguarding The lack of follow up of the incidents where carers are not turning up. This still persists up to 18 August.

The inadvisability of Extra Care Housing given advancing dementia.

3.4  The period from Ms BB’s discharge from hospital on 20 August until her readmission to hospital, on 18 September 2015

20 August: On Ms BB’s discharge from hospital, district nurses, a care provider and equipment were in place. From this first day following discharge from hospital Ms CC was resistant to carers going in to Ms BB.

21 August: The GP practice was advised by Adult Social Services of Ms BB’s discharge from hospital. They had not yet received the discharge summary from Mile End Hospital.

26 August: District nurses recorded Ms BB’s pressure ulcer as grade 4. On 21 August they had recorded it as grade 3. The tissue viability nurse first visited on this date. The District nurse recorded that the tissue viability nurse is to contact Adult Social Services in regards to positioning charts as carers state that they have none. At the same time the District Nurses (DN) raised a safeguarding adults referral because of “Concern for welfare, risk of overdosing, medication, denying access to DN”

27 August: On finding Ms BB with the catheter out and no catheter available the district nurses examined Ms BB; they found no fluid retention but she was in pain. They advised the carers to call out London Ambulance Service (LAS) and left the patient with carers to await LAS. LAS transferred Ms BB to the Royal London hospital and in doing so tore the skin on her left lower leg by catching it accidentally with a strap. Ms BB was discharged from hospital at 11pm. There were recurrent
issues in respect of catheters during September as well as issues with supplying incontinence pads.

11 September: The carers reported the pressure ulcer to be deteriorating.

14 September: The family reported significant decline when they had visited at the weekend.

18 September: A carer and a member of the public reported to the Police that Ms CC had locked herself and a carer outside the flat leaving Ms BB inside. The Police called London Ambulance Service. The record further sets out that Ms CC had, according to the carers, tried to run outside (putting herself a risk) so the carers tried to prevent her from doing so by closing the door. Her hand was trapped in the door. She had an injury to her left hand which was bleeding. The police expressed concerns with regard to the carers given Ms BB’s condition and the fact that she had 24 hour care. The London Ambulance Service record indicates that on examination Ms CC was alert but unable to recall what had happened. Ms CC was transferred to University College London Hospital.

A second ambulance was requested for Ms BB following welfare concerns raised by the police on scene. The London Ambulance Service record states: “on examination Ms BB had a strong aroma of UTI, was hypotensive, malnourished and dehydrated”

**Issues reflected during this period**

The issue of **reviews**: even where reviews were planned to take place they were not carried out, such as after a two week period where Allied Healthcare is considering its position as care provider for Ms BB and Ms CC (and has indicated a wish to withdraw from the care package).

**Pressure ulcer care for Ms BB**: how far are care agencies locally educated on this issue and aware of or supplied with clear guidance? This is an urgent area for focus. The communication between key staff or professionals around the person is a significant issue here too. The carers should have received very clear instructions at the very outset of taking on the care package on Ms BB’s discharge from hospital. This would include the use of incontinence pads where there is a sacral pressure ulcer. The carers seem to have been told to reposition Ms BB at each opportunity where there are two carers. It appears that there are insufficient double ups of carers to allow two hourly turns. There is a lack of a shared understanding too around when a pressure ulcer needs to be reported as a safeguarding concern.
In particular Barts Health NHS Trust were not in agreement with other involved organisations that a safeguarding concern should have been raised in relation to the pressure ulcers.

**Commissioning**: the issue of whether it is helpful to have an inflexible rule about block contracts over a specified care ceiling when this may indicate significant change for service users at a critical point. In addition the role of commissioning in monitoring the practice of care providers. For example, where carers fail to turn up on several occasions, what is the role of commissioning? The impact of the competitive climate in which there are only 3 block contracts for Islington may be to encourage a provider to continue to provide in circumstances which ought not to be sustained without issues being addressed.

Effects of **poor discharge planning** surfaced: no joint understanding of roles and responsibilities across: district nurses, carers, GP, ambulance service, hospital. Examples include: responsibility for provision of incontinence pads and continence assessment; responsibility for provision of and changing of catheter if it is blocked or falls out; who should give the carers advice on repositioning a service user with a pressure ulcer? A robust plan is not in place that ensures everyone knows what their key accountabilities are as well as involving the family in understanding this...who should do what and who should be approached on which issues?

**The practice around Continuing Healthcare assessment.** Accountability for this is very blurred in the records with no one clearly accepting responsibility for taking this on and seeing it through. This has partly to do with the fact that responsibility changed from the time of inpatient care at Mile End Hospital and then once discharged back home. Whilst Ms BB was in Mile End Hospital, Barts Health NHS Trust took the lead for assessment in this case. Once Ms BB had been discharged back home Ms BB came under Islington Continuing Healthcare procedures. Within Islington, Whittington Health are the lead agency for Continuing Healthcare, however both health and adult social care have a responsibility to identify possible cases for consideration for Continuing Healthcare. A Continuing Healthcare assessment / review was not completed.

**Accountability** is a key issue in this review. The social worker for Ms BB was on leave from the date of discharge for two weeks. The social worker for Ms CC appears from the records not to have been proactive during this time.

**Assessment and care planning**: the care agency did not have basic information about Ms BB and Ms CC, for example the date of birth of Ms CC, in order to liaise effectively with the GP surgery. Care plans were not provided by Adult Social Services in a timely way for either Ms BB or Ms CC. There was no multiagency assessment or risk assessment pulled together with input from all of the key
Response times on high risk issues appear slow. For example referral to the GP by district nurses only on 27 August when the assessment of high risk for malnutrition was conducted on 24 August. The GP however responded immediately on referral.

Issue of mental capacity and a shared understanding of the capacity of Ms BB and Ms CC. For example on the 26 August the tissue viability nurse recorded that she felt the patient (Ms BB) “understood the risks of deterioration of the pressure ulcer”. It is unlikely that this was the case and in any case the occupational therapist earlier assessed that she would be unable to retain the information even if this was understood in the first instance. There is no recorded evidence that anything was used to support such an understanding (such as tools designed specifically to help patients and family members understand pressure ulcers and to be part of the “team” in mitigating the risks associated with them). However when the community occupational therapist liaised with the tissue viability nurse on the issue of whether Ms BB should sit out of bed the tissue viability nurse ultimately advised that Ms BB should not sit out of bed given her poor state of health and the position of the pressure ulcer “unless this is an expressed wish of Ms BB and she has the mental capacity to accept that the pressure ulcer may deteriorate further” This represented an understanding of Mental Capacity Act 2005 as a key issue but there was no assessment.

The issue of Do Not Attempt Resuscitation (DNAR) emerges once again in the GP records. This has not been discussed fully with relatives. The District Nurses (24 August) identified the need for review of the DNAR in place since March 2015.

There was no proactive response to a request from the care provider stating that they wished to hand back the care package. Islington councils Adult Social Services Individual Management Review acknowledges that there was “no action put in place to mitigate the risk to service provision.” It had been discussed on 23/24 August that the provider would continue to provide this package of care and that it would be reviewed in two weeks. It was not.

3.5 The period in hospital for both Ms BB and Ms CC from 18 September until Ms BB’s death on 1 October and Ms CC’s move to a nursing home.

18 September: On admission to hospital of Ms BB and Ms CC University College London Hospital recorded detailed admission assessments for both Ms BB and Ms CC. These included:
For Ms BB:

- a safeguarding alert was raised
- Ms BB was assessed as agitated and malnourished
- on admission, Ms BB’s continence pad was found to be soaking in urine despite the presence of a catheter. Catheter found to be bypassing and was removed. A new catheter was inserted and a urine sample collected.
- Ms BB’s admission diagnosis was a probable urinary tract infection and an infected pressure ulcer.
- Ms BB was made Not for Cardio-Pulmonary Resuscitation (CPR) with a ward based ceiling of care due to being very frail and would be unlikely to survive CPR. Her next of kin, Ms CC was noted to lack capacity to make decisions. Staff were unable to ascertain if there were other family members at this point.
- a nursing assessment was completed. Ms BB was referred to the dietician, a pressure relieving mattress was ordered, a falls care plan was completed and she was commenced on a SSKIN bundle (pressure ulcer prevention tool) every 2 hours. Daily dressing advised for Pressure Ulcer.
- Ms BB was placed in the bed beside Ms CC

Ms CC records on admission include:

- Ms CC’s presenting complaint at Accident and Emergency department was for a laceration of her left hand and she was assessed as being a vulnerable adult.
- a safeguarding alert was raised and the safeguarding team at University College London Hospital was informed. The safeguarding team reviewed Ms CC directly after the referral was received.
- a phone call was made to Ms CC’s GP to ascertain Ms CC’s history. The GP confirmed Ms CC had a history of dementia which was now severe, that she lived with her partner, Ms BB and that they had a package of care from Social Services.
- Ms CC’s final admitting diagnosis was documented as dementia with left finger lacerations and a vulnerable adult.
- Ms CC declined to complete an Abbreviated Mental Test (AMTS). Ms CC was prescribed 0.5 mg of Risperidone as required for significant agitation and a request was made to avoid unnecessary blood tests and procedures and to try and keep nursing staff as consistent as possible.
- Ms CC was assessed as being at high risk of developing delirium due to her cognitive impairment, age, the presence of pain due to her hand injury and a new environment. A plan was put in place to manage this risk which included keeping Ms CC and Ms BB together.

19 September: Ms CC was “currently well and on a course of antibiotic therapy. Unsteady on feet/risk of falls. Deprivation of Liberty Safeguards considered but deemed not required".
19 September: University College London Hospital record includes:
- that Ms BB is very drowsy with little oral intake
- weight noted to be 43.6 kg (approx. six and a half stones)
- nursing staff concerned regarding Ms BB’s swallow so referral to speech and language therapist
- **Ms BB had lost around 10kg in weight since her discharge from hospital a month earlier**

23 September: University College London Hospital review of Ms BB by Acute Geriatrics multidisciplinary Team

“A capacity assessment was completed by the doctors. Ms BB was found to be unable to process information or communicate decisions in her current state”.

“Agreed that if Ms BB continues to deteriorate she would be for comfort measures only.” Ms CC was “formally assessed for capacity by the Social Worker. Ms CC was deemed not to have capacity to make decisions for herself or for Ms BB.”

Ms BB received end of life care and a plan was in place to discharge Ms CC to a nursing home.

On 1 October Ms BB died. The cause of death was cited in the review chronology as “dehydration and infection secondary to a grade 4 pressure sore”.

Ms CC was offered bereavement support and was discharged to a care home.

**Issues reflected during this period**

A range of good practice by University College London Hospital staff in respect of end of life care including the identification of the importance of the relationship between Ms BB and Ms CC and the need to keep them together (in University College London Hospital). Ms BB and Ms CC were treated with dignity and respect and a positive and safe discharge planned for Ms CC.

There was good practice in the context of the Mental Capacity Act 2005 in University College London Hospital including a best interests meeting on 25 September. However there was an absence of a Deprivation of Liberty Safeguards referral by University College London Hospital (19 September chronology entry stated this was considered but not carried out.)

The issue of the poor state of health of Ms BB and how far this reflected on earlier practice and decision making. For example it was recorded “it was possible the dysphagia was longstanding given Ms BB’s reduced intake and presentation of emaciation and frailty”. (21 September). **Records indicate that by 19 September she had lost 10kg in weight since her discharge from hospital on 20 August.**
The issue of the lack of a shared understanding and practice around notification of pressure ulcers under safeguarding.

The conversation Ms BB’s brother had after Ms BB’s funeral with the district nursing service, voicing concerns he should have had a chance to voice much earlier.

4 Analysis of key themes arising from the chronology of events and interventions.

4.1 The learning

This review into the circumstances of Ms BB and Ms CC may indicate individual practice that was found to be wanting. However, it is important to recognise the context in which that individual practice takes place and to ensure that the actions that follow the writing of this report cut across all domains within that context that are capable of influencing positive developments in practice. The aim is to make a real impact on the lives of people like Ms BB and Ms CC.

Research set out by Professor Michael Preston-Shoot, 2016 which contributes to the knowledge base around serious case reviews in cases of self-neglect draws attention to the need to look, not only at individual professional practice around the individual but to consider necessary learning and development in respect of organisational context (policy and culture for example). The journal editor notes the relevance of this model/framework for analysis and review for other types of review; not just in self-neglect. It is a helpful framework for reviewing the circumstances and practice surrounding Ms BB and Ms CC.

The research suggests a focus on four domains in considering the challenges and themes where learning and development need to take place. A number of the challenges/themes that presented in the situation surrounding Ms BB and Ms CC can helpfully be seen as being located in those four domains:

- The practice interface with the individual adult
- The professional team around the adult
- The organisations around the professional team
- The Local Safeguarding Adult Board (LSAB) around the organisations and the exercise of interagency governance

4.2 A similar methodology is used to positive effect by Whittington Health NHS Trust in their own review of the work with Ms BB and Ms CC, undertaking a Root Cause Analysis that locates contributory factors and lessons at individual, team and organisational and cross organisational level. The Trust has set out a

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comprehensive action plan at all levels. This review will recommend actions at all of these levels to improve practice.

4.3 Examples of positive practice
The analysis below focuses chiefly on areas for development. The Panel also wants to acknowledge some particularly prominent examples of good practice that emerged from the events of this review. There were other examples but these are the most striking:

- Islington council’s occupational therapist and her consistent communication across the multidisciplinary team as well as putting clear and planned measures/equipment in place.
- Allied Healthcare referrals to the GP regarding concerns about for example: the catheter, pressure ulcer, medication blister pack, swallowing difficulty, buying incontinence pads.
- A range of organisations recognising safeguarding issues and reporting these appropriately (Provider services; London Ambulance Service; Police; University College London Hospital; District Nurses)
- Dementia navigator: sensitive, respectful, person centred engagement with Ms BB and Ms CC
- GP: sensitivity to the wishes of both Ms BB and Ms CC, this was underpinned with a person centred approach in getting to know them and what was important to them over 18 years of being their GP. This person centred knowledge was applied in decision making and in supporting planning ahead for future decisions or crises.
- At the end of Ms BB’s life the care at University College London Hospital took every possible care in ensuring that they were together. The end of life care of Ms BB and the compassion for Ms CC was very positive.
- Whittington Health NHS Trust in terms of the learning/action plan they have set out and begun work on following their own review of the practice and circumstances of Ms BB and Ms CC. This demonstrates a real commitment to learning necessary lessons. It will benefit other organisations to adopt a similar methodology and level of rigour.

The analysis considers the following areas of learning

- Identification, assessment and management of the range of needs and risks that presented for Ms BB and Ms CC
  - A focus on Ms BB and Ms CC and their families
  - Practice in respect of assessment, care planning, monitoring and review
  - Practice in respect of specific aspects of the range of needs presented by Ms BB and Ms CC
Hospital Discharge Policy and Practice
Achieving a shared understanding and shared decision making and action within and across organisations
Safeguarding Adults from abuse and neglect
The role of commissioning and contract monitoring
The areas of similarity with the Serious Case Review in respect of Mr AA, Islington Safeguarding Adults Board, 2015

4.4 Identification, assessment and management of the range of needs and risks that presented for Ms BB and Ms CC

- A focus on Ms BB and Ms CC and their families; a personalised approach
- Practice in respect of assessment, care planning, monitoring and review (Including Mental Capacity Act assessment; Continuing Healthcare Assessment; risk assessment; balancing choice and risk; carers assessment)
- Practice in respect of specific aspects of the range of needs presented by Ms BB and Ms CC (Pressure ulcer prevention and practice; incontinence management; catheter care; nutrition; dementia, falls)

4.4.1 A focus on Ms BB and Ms CC and their families; a personalised approach

The degree to which the nature of the relationship between Ms BB and Ms CC was understood and the level of insight into their wishes and preferences impacted considerably on effectiveness of interventions.

There was very positive engagement with Ms BB and Ms CC as individuals from their GP. Other organisations too gained insights into aspects of their life together. However there is some evidence in the records that at times there was insufficient communication with Ms BB and Ms CC and their families and that what was known of their preferences and wishes was not universally known and/ or used to inform practice.

The GP with primary responsibility for Ms BB and Ms CC recorded that “Having known Ms BB & Ms CC for 18 years we were very aware of their characters. We were sensitive ...towards their relationship with each other, considering them a team / family unit / partnership. We always considered the impact on both women and how input to one would affect the other. We acted as their advocate when discussing with outside agencies to as far as possible keep them together.”

At the end of Ms BB’s life the staff at University College London Hospital took every possible care in ensuring that they were together and that their joint needs were taken into account.

The Whittington Health Individual Management Review report said that throughout the period of March 2013 to Sept 2015 “records for both Ms BB and Ms CC indicate the two were recognised as a couple, with individual needs.”
The Dementia Navigator recorded that “both BB and CC didn’t like to be asked too many personal questions with both communicating finding this intrusive”

The Barts Health NHS Trusts Individual Management Review on the other hand tells us: “Apart from identifying [Ms] CC as a vulnerable adult there is no identification of her as partner ...with [Ms] BB and no evidence of discussing the above with her.”

There is a range of terms used in records and reports to describe the relationship from “flatmate” to “friends” to “partners” to “a couple”. This indicates a lack of a shared understanding and/or acknowledgement of the relationship which was so important to them. One of the professionals who formed the Panel for this Safeguarding Adult Review said that they “had the sense that people were not clear about their relationship, possibly, or fear of getting it wrong.”

The GP Individual Management Review report and presentation to the Panel was clear that there were some very clearly stated wishes from Ms BB and Ms CC at a time when they still had capacity. First they did not want further medical investigation and intervention; they wanted to remain together in their home; they wanted to die at home; they wanted in particular to avoid being in hospital. Their overriding wish was to remain together. They did not like too many people going into their home. They saw this as an intrusion. “They guarded their privacy and relationship.” There was anxiety as a result of all the different people going in to them.

“Both women always expressed their wish not to go into hospital” This was entered on the Coordinate my Care record.

All of this needed to inform practice. At times the lack of a personalised approach impacted for example in: the level of resistance from Ms CC in particular to professionals or carers going into the home; at times, the lack of attention to minimising the number of professionals going in; the allocation of two social workers to Ms BB and Ms CC; the admissions to hospital without reference to or careful consideration of the clearly stated wish to avoid hospital admission (and any possible alternative); the protocols that did not make it easy to achieve consistency of personnel going in to the home. For example, the change to a block contract which necessitated a sudden (last minute) decision to change care agency because the package had increased in cost (and there is a cost ceiling for spot purchase). This meant that familiar carers were replaced without warning, discussion or explanation.

The complexity of the situation necessitated the introduction of additional professionals (such as the tissue viability nurse and dietician). It became necessary with the increasing frailty of Ms BB and Ms CC for care to be introduced into their home. This was unavoidable.

It was not always possible to avoid the intrusion felt by Ms BB and Ms CC but it would have been possible for the issues that were so important to them to be openly discussed across all those involved and to find ways of minimising this intrusion. This may have led to reduced resistance and reduced risk. There were examples of good practice such as the GP balancing the need for medication with the wishes of Ms CC and Ms BB for reduced intrusion. He minimised the medication prescribed (whilst
making sure the reduction was monitored) so as to minimise the intrusion necessitated for administration of medication.

The issue of their having been two social workers one working with Ms CC and one with Ms BB across most of the period covered by this review was problematic. It made communication and decision making more complicated and less effective than it might otherwise have been. It failed to recognise the significance of the relationship and how this should impact on the care package. It failed to respond to the clear wish to minimise intrusion into the home. It is clear that the social worker for Ms BB had by a very long way the greatest level of involvement and therefore had a much greater awareness of Ms BB and Ms CC as individuals. The implication is that there was less of a focus on understanding and assessing Ms CC and her wishes and desired outcomes or on supporting her to accept necessary care.

It is unclear what or who prompted this decision. The arrangement whereby Ms BB and Ms CC had two separate social workers emerged as flawed ...There is little on record from Ms CC’s social worker, blurred boundaries and confusion as to the care being discussed at Panel. This is reflected in the recording of SW1’s communication with the senior practitioner for example on 1 April. “I am only allocated to Ms BB [but] the issues need to be urgently addressed to support Ms CC”.

It is unclear who is getting which care from which agency. The Panel decision is clearly recorded as 12 hours for Ms CC and 12 hours for Ms BB when Ms BB is discharged from hospital. It later emerges that there has been an oversight and Aquaflo Care is still providing care for Ms CC. 4 June SW1’s record in response to questions from the Panel again indicates the difficulties inherent in this arrangement “it is possible for both to be placed together but Ms CC’s social worker would need to look into the option”.

The Social worker (SW2) was allocated to Ms CC on 27 February. The first entry in the chronology from this social worker is 22 April. This is despite concerns for Ms CC’s wellbeing since Ms BB was admitted to hospital on 22 March.

There was significant delay in Ms CC being assessed in her own right as well as arguably a significant impact on the timeliness and effectiveness of decision making because of this arrangement. As there is no question of intentional abuse or conflict between Ms BB and Ms CC it should have been possible for one person to have worked with both as their wellbeing and safety were so much linked together. They lived as a close and loving partnership; it is difficult to see a rationale for allocating a second social worker. A degree of objectivity and ensuring that both sets of needs and wishes are considered can be achieved through support and supervision offered by a senior practitioner. If necessary an advocate could be offered to one or both.

Ms BB and Ms CC had in place with their GP an agreement that unplanned hospital admissions would be avoided in the context of them wanting to stay at home as far as possible. This should therefore have been a consideration at the point of admission of Ms BB to hospital (and should have been shared with other professionals such as the district nurses). This hospital admission is a pivotal point for Ms BB and Ms CC. It brings into focus the need for: local discussion of
initiatives that support alternatives to hospital admission; robust contingency planning and development of clear personalised pathways for the support of those with progressive illness; clear communication and available information across organisations.

It might have been possible to consider in advance of a crisis a shared understanding of the pros and cons for Ms BB of hospital admission and the things that would be taken into account in such circumstances along with appropriate thresholds for decision making in those circumstances. These would need to be made known across organisations and engagement with the families of Ms BB and Ms CC would have supported this.

In terms of communicating with Ms BB and Ms CC and their families about their needs and wishes, Barts Health NHS Trust for example acknowledges that there was “no evidence of communication with [Ms] CC regarding care or discharge plan”. They describe “Limited evidence of keeping [Ms] BB informed of care and plans” and that...."Although there was communication with family (brother) regarding care and discharge it appears limited considering the period of time care was given. No evidence of communication with [Ms] CC regarding care or discharge plan”.

The communication with the families of Ms BB and Ms CC failed in general to engage with them sufficiently to gain an understanding of the valuable insights that they had (given that they were so involved in supporting them) and their views as to the arrangement that would most suit their needs. There was a failure too to keep them updated with assessments and information. An example is in the delay in advising the family of the diagnosis in respect of Ms CC of vascular dementia.

The author of this report and the Safeguarding Adults Policy and Practice Officer, London Borough of Islington have both subsequently spoken with Ms BB’s brother and Ms CC’s sister. At the time they had a great deal of information as to the situation in the home of Ms BB and Ms CC as they visited at weekends. This would have been valuable had it been sought to contribute to assessment, care planning and review.

They informed this review for example: in respect of the significant weight loss in Ms CC and Ms BB; about the concerns that Ms BB and Ms CC were not eating and that carers were not spending sufficient time encouraging them to do so (describing one instance where a carer gave one spoon of yoghurt, then walked away); about the quality of care in general and the level of training of carers. They had observed that some carers seemed to have a more or less positive relationship with Ms BB and Ms CC. A view was offered too that it would have been better for one social worker to deal with both women and that “so many different faces is difficult especially with dementia.” They pointed out that no one took responsibility. All of this would have been helpful if the family had been able to join in reviews at the time or had been given the chance to contribute to them in some other way. All of the insights from the family have been extremely valuable in this review. The issues they reflect are issues at the heart of the analysis of what went wrong.
The decision made in a meeting on 29 June 2015 of both social workers with their senior practitioner that they would visit the family in Potters Bar was the right way forward. It was a pity that the call to the family from the hospital discharge coordinator made this appear unnecessary to them.

The family shared concerns that have never been addressed about for example the injury to Ms BB’s leg when she was admitted to hospital on 27 August and the events that led to both women being admitted to hospital in September 2015. They are still left with unanswered questions about these incidents. This needs to be addressed.

What these family members have shared with the review reflects a lack of information offered to them at the time. For example, Ms BB’s brother was concerned that when the district nurse visited, his sister cried out in pain when the nurse turned her over. This enduring concern about that experience probably reflects a lack of any conversation with the family about the pressure ulcer that Ms BB had acquired in hospital. Ms BB’s brother directly referred to professionals not approaching or communicating with the family and felt that others did not listen or take account of their views. The view of the family members of both Ms BB and Ms CC was very strongly that their health and wellbeing would be best served by being admitted to a care home together. The two families are very close. Ms CC is now in a care home which is closer to Ms BB’s family geographically and both families continue to enjoy visiting her.

**Carer assessments**

There was a legal responsibility to carry out carer assessments in respect of Ms CC and potentially other family members who provided support at weekends.

A carer assessment is first indicated on 31 July 2014. This remains unresolved. A social worker is not allocated to Ms CC until the end of February. Even then a carer assessment is not carried out.

The Adult Social Services Individual Management Review refers to the lack of a carer assessment as a major omission. This refers to both CC and their relatives as carers because the latter had flagged up difficulties in their caring role. The Individual Management Review reflects that the Care Act makes it clear that a carer does not have to be living with the cared for person to be considered a carer.

The Whittington Health Individual Management Review acknowledges that “the needs of Ms CC as a carer ... were not evident” There is no carers policy in Whittington.

**4.4.2 Practice in respect of assessment, care planning, monitoring and review (Including Mental Capacity Act assessment; risk assessment; balancing choice and risk)**

There was a range of assessments, care plans and reviews made available to the review. These and/or the issues/events surrounding them are referred to in section 3. Seen together and with the benefit of hindsight the range of assessments gives an overview of the needs and risks presented by Ms BB and Ms CC. However the
way in which assessments and reviews were carried out and recorded did not facilitate easy access for any of the professionals either individually or collectively to an overview and it did not help in keeping track of events and changes or in identifying accountability or responsibility for particular areas of risk or need.

**Recording issues** The Camden and Islington NHS Foundation Trust Individual Management Review report highlights that care plans and reviews were not kept in separate sections of record. This is a flaw across a number of organisations. For example the initial assessment supplied to the review by London Borough of Islington Adult Social Services (which was recorded when the social worker (SW1) assessed Ms BB for the first time in January 2015) offers a great deal of information incorporating this January assessment as well as review information from May 2015. It is not easy to identify the timing of issues recorded or the key needs and risks. Because needs and risks are not highlighted clearly there is a danger that they are not identified and followed through in ensuring necessary actions take place in a timely way. There are many examples of this in the case of Ms BB and Ms CC. For example, the assessment in January 2015 indicated the need for Ms CC to be assessed in her own right. A social worker was not allocated to Ms CC until 27 February and that social worker’s first entry in the records is on 22 April. This despite clear risks and needs being identified.

Likewise the Whittington Health Individual Management Review report acknowledges that the care plan outlined when Ms BB was discharged from Mile End Hospital as set out in the referral to the district nurses was not followed up in a formal review document but the plan was followed up in the daily records and reviewed at each visit. This tendency makes it difficult for a range of professionals or staff to keep track of the impact and success of the care plan and whether adjustments need to be made in response to circumstances.

**Follow-up and review of need and risk**

This issue of lack of a separate record is not simply a reflection on recording; the recording reflects the fact that in practice patterns and issues were not identified and addressed. They became lost amidst the complexity. The Camden and Islington NHS Foundation Trust Individual Management Review questions the level of follow up of care plans in respect of actions between assessment and review meetings. It identifies too the fact that the dementia navigator highlighted fire risk as an issue and intended to carry out a joint visit with the fire service. This is not followed through. There are numerous examples across agencies of issues being identified in assessments but not followed through and picked up in reviews. There are examples too when reviews are indicated or promised and they do not take place. Safeguarding issues remain not concluded.

A review was promised when Allied Healthcare, having decided to hand back the care package due to the challenges presented by Ms CC, agreed to continue to provide care for two weeks and then this would be reviewed (see 3.7.1). The issues are not monitored and reviewed. The situation simply continues to drift. This is acknowledged in the London Borough of Islington Adult Social Services Individual Management Review report: “There appeared to have been drift/delay in particular,
when issues raised by the care agencies, relating to the challenges they encounter with [Ms] CC. The Adult Social Services department puts this down to “distant” communications by the care providers (email and phone) rather than face to face communications. This required Adult Social Services as the commissioner to meet with the provider to formally review the needs and risks and whether or how these could be met by the provider.

When care plans are drawn up it is necessary for commissioners to be clear with providers that a review should be requested where it becomes impossible to carry out the care plan. Such review seldom took place in the case of Ms BB and Ms CC although it was frequently the case that the care plan could not be delivered. For example: on 17 June: concern for Ms CC was expressed by the family. “lost weight appears to be living on biscuit and cake; house in poor state of hygiene; dirty clothes in bathroom (not sure carers are doing washing despite family leaving money to do this); carers have reported to family that they do not spend all their time with Ms CC ‘because Ms CC is often asking her to go when she visits’” The social worker discussed this with the care agency outlining their duty to inform Adult Social Services when they are unable to fulfil the work as set out in a care plan. This does not form the basis of rigorous action and ongoing review.

The review record in May 2015 following assessment of Ms BB in January 2015 conveys a great deal of information but it is difficult to extract key issues and actions. What is required is a clear assessment of need and risk with actions associated directly with each of those needs and risks. This was a complex situation. The assessments and reviews needed to “untangle” this and make it clear what necessary actions or inputs were required in care plans and who would be accountable for those. This needed to be balanced with an understanding of the factors which created wellbeing in the lives of Ms BB and Ms CC and a process of negotiation with them and liaison with their families to facilitate an acceptable balance between wellbeing and safety. Practice in respect of assessment and review is highlighted in section 3.

In common with advice in other adult safeguarding Serious Case Reviews it is recommended that the following guidance on reviews set out in the (now superseded) Department of Health guidance on eligibility which is relevant across agencies is used to support local practice:

- establish the extent to which the risks identified in the risk assessment are being reduced via the arrangements set out in the action plan
- consider whether the needs and circumstances of the person and/or their carer(s) have changed and how this impacts on the level of risk;
- support people to themselves review the risk decisions and how arrangements to manage the risks might need to be amended over time;

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2 For example the case of JT, Dorset; BB, Westminster; ZZ Camden; A2 Birmingham
3 “Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care”, Guidance on Eligibility Criteria for Adult Social Care, England, Department of Health, 2010
• demonstrate a partnership approach across agencies and with the service user as well as their family and friends if they choose;

• ensure that the risk assessment recorded in the care plan is up to date and takes account of new information / developments and identify any further action that needs to be taken to address issues relating to the risk;

• support people to strengthen their informal support networks;

• a written record of the results of these considerations should be kept and shared with the person.

Working with risk These same Serious Case Reviews undertaken over a five year period all indicate the need for a robust approach to identification, assessment and management of risk. This has been identified above and as a recurrent issue including in section 3 in respect of the support of Ms BB and Ms CC.

There is a clear indication from this review of practice with Ms BB and Ms CC of an absence of holistic risk assessments and risk management plans. There is a range of assessments of individual areas of risk such as risk associated with pressure ulcers; risk associated with malnutrition and dehydration; risk assessment by the dementia navigator to determine frequency of reviews; risk of unplanned admissions to hospital by the GP. There is however no record anywhere of a holistic assessment drawing all of the information together and outlining clear accountability for actions in specific areas for named professionals. The impact of this is a lack of coordinated activity around the person and that some areas of risk/actions are lost in the complexity and remain unresolved. For example, a real and constant risk to Ms BB throughout the periods when she was at home, was that Ms CC would not allow carers and district nurses in to perform essential tasks for Ms BB’s health and wellbeing (for example pressure ulcer care; medication; personal hygiene; catheter care). Therefore access to the flat was an important issue or Ms BB would potentially be at risk of neglect. Despite the hospital discharge coordinator advising the family of Ms BB and Ms CC that a key safe would address this issue she did not communicate this to the multiagency team as part of a recognised action plan to address the risks. A key safe was never installed.

The Serious Case Review in respect of ZZ, Camden⁴, 2015 outlines some principles for a framework for working with risk. This is also relevant in the case of Ms BB and Ms CC. It states: “Most guidance on working with risk is based upon a framework which involves the gathering of information in respect of a given situation or decision and evaluation of the potential severity of outcomes/impacts as well as the likelihood/probability of those outcomes occurring. Based on this assessment, risk management is about using available resources to put in place an action plan to reduce the likelihood of potential harmful outcomes and to increase the probability of beneficial outcomes.

⁴https://www.camden.gov.uk/ccm/cms-service/stream/asset/?asset_id=3372170&
Such action plans must be clear about:

- actions required in respect of all identified areas of risk
- who is responsible for those actions?
- within what timescales
- monitoring and review arrangements and timescales for this"

It is clear from the chronology that such a framework did not form the basis for working with Ms BB and Ms CC.

In **Islington a Risk Enablement Policy and Procedures (v2), 2013** exists. It is badged as a joint policy (Whittington Heath and London Borough of Islington Adult Social Services) although the review was advised that this has not been formally approved by Whittington Health policy approval process and therefore its status currently is as a London Borough of Islington policy. This is currently under discussion.

It will be helpful to revisit and update this policy in light of the Care Act and the learning from this Safeguarding Adult Review.

It includes some relevant guidance. For example:

- The importance of sharing information about potential risks and planning for prevention with other relevant people in prevention of harm
- The importance of detailed up to date information about the risks/context and contingency planning in case risks increase
- Making carers and personal assistants aware of possible risks and involving them in assessment and management of risk
- The availability of weekly Panel meetings within London Borough of Islington Adult Social Services in a “risk enablement” section of the meeting for social workers to present risk issues for discussion (the possibility of families/carers attending too). This offers guidance on managing complex situations and “where risks are perceived as barriers to enabling people to achieve choice and control”.

It also promotes the principle of a comprehensive tool (already in existence) to record multiagency risk assessments. This Safeguarding Adult Review indicates that a *stand-alone* risk assessment shared across organisations would have been helpful.

Certainly to have had an opportunity to explore the risks at the Adult Social Services Integrated Quality Care Meeting (Panel), where the case for services to support Ms BB was presented, would have been positive. This local policy states that comprehensive risk assessments are often required at funding panels. A clear and comprehensive presentation of the risks was not evident in the case of Ms BB and Ms CC.

A significant issue for those working with Ms BB and Ms CC was the **refusal of care and support or access to professionals and care staff**. At the heart of this is the
The dilemma of balancing risk and choice. Organisations were generally unaware of any guidance available locally to support practice in such situations. In fact the same risk enablement policy offers a little support but needs to be updated and extended in the light of the Care Act.

The risk enablement guidance on this issue acknowledges service refusal as particularly challenging in managing risk. It highlights mental capacity as a key consideration. It highlights the need to balance risk and duty of care, and the need to negotiate with the service user. It underlines the importance of taking action where there is a marked increase in risk and of recording decisions/actions, promoting the use of the Comprehensive Risk Assessment tool in documenting a risk reduction plan and establishing contingency planning.

It is clear from section 3 and the above commentary that these aspects of practice were not evident in the case of Ms BB and Ms CC.

This challenging area of practice will require further guidance and development opportunities and case reflection opportunities (including reflection on practice through this case of Ms BB and Ms CC) for practitioners. The Whittington Health Individual Management Review report for this review suggests that “Developing strategies for working with patients who require services yet refuse these is something which the wider Safeguarding Adults Board will need to be part of”.

Addressing practice development in the above areas of assessment (including risk assessment, monitoring, review and care planning) will support this. So too will work to develop a response to Self-Neglect which is now an expectation for Safeguarding Adults under the Care and Support Statutory Guidance, March 2016. Recent research on self-neglect can support practice development in the context of refusal of support. The definition of self-neglect centres on:

• lack of self-care – neglect of personal hygiene, nutrition, hydration, and/or health, thereby endangering safety and wellbeing, and/or

• lack of care of one’s environment – squalor and hoarding, in the context of

• refusal of services that would mitigate risk of harm.

Certainly at times some of these issues were active in the case of Ms BB and Ms CC.

The research suggests that mental capacity; risk; involving the right people; engaging with the individual; legal literacy are all areas that require attention in working in these situations.

The Serious Case Review in respect of ZZ, Camden, includes reference to relevant learning on self-neglect.

**Mental Capacity Assessment** The above risk enablement policy states: “It is essential if there is any question about a person’s mental capacity to understand the risks they are experiencing, and the consequences of those risks, that a Mental Capacity Assessment is completed”. It needs to go further than this in indicating the need for supported decision making and/or best interests decision making.
Practice in the context of the Mental Capacity Act, 2005 in the case of Ms BB and Ms CC was problematic more broadly and including in this area of balancing risk and choice. This is evidenced in the key issues highlighted from the integrated chronology in section 3.

The areas of practice in the context of the Mental Capacity Act 2005 which are clearly indicated in the review as requiring attention are:

- Understanding when and why an assessment of capacity is called for and how this must be carried out and recorded
- Supporting people to make informed decisions and to understand the consequences of their decision making (including understanding the risks)
- Assessing best interests and making decisions in a person’s best interests
- Applying all of this in balancing choice and protection and making decisions as to where assertive action is required
- Do Not Attempt Resuscitation decisions
- Application of Deprivation of Liberty Safeguards

The areas highlighted in the chronology indicate a lack of understanding of the circumstances in which a capacity assessment might be indicated (despite a range of decisions which were problematic there were very few assessments undertaken during the course of involvement with Ms BB and Ms CC) or the correct methodology for doing so. There was contradiction and confusion on this issue.

There was good practice in the context of the Mental Capacity Act 2005 whilst Ms BB and Ms CC were inpatients at University College London Hospital, with the exception of issues acknowledged by University College London Hospital in respect of recording of decision making on or application of Deprivation of Liberty Safeguards, as indicated in 3.5 in respect of Ms CC. (see 3.8.1 and end of 4.4.2). Mental Capacity Act 2005 compliant mental capacity assessments took place in respect of both women on 23 September; a best interests meeting on 25 September which their families attended concluded that it would be in Ms CC’s best interests for her to be placed in a nursing home near to her relatives and that Ms BB would receive end of life care in hospital. This meeting and decision making was fully recorded. Do Not Attempt Resuscitation decision making at University College London Hospital involved the family. When her condition deteriorated significantly on 27 September it was agreed with her family that she was “for supportive management only and that she would start on the Excellence End of Life Pathway”

A House of Lords Select Committee report in February 2014 on progress in implementing the Mental Capacity Act, 2005 concluded that its “empowering ethos” had not been delivered. This report underlines the need for ensuring: quality capacity assessments are carried out where appropriate; supported decision making

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5 House of Lords select Committee on the Mental Capacity Act 2005, March 2014
to be embedded; addressing risk aversion and paternalistic cultures; best interests
decision making must be carried out as intended in the Act (including the wishes,
thoughts and feelings of ‘P’); pursuing least restrictive alternatives. It underlines that
“Best interests decision-making is often not undertaken in the way set out in the Act: the wishes, thoughts and feelings of P are not routinely prioritised. Instead, clinical
judgments or resource-led decision-making predominate”.

Some of the assessments of capacity undertaken in respect of Ms BB and Ms CC
reflect the Select Committees observation that: in making assessments of capacity
and best interests, clinical judgments or resource-led decision-making predominate
rather than a principle of empowerment of the individual. The circumstances of
these assessments in general bears this out. They are undertaken at points where
hospital discharge and care placements were an imminent issue.

The following assessments were undertaken:

There was a capacity assessment undertaken by Adult Social Services on 21 April in
respect of Ms BB on the issue of capacity to make a decision as to where she
wanted to live. This concluded that she lacked capacity to make decisions about
where she wanted to live. This is recorded on a standard format but not all of the
detail as set out in the Mental Capacity Act 2005 was seen by the review Panel.

On 23 April a capacity assessment is recorded in the records by a Mile End Hospital
psychiatrist. The purpose of the assessment was “as I was asked to comment on
her capacity to decide on discharge destination”. The record stated: “she lacks
capacity to make decisions about her discharge destination therefore she needs
decisions made in her best interests...It would appear sensible and kind to place her
with her long standing partner [Ms CC] which, I understand, is the plan currently in
place.” Again this is not recorded according to the requirements of the Mental
Capacity Act 2005 Code of Practice i.e. in terms of how the decision was reached.

On 19 October 2015 Ms CC’s capacity was assessed by Adult Social Services to
“determine discharge destination” it was concluded that Ms CC was unable to make
this decision. This is the only Mental Capacity Act assessment undertaken which
sets out all of the assessment stages as required in the Mental Capacity Act 2005
Code of Practice. This and an assessment in November 2014 were the only two
assessments of Ms CC’s capacity despite problematic decision making in the
intervening period.

However, in the case of Ms BB and Ms CC the GP in particular was aware of and
supported Ms BB and Ms CC in planning for their future. He involved the Palliative
Care service. Both the GP practice record and that of the palliative care service
reflect the wishes expressed. There is an entry by the palliative care service (made
10 June 2014) on the Coordinate my Care record in respect of Ms BB to the effect
that a Do Not Attempt Resuscitation decision was made and that her preferred place
of care (and death) is “home.” The manager of the Coordinate my Care record does
not view this as a quality care plan however as there is little information included and
it would have done little to advise urgent care services who might be called in. The
feedback from the Director of Nursing for the Coordinate my Care Service included
that “The key to a good care plan ...is not just to record the preference but to give useful advice and instruction to urgent care services so that they know what to do to facilitate the wish i.e. the ‘how’ as well as the ‘what’. In this case there wasn’t anything useful.” There was a clear wish recorded in records elsewhere to avoid hospital admission. This needed to be recorded explicitly on the Coordinate my Care record alongside the wish to be cared for at home. The records in the GP practice notes convey much more of the decision making and of the person behind the decisions but these never formed the basis of a best interests meeting or decision making or discussion across organisations involved.

An assessment took place in November 2014 undertaken by a consultant psychiatrist. This was in response to a request from the GP to assess Ms CC’s capacity because she was refusing to allow carers in to the flat to look after Ms BB. This assessment considered decision making around acceptance of carers, support and of healthcare including medication support. It concluded that there was a lack of insight and capacity to make these decisions and that there was a “likely need” to take these decisions on a best interests basis. The assessment, although in line with the principles of the Act does not spell out clearly the basis for the decision indicating each step of the assessment laid down in the Mental Capacity Act 2005 Code of Practice. The finding of the assessment was communicated to the GP.

There was no formal assessment of Ms BB’s capacity on this occasion but rather a comment that “Ms BB lacks capacity and insight also.”

The records do not reflect that any of the professionals took a lead in following up on this assessment with support from an advocate or a best interests decision on any of the presenting issues. There was no consideration as highlighted in the Camden and Islington NHS Foundation Trust Individual Management Review report as to “whether essential care should be provided assertively if deemed to be in CC’s best interests.” There were increasing risks.

Despite numerous indications of problematic decision making on the part of Ms CC and Ms BB and despite an understanding on the part of some professionals at any rate that both Ms BB and Ms CC lacked capacity in relation to decisions around where to live and receipt of care and treatment there was no best interests decision nor any advocacy support to assist.

The local government and health service ombudsman in 20116 reflected on similar issues in respect of a man who was self-neglecting. The report refers to an “inappropriate hands-off approach”: It highlights: “failing to [arrange a review meeting] was a missed opportunity. Such a meeting involving everyone who was involved in Mr B’s care would have enabled an overall picture of developing risk to have emerged and been dealt with appropriately, perhaps by referral to the assertive outreach team or, at least, by a full review of the care package....and a discussion about Mr B’s capacity to make decisions about his own care”

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It goes on to say...“We have not seen robust evidence that Mr B’s capacity to make decisions was ever seriously considered or that there was discussion about the balance to be struck between an individual’s autonomy and dignity. Mr B’s rights were central in this matter but we have not seen evidence that [professionals] had regard to or took specific account of Human Rights law or the provision of the Mental Capacity Act in making their decisions”

On the issue of assumption of capacity....“If he did have capacity, then he was fully entitled to let his physical health and living environment deteriorate...If however he lacked capacity in relation to those matters, those caring for him would have been entitled under s.5 of the Mental Capacity Act 2005 to provide care for him.....provided that they reasonably considered themselves to be acting in his best interests”

Section 5 allows a person to do caring acts for a person who lacks capacity to consent to those acts, if the carer has taken reasonable steps to ascertain if the person has capacity and reasonably believes that the acts are in the person’s best interests. This learning is significant for the case of Ms BB and Ms CC. Case law such as this can support learning locally.

Mental Capacity Act assessments in respect of Ms BB and Ms CC in general were not fully compliant with the Mental Capacity Act 2005 Code of Practice. The palliative care service referred to their practice of recording capacity assessments within the body of their records rather than in a Mental Capacity Act 2005 Code of Practice compliant format (they concede in their Individual Management Review that “the assessment could have been documented with better use of headings and clearly demarcating it as a capacity assessment”. Allied Healthcare also recorded a capacity assessment. It appears to assess capacity as a ‘blanket’ issue rather than as a decision specific issue. This concluded that in August 2015 Ms BB had been assessed as having capacity “but needs to be encouraged and motivated at times to do things. She is able to retain information but it takes her time to process information. “The assessment also records “no impairment” when we are aware that Ms BB has vascular dementia. The mental capacity assessment format in use at Allied Healthcare is flawed and requires revision and associated training.

The lack of a consensus about whether or not Ms BB and Ms CC had capacity led to an associated lack of consensus and discussion as to how far their views should be taken into account; how far there needed to be/could be support to inform decisions about care and support and including how they might be enabled to understand the consequences of those decisions.

There is little evidence of discussion with Ms BB and Ms CC about the potential impact on their health and wellbeing of their decisions about personal care and healthcare. They were not supported throughout to understand the risks they were running.

The requirements of the Mental Capacity Act 2005 and the contribution it can make in situations such as that of Ms BB and Ms CC need to be understood and embedded into practice.
**Do not attempt cardiopulmonary resuscitation (DNACPR) or Do Not Attempt Resuscitation (DNAR).** There was a lack of consistency in applying DNAR guidance and best practice including in recording decisions and best interests assessments.

In June 2014: A palliative care service nurse conducted a DNARCPR discussion with Ms BB with the GP present. This was recorded on the Coordinate my Care record which states not for cardiopulmonary resuscitation. Ceiling of treatment was not recorded. The panel has not had sight of the form although the Clinical Nurse Specialist noted that she completed a Do Not Attempt Cardio Pulmonary Resuscitation form for Ms BB and would complete a Coordinate my Care record. The record was clear that “despite ...poor memory she was very clear about not wishing to go into hospital via a 999 call; the community nurse specialist is clear that Ms BB had capacity for the particular CPR decision...”

On 11 September 2014 the GP recorded that Ms BB “is for resuscitation” following Ms BB being asked directly. A form has not been seen by the review Panel but this conversation is recorded in the GP practice records.

On 15 July 2014 the University College London Hospital discharge letter noted that a Do Not Attempt Resuscitation decision was needed.

On 23 March 2015 whilst an inpatient at Barts Health NHS Trust a Do Not Attempt Resuscitation formal decision was recorded and signed by a nurse and validated by the consultant physician. The reason for the decision is recorded as “Frailty-patient’s wishes”. Confirmation is given that this had been discussed with the patient who was in agreement. This was not discussed with the relatives of Ms BB according to best practice and the organisation’s policy. This was later acknowledged and discussed with the family. The form confirms this decision as being in the patient’s best interests (BI) but there is no BI assessment recorded.

The ward record/notes reflect around this time a level of confusion in Ms BB. For example: 27 March and 31 March: confusion noted; 1 April an occupational therapist assessment notes: significant cognitive impairment; poor insight; not oriented; poor information processing; hallucinations (patient addressing people not in the room). In the light of this a best interests discussion or decision would have been indicated.

The Do Not Attempt Resuscitation decision was recorded on the discharge letter to the GP and district nurses. The District Nurses requested a review of this on 24th August 2015.

There is discrepancy across these decisions and the GP described this as follows at the meeting of this review Panel.

“the discrepancy is that when Ms BB was asked on the home visit by Dr A , Ms CC was present and ‘persuaded’ Ms BB to change her mind to ‘for resuscitation’” When asked with Ms CC not present in the hospital she always said Do Not Attempt Resuscitation. This was changed on the GP record after receipt of the discharge letter from Barts Health NHS Trust on 24 August 2015.”
There is no record of a Do Not Attempt Resuscitation decision or discussion with Ms CC at any point.

This suggests the need for collective action to ensure best practice in supporting decision making on Do Not Attempt Resuscitation; in associated best interests assessments; in recording of decisions; in considering the basis upon which these decisions are made and the need to involve family members in discussion. The Palliative Care service has a role in supporting this action.

**Deprivation of Liberty Safeguards**

There was only one occasion when a Deprivation of Liberty Safeguards authorisation was made following assessment. This was on 6 August 2015 for 28 days. This was because Ms BB required “regular supervision including turning every two hours to prevent bed sores and support with all aspects of daily living...to facilitate medical treatment. Patient nursed in an area where not free to leave”. This was authorised by London Borough of Islington Adult Social Services.

Barts Health NHS Trust, in its Individual Management Review, acknowledges that earlier on records show that Deprivation of Liberty Safeguards was queried as being needed. This was not carried through. This was an issue too in University College London Hospital in September 2015 in respect of Ms CC. University College London Hospital (with hindsight) acknowledges that the language used in the record that Deprivation of Liberty Safeguards was “not required” is not useful or informative. It does not reflect that Deprivation of Liberty Safeguards was considered on a daily basis with careful consideration of the core principles of the Mental Capacity Act 2005. All organisations must consider the implications of not fully recording assessment and decision making in this context.

**4.4.3 A focus on specific aspects of the complex range of needs and risks presented by Ms BB and Ms CC**

There were aspects of the care of Ms BB and Ms CC that require a particular focus in this review so that associated learning can be taken on board by relevant organisations. There are issues in respect of these that have to do with understanding and putting into practice principles, procedures and guidance. Practice in these areas also shines a spotlight back on to the areas recorded above around assessment, care planning, monitoring and review which were crucial in these particular aspects of care and treatment and yet on occasions were found to be wanting.

There was a range of conditions that required professionals to be vigilant. Some were more significant in their impact and in terms of the necessary learning from this review. These are analysed below. Those which are less prominent included Ms BB’s visual impairment; she had macular degeneration which was noted by the GP as far back as July 2010. The impact of this was noted by the Dementia Navigator in January 2015. Ms BB had poor vision “found it difficult to locate her chair and required guidance from Ms CC.” This issue is not acknowledged or noted as a risk by the majority of those who were involved with her although there was clearly marked impairment. Ms BB had mobility issues presumably as a result of a knee
replacement. Ms CC had had both hip and knee replacements. There was a risk of falls noted very early on. This was not actively monitored and reviewed.

Both Ms BB and Ms CC suffered with dementia, with Ms CC’s diagnosis coming after that of Ms BB. This had a significant impact on their ability to carry out daily living tasks, on their decision making and on their willingness to accept interventions.

There are learning and development implications in this respect for those involved in their care. For example, Allied Healthcare state they need to tell carers not to try to stop challenging service users, but to withdraw. (Following the incident on 18 September)

Whittington Health remarked at the meeting where Individual Management Review reports were presented to this review: “the key issue for Whittington Health was around how to deal with people with dementia.” Organisations will have their own particular needs in terms of developing staff in this area that fall out of this review. Whittington Health has set out a robust response to the review in this respect. Other organisations must take an equally robust approach.

Ms BB’s brother referred to the need to understand that active help was needed with eating.

Issues that are most prominent in respect of working with the dementia (a feature for both Ms BB and Ms CC) are: understanding the capacity of the individual to make specific decisions and documenting this; working with the risks presented and balancing these against the wishes of the individual; understanding and working effectively with challenging behaviour; working in a person centred way so as to reduce such challenge and to reduce anxiety/stress for the individuals concerned; developing an understanding of the experience of dementia; drawing on the skills of the multidisciplinary team to maximise effective interventions; working with individuals at an early stage to understand what is important to them and what their wishes are for the future when they have lost capacity (and documenting this); in this latter context putting in place contingencies for a time when there are specific issues/risks emerging (mapping out a pathway of care setting out that when ‘x’ happens then ‘y’ will need to be put in place). There must be a focus on wellbeing as well as safety.

Whittington Health has a wide ranging development programme in place including a range of training and the introduction of dementia champions to support person centred dementia care across the Trust. Even so the Trust has acknowledge the need to introduce further detail into this development programme as a result of this review including in some of the areas listed above. Other organisations must consider a similarly robust approach.

**Pressure Ulcer prevention and care**

There are significant implications from this review for practice in the prevention and care of pressure ulcers. This aspect of practice links closely with others: continence; catheter care and nutrition.
Pressure ulcer care in the hospital

Ms BB developed pressure ulcers whilst in the care of Barts Health NHS Trust and these were recorded in the records (patient notes; Individual Management Review; chronology; Root Cause Analysis) submitted by Barts Health NHS Trust for the review (including s RCA report) as follows;

24 June: Tissue viability assessment revealed: right heel (possible deep tissue injury). All other pressure points observed to be intact: pressure relief, diet reviewed, and mobility.

A record by the tissue viability nurse in the notes on 17 July records that on 26 June a grade 2 pressure ulcer to the sacrum had been recorded. This had been noted resolved on 6 July but then by the 14 July was recorded grade 3. This was noted to be possibly developed through acute illness on 15-16 June.

Ms BB was transferred from a foam mattress to an air mattress on 17 June.

On 17 July the record said that the tissue viability nurse was unable to exclude a grade 4 pressure ulcer.

It was noted “continue to support nutritional intake-has been losing weight”.

5 August: grade 3 sacral pressure ulcer “borderline grade 4” Heel ulcer healed.

12 August: tissue viability nurse review...."exuding large amount of yellow discharge”

Preventive measures were in place (some indicated above) including a pressure ulcer prevention tool (known as a SSKIN bundle); repositioning; nutrition advice; pressure relieving mattress.

The Barts Health NHS Trust Root Cause Analysis indicates that Ms BB was admitted from Royal London Hospital to Mile End Hospital with a “moisture lesion” to her sacrum. She “was bedbound and was high risk of developing pressure damage due to slow rehabilitation. In addition patient had a significant deterioration in medical condition developing hospital acquired pneumonia and sepsis”

A moisture lesion is defined as being caused by urine and/or faeces and perspiration. Moisture lesions cause superficial loss of epidermis and/or dermis...They will usually cause pain.

Whilst pressure ulcers and moisture lesions require different interventions moisture lesions do indicate a need to assess the need for preventive measures to be in place (especially where a patient is at high risk of developing pressure ulcers as Ms BB was). Repositioning and pressure relieving equipment are indicated.

This indicates the importance of the pressure ulcer prevention tool (SSSKIN bundle) when Ms BB was admitted to Royal London Hospital. However this was inconsistently carried out. This along with her general presentation might have indicated the need for a pressure relieving mattress earlier on. The Root Cause

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7 All wales best practice statement on Prevention and Management of Moisture Lesions (All Wales Tissue Viability Nurse Forum, 2014)
Analysis gives little attention to a focus on the moisture lesion and prevention in place/consideration to known preventive measures such as pressure relieving equipment. (Albeit Ms BB was at that point at Royal London Hospital. This is still part of Barts Health NHS Trust). The risk factors were present and known. It is perhaps surprising that a pressure relieving mattress was provided only on presentation of a grade 2 pressure ulcer.

The Root Cause Analysis acknowledges a delay in the nursing team reporting to the tissue viability nurse on first identifying the deterioration to the sacrum. The chronology in the analysis also notes a delay of 3 days between referral to the tissue viability nurse on 14 July and the tissue viability nurse attending on 17 July.

A SSKIN bundle was used from the day Ms BB was admitted to Mile End from the Royal London Hospital. (This is a prevention bundle used in healthcare to address five elements; skin, surface, keep moving, incontinence and nutrition).

The Adult Pressure Ulcer Prevention and Management Policy, Barts Health NHS Trust March 2015 indicates that where there is a Waterlow⁸ (pressure ulcer screening tool) score 10 or more and / or mobility and unable to change position independently a SSKIN bundle is indicated. The Barts Health NHS Trust Individual Management Review report states that between 22 March and 16 April whilst SSKIN bundles were present there were gaps in care noted. It is likely that Ms BB scored around 15 at this time. We know that when the Continuing Healthcare assessment was undertaken in early June she scored 15 and this rose to 18-20 on discharge.

The Root Cause Analysis records that there were discussions with the family and that they would be fully informed of the investigation. Records of discussions around this time with the family do not record discussion of the pressure ulcer. Furthermore there is no indication that the family is advised of the need for pressure ulcer care on discharge of Ms BB from hospital.

The Root Cause Analysis records an increasing trend in hospital acquired pressure ulcers grade 3 and 4 over the past 12 months (5 in 12 month period). The analysis acknowledges “there was a delay in reporting the deterioration to the sacrum when first identified by the nursing team.” It states that “Patient was bedbound and was a high risk of developing pressure damage due to slow rehabilitation. In addition patient had a significant deterioration in medical condition, developing hospital acquired pneumonia and sepsis”. It appears that the deterioration/pneumonia happened after the pressure ulcer deteriorated as the pressure ulcer was noted to have deteriorated on 17 July and the pneumonia on 24 July.

On 1 June it was noted that weight was to be monitored because of poor oral intake. It is not clear to what extent weight was monitored. Although on 1 June an intention to monitor weight is recorded there are only two records of weight.

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The Root Cause Analysis undertaken by Barts Health NHS Trust when the grade 3 or 4 sacral pressure ulcer developed records..."lessons learned: none". The above perhaps indicates that further action is required.

Safeguarding and pressure ulcers: Most organisations in Islington share a consistent understanding of the circumstances in which a hospital acquired pressure ulcer is required to be referred in to safeguarding. However there was unease amongst members of the review Panel in respect of the view taken by Barts Health NHS Trust as to circumstances in which a pressure ulcer requires a Safeguarding Adults referral and the timing of that. This requires discussion and resolution across Borough boundaries. At a meeting, where this review Panel heard presentations of Individual Management Reviews, the Clinical Commissioning Group raised the point that in general in Islington a grade 3 or 4 pressure ulcer requires a safeguarding adults referral especially if the pressure ulcer is avoidable. Barts Health NHS Trust states that they follow the NHS guidance on reporting pressure ulcers as safeguarding concerns. Safeguarding alerts are raised on detection of a pressure ulcer where the risk assessment and/or care plan is inadequate. Where a Root Cause Analysis is completed, this is reviewed for any safeguarding concerns. In this regard London Borough of Islington Adult Social Services has identified a need for consistency around what factors trigger a safeguarding enquiry and the circumstances that require an objective external enquiry. For example Adult Social Services are concerned that their experience was that the ‘safeguarding procedure at Mile End Hospital is different to that of Adult Social Services in that a safeguarding alert would be raised if the service user went into hospital with a grade 3 pressure ulcer rather than if developed whilst in hospital. This ambiguity it is believed should have been escalated to both the London Borough of Islington safeguarding team and senior management’.

The Independent Chair of the Islington Safeguarding Adults Board has undertaken to initiate discussion, initially with colleagues in London Boroughs of Newham; Tower Hamlets and Waltham Forest, to consider the above inconsistencies. It may be appropriate too to make links more broadly across London in the context of pan London procedures (regarding pressure ulcer and adult safeguarding). This case review may support an argument that referral in to safeguarding can add value. The finding of the Root Cause Analysis carried out by Barts Health NHS Trust, that there were no lessons to be learned, was inconsistent with aspects of the detail of that Root Cause Analysis highlighted above. Perhaps it would support broader development or improvement if the Board were to receive an overview of the number of avoidable hospital acquired pressure ulcers and the issues across health providers and a comparison with other Boroughs.

Pressure Ulcer prevention and care in the community

The following extracts provide information as context to the analysis around specific needs of Ms BB in particular.
Table 1

The hospital discharge referral (August 2015) to the district nursing service (Whittington Health) included the following information regarding Ms BB:

“Her Waterlow score is 18.

The reason for the referral: “to change dressing on sacrum. [Ms BB] has a grade 3 pressure ulcer, and to monitor catheter, patient has been referred to Trial Without Catheter (TWOC) clinic current catheter has been inserted on 30.7.15 (size 14”)

Date of first visit between 1500 and 1700
Pressure ulcer graded 3. Factors that may delay healing were noted as: immobility; poor nutritional status; incontinence.
Objectives were noted as: promote healing; prevent infection; daily dressing change”.
This level of detail is not as detailed as is set out in expectations of the Whittington Health catheter care policy nor are nutritional needs sufficiently clear.

Table 2

The Allied Healthcare care plan dated 21 August includes:

Reference to a pressure ulcer grade 3 and Waterlow score 21
“it is important that I change position regularly in bed to ease pressure on my pressure sore”
“Carers to ensure that [Ms BB] changes position each visit to help with pressure sores”
Nutrition..."to record everything [Ms BB] eats and drinks in the carers daily log”
“Carers to encourage [Ms BB] to eat and drink”
“Carers to access the property by ringing doorbell and awaiting response”
“Carers to position [Ms BB] and fill in positioning form and to reposition [Ms BB] with double up care”. (NB this double up was 4 times each day)
Notes risks as falling; un-wilful neglect due to.... (but doesn’t specify) Other risks: poor nutrition and fluid intake; noncompliance with medication; risk of further pressure ulcers or decline in existing pressure ulcer (and district nurse to dress and monitor)
The care plan gives 24 hour cover with some double up carers and waking night carers. It appears that double up is not sufficient that two are there every two hours for turning. The plan does not specify repositioning every two hours.

Despite it being noted that the Continuing Healthcare assessment needed to be updated this never happened either within the hospital or the community. The assessment was in early June before pressure ulcers were an issue.
(23 July 2015 Discharge coordinator recorded Skin damage on Decision Support Tool needs to be updated by nursing staff. We can then re-submit to Islington Continuing Healthcare Team for review at Panel”). The Continuing Healthcare assessment is considered below.
The pressure ulcer was a real risk to Ms BB and yet the above are insufficiently
detailed. There are serious care issues that will require regular attention and it is
known that Ms CC is obstructive to carers going in. What is the contingency for this?
How far is the plan for two hourly turning advised to all who need to know?

In addition concerns were raised by the social worker for Ms BB on 13 August whilst
she was an inpatient about the depth of the pressure ulcer and that there was
discharge from it. Nursing staff reassured her that there will be tissue viability nurse
involvement. Two hourly turning will be required and Ms BB will not be able to sit for
long. The social worker recorded her concerns in the hospital communication book.

Concerns were also expressed by the GP who had no information about the
pressure ulcer from the hospital. However, “Patient was on a flow mattress and Dr A
did feel confident that the district nurse, who was also present at that home visit and
responsible for the pressure ulcer care, was able to provide adequate care in that
setting or inform us if care wasn’t possible at home”. The GP practice Individual
Management Review notes: “discharge letter Barts Health NHS Trust and the
London NHS Trust 16th April 2015 - 20th August 2015 does not mention a pressure
ulcer. Also concern that with care at Mile End hospital she required re catheterisation
due to retention of urine secondary to dehydration and sepsis. ‘Try without catheter’
failed yet she was still discharged”. Dr A did raise his concerns further and tried to
gather further information. He contacted the Community Matron who had links with
the hospital

There is no record of any professional from the hospital or the community, engaging
with family members to explain that Ms BB had a pressure ulcer and to raise their
awareness about how to prevent deterioration and to advise of the circumstances
where they might alert professionals of any concerns. This would represent best
practice.

Whittington Health has evidenced that repositioning began on discharge and there is
a record to say that this was done with the help of a carer on 23 August. However
there is a high degree of confusion as to ensuring that carers have repositioning
charts and all of the necessary advice/information. It was not clear whose role it is to
ensure this happens. This must be clarified. Those charts were not given to the
carers until 27 August. However it is clear that ahead of this they had been given
advice by the district nurses.

There was an issue about frequency of repositioning. The carers are recorded as
saying to the district nurse on 24 August that Ms BB is repositioned at each double
up. Looking at the care plan this is every four hours. This is a crucial issue for
managing the risk of further deterioration.
The tissue viability nurse advised Adult Social Services that carers need to complete
the repositioning chart so that it can be assessed whether the current regime/care
package is sufficient. There is no evidence of such a review in circumstances where
there is significant risk.
**Nutrition and Hydration**

Although it was a stated intention (1 June) within the hospital to monitor weight. There are only two records of weight whilst Ms BB was in hospital which have been made available to the review. These are as follows:

The dietician at Mile End Hospital recorded on 15 June 2015 Ms BB’s weight as 54.3 kg. Weight had reduced by 5.3 kg since 23 April. Height 1.676m. On 15 June BMI was recorded as 19kg/m² Malnutrition Universal Screening Tool (MUST) score 2.

15 June: The dietician recorded an aim “to support oral intake ... to prevent further weight loss” and for ongoing review. The next full review wasn’t until Ms BB was discharged 2 months later.

23 July: The dietetics record notes..."No improvement in appetite. Patient managing ¼ to ½ breakfast, half of all main meal, little or no evening meal...patient requires +++encouragement to eat and’ drink. Very minimal fluid intake”.

19 August: A dietician review of the above is recorded. Weight is 53.8kg so a very slight increase of under 1kg. The dietician recommended dietary supplements on discharge and to continue to encourage oral intake of food, fluids and supplements. A referral to a dietician in the Islington area was recommended.

This should have informed the discharge summary; it did not. By the time Ms BB was admitted to University College London Hospital (when weighed on 19 September) her weight had dropped by around 10kg to 43.6kg in one month. The Whittington Health Individual Management Review states that district nurses were not informed upon discharge that Ms BB had been prescribed dietary supplements whilst in hospital, so could not immediately monitor this”. Whittington Health has highlighted too: “It is key that there was no information about dietary supplements. There was a delay until 28 August until they were prescribed.” Table 1 shows the extent of mention of nutrition in the discharge referral.

A referral was not made to the community dietician until 24 August so after the hospital discharge. There was no dietician involvement until 7 September.

“Concerns about dietary intake were raised by the tissue viability nurse, who made contact with both the GP and dietician – this is important as hydration and nutrition are important for pressure ulcer care and skin viability.” The GP had prescribed Complan at the visit on 28 August following District Nurse and tissue viability nurse concerns raised to the GP.

Hydration was equally an issue with fluid challenges and Ms BB having required intravenous fluids whilst an inpatient. When Ms BB was re admitted on both 27 August and 18 September she was dehydrated. The records do not evidence proactive steps taken in this respect.
From as early as 1 April the speech and language therapist stated in the hospital record that Ms BB “required full assistance with feeding. Can initiate task with prompts and pick up knife and fork but unable to complete task (cut food, lift fully to mouth).” This was reflected in the dietician assessments and appeared as a task in the care plan (table 2) for Allied Healthcare staff. However it did not appear in records as a focus of monitoring and review activity.

Ms BB’s brother observed that carers needed to spend time with Ms BB supporting her and encouraging her in eating. There is no evidence that the importance of this for her overall wellbeing including implications for the pressure ulcer were explained to carers.

**Catheter care and continence issues**

The Barts Health NHS Trust discharge summary to the GP states: soon after transfer to Mile End Hospital for rehabilitation on 16 April Ms BB “went into urinary retention associated with dehydration and a high temperature. A urinary catheter was inserted.”

It goes on to say the catheter was removed 2 weeks later but Ms BB went into urinary retention again 24 hours later. Removal was tried once more and was unsuccessful.

The Whittington Health ‘Insertion and Management of Urinary Catheters for Adults in the Community’ Policy (ratified January 2015 issued June 2015), is clear that hospital discharge should see the patient discharged with a range of supplies associated with the catheter including one catheter if the patient has problems with allergy, or the catheter is not of routine stock kept for emergencies.

In addition the discharge letter must set out clearly fine detail of the reason for catheterisation; the details of the catheter used; the specification of equipment and supplies being used; any specific issues/problems with initial insertion which may affect future insertions. This is not the case in the discharge summary reflected in table 1.

There is no indication in the district nursing policy on insertion and management of urinary catheters that community nurses cannot insert/change catheters but that specific training must have been undertaken. The Whittington Health Individual Management Review draws attention to the fact that “There is evidence of the district nurse manager emailing all staff about the need to take adequate supplies of catheters to avoid patients having to be taken to hospital as occurred on 27 August”

There were a number of occasions when catheter care was a significant issue including:

1 September: “unable to change catheter as no supplies so patient was padded for the night”

6 September: “no catheter so unable to change catheter. Patient padded for the night”
12 September: “catheter not patent, awaiting supplies Monday”

On 27 August (a week after discharge Ms BB was admitted to Royal London Hospital because the catheter had fallen out and there was no replacement catheter available. This is outlined in the narrative chronology in 3.7.

There are also indications in the records of the district nurses noting that carers were using double incontinence pads for Ms BB...this could impact significantly on pressure ulcer care.

The supply of incontinence pads was an ongoing issue following Ms BB’s discharge from hospital. On 14 September carers were still waiting for the issue to be resolved. In the meantime the carers were buying these with money left by the family. The care agency had advised the GP and district nurses that this was the case.

**Continuing Healthcare Assessment (CHC)**

The complex range of needs indicated that a Continuing Healthcare assessment should be undertaken. This was carried out in June 2015 after some considerable prompting by the social worker (SW1). However this was not reviewed when deterioration in Ms BB’s condition took place and following the acquired pressure ulcer.

This review should have been carried out in the hospital and indeed on 23 July the discharge coordinator acknowledged that it needed updating. This was never carried out.

The Whittington Health District Nursing ‘patient of concern’ process is part of its policy and practice around care co-ordination and escalation. Ms BB should have been referred as a patient of concern and this would have been a possible route in to a review of the Continuing Healthcare assessment once Ms BB was back in the community if discussion with the Lead District Nurse had deemed this appropriate.

It appears from the process and guidance for Continuing Healthcare that had Ms BB been re assessed she would have qualified. She had particularly significant needs around continence; nutrition; mobility and skin (4 domains which are assessed in considering need for Continuing Healthcare). For example at the June Continuing Healthcare assessment a Waterlow score of 15 was entered. This is variously reported as 18 and 21 towards the end of her life. The health needs assessment was completed on 4 June. Ms BB deteriorated soon after this.

This represents a further aspect of assessment which was not reviewed and with which there are some issues about the way in which it was carried out.

The assessment and decision making process around NHS Continuing Healthcare funding comprises the completion of a recorded health needs assessment to determine eligibility for Continuing Healthcare. The Decision Support Tool is then based upon this assessment and there follows a multi-disciplinary Panel decision. There was an evident lack of clarity in this case as to who should complete an initial
checklist indicating the need for an assessment. The Social Worker (SW1) initially completed this.

The assessments and tools for NHS Continuing Healthcare decision making are prescribed nationally and there is associated guidance. This is National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012, (revised). Alongside the national framework there is a national tool for guiding and recording the decision relating to eligibility for NHS funding decisions. This was used to record the assessment in Barts Health NHS Trust.

When Ms BB was discharged back into the community Ms BB came under Islington Continuing Healthcare procedures. Within Islington, Whittington Health are the lead agency for Continuing Healthcare, however both health and adult social care have a responsibility to identify possible cases for consideration for Continuing Healthcare. Whilst Ms BB was in Mile End Hospital this lead responsibility rested with Barts Health NHS Trust. This perhaps created an element of confusion around accountability for Continuing Healthcare assessment/review.

The Continuing Healthcare assessment did not offer the support of a family member or advocate when Ms BB was not able to participate due to cognitive impairment.

The assessment might have been helpful had information from it (for example it gives an overview of support required with eating) been made available to other professionals/ carers.

This Continuing Healthcare assessment completed in June was only sent to the social worker after many reminders that it was needed. This did not therefore form part of the information presented to the Islington council Adult Social Services panel that decided on Ms BB’s future care needs/provision.

4.5 Hospital discharge: policy and practice

Practice around hospital discharge connects with key aspects of the above analysis. It will connect too with the following section of this report on communication across and within organisations. All of the available guidance stresses that discharge planning begins before admission. Hospital discharge is built on a firm foundation of quality assessment, monitoring and review before and throughout an inpatient episode as well as on communication and joined up understanding of the person and their needs. It requires effective and meaningful communication with patients and their families. National guidelines repeatedly emphasise these core principles and aspects of practice in respect of hospital discharge.

The Barts Health NHS Trust Policy offered to the panel as currently in use at the time Ms BB was being cared for in hospital appears to have been agreed in 2009 and was for review in October 20129. This policy was produced ahead of current national guidelines and is in need of updating. As the Trust is situated within London Borough of Tower Hamlets it is listed as having been distributed to them. There are a number of issues in this review that highlight the lack of coterminosity with London

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9Barts and the London NHS trust discharge planning (joint hospital, Tower Hamlets primary care trust, the London Borough of Tower Hamlets & the Health and Wellbeing teams) Trust core policy, 2009
Borough of Islington policies and procedures (including safeguarding). This is an area for attention.

Barts Health NHS Trust also shared with this review that they have referenced a national guidance document to guide local practice.\textsuperscript{10}\footnote{\textbf{TEMPLATE POLICY: SUPPORTING PATIENTS’ CHOICES TO AVOID LONG HOSPITAL STAYS \textsuperscript{dated March 2016. Prepared by: Partnership of organisations from across the health and social care sector (NHS England and partners published a series of Quick Guides to support local health and care systems. The guides provide practical tips, case studies and links to useful documents, which can be used to implement solutions to commonly experienced issues}.} This national guidance includes a checklist for local areas to use to identify areas for improvement. This is a necessary step for Barts Health NHS Trust in partnership with a range of local health and social care organisations. NICE guidance: Transition between inpatient hospital settings and community or care home settings for adults with social care needs (December 2015) should also inform development.

The Barts Health NHS Trust 2009 discharge procedure sets out a checklist of areas for attention. The following in particular required further commitment in the case of Ms BB:

- facilitate effective multidisciplinary communication and interdisciplinary working through, for example, team meetings, case conferences and integrated health care records.
- the need for the negotiation and involvement of patients, clients, their carers and families at each stage of the discharge needs assessment and discharge planning process.
- facilitate the communication of all appropriate discharge information and risk factors, including behaviours which may put staff at risk.

There is also a commitment in the policy ...“to review patient information on admission to identify any areas of vulnerability”

Information about the hospital admission was inaccurate. The London Ambulance Service (LAS) description of Ms BB when they arrived at the flat and transferred her to hospital in March was very much at odds with the information recorded by the hospital. The discharge summary to the GP gives information about how the patient was admitted as follows: “LAS noted she was lying on the floor incontinent of urine with a ?long lie” This was not at all what the LAS record said: “Ms BB had fallen on the floor that morning whilst getting out of bed....On examination Ms BB was sitting in bed alert, there were no obvious injuries, Ms BB denied having any pain, was incontinent x1, breathless on exertion. Ms BB had difficulty mobilising and weight bearing.”

The discharge letter to the GP arrived late. Barts Health NHS Trust explained to this review: in respect of timing of discharge letter to GP: “all out of Borough GPs are sent a copy of the discharge summary by mail on the day of discharge. I will suggest that the discharge was on a Thursday this was placed in the post and processed through the mailing service on Friday and arrived with the GP either Saturday or
Monday”. For a patient who has complex needs including the need for two hourly repositioning and food supplements this is not sufficient.

Table 3

The information on the discharge summary sent to the GP Practice included:

A Do Not Attempt Resuscitation form was signed in hospital
Details of treatment given on admission (including antibiotics and treatment for fluid overload)
Transferred to Mile End hospital 16 April soon after which a consequence of urinary retention a urinary catheter was inserted
Her catheter was removed; reinserted when she went into urinary retention again; one more unsuccessful attempt without catheter. She has been referred to the Trial Without Catheter clinic on discharge.
Now stable on discharge.

Notably the summary did not include any mention or detail in relation to the pressure ulcer or the nutrition and dehydration issues experienced in hospital including the need for dietary supplements.
This was remarked upon in the GP practice Individual Management Review.

At a meeting of the Safeguarding Adult Review Panel with Individual Management Review report authors, the GP expressed concern about the quality of hospital discharge letters in general. He said that hospital discharge letters to GPs do not ever include important nursing details. He drew attention in this instance to the lack of information on Ms BB’s pressure ulcer or her ability to feed herself. There is no information on decision making and assessment surrounding Do Not Attempt Resuscitation or often on the patient’s level of functioning on discharge (especially where they have been inpatients for a long time). Nor do GPs receive information of the care that is to be put in place. The GP said that there “needs to be improved integration between secondary and primary care providers particularly for at risk clients on discharge”

On a visit to Ms BB on 28 August (8 days after discharge) Dr A was concerned at her level of frailty and dependency. He was working with a complete lack of information about her level of functioning in hospital and the pressure ulcer. He was also unaware that just the previous day she had been admitted to hospital for several hours (discharged at 11pm) because notification of that admission would not yet have reached him. Dr A contacted the community matron to gather information that he had not received from the hospital.

There were similarly omissions from the discharge letter to the district nurses (key extracts from which are given in table 1 on page 44). These have already been highlighted in the commentary around pressure ulcers, nutrition and catheter care. The Barts Health NHS Trust policy suggests that in complex cases district nurses are invited to attend discharge planning meetings. This did not happen.
The hospital discharge on 27 August at 11pm was inadvisable especially as Ms CC had advised that she was going to bed and therefore Ms BB should come home in the morning. The hospital proceeded to have a conversation with the care agency who said that they would arrive for the waking night shift at 11pm and therefore Ms BB should not be returned home until then. Given an injury to Ms BB’s shin (caused accidentally by a strap on the ambulance equipment) and given the description of her by both the GP and district nurse the following day it is even more surprising that she was discharged at this late hour (if at all).

A recent report by the Health Service Ombudsman (May 2016) summarises: Best practice guidance has been consistent over the past decade in stating that ‘discharge is a process and not an isolated event at the end of the patient’s stay’ (Ready to Go 2010). The key steps and principles identified to enable appropriate discharge include:

- starting discharge and transfer planning before or on admission to hospital, to anticipate problems, to put appropriate support in place and agree an expected discharge date.
- involving patients and carers in all stages of the planning, providing good information and helping them to make care planning decisions and choices.
- effective team working within and between health and social care services to manage all aspects of the discharge process, including assessments for social care, continuing healthcare and, where necessary, assessments of mental capacity.
- community-based health and social care practitioners should maintain contact with the person after they are discharged, and make sure the person knows how to contact them when they need to.

The ombudsman report highlights three themes in respect of problematic discharges; two of these are particularly pertinent in the case of Ms BB: Carers and relatives not being treated as partners in discharge planning... (“it is vital that hospitals treat them as partners throughout the discharge planning process and don’t treat their involvement as an afterthought”); poor co-ordination within and between services. Both of these issues were prominent in the discharge of Ms BB from hospital.

The ombudsman report highlights too some serious issues in relation to hospital discharge. One area highlighted is “Patients not being assessed or consulted properly before their discharge: While a person may be ‘medically fit’ to leave hospital, they may not be practically ready to cope at home. If a rounded picture of a patient’s needs (including their mental capacity) is not established on admission to hospital and then regularly monitored, they could be sent home alone, afraid and unable to cope”.

Discussion with Ms BB’s family over the whole period of the admission as well as establishing an understanding as to any previous hospital admissions/discharges

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11 A report of investigations into unsafe discharge from hospital; parliamentary and health service ombudsman, May 2016
would have exposed the issues around the lack of inclination on the part of Ms BB and Ms CC to cooperate in letting carers and nurses carry out essential care and treatment. This was never sufficiently explored and the full implications were not recognised by the hospital. The discharge coordinator imagined that a key safe would address what she understood of the issue and advised relatives of this. This did not constitute engaging sufficiently with the issue or with the family of Ms BB.

It is possible to tick the boxes on hospital discharge checklists without really engaging with the fundamental principles beneath these. Multi agency cooperation to improve working together locally on hospital discharge must go beyond those checklists.

Guidelines published by the National Institute for Health and Care Excellence in December 2015, on transition from inpatient hospital settings for adults with social care needs, recommend that a single health or social care professional should be made responsible for co-ordinating a person’s discharge. The discharge co-ordinator should be the central point of contact for other health and social care professionals, the person and their family during discharge.

However these changes in structure/roles require associated culture change and mutual trust. There is a need for transparency and open discussion of conflicting agendas in each case rather than new titles and procedures simply acting as a veneer that sits on top of all of the old conflicts (the most obvious being the conflict between resource constraints/ the need to clear a hospital bed and the need to engage with and resolve real issues for people that might mean a delay) “What people who use services want is a seamless service where people on the ground work well together in spite of different structures and systems – it is about improved relationships between NHS and non-NHS staff as well as the wider voluntary and third sectors”\(^\text{12}\). Review of hospital discharge arrangements is a task that requires engagement at all levels from safeguarding adults board to individual practitioner in order to address the cultural shift required.

### 4.6 Achieving a shared understanding and shared decision making and action within and across organisations

All of these issues rely upon effective information sharing and communication. Issues in this respect that have emerged within the discussion on assessment, care planning, monitoring and review and in respect of managing the complex range of needs presented by Ms BB and Ms CC. It is not necessary to repeat these here. The review of the discharges from hospital brought this issue sharply into focus.

The role in this case of the **London Borough of Islington Adult Social Services Integrated Quality Care Meeting (IQCM)** also offers examples of communication issues that can form the basis of learning for the future.

\(^\text{12}\) Compassion in Practice Dec 2012 NHS commissioning board &DH
The social worker for Ms BB (SW1) first submitted a referral to the Integrated Quality Care Meeting on 20 May 2015. This followed a long period from January when she had discussed the idea of Ms BB and Ms CC living together in a care home. So much so that this had become known across professionals and by the family as the likely outcome. This clear narrative had changed when on 9 March the social worker (SW1) advised the dementia navigator that “I have discussed the case with my manager and he advised that we need to increase the service and review it, before making a plan for any placement.” It is possibly the case that having been sufficiently confident to share the plan widely with other professionals, the social worker is reminded of a departmental principle (clearly set out in the Integrated Quality Care Meeting protocol) which has to do with attempting not to place people in care homes direct from hospital. Staff need to be empowered to use high quality assessments and reviews to identify situations which may present the need for exceptions to general principles and to use this to advocate on behalf of service users where this is necessary.

The case presented to the Panel left them unclear as to the views of Ms CC or whether residential or nursing care was being requested. The request did not seek placement for both women (as had been the social worker’s initial plan). The question was asked as to whether they might be placed together in a care home. The social worker is asked to re submit the request having worked on these issues. When the request is re submitted to panel on 4 June without adequately addressing the questions the request for a care home placement is declined in favour if either 24 hours care at home or discharge to extra care sheltered housing.

All of the information on need and risk is not conveyed to the Panel nor does it seem is the situation fully understood by them. The social worker's request to the Panel is unclear and perhaps reflects a lack of clarity/confidence in her own assessment and decision making. Certainly the request does not include all of the key points. (The role of staff support and supervision is underlined here in this illustration of a change in direction following discussion with a line manager and yet an apparent lack of confidence in this. Supervision should offer the opportunity to explore the risks and the issues). There were changes in the membership of the Panel during the course of the process and the Panel received two further reports on 2 July and then on 17 August indicating the sacral pressure ulcer. This latest request clearly indicated that the wider family favoured a care home placement. This was turned down in favour of 24 hour care at home.

There is a range of issues regarding communication and shared decision making surrounding this:

The protocol for this Panel is clear on the following:

“All staff requesting funding for packages will be able to attend by booking a slot...”

“Social workers must be contactable by phone during Integrated Quality Care Meeting for clarification/further info. “

“A practitioner can ask to present their case in person if...complex case or in the case of resubmission for clarification”
Paperwork required includes Continuing Healthcare (if relevant). It also asks for occupational therapy/physiotherapy reports/nursing reports; comprehensive risk assessment; Mental Capacity Act assessments. These are not communicated to the Panel in the case of Ms BB and Ms CC as some of these are not yet available.

It is made clear that the justification for the support plan must be set out clearly.

There is a clear statement that “Islington is looking at how to avoid placing people in residential care directly from hospital setting etc....” and...

“Reasons why a residential placement is the only alternative and why there is no potential for the person to improve their ability to cope at home will need to be made very clear.”

In the case of Ms BB and Ms CC the balance in this decision making relied on a number of factors. Communicating these would have been more effective through one social worker only working with the two women and attending the Panel in person. The clear impression given to the Safeguarding Adult Review Panel is that in reality social workers do not attend this Integrated Quality Care Meeting Panel.

There is an issue regarding consistency of panel membership. There need to be measures in place to mitigate the risks this introduces.

Finally a lack of adequate communication was illustrated in that the decision of the Panel is clearly recorded as that Ms BB and Ms CC will each be funded for 12 hours care. This is not reflected in any later planning and discussion. It is assumed across organisations that this is a 24 hour package of care for Ms BB.

A number of organisations involved in this Safeguarding Adult Review have underlined the need for greater communication and coordination across agencies as follows:

GP practice Individual Management Review... “All Allied staff being 'separate' can mean no leadership except within our own practice is identified – difficult to know who to contact in relation to: any concerns – couldn't even establish who was providing the 24hr carers in this case and how long they were intended to remain in place”.

Camden and Islington NHS Foundation Trust “there did not appear to be a time ...that all partners came together to discuss a joint plan and action across the partnership to address concerns shared by ... agencies involved”

There was a great deal of passing of information from one professional to another within and across organisations with an associated reluctance often for individuals to take responsibility and act. An example was around the issue of repositioning charts that were required by carers in August 2015.

Camden and Islington NHS Foundation Trust commented in its Individual Management Review that “the service shared information from their visits....with appropriate partner agencies...” This sharing can be perceived as joint working when in fact it is simply shifting the issue from one person to another. Likewise Barts Health NHS Trust in its Individual Management Review highlights ....”MDT
assessment throughout care episode which included medical nursing, speech and language therapies, tissue viability nurse, dietician and social worker. There is a difference between a range of professionals undertaking assessments and a true multidisciplinary team which pulls these together to address the combined impact of the assessments. Who was piecing together an emerging picture and putting in place a necessary action plan with named leads on specific issues?

There were unresolved issues both of accountability and coordination. A multi-disciplinary review involving all those who were working with Ms BB and Ms CC, at more than one stage in this chronology of events, might have facilitated a clearer and shared view and necessary and appropriate responses. This needed to be combined with more effective recording, firstly so that each agency involved could maintain a clear overview and understanding of the situation and present it coherently to others. Secondly where recording systems exist that are capable of being accessed across organisations these need to be used to maximum effect (such as the Coordinate my Care record).

The Aquaflo Care Individual Management Review acknowledges this, stating that they have learned that “regular meetings with stakeholders including district nurses; social worker and family” are important.

The Allied Healthcare Individual Management Review states that the learning includes: “ask for a meeting before taking on a complex case...Request a detailed care plan including past history”

There are some existing forums / processes in place that might be developed further to facilitate the necessary sharing of information, decision making and action. For example the GP practice has multidisciplinary weekly meetings which are attended by all clinicians, practice nurses, head receptionist, practice manager and practice secretary. “This allows team discussion and input of ideas as well as shares information and care plans amongst all the team so everyone is aware”.

“Within the Practice peer review takes place of individual professionals’ decision-making at weekly clinical meetings and at any MDT meetings with other agencies. Also joint home visits”. This model needs to be applied for complex cases across organisations. This it seems is developing locally via the new Integrated Network Coordination (INC) service.

The Coordinate my Care record exists to support sharing of key information/wishes. It allows healthcare professionals to electronically record patient’s wishes and ensures their personalised urgent care plan is available 24/7 to all those who care for them. It is used to summarise any advance care planning or other emergency information. The record can be updated. It is the responsibility of any healthcare professional trained in using the system to add to it and to refer to it. In view of the fact that there was just one brief entry on this record (by the Palliative Care Team) and only one occasion when it was checked by the ambulance service this is an area for development.
The Whittington Health Individual Management Review suggests that “It would be useful to discuss with partner agencies appropriate referrals to the community matrons to oversee service provision when there are multiple agencies involved”.

This Individual Management Review also said that “It would be useful to have an agreed process to ensure all agencies are aware of the roles and responsibilities of each agency and an agreed format to ensure any concerns from any agency are escalated and shared appropriately. Communication between agencies is key. It would also be useful to consider developing a process by which one person has an overview of the care package as outlined in the Care Co-ordination policy which had previously been a jointly agreed policy between adult social care and Whittington Health.

The new Integrated Network Coordination (INC) Service has offered a new forum in which there are weekly meetings at GP surgeries attended by a community matron, social worker and GP. This was not in place at Ms BB and Ms CCs surgery before September 2015, but is now.”

The INC Service is a partnership initiative (London Borough of Islington; Islington Clinical Commissioning Group; University College London Hospital; Whittington Health NHS Trust; Camden and Islington NHS Foundation Trust; Islington Age UK). It seeks to “deliver more joined up and co-ordinated care to those who need it.” The networks (approximately 10) all have multidisciplinary team meetings (MDT) and each encompasses around 3-4 GP practices. The vision attempts to deliver on some of the principles outlined above about required culture change, transparency and shared values...A key ingredient is that this works as a “supportive, reflective multi-disciplinary team. This means consistent engagement from professionals, who are given time and support to develop as an MDT”. They also have delegated authority to make decisions. The cohort for discussion at these meetings includes those being discharged from hospital. Perhaps consideration could be given to ways in which other hospitals to which Islington citizens can be admitted might have some involvement.

There are initiatives elsewhere too that might inform further development of the INC and that ensure that the principles already operating in the INC facilitate the setting up of a system for some patients with complex needs whereby it is possible to realise the aspiration of Ms CC and Ms BB to be cared for at home and to die at home.

Alongside active and clear communication about needs and risks in respect of individuals, there must be honest acknowledgment of the pressures and priorities within and across organisations that may impact upon being able to deliver on solutions that patients and service users aspire to. These pressures and priorities are a constant reality and it was clear that these had an impact in the case of Ms BB and Ms CC. If this review fails to acknowledge those it falls into the trap that was evident in practice. These issues need to be openly confronted and a balance found between the needs of the individual; the constraints on the organisations involved and the dominant ideologies. Without such honest discussion organisations and professionals struggle to work effectively together. An example was when the
discharge of Ms BB was imminent and circumstances threatened to delay the discharge. Tensions were high between health and social care professionals (illustrated in an entry in the chronology: social worker and ward sister August 6, 2015).

Clear assessment of need and risk and the clarity that flows from that in advocating for individuals are key in finding a right balance in the above context.

The tension between individual perspective/needs and organisational constraints/needs was evident at a number of points. For example, the clear protocol for the Integrated Quality Care Meeting in Adult Social Services which states:

“Islington is looking at how to avoid placing people in residential care directly from hospital setting etc....”

“Reasons why a residential placement is the only alternative and why there is no potential for the person to improve their ability to cope at home will need to be made very clear”

This needed to be set transparently alongside the assessment of the circumstances and risks surrounding Ms BB and Ms CC.

The need for the discharge coordinator to effect a hospital discharge must be set in the context of a clear discussion (including relatives) of the individual circumstances and risks.

The expectation that all care packages will be from providers with block contracts above a certain cost ceiling needs to be set against any additional and particular risk that this might introduce in individual circumstances.

The range of priorities and agendas from different perspectives within and across organisations needs to be transparent and openly discussed in order to assess what should be the dominant consideration at any one time/in any one situation. This kind of open discussion needs to extend to staff supervision. The example of the social worker (SW1) (following discussion with a manager who was himself expected to ‘avoid placement in residential care from hospital) changing course in her hitherto strongly held conviction that a care home for both women would be the desired outcome serves to illustrate the point.

Perhaps the Integrated Network Coordination (INC) framework can support a more balanced and transparent approach.

4.7 Safeguarding Adults from abuse and neglect

With reference to the range of chronologies and Individual Management Reviews the circumstances that were alerted to London Borough of Islington as safeguarding concerns were as follows. There were six instances:
Table 4

Safeguarding alerts/referrals

1  **26 August 2014** when the district nurses had not gained access for 3 days and were concerned regarding neglect of Ms BB’s needs.

2  **21 June 2015**: an alert because carer failed to attend as in the package of care “a carer failed to attend as arranged and was suspended. Social worker SW1 raised a safeguarding concern especially in view of earlier concerns reported by the family”.

3  **26 August 2015** an alert was raised by the tissue viability nurse in the community (Whittington Health) regarding a hospital acquired pressure ulcer

4  **26 August 2015** District nurses alerted circumstances where Ms CC’s behaviour was described as aggressive and there was concern for Ms BB’s welfare and about risk in respect of medication needs, as Ms CC was denying access to District Nurses”

5  **29 Aug 2015**: a referral following a wound on Ms BB’s leg following transfer by ambulance to hospital. The district nurse raised this alert. This turned out to be an accidental injury caused by a strap on equipment in the ambulance.

6  **18 September 2015**: a referral following an incident attended by Police and Ambulance Service where Ms CC’s hand was trapped in the door to the flat and the condition of Ms BB was a matter for concern (given 24 hour care had been provided).

The review requested all meeting minutes for safeguarding concerns. One set of minutes was provided. This was in respect of a strategy meeting on 16 October 2015. The purpose of the meeting stated in the minutes was that the meeting was convened as a result of referrals from the London Ambulance Service and Police expressing concerns about the condition in which they found Ms BB when both Ms BB and Ms CC when both were admitted to University College London Hospital on 18 September. The safeguarding meeting was in respect of Ms BB only. Ms CC had also sustained an injury. The meeting goes on however to discuss the hospital acquired pressure ulcer in some detail. It deals with issues 3 and 6 in table 4.

The minutes of the meeting are a verbatim report of the discussion and are confused as to whether just Ms BB or Ms BB and Ms CC are the focus of the meeting. They are a general pouring out of information with no real focus and no structure. They relate information across the whole of the care episode.

There is a lack of any clear plan or conclusion in respect of risks. It is not clear, even 9 months on, whether anything has been done to progress the inconsistent understanding of when pressure ulcers must be referred as safeguarding issues.

The minutes include a statement that a Safeguarding Adult Review was to be convened “to prevent what went wrong from happening again.” The section at the end of the meeting proforma is not completed regarding whether an investigation would be conducted; action plan with named people to take actions; a protection
plan and next steps, communications. The chronology of details earlier in the proforma simply refers to the root cause analysis regarding the hospital acquired pressure ulcer.

There are no other minutes provided in respect of any other alerts/referrals and it is assumed therefore that all other ‘meetings’ must have taken the form of strategy discussions and are referred to in case notes in the chronology. This has not been effective as there was no structure to ensure that the issues were clearly identified, reviewed and timely action taken. Indeed the safeguarding alerts are not easy to find amidst all of the records and it is easy to see how they might slip off the agenda. This is illustrated by the fact that the Adult Social Services Individual Management Review highlighted only three out of the six safeguarding alerts: “Safeguarding alerts: 22 June 2015 re neglect/acts of omission; 22 June 2015 tissue viability nurse pressure ulcer...fact discharged from hospital with this; 31 August 2015 District Nurse visited day after Ms BB had gone to hospital re catheter issues and there had been an injury to her leg caused by a strap on the equipment in the ambulance”.

Without analysing each of the alerts in detail, the most pertinent learning is that:

- the focus of concerns needs to be clearly identified
- an action plan must be set out to address the concerns
- a review of the extent to which the actions have taken place and have addressed the concerns must take place.
- recording needs to reflect this clear structure
- a clearer format for minutes that drives the above is called for

In terms of outcomes of safeguarding alerts or referrals; issues 1 and 4 in table 4 remained unresolved. These were ongoing issues which challenged professionals throughout and which the combined action of a range of agencies was unsuccessful in adequately addressing. Some of the issues responsible for this have been set out above. Issue 5 was accounted for and recorded. This was accidental injury. Issue 3 in respect of the hospital acquired pressure ulcer remains the subject of discussion and will form part of the action plan following this review. Issue 6 is the subject of this review and the actions from the Safeguarding Adult Review will seek to address what went wrong. Issue 2 is not concluded. It raises the issue of how far contract monitoring staff need to engage with safeguarding.

The issue of the circumstances in which pressure ulcers must be referred in to safeguarding and the anomalies across local authority areas and organisations has been discussed earlier on in the analysis (see 4.4.3). This needs to be resolved as set out in recommendation 6.8. The Adult Social Services Individual Management Review outlines the issue as follows identifying the need for standardisation of what grade of pressure ulcer triggers a safeguarding investigation: “the safeguarding procedure is different to London Borough of Islington [at Mile End Hospital] in that a safeguarding alert would be raised if the service user went into hospital with a grade 3 pressure ulcer rather than if developed whilst in hospital. This ambiguity should have been escalated to both the London Borough of Islington safeguarding team and senior management.”
In two instances (1 and 4 in table 4) these safeguarding referrals might arguably have been dealt with through a robust multiagency assessment and review of risk in a complex situation. The safeguarding process, whilst technically appropriate (because of risk of neglect) added nothing as it did not address the identified failings elsewhere in terms of the need for robust identification of need and risk; review; decision making; accountability for taking necessary action.

It seems that safeguarding was seen as possible route in to multiagency discussion and accountability in respect of the range of risks that resulted from refusal of care. As discussed elsewhere in this report such multiagency assessment and management of risk must be addressed in other ways and become more a general part of practice, rather than a safeguarding referral being perceived as the only route in to a multiagency response. In fact safeguarding did not fulfil that expectation.

### 4.8 The role of commissioning and contract monitoring

There are issues represented above that it is worth highlighting briefly in respect of commissioning of independent domiciliary care providers. It is important that commissioning and contract monitoring are seen as significant partners in ensuring effective care.

In the case of Ms BB and Ms CC the following were significant:

There are two recurrent issues in this case. One is the quality of care plans received by providers from Adult Social Services social workers. This is mentioned in minutes of a contract monitoring meeting with Allied Healthcare on April 2016. Aquaflo, at the Safeguarding Adult Review Panel meeting referred to delays of months in receiving care plans. The other issue is late arrival of care workers with service users. This is mentioned in the minutes of the May 2015 meeting. This case review highlights the need to follow up on these issues.

The question of the block contracting in Islington with three providers is not without impact in individual circumstances. The meeting in which the Safeguarding Adult Review Panel met with organisations involved with Ms BB and Ms CC discussed the impact this has on the willingness of providers to challenge the council in individual circumstances. Arguably part of the reason for Allied Healthcare following the advice of Adult Social Services to continue to deliver the care package despite the challenges and risks (when Allied Healthcare had said they wanted to hand back the care package) was in order to maintain a healthy relationship with the local authority. This, alongside the fact that they added “Ms CC’s behaviour settled for some time”

A further impact related to the block contract issue was that there is a cost ceiling imposed on spot purchase arrangements. This meant that when the 24 hour per day care package was purchased it had to be purchased from one of the three block contract providers. This necessitated a change in provider and carers. This was far from ideal in circumstances where Ms CC accepting carers was critical to the success of the care package.
This indicates the important role of commissioning and contracts as part of the team around the person and direct communication needs to take place where issues such as these arise and require joint resolution. There needs to be clarity in the Relationship between commissioner/provider/care management.

4.9 The areas of similarity with the Serious Case Review in respect of Mr AA, Islington Safeguarding Adults Board, 2015

There are some common themes across the two Safeguarding Adult Reviews as follows:

- **Social work involvement in hospital discharge** (albeit it in respect of a different hospital and different issues)
- **Care planning** following hospital discharge and taking account of the range of information/assessments
- **The Mental Capacity Act.** The Serious Case Review in respect of Mr AA states that this “has been a problem in its application and understanding in a number of areas of this review. If not already on the agenda the Safeguarding Adults Board should think about how it contributes to increasing the awareness, understanding and implementation of the Act across a range of settings.
- **End of life care** and reference to the need for robust care planning: assessing needs and preferences, agreeing a care plan to reflect these and reviewing these regularly; coordination of care; person centred approaches engaging with the individual to discuss preferences for end of life care.
- **Pressure ulcer care** and the links with safeguarding
- **Recording practice**
- **Involvement of families and next of kin** in drawing up care plans; more personalised care.

Whilst the emphasis and detail in learning on these issues is different across the two reviews, the fact that the issues occur in both reviews is further indication of the areas of focus required of relevant organisations and the Safeguarding Adults Board.

5 Conclusions

At the centre of this review is a focus on best practice in working with need and risk in complex situations and on ensuring that engagement with service users and their families is central to practice. University College London Hospital modelled good practice in respect of bringing a clear understanding of the importance of the relationship between Ms CC and Ms BB into end of life care planning. The GP sought to empower Ms BB and Ms CC by encouraging planning for their future as their independence was gradually eroded, in part by the onset of dementia. However the insight into their wishes gained from this needed to be communicated more widely and acted upon by a range of professionals. These insights needed to be integrated into contingency planning and a clear personalised pathway of care for Ms BB and Ms CC in discussion with them and with their families.
There was a lack of rigour in carrying out and recording assessments, identifying key needs and risks and reviewing and monitoring these. Care plans reflected a similar lack of detail and accuracy. These were not provided in a timely way. The approach to progressing safeguarding referrals revealed similar issues relating to lack of clarity and structure in assessment, action planning and review around concerns.

There was an absence of holistic risk assessment in the case of Ms BB and Ms CC. This complex situation required clarity about the nature of the risks, constant review in keeping this assessment up to date, communication across all of the involved professionals and a willingness to act and to share accountability for managing the risks. Local guidance on working with risk needs to be updated and accompanied by development opportunities across agencies. The review indicated a particular need for a focus on balancing choice and safety in situations where individuals decline support or treatment.

There is a clear need for practice development in the context of the requirements of the Mental Capacity Act 2005. This was particularly significant in a situation where problematic choices were made by Ms BB and Ms CC which potentially put them at risk. They needed to be supported to understand the risks as far as possible. Professionals needed to be clear about the decisions on which they lacked capacity in order to judge where assertive action in their best interests was indicated. Examples where capacity assessments were carried out indicated a tendency to apply the Act in order to facilitate necessary resource-led activity (such as hospital discharge) rather than to empower Ms BB and Ms CC.

There were specific aspects of the care and treatment of Ms BB and Ms CC which were problematic. Practice in the above areas on occasions compounded a lack of attention to procedures and available guidance. There are, in particular, significant implications in respect of the need to develop practice in pressure ulcer prevention and care across organisations. This learning arises from both the care and treatment of Ms BB in hospital and in the community. It ranges from attention to prevention; the links to safeguarding; communication on hospital discharge; communication with family members; review of the Continuing Healthcare assessment. There is a need too for training and awareness in the domiciliary care sector.

The focus on practice in respect of pressure ulcers connects with issues that arose in the review in relation to nutrition, hydration, and catheter care/continence. Nutrition is a critical factor in pressure ulcer care. It was not emphasised in notifications/referrals to professionals on discharge of Ms BB from hospital. There was an apparent lack of monitoring/review of weight despite the care plan stating that Ms BB was to be encouraged to eat and that her intake must be recorded. There was a delay in engaging a dietician and in asking the GP to prescribe dietary supplements. Ms BB’s weight reduced from 53.8kg on 19 August to 43.6kg on 19 September (on admission to hospital). This was a reduction in weight in the one month following discharge from hospital of around 10kg. There were failures too in implementing policy and procedures in respect of catheter care as well as confusion as to responsibilities in both catheter care and the provision of continence pads.
Ms BB’s deteriorating condition, particularly after acquiring a pressure ulcer, indicated a clear need to review the Continuing Healthcare assessment. This was intended but never carried out.

Attention has been drawn at a number of points in this review to the problematic discharges of Ms BB from hospital (in particular the discharge on 20 August 2015). All of the available guidance stresses that discharge planning begins before admission. Hospital discharge is built on a firm foundation of quality assessment, monitoring and review before and throughout an inpatient episode as well as on communication and joined up understanding of the person and their needs. It requires effective and meaningful communication with patients and their families. National guidelines repeatedly emphasise these core principles and aspects of practice in respect of hospital discharge. There is a real need for local multi-agency cooperation to improve joint working on hospital discharge. There is a specific need for learning from this review to be actioned by Barts Health NHS Trust.

All of the above rely upon effective communication. The review highlights some specific areas where communication must be enhanced. It highlights too some positive local initiatives which offer the potential for development. Communication is not simply about passing on information. It requires joint commitment and a shared understanding of responsibility and accountability to act. This communication needs to include honest and open discussion of competing agendas and pressures from individual to organisational level.

The six principles for Safeguarding Adults set out in the statutory guidance: empowerment; prevention; proportionality; protection; partnership and accountability are fundamental in underpinning the necessary development in response to this review. The balance between empowerment and protection was at the heart of this situation. Sound practice in balancing choice and safety relies on a proportionate response. A robust, person centred and positive approach to working with risk will support this. Prevention is a key issue particularly in respect of pressure ulcers and nutrition/hydration. The need for accountability was clear, particularly the associated “I” statement in the guidance which explains accountability as: “I know what everyone’s role is and so do they”. In complex situations where there are a wide range of organisations involved this clarity is crucial.

6 Recommendations

Those recommendations marked (*) are similar to recommendations in the case of ZZ, Camden (2015). It may be possible to work across Boroughs on some of these actions.

Individual agency recommendations are included below where they underline highly pertinent matters and the Safeguarding Adults Board needs to be particularly alert to them.
* 6.1 Engaging with people who use services and their families/carers

Islington SAB will continue to develop its engagement as a whole partnership in *Making Safeguarding Personal* ensuring that person-centred principles are embedded in all relevant policies, procedures and guidance, in front line practice and in commissioning of services.

It will identify several basic and practical tools (such as the supported decision tool, DH 2007\(^{13}\) to support front line staff across agencies to begin to make this shift in practice (from completing processes and ticking boxes to having meaningful conversations with people about what is important to them and the outcomes they want from health and social care support.)

There will be a focus on this aspect of practice in case file audits.

The Board will seek assurance that training and other support is in place to develop the necessary skills so that staff can make this shift in practice: specific training courses; reflective learning opportunities; staff supervision.

The Board will seek evidence of engagement with carers and informal networks including seeking evidence of carrying out of carers assessments.

* 6.2 Practice in the context of the Mental Capacity Act 2005 (MCA)

The areas of practice in the context of the Mental Capacity Act 2005 which are clearly indicated in the review as requiring attention are:

- understanding when and why an assessment of capacity is called for and how this must be carried out and recorded
- supporting people to make informed decisions and to understand the consequences of their decision making (including understanding the risks)
- assessing best interests and making decisions in a person’s best interests
- applying all of this in balancing choice and protection and making decisions as to where assertive action is required
- Do Not Attempt Resuscitation decisions
- application of Deprivation of Liberty Safeguards Alongside a continuing emphasis on engagement in training across all organisations there will be:
- a focus in case file audit on practice in respect of the core principles of the Act and the above aspects of practice.

\(^{13}\) Independence, choice and risk: a guide to best practice in supported decision making, DH 2007
• all organisations must put in place support for all levels of staff to help them to understand how the principles of the Mental Capacity Act 2005 must be worked out in practice. Real examples must be used to convey this learning and to support staff/professionals in understanding their responsibilities under the Mental Capacity Act 2005 Code of Practice. The Islington Safeguarding Adults Board will hold organisations to account in this respect.

• the case of Ms BB and Ms CC will be used in Mental Capacity Act training to demonstrate the necessary learning, along with other relevant case studies referred to in this review.

• the Board will ask of commissioners that they have assurance of integration of the requirements of the Mental Capacity Act 2005 in practice.

• the Board will respond to the recommendations of the House of Lords Scrutiny Committee on the Mental Capacity Act 2005.

• Barts Health NHS Trust and University College London Hospital will audit practice in respect of Deprivation of Liberty Safeguards and address any gaps in policy/practice.

*6.3 Working with risk

• Adult Social Services and Whittington Health will lead improvement in this area of practice with the re-development of the joint risk enablement policy. This will incorporate learning from this review as well as reference to practice development elsewhere from similar case reviews (for example Camden ZZ; Slough DD).

• The above will incorporate the development of tool(s) for recording risk assessment and risk management in line with the new policy/guidance.

• The existing risk enablement policy includes reference to working with people who are reluctant to engage with services/support/treatment. This must be redeveloped in the light of this review including reference to good practice in the context of the Mental Capacity Act 2005.

• The guidance must reflect the need for coordination and communication so prominent in this review.

• The Safeguarding Adults Board will develop an implementation plan to include staff training and the support and development of front line staff in working with risk.

• Specifically training in risk assessment and risk management will be reviewed in the light of this Safeguarding Adult Review across agencies.

The above will be a focus in case file audit.
6.4 Improving practice in respect of assessment, care planning and review.

Member agencies to the Safeguarding Adults Board (SAB) will specifically ensure that key assessments, reviews and any changes to agreed care plans are robustly recorded and communicated across all relevant agencies so that all are clear about the key issues and risks and all understand their roles and responsibilities.

- The SAB will disseminate the learning in respect of multidisciplinary assessment and on carrying out reviews as set out in this Safeguarding Adult Review (in particular in 4.4.2). This will include drawing attention to the need to bring in specialist assessments/expertise where indicated (for example Tissue Viability Nurse; continence adviser)

- Adult Social Services will review practice guidance and recording formats for assessment, care planning and review to reflect the lessons from this Safeguarding Adults Review. Guidance locally will reflect the lessons highlighted in this review and this will be:
  - supported through training and staff support/supervision, and
  - monitored through a focus on these aspects of practice and recording in future case file audits.

- Locally commissioning and procurement will support providers in reviewing this area of practice and recording and focus on the regulatory requirement in respect of coordination and communication between commissioners and providers on care plans and reviews.

- Individual organisations involved in this review will have a focus on recording in their individual action plans.

6.5 Achieving a shared understanding; shared decision making and action within and across organisations

All agencies must be sighted on key issues, keep track of developments, agree responsibilities and accountabilities and offer support to achieve positive outcomes.

- The Adult Social Services Integrated Quality Care Meeting (the Panel that made decisions about care options for Ms BB and Ms CC) protocol and practice will be reviewed in the light of learning from this review. Issues highlighted in section 4.6 of this report must be addressed. The Board will seek assurance that this has been actioned.

- An analysis will take place across organisations as to what went wrong in the context of multiagency communication. This will scope existing forums and protocols including the Integrated Care Network Service; Care Coordination Policy; Integrated Patient Units; GP practice weekly meetings; the Integrated Quality Care Meeting. Best practice will be developed to respond to the learning in this review.
Specifically this review will directly inform the development of the new Integrated Network Coordination Service (INC).

These forums and others where relevant will, as part of their protocol, make explicit reference to the requirement to deal transparently with the sometimes competing interests of the organisations and individuals. Clear assessment of need and risk and the clarity that flows from that in advocating for individuals are key in finding a right balance in this context. (This tension between individual perspective/needs and organisational constraints/needs was evident at a number of points. For example, the clear protocol for the Integrated Care Quality Meeting favouring avoidance of placing people in residential care directly from hospital settings; the competing demands surrounding hospital discharge; the policy for block contracts above a specified cost ceiling).

The role of the community matron will be clarified in the context of this review so that partner agencies are enabled to make appropriate referrals to the community matrons who can oversee service provision when there are multiple agencies involved.

The shared approach to working with and recording risk in 6.3 will support this.

Practice in respect of the Coordinate My Care record will be reviewed and reported back to the Board.

Roles and responsibilities in respect of Continuing Healthcare will be clarified across organisations. There will be a particular focus on this within Barts Health NHS Trust where there was a failure to review a Continuing Healthcare assessment when necessary.

6.6 Hospital discharge policy and practice

Islington Safeguarding Adults Board will in the light of this Safeguarding Adult Review, through the Quality Audit and Assurance (QAA) subgroup, influence the development of single and multiagency policy and practice on hospital discharge. In particular the issues listed in this report in respect of hospital discharge practice must be addressed with reference to resources and guidance which are current nationally and referenced in the Safeguarding Adult Review report.

Existing discharge policies will be audited by the QAA subgroup against the issues raised in this review. A multiagency audit of several cases will be carried out after one year.

Commissioners will monitor practice in this respect against core expectations.

Specifically Barts Health NHS Trust will update its discharge policy in line with current national guidance and the Board will seek evidence that this has been achieved. The Board will link with other relevant Safeguarding Adults Boards in highlighting this need (Tower Hamlets; Waltham Forest).
6.7 Practice in respect of safeguarding adults

Practice and guidance must address the issues set out in section 4.7 of this review. This will be addressed by Adult Social Services and assurance offered to the Board.

The issue of the circumstances in which pressure ulcers must be referred in to safeguarding and the anomalies across local authority areas will be resolved. This action must engage all four Boroughs (Islington; Waltham Forest; Tower Hamlets; Newham). This will be raised with Barts Health NHS Trust, evidencing from this review the benefits of external scrutiny for future learning and practice improvement.

6.8 Practice in relation to Pressure Ulcers

The Independent Chair of the Islington Safeguarding Adults Board will initially approach the 3 Safeguarding Adults Boards in Newham; Tower Hamlets and Waltham Forest (Boroughs having the most dealings with Barts Health NHS Trust), highlighting the findings of this Safeguarding Adult Review in this respect. A joint review (and associated actions) of issues that are highlighted in respect of the Barts Health NHS Trust approach to pressure ulcers and the links to Safeguarding Adults will be suggested. Links will be made more broadly as appropriate in the context of pan London procedures.

Barts Health NHS Trust will analyse the reasons for an increasing trend in hospital acquired pressure ulcers grade 3 and 4 over the past 12 months (5 in 12 month period). This analysis will be presented to the above Boards alongside comparative figures from neighbouring Health Trusts. The Trust will present evidence of impact of revised policy and practice.

The Board will coordinate awareness raising across organisations and for the public on prevention and management of pressure ulcers. National publicity material is available.

This to include awareness raising across domiciliary care providers through Adult Social Services procurement and with the support of relevant Health professionals. This to include:

- the need to identify early signs and symptoms
- how/when to escalate concerns
- who needs to be involved where there is a risk identified?
- links between pressure ulcers and nutrition/continence/immobility

This to be supported by commissioning and to form a key focus in contract monitoring.
6.9 Risk in relation to nutrition

The Board will seek assurance that those at risk of malnutrition are identified and work is undertaken to mitigate the risks. There must be a particular focus on those with dementia and on communicating risk and identifying accountability across organisations (including on discharge from hospital).

The Board will seek information from Dorset County Council, who have implemented a highly successful strategy and programme to identify and address malnutrition and dehydration in adults following a Serious Case Review in 2012 (JT), with a view to scoping the potential for a local pilot.

6.10 Management; Islington Adult Social Care

Islington Adult Social Services management will identify the scale of issues in relation to the quality of care plans provided by Adult Social Services care management to care providers. Findings will indicate necessary actions within care management.

Islington Adult Social Services management will take steps to address the implications of the block contract raised in this review. In particular steps will be taken to offer flexibility in high risk situations where a sudden change of provider is indicated due to the cost ceiling on spot purchase.

6.11 Engagement in the Safeguarding Adult Review process

There has been a range of levels of engagement and transparency in this Safeguarding Adult Review process. Examples are set out of good practice (particularly in respect of Whittington Health NHS Trust) but also of a reticence either to learn lessons or to offer transparency in other organisations. This is evidenced by the extent to which additional information had to be sought and analysed as it was not included in Individual Management Reviews and the scant action plans set out by some organisations. The Chair of the Board will meet with relevant chief executives to consider and address the reasons for this and to enhance engagement in future Safeguarding Adult Reviews.

6.12 Single agency action plans

Progress on the range of action plans which have been set out by individual organisations (in addition to the above recommendations) will be monitored by the Islington Safeguarding Adults Board Safeguarding adults Review subgroup.