Islington Safeguarding Adults Board

Serious Case Review in respect of a male adult

AA

Died June 2013

Overview Report

This Overview report is based on information taken from individual reports (IMRs) completed by each of the organisations involved. There is a presumption that when an organisation completed an IMR, all relevant people were consulted with. The views expressed in the report are those of the report’s author as well as the Serious Case Review Panel. Names have been anonymised throughout this report.
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1 **Background**

1.1 Mr AA died early in the morning of 13.06.13 at Highgate Nursing Home (HNH) where he had lived for just over 2 weeks. Prior to this he had lived at Lennox House Residential Care Home (LH) since July 2008.

1.2 From early in January 2013 Mr AA had 3 admissions of varying lengths to Whittington Hospital until his discharge to HNH on 25.05.13. During this time he had acquired a grade 3/4 sacral pressure ulcer.

1.3 Immediately prior to the second admission a district nurse raised concerns about his care at Lennox House, which was treated as a safeguarding alert. At the point of admission (25.2.13) a registrar in the hospital's Emergency Department (ED) also raised a safeguarding alert because of the nature of Mr AA's condition on admission including a grade 3/4 pressure ulcer. These were treated as the same concerns.

1.4 Immediately after his death serious concerns were raised by Mr AA’s close friend/Next of Kin (NoK) concerning the care afforded to Mr AA at the end stage of his life. London Borough of Islington (LBI) treated this as a second safeguarding alert.

2 **Purpose, terms of reference and methodology**

2.1 A formal decision to conduct a Serious Case Review (SCR) was taken on 17.10.2013 by the Serious Case Review sub-group in accordance with the inter-agency safeguarding procedures on the following grounds:

- an adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death;
- the case gives rise to concerns about the way in which local professionals and/or services work together to safeguard adults at risk;

2.2 The local inter-agency procedures states that the purpose of an SCR is to:

- Learn from the way local agencies, staff and volunteers worked together to safeguard adults at risk (both what did and did not work well):
• Agree how this learning will be acted on and what is expected to change as a result;
• Identify any issues for multi or single agency policies and procedures;
• Publish a summary report, which is available to the public.

The desired outcome of a SCR is that:
• Through improved inter-agency working, adults at risk are better safeguarded from significant harm.

2.3 The terms of reference for this SCR are:

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

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

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

2.4 Panel Membership:
David Hutcheson/ Paul Cheadle, Metropolitan Police (Panel Chairs)
Martin Machray, Islington Clinical Commissioning Group
Jo Holloway, London Borough of Islington
Elaine Oxley, London Borough of Islington
Emma Whitby, Healthwatch Islington
Colin Plant, Camden & Islington NHS Foundation Trust
Jane Ashman, Independent Overview Author

2.5 Methodology

- Individual Management Reviews (IMR) were commissioned from:
  Archway Medical Centre
  Highgate Nursing Home (Bupa)
  Lennox House Care Home (Care UK)
  London Borough of Islington (Housing & Adult Social Services)
  London Ambulance Service
  Northern Medical Centre
  Whittington Health NHS Trust:
    District Nursing Service
    Tissue Viability Service
    Continuing Healthcare Team
    Inpatient Services

- Highgate Nursing Home supplied 2 separate parts to their review, which appear to have been completed at different times by different people and where referred to are marked HNHv1 and HNHv2.
Key reports from 2 safeguarding investigation processes, these included a detailed nursing report undertaken by the Lead Nurse for Quality & Assurance Care Homes, a joint appointment between the Clinical Commissioning Group (CCG) and LBI, into the nursing care delivered during Mr AA’s stay at HNH. This report is referred to as SGNR (safeguarding nurse report).

All of the agencies were asked to produce a chronology of their involvement with Mr AA and where provided, these were collated to form an over-arching chronology.

An independent overview report writer was commissioned to work with the SCR panel to prepare a report informed by their work. The independent person provided external objectivity to the process.

The author has had access to independent clinical advice when needed.

The IMR authors presented their reports at a meeting with the SCR panel on 13.08.14 followed by questions and discussion. Additional information was requested from some of the organisations to inform the analysis and overview report.

A meeting was held between the overview author and the NoK of Mr AA on 26.09.14.

Where issues were identified these were subject to further analysis with reference to relevant existing policies and literature.

Further meetings of the SCR panel took place on 06.10.14 & 04.12.14 to consider the draft report.

3 Background of Mr AA

Mr AA was born in Hampshire in 1929 and joined the Armed Forces aged 16. He was initially in the army then transferred to the RAF specialising in film technology and radar. He left the RAF after 22 years with an exemplary service record and took up lodgings with a family in Islington, London. He remained with the same family for the next 40 years and was well known in his local community, helping out at the local church and doing odd jobs. He was an avid reader of newspapers usually taking 4 or 5 a day. He had been estranged from his birth family for several decades but was supported by Mr & Mrs O. Mr O is the son of the family he lodged with for 40 years and whom Mr AA nominated as his NoK and named to help with his affairs when needed. Eventually his health deteriorated and he was admitted to LH in July 2008. LH provides both residential care and registered nursing home care in separate units. Mr AA lived within a residential care unit in the home.
4 Narrative chronology of key events
(As described in the IMRs and chronologies)

4.1 This review has been commissioned to consider events from the start of January 2013 and the first relevant record is that on 22.01.13 LH staff noticed blood in Mr AA’s urine when visiting his room at breakfast time. He was taken to hospital by ambulance and following assessment in the ED was admitted initially to an assessment unit but later transferred to the Intensive Therapy Unit (ITU) with urinary sepsis where he was treated with intravenous antibiotics. LH staff kept in touch with the hospital during the day including a visit later in the afternoon. The Care Home record shows that they were asked for NoK details during this visit. LBI, the funding authority was informed of the admission the following day.

4.2 Mr AA was transferred to a ward specialising in care of older people on 25.01.13 and the notes state that amongst other things there was a “pressure ulcer care plan” for him on the ward. On 28.01.13 he had a surgical procedure to reinsert his catheter. Various observations in the hospital records note his cognitive impairment. A “consent form 4” (for adults unable to consent to treatment) was partially completed, but the areas covering how the judgment was made, best interests decision and any contact/discussion with family were insufficiently completed.

4.3 On 31.01.13 a tissue viability nurse (TVN) saw Mr AA and noted that he “…had been admitted from Lenox House with a grade 3 pressure ulcer. Treatment plan suggested”. The inpatient IMR is clear that during this admission Mr AA developed a grade 4 sacral pressure ulcer, probably as a consequence of his time and treatment in the ITU, though a subsequent (April13) root cause analysis was unable to pinpoint exactly when it occurred. It is known that Mr AA had had a sacral pressure ulcer in 2009, which had healed, but may have left some skin vulnerability.

4.4 On 01.02.13 the ward made a referral to the District Nursing Service (DNS) for pressure relieving equipment. An LH note on 01.02.13 states that Mr AA was to be discharged the following day, however Mr AA was discharged back to LH on 01.02.13 at 18.40pm. No pressure relieving equipment had been delivered. The discharge letter to the GP that accompanied this discharge did not mention the pressure ulcer. The

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1 A form used by Whittington Health-the Hospital to help safeguard people who lack capacity by documenting key issues such as treatment needs, mental capacity etc.
IMR states that the discharge planning record was not adequate enough to assess the decision making process behind it.

4.5 At LH Mr AA was noted to be coughing, refused meals and needed help to transfer. At 05.30 the following morning blood was observed in his catheter bag and at 08.50 an ambulance was called as his temperature and pulse rate were very high. The London Ambulance Service (LAS) record noted dried blood around Mr AA’s groin area. A member of staff from LH accompanied him. He was re-admitted with a preliminary diagnosis of sepsis and placed back in the same ward he had been discharged from the previous day. It was noted that the patient had no NoK and that an independent mental capacity advocate (IMCA) was required. There does not appear to have been a mental capacity assessment to inform the need for an IMCA. An IMCA attended on 04.02.13 and contacted LH as part of her assessment; apparently in support of a possible do not attempt resuscitation (DNAR) decision. She enquired about decision-making ability and mental capacity also of any known NoK and was given Mr O’s contact details.

4.6 Mr AA was discharged back to LH on 11.02.13 arriving back at 16.00hrs. The ward made no referral for any pressure relieving equipment or for district nursing. The home noted the following difficulties: a grade 3 pressure ulcer was still present, the dressing for the ulcer was found in the incontinence pad and was noted to have been very small for the size of the wound. He was wearing 2 incontinence pads, which exacerbated the wound, and there was evidence of a lack of personal care in Mr AA’s groin area. A cannula on Mr AA’s right arm had not been removed. LH raised a “discharge alert report”, a form introduced by Whittington Health – the Hospital to raise concerns around hospital discharges. The DNS IMR states that they are unsure if a discharge alert was raised, as there was no clear collation process for them at that time. The home also made a referral to the DNS on 12.02.13 regarding the need for pressure relieving equipment. LH’s IMR states that a referral was also made to the Community Tissue Viability Service (CTVS) though the corresponding CTVS IMR does not mention this referral. The discharge summary provided by Whittington Health – the Hospital to the GP practice did not mention the continued grade 3 pressure ulcer.

4.7 A GP from the Archway Medical Centre (AMC) which provides a GP service to LH, visited on the 15.02.13 and a DNAR form was signed and left with the home. There is no corresponding record of this assessment and decision in the GP notes or IMR. The NoK were not consulted.
4.8 The DNS visited Mr AA following the referral of 12.02.13, on 16.02.13. He was noted to be lying on his back which was detrimental to the sacral pressure ulcer, the care workers stated that they were aware of the need to lie him on his side but that Mr AA would reposition himself on his back. He was also noted to have faecal incontinence. The care workers were shown how to position Mr AA and daily visits by the DNS were planned. The same evening, a referral was made by the DNS manager for a CTV Nurse to visit (16.02.13).

4.9 The following day 17.02.13, a district nurse made a detailed assessment of the pressure ulcer using the Waterlow Pressure Ulcer Risk Assessment and a care plan was established detailing requirements for the LH care staff and the DNS. On 18.02.13 the visiting district nurse agreed to chase up the CTV referral and order a pressure relieving mattress.

4.10 A joint visit between a district nurse and a tissue viability nurse took place on 19.02.13 and the notes state a pressure relieving mattress and cushion were in place. The LH IMR states this was sourced from a “sister” Care UK service on 12.02.13. There is no evidence in the IMRs or chronology of the NHS equipment said to have been ordered, being delivered. The CTV nurse also put a care plan in place for the home and the DNS to follow. On the same day a GP also saw Mr AA to review a chest infection, which was noted as having cleared, 2 blisters on the knee were observed to have burst but their origins were not known.

4.11 Daily DNS visits took place on 20th and 21st February, Mr AA was again found on his back though the care home staff were noted to have been completing the “turning charts”.

4.12 On 22.02.13 (Friday) Mr AA was found on the floor in his bedroom, he told staff he had been trying to go to the toilet and lost his balance. When the district nurse visited that day he was sitting in a chair, not all of the pressure ulcer dressing was in place and significant faeces were present. The records (DNS & LH) state that he had acquired 3 new grade 3 pressure ulcers on his back left thigh, as a consequence of the fall. The District Nurse discussed the possibility of moving AA to another wing of LH that was registered for and provided nursing care. The IMR states that the deputy manager was not able to make such a decision until the manager came on duty the following Monday. The District Nurse therefore made a referral to LBI expressing concerns
about Mr AA’s care and requesting an urgent move to the nursing wing. She also requested a further visit from the CTV nurse.

4.13 The referral was received and reviewed by LBI’s “access” team on the same day. Some initial information was gathered by the receiving worker and passed to the Team Manager who marked the referral for allocation due to Mr AA’s changing needs. She also contacted the home on the same evening to enquire how Mr AA was and was told “fine” by the care staff.

4.14 The DNS visit on 23.02.13 noted the dressing had been removed and the wound actively bleeding. The visit on 25.02.13 was by the same nurse who had visited on the 22nd and she found Mr AA again with no dressing, a wet incontinence pad and signs of infection. The pressure areas acquired from the fall had not improved and the turning charts had not been completed over the weekend. She considered his deterioration such that urgent admission to hospital was required and called the ambulance service at 12:47. The LAS notes state that the district nurse was concerned that pressure ulcer dressings were being removed and not redressed and that she had complained to Social Services to that effect.

4.15 Mr AA was taken to the ED at Whittington Hospital shortly after 1 pm where his condition was noted, photographs of the wounds taken and a safeguarding alert raised by the ED Doctor because of possible neglect. He was subsequently admitted, eventually moving onto Meyrick ward on 28.02.13

4.16 The AMC IMR states that Mr AA was “seen by a practice clinician on two occasions.” The first on 19.02.13 by Dr Y for a respiratory tract infection when he was also found to have 2 blisters on his knees. The second was by Dr Z and was the same day as the above admission (4.14). The IMR states:

“25th February 2013 – seen by Dr Z after he was found on the floor trying to get to the toilet in the night. He was noted to be well and mobilizing slowly and no injuries were found. Neither Mr AA nor the care staff of LH had concerns around the fall and no further action was taken.”

The contemporaneous clinical record states

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2 As the funding authority, it is ultimately the Local Authority’s responsibility to agree the need for nursing home care as it is more expensive than residential care.
“Problem: Patient has had a fall (first)
History: “fell 1 week ago when trying to get to toilet in night – was found on floor no injuries noted and been well since – mobilises very slowly around unit but can not sit for long as needs to have soft mattress for bed sores dressed daily by DN
Comment: no concerns from pt/staff around fall.

As part of the SCR process the overview author sought clarification as to whether the patient was actually seen on this occasion, bearing in mind he was admitted to hospital as an emergency the same morning, the following information was received:

“I was asked to clarify the mode of Dr Z’s consultation with AA on 25 Feb 2013.

Dr Z’s recollection is that she discussed AA’s fall with the home’s clinical lead at a ward round on that day but did not see AA himself.”

4.17 A strategy meeting was held on 04.03.13 in accordance with the multi-agency safeguarding adults policy and procedures following up the safeguarding alerts raised in the District Nurse’s referral of 22.02.13 and hospital registrar’s alert of 25.02.13. The available information was considered and the following actions agreed:

“LH to write a report accounting for the missing documentation from the district nurses and for staff not following the care plan provided by the district nurses to manage the pressure sores, including issues with continence and missing dressings.

District nurses to investigate the delay in their service seeing AA between the care home referring him on 12/02/13 and their initial visit on 15/02/13, and to put this in writing.

Whittington Hospital to provide a report looking at the discharge planning from Claudesley ward on both 01/02/13 and 11/02/13 for AA and how this might have contributed to the situation, including no district nurse referral or referral for pressure equipment. It should also include if any actions were taken following receipt of the discharge alert. XX will take this back to the relevant matron to follow up.
Mental Capacity Assessment to be completed”

4.18 Mr AA remained in hospital for the next 13 weeks receiving care according to the presenting needs. Surgery was carried out to debride the pressure ulcer on 16.03.13 and again on 19.03.13. Consent Forms 4 were used but not properly completed and no mental capacity assessments are noted. At this stage the notes were recording the pressure ulcer as a grade 4. A hospital dietician was also involved
during this period and “strict food charts” requested to monitor Mr AAs intake and weight monitoring.

4.19 On 18.03.13 the LBI notes state that the Multi-disciplinary team had agreed there was no rehabilitation potential and recommended a nursing home placement on discharge and the notes record this as having been agreed. A mental capacity assessment was started on 20.03.13 and completed on 26.03.13. Mr AA was deemed to lack capacity to understand a decision about a move to a nursing home and a best interest’s decision was made.

4.20 The possibility of a colostomy to assist with future management of the sacral pressure ulcer began to be considered on 20.03.13 as a means of reducing the re-infection of the pressure ulcer but was considered high risk. On 28.03.14 the possibility of the colostomy and associated risks were discussed with Mr & Mrs O who felt that surgery would be in his best interests.

4.21 An assessment for eligibility for Continuing Health Care (CHC) funding began on 28.03.13 and involved contact with the NoK. It was approved on 05.04.13. Also on 05.04.13 the case conference following the first safeguarding alert was held. The planned actions arising from the meeting were:
LH, District Nurses and Cloudesley ward to complete reports outlining their areas of learning from this investigation and actions needed to address this. Timescale 2 weeks.
Review meeting to see how actions have been implemented in 2 months time. Timescale 2 months.
Feedback to NoK, Mr O, by LBI Senior Practitioner.

4.22 On 09.04.13 a consent form was used but inadequately completed and no best interests decision documented. This was in preparation for surgery the following day. The notes also document a discussion with NoK that registered concerns expressed by them. According to the chronology it was about insufficient consultation re surgery. The IMR states concerns were raised about the quality of nursing care, Mr O having found Mr AA unshaven, in a soiled bed and with his medications by his bed. The notes also state that the comments had been made previously to a social worker on 15.03.13. The surgery due on 10.04.13 was cancelled due to the length of the list and did not take place until 16.04.13. Following the surgery, Mr AA was in ITU

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33 An entitlement to have all health & care needs funded by the NHS (wherever provided) due to the complexity and volatility of health problems.

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and the NoK informed that the prognosis was poor due to his frailty. A medical review of his care plan observed the DNAR and not for intubation notice.

4.23 Mr AA did make a limited recovery and was transferred back to Meyrick ward on 23.04.13 where planning for discharge was resumed. The TVN reviewed the pressure ulcer on 29.04.13 and it was judged as much improved with no clinical signs of infection. The CHC team began looking at suitable nursing homes and HNH was invited to visit and assess Mr AA, which they did on 17.05.13, but he was not medically fit having another episode of sepsis. The NoK were contacted again and supported the DNAR status.

4.24 Once more Mr AA showed signs of improving and his sepsis was resolving by the 21.05.13 when he was assessed as medically fit for discharge. The need for a specialist piece of equipment (Vac Pump) to support the management of the pressure ulcer was identified on 24.05.13 and had to be ordered by the CHC team. Discharge was delayed as a consequence however the LBI records state he was discharged on 24.05.13, which is not accurate.

4.25 Mr AA was discharged to HNH on 28.05.13 arriving in the early afternoon. A letter was faxed by the Home to the AMC asking for any relevant past medical history and a current list of medications prescribed for Mr AA to be faxed to the nursing home. It also asked if they would continue to provide his GP care or if he was to transfer to the medical centre which provided cover to HNH. The electronic GP patient record indicates that a discharge summary was received 24.05.13 (when it was thought he would be discharged) and this contained some 5 pages of information from Whittington Hospital that detailed the medications he was on including thickened drinks and liquid food.

4.26 A summary printout of the information in Mr AA’s GP electronic clinical record was faxed to HNH on 28.05.13. On the same day, but chronologically after the summary printout was inserted to the running record, a discharge summary from the Speech & Language Therapy Team (SALT) team was entered. The following day 2 additional “discharge summaries” were attached to the patient record. The HNH request was attached to the record on 04.06.13 and the next entry states a fax was sent to HNH on 13.06.13 (the day Mr AA died). This was to state that HNH was outside their catchment area and Mr AA would need to be registered with their usual or local GP practice.
Subsequent to the receipt of IMRs further clarification was sought from Bupa about what information was available from the point of admission. They state that the home had received a faxed copy of the discharge letter, a copy of the dietician (SALT) discharge letter and a nursing transfer letter from the ward by the 28.05.13.

4.27 Along with his medication, Mr AA was discharged with 28 days worth of a range of nutritional aids and food substitutes:

- Calogen strawberry liquid 3x daily
- Ensure twocal liquid food 4x daily
- Forceval capsules 1 daily
- Resource Thicken Up Clear powder PRN
- Resource Thickened Drink apple/syrup Feed PRN
- Resource Thickened Drink orange/syrup Feed PRN

His main discharge letter stated he was receiving a pureed diet and nutritional supplements. His SALT discharge letter referred to a soft diet and emphasised the need for thickened/syrup consistency drinks. The HNH IMRv1 states that these were given as prescribed. It also refers to the admission assessment indicating the need for thickened fluids and a liquidised diet as Mr AA was at risk of aspiration or choking.

4.28 A CTV nurse visited on 30.05.13 as the “Vac Pump” had been delivered and it was put in place with instructions to change the dressing each Monday and Thursday. Mr AA’s position was to be changed 2 hourly on alternate sides and he was only to be on his back for medication. A note was made to ask for the GP to review Mr AA’s pain management as he was observed to be in pain when his dressings were changed. It had already been noted that he was uncooperative when turns were made and fighting off staff attempting personal care.

4.29 An entry on the HNH chronology on 30.05.13 states: “spoke to Dr [L] – unable to make decision for DNA–CPR” it is presumed this was a telephone discussion. There is nothing in any of the documentation provided to the SCR process to suggest why HNH initiated this discussion at this point. An entry the same day states “GP to review PRN” The following day Dr L from the Northern Medical Centre (NMC) which supports the residents at HNH, visited as part of the home’s regular “ward round”, examined Mr AA and ‘clerked him in’. There is no record in either the HNH or NMC chronologies of a review of his PRN medications, a mental capacity assessment (though he was noted to
have dementia) or a discussion about DNAR – CPR. The medical notes as described in the NMC IMR make no mention of his NoK.

4.30 The HNH chronology charts some of the day to day activities for the next 5/6 days and is relatively unremarkable except for instances of Mr AA not co-operating with some of his attention for personal care and is recorded to shout and hit out at such times. Although prescribed paracetamol 500mg PRN on admission, this was only given once on 29.05.13. Dr L according to HNH, prescribed co-codamol on 03.06.14 but this is not on the GP information provided. According to the SGNR none was recorded as having been given until 08.06.13.

4.31 HNHv1 states that “On 6th June Mr AA does appear to have changed from a soft diet to a pureed diet and there is nothing in the plan of care to indicate the reasoning for this.” The following day the home made a referral to the Speech and Language Therapy (SALT) team as he was unable to tolerate thin liquid and was coughing.

4.32 The Safeguarding records note that at this stage reports requested at the early April case conference had still not been received from the DNS and LH and the planned review meeting had been cancelled.

4.33 The HNH chronology records that Mr O visited on 10.06.13 and complained that Mr AA’s lips were cracked and he was drowsy and dehydrated, when he asked if a drip would be set up he was told that it "was not something the home did". A comment in the chronology says this information came from a subsequent letter of complaint from Mr O rather than contemporaneous home records.

4.34 The CTV nurse visited on 11.06.13 to review Mr AA’s pressure ulcer. She recorded “Unable to review patient today as staff on the floor said that they needed 3-4 members of staff to assist as patient could become agitated and was very difficult to move. Agreed that we would review another day”.

4.35 On 12.06.13 Mr AA was noted to have slept for most of the day and that his diet intake was poor. He was given oxygen through a nasal spec at approximately 13:30 and the record notes that Mr AA’s friend had been informed of his condition. The HNH records that a GP, Dr M, reviewed Mr AA during a routine “ward round” visit on the same day. The medical centre IMR states:
*Information:* “Past medical history noted. On examination patient was not responsive, increased effort of breathing, patient was not in distress.

*Outcome:* Due to multiple co-morbidities, decision was made to keep patient comfortable.”

Dr M wrote on the CTV nurse pressure ulcer care plan in the HNH notes:


4.36 Mr AA is known to have died by 05:00 on the morning of 13.06.13.

4.37 The HNH chronology continues with the information that follows, but this was extracted from the subsequent records relating to Mr O’s complaint and was not contemporaneously recorded. Mr O contacted HNH later in the evening of the 12.06.13 and was informed Mr AA was less drowsy and taking sips of water. When he contacted the Home the following morning at 07:10 and learned he had died he was very upset. Mr & Mrs O received a phone call from HNH 10 minutes later (apparently in error thinking it was a social worker’s number) to obtain details about when Mr AA’s “body” would be moved from the home. The nurse apparently went on to ask Mrs O whether she wished a drain to be removed from Mr AA. Mr O visited the home at 08:00 and when taken to Mr AA he was surprised to find his mouth and eyes open. He was left on his own as the nurse had to attend to another resident and he was not offered a cup of tea. Mr O also reported at interview with the SCR author that, despite the home having workmen on site outside Mr AA’s room the curtains on the window above Mr AA’s bed had not been closed.

4.38 Dr M visited the home at 18:00 on the evening of 13.06.13 and signed the death certificate, some 13 hours after Mr AA’s death. The undertakers subsequently collected Mr AA’s body and were unable to close the lid of the transfer unit due to the position of the body, which was not lying flat. The HNH IMRv.1 states that Mr AA had been laid out flat with a flower placed on his chest.

4.39 Mr & Mrs O made a formal complaint to and to the NMC on 19.06.13 about the standard of care received by Mr AA before and immediately after his death. Copies were also sent to LBI and it was subsequently decided to treat the concerns as safeguarding issues and begin a second investigation.
5 Analysis

Initial caveats:

5.1 IMRs and chronologies were received from all those requested but were of varying detail and quality. Where possible information has been clarified and/or more detail sought and responses to these requests have also varied. As such it cannot be assumed that all of the analysis, key learning points and recommendations will have complete and unanimous agreement of all IMR authors and/or the individuals who contributed to each IMR and/or the organisations. Additionally, because of the variability in detail, the actions of some organisations may have been taken from the chronologies of others, having not been included in their own.

The following paragraphs address each specific question contained in the terms of reference:

The circumstances around each episode of care. This is in relation to discharge planning and reasons for re-admission.

5.2 There are no disagreements that Mr AA’s first admission (within this review’s time frame) from LH on 22.01.13 was an appropriate admission to meet acute medical needs that included a period in ITU; following which he was transferred to a medical ward designated as specialising in care of older people. He was noted at some point after this transfer to have a pressure ulcer. It was appropriately assessed by a specialist tissue viability nurse, as a grade 3 and deemed that Mr AA had been admitted from LH with it. This is the first point of concern. If a frail older person is admitted from residential or nursing care with a grade 3 pressure ulcer, it suggests that home is not adequately caring for the individual and at a minimum, should cause enquiries to be made about its suitability as a place of discharge. This could have been done by either ensuring a social worker was involved in the discharge planning to see if the care provider could still meet his needs or by raising a safeguarding alert. It is not unreasonable to expect that a specialist TVN would, in particular, have knowledge of the risks of serious pressure ulcers in older people and the safeguarding policy specifically relating to them.4

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4 London Borough of Islington Appendix to the Pan London Safeguarding Adults Policy: “Appendix N: Pressure Ulcer Policy”.
5.3 Mr AA was discharged back to LH the following day without its suitability being questioned. A pressure relieving mattress was requested from the DNS by the ward but only on the day of discharge, which gave inadequate time for it to be delivered before Mr AA’s discharge. Additionally, the ward informed the Care Home on the 01.02.13 that he would be discharged the following day; he was then discharged in the evening of the same day without further notice. The IMR for the in-patient episodes is unable to give much detail about the discharge planning that took place, as it is ward based and a “white board” used for much of the process. A discharge planning policy was in place but it is not possible to analyse actions against the policy, as there is little permanent record to do this with. It is evident that ward staff thought LH was a nursing home (or perhaps didn’t understand the difference between nursing and residential homes?) and that there were 3 agency nurses on duty on the discharge day including the lead nurse. The discharge letter to the GP did not mention the pressure ulcer; it also described LH as “sheltered accommodation”. It is assumed this is a further example of lack of knowledge of the range of care settings for older people, as “sheltered accommodation” would offer less care than a residential home and if that was understood it would raise even more questions about the suitability of the discharge arrangements.

5.4 LH was, even in its own view, too passive in the discharge of Mr AA. On one level it is understandable that they didn’t really question his return as he had lived with them for more than 4 years and it was “his home”. On the other hand he had been seriously ill, the home was aware that he now had a pressure ulcer and the policy of Care UK is to assess or re-assess prior to admission from hospital, which was not followed. He was re-admitted to Whittington Hospital as an emergency the following morning with a severe cough, blood in his urine and he also had a very high temperature. He had sat in a chair all night (at his own request) and refused food. A member of staff accompanied him to the hospital, which was good practice. Although the IMR states that Mr AA had no pressure ulcers before he was admitted to hospital on 22.01.2013, LH staff did not raise a safeguarding alert about this in accordance with the local Safeguarding Adults Policy or check to see if its cause was already being addressed, which could justify a decision not to accept him back.

5.5 Mr AA was again discharged to LH from the same ward as his previous discharge on 11.02.13. Again ward staff assumed he would be receiving nursing care, consequently no referrals were made for
pressure relieving equipment or district nursing. Additionally Mr AA arrived at LH with a number of problems that reflected poor nursing care on discharge (see above 4.6). The discharge letter to the GP still did not mention the pressure ulcer and again described LH as “sheltered accommodation”. LH staff still did not take the opportunity to re-assess Mr AA before discharge to see if they could meet his needs, which had increased significantly.

5.6 LH did make a referral to the DNS requesting an airflow mattress and borrowed some pressure relieving equipment from a Care UK sister service in the meantime. They raised a discharge alert about the whole process in accordance with the local Whittington Hospital protocol. The purpose of an alert is “…to alert senior managers to problems around discharges from hospital”. The home never received contact or feedback about this alert and it is evident from the notes of the safeguarding case conferences and reports provided to them that there was no means to store and collate these alerts and therefore little evidence that in this case at least, anything was done with it. The opportunity to identify poor discharge processes and put in steps to improve was lost.

5.7 Mr AA was again admitted to Whittington Hospital 25.02.13 during a regular visit by a district nurse to dress the pressure ulcer. The nurse had been becoming concerned at the Care Home’s ability to manage the wound and meet Mr AAs healthcare needs. She observed the wound to have deteriorated and that it was becoming infected and there were other issues. She called an ambulance and he was taken to the ED, This was appropriate and decisive action. She had already raised serious concerns with LBI 3 days earlier. Following examination and subsequent admission the duty Doctor raised a safeguarding alert because of the presence and condition of the pressure ulcer and general neglect/soiled clothes. Again this was an appropriate response.

5.8 The final hospital discharge on 28.05.13 was to a different home registered for nursing care (HNH) funded through CHC. A social worker undertook a mental capacity assessment and best interest’s decision in relation to moving to a different home. This was correct, as was the involvement of the NoK in that decision. He was discharged with the required medications and nutritional and hydration supports. His discharge was also appropriately delayed for 4 days whilst a specialist piece of equipment needed to manage his pressure ulcer was obtained. A comprehensive discharge letter and supporting documents were sent to the original GP (at AMC) Mr AA was registered with. Following subsequent enquiries as part of writing this overview report,
HNH confirmed that a copy of the discharge letter, a nursing transfer letter and a discharge letter from the dietician were also faxed to HNH.

5.9

**Key Conclusions:**

*Discharge planning* from the same ward to LH was poor on both occasions, even though the ward specialised in care of older people and the clinical specialty was geriatric medicine. It is recognised that acute hospitals are under huge pressure to release beds for other very sick people. However on these 2 occasions at least, fast discharge appears to have taken precedence over safe discharge. On both occasions it resulted in much longer subsequent admissions (a total of 103 bed days) and is likely to have contributed to the significant deterioration in Mr AA’s overall condition. It is unlikely the hospital’s discharge policy was adhered to but the manner in which records are kept (or not) make it difficult to be certain. This raises a question about how the hospital audits the quality of its discharges particularly when aligned with the knowledge that the discharge alert protocol raised by LH does not appear to have been utilised for this purpose either.

The third discharge to HNH seems to have been much more thorough, with comprehensive information sent to HNH and discharge delayed from the planned date when the necessary equipment to manage the pressure ulcer safely, was not available.

The inability to collect and collate information from discharge alerts renders questions about their purpose and function. Potentially it could provide valuable qualitative and quantitative information to audit and improve the discharge process but that does not appear to have been done here.

*Safeguarding alerts* in relation to the serious pressure ulcer were not considered or raised until 25.02.13, Mr AA had been known to have a grade 3 pressure ulcer for at least 4 weeks and had been seen by numerous healthcare professionals in that time. If the origins of the wound had been investigated and understood and the patient (or others in the same care setting) deemed not to be at risk, safeguarding procedures would not need to be used. This was not the case during the 4 weeks in question. It is of particular concern that even the tissue viability specialists did not appear to consider safeguarding concerns that should have been triggered by Mr AA’s condition, prior to 25.02.13.
The care received by Mr AA during hospital admissions

5.10 There is nothing to suggest that there was anything wrong with the clinical care Mr AA received during his first admission at Whittington Hospital. However, at the time the nursing and medical staff did not know this. It was observed (after several days) that he had a grade 3 pressure ulcer, specialist advice was sought and a care plan put in place. No consideration appears to have been given as to how it had occurred or the implications of that knowledge. Subsequently (26.04.2013) a root cause analysis established the most likely cause to have been during his period in intensive care, where the treatment he received suggested it was unavoidable.

5.11 LH informed the hospital of the identity of Mr AA’s NoK on 22.01.13 but there seems to have been no contact with them or involvement in the treatment decisions or discharge process of this first admission.

5.12 The proper consideration of Mr AA’s significant cognitive impairment was an issue during this admission. There was little documented formal mental capacity assessment or best interest decisions to inform treatment, or involvement of NoK.

5.13 The second admission again contained incomplete mental capacity assessment information. However, when consideration for a DNAR notice was being given, the intervention of an IMCA was sought. At this stage the information about the involved NoK that had been given at the previous admission had not carried through, however the IMCA obtained their details via contact with LH and involved them.

5.14 The condition Mr AA was in when discharged back to LH, as described in the discharge alert report, must raise serious questions about the quality of nursing care received on the ward prior to discharge.

5.15 There were many positives about the treatment and care given during the third admission. Despite a decision not to resuscitate during his previous admission, active treatment and interventions were made to improve the condition of the pressure ulcer including surgical debridement and ultimately a colostomy. These were undertaken in consultation with the NoK and the risks were explained. The purpose was to reduce the rate of re-infection thus making safe management of the pressure ulcer more viable and Mr AA more comfortable. However, the concerns raised by Mr O in March about poor nursing care, initially to a social worker and in a telephone conversation in April with a junior doctor appear to have been unaddressed, despite being documented in the medical notes.
Key conclusions: use of the Mental Capacity Act was patchy, given Mr AA’s dementia this is a cause for concern though in the experience of the author, not unique to Whittington Hospital. Mr AA recovered from two very serious bouts of illness against expectations, which suggests that on balance he received good medical and nursing care. However, as described above the discharge alert raised questions about the standard of nursing care on the ward he was discharged from and the failure to follow up the alert was a missed opportunity to check this. Further concerns about basic nursing care were also raised during the third admission and is suggestive of a pattern of some sub-optimal practice in an acute hospital in the care of frail older people, particularly those with dementia, that has been observed in some hospitals throughout the country via regulatory inspections and other means. A subsequent Care Quality Commission inspection of Whittington Health-the Hospital in January 2014 and published March 2014 confirms that there were still concerns in relation to “care and welfare of people who use this service” after inspecting an older people’s ward and the ED.

The care Mr AA received at LH in the periods between discharge from hospital and readmission to hospital and how Mr AA’s increasing care needs were addressed.

5.16 When Mr AA was discharged on 01.02.13 he was accepted in, even though it was the evening, the day before they had been told he would be discharged and with no pressure relieving equipment, which had also been promised. A representative from LH at a safeguarding case conference on 05.04.13 stated that had she been on duty she would have not accepted AA from the hospital or would have called out the GP and District Nurse that evening. The staff on duty however, were placed in a very difficult position. LH had been Mr AA’s home for over 4 years and sending a frail elderly person backwards and forwards in an ambulance could be deemed more inhumane than receiving him back when poorly equipped to care for him. Additionally, it can be difficult for a non-clinically qualified care worker to challenge the medical decision of fit for discharge. The consequence was that Mr AA spent a difficult night sat in a chair as he refused to be put to bed, (possibly because of the discomfort?) and with a rapidly worsening cough and rising temperature. He was taken back to hospital by ambulance the following morning and readmitted through the ED.

5.17 When Mr AA was discharged on 11.02.13, LH had again failed to assess him before he returned to the home, which as already stated,
was against company policy (Care UK). This meant that although they were aware his needs had increased they did not really have any idea whether they could meet them. This passivity, together with poor discharge planning by the ward meant Mr AA was sent to a home not physically equipped (pressure relieving) or skilled (nursing) to care for him and with no referrals to provide these externally. As already described he did not return in a well cared for state and to some extent this set the tone for the next 2 weeks. To the credit of LH staff they sourced a couple of pieces of pressure relieving equipment though it will not necessarily have been the correct ones for Mr AA’s condition. They contacted the ward and the missing dressings were sent by taxi. They also thought they had made referrals to the CTV nurse and DNS for NHS pressure relieving equipment the following day. A subsequent case conference revealed the appropriate “protocols” had not been followed for such referrals and they therefore did not progress. “The TVN referral is processed through a central office and as residential units do not refer to TVN but to DN, it is likely an assumption was made by the central office that AA was in a nursing home and referral sent to wrong person.”5 Whilst it is desirable for organizations to have their processes understood by external people trying to use them, it is unreasonable to make assumptions based on a lack of that understanding. Consequently, from an already poor start, Mr AA was managed for 5 nights and days by care staff who had not received any guidance about how to care for his physical health needs. After being chased up by LH staff, daily district nursing visits commenced on 16.02.13 and a promise to follow up the request for specialist equipment made on 18.02.13. It is not clear from the IMRs of LH, the DN or CTV services whether this equipment ever arrived.

5.18 Through the following days the DNS IMR states that Mr AA was usually found on his back, despite requests for regular turning. It seems Mr AA could reposition himself from his side to his back and often did. He was by this stage incontinent of faeces and the DNS frequently had to clean him to change his dressings, suggestive of LH not managing Mr AA’s basic hygiene properly. Mr AA’s mobility had declined and he needed 2 staff to mobilize. The picture was developing of a service not able to cope but not necessarily recognizing that.

5.19 The following statement was made in the LH IMR “No formal assessment of mental capacity was undertaken within Lennox House, as Mr AA was considered to have the ability to make day to day

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decisions about his life and he had a nominated advocate Mr O to support with more complex decision making”. This suggests that the IMR author as well as the staff do not understand the Mental Capacity Act. An assessment at this point could have empowered staff to (sensitively) carry out physical interventions such as turning and personal hygiene even when it appeared to be against his wishes, if it was deemed in his best interests to assist with his physical welfare.

5.20 A critical point at which the inability to cope could/should have been recognized was when Mr AA was found on the floor following a fall. He is described by the home as having acquired 3 new grade 3 pressure ulcers as a consequence. This description was repeated in the DNS notes. It is not possible to “acquire” such harm unless the skin was already very close to breakdown and the impact exacerbates it. The overview author therefore requested a review of the available information about these “3 new pressure ulcers” by a specialist tissue viability nurse. It has now been confirmed that as these “pressure ulcers” do not appear on any records after Mr AA was re-admitted it is extremely unlikely that they were pressure ulcers, despite being continually referred to as such in the DNS notes. They were more likely to have been skin damage caused by the fall.

5.21 The regular DNS visit following the fall did recognize that LH was not coping and discussed transferring Mr AA to the nursing unit attached to the home. In the absence of the deputy manager the care staff on duty did not feel empowered to make such a decision. The nurse also contacted LBI's access team with her urgent concerns for his increasing need for continuous nursing care. Unfortunately, although the Team Manager contacted the home for more information on the day, she was readily re-assured by the home staff that they were managing and Mr AA was comfortable. The DN referral stated that he needed to be “urgently moved to the nursing floor where he would receive appropriate care provided by the nurses”. The referral also stated (erroneously) that Mr AA had acquired 3 new pressure ulcers. The LBI team manager did not consider the issues urgent enough for immediate action. As it was a Friday with only emergency duty team cover for LBI Social Services over the weekend, his nursing needs remained largely unmet by the Care Home, LBI and DNS until Monday. (The DNS did visit over the weekend to dress the wounds but would have been there for; say 1-2 hours out of 24). It is likely that this decision by the Access Team Manager would have been made by many of her peers in the same circumstances. Unless there was a suggestion of active and intentional harm, Mr AA would have been
5.22 The home continued not to recognize their limitations and on the Monday morning of the 25.02.13 a member of staff informed the GP during her weekly “ward round” visit that he had had a fall but that he was “fine” and appears not to have encouraged her to physically see and assess him. Within a couple of hours of this, the DN visited and considered Mr AA’s condition so poor and risky as to require a further admission to hospital. According to subsequent information from the GP practice, the GP met with a “clinical lead”. This would suggest the senior nurse on duty for the nursing care side of LH. If so, it is difficult to believe that the nurse had actually seen Mr AA that morning if his condition was such that another nurse deemed it necessary to send him to the ED. The alternative possibility is that the “clinical lead” was in fact an unqualified care worker, who as already observed, was unaware of the home’s deficiencies in meeting Mr AA’s needs.

5.23 **Key conclusions:** LH was not able to meet Mr AA’s increasing needs but at the time did not recognise that. They were not assisted in doing so by the condition he returned to the home in and the 5 day delay in getting DN services and pressure relieving equipment to him. It is likely his condition deteriorated unnecessarily in that time and he was probably in considerable discomfort. Unqualified care staff at LH would give re-assurance to professionals based on dubious evidence, which was readily accepted. The discussions between the GP and care home staff (whoever it was) were inadequate to help make an appropriate assessment of whether to personally examine Mr AA and must therefore raise the question as to whether decisions about other residents are based on full and accurate information. This also assumes that the contract with the GP practice (see below) tolerates a “ward round” being selective. Funding issues further diminished Mr AA’s situation. The care home staff couldn’t make a decision about transferring him to the nursing care wing without more senior intervention (which they either didn’t feel able or didn’t see the need to seek over the weekend). LBI didn’t feel able to make such a decision without a fuller assessment and didn’t see the indicators of neglect/abuse to cause it to be urgent, so again nothing was planned until after the weekend, by which time Mr AA had deemed “safe” within a 24 hour care setting. The potential for serious harm due to nursing needs not being adequately met during this weekend period would not necessarily be recognized and is a learning point for those responsible for assessing risk.
been re-admitted to hospital.
As with the hospital ward on discharge, assumptions about safety were mistakenly made because Mr AA was in a care setting and professionals were too ready to be re-assured by care workers at LH. This is an important learning point for all agencies as people are discharged from acute hospitals in increasingly frailer states and this is clear policy intent. The potential for risk and harm if they are not in the right “care” setting is greater and more immediate than currently assumed by most professionals.

The care Mr AA received while at Highgate Nursing Home

5.24 Mr AA moved into HNH on 28.05.13, the home had carried out a pre-admission assessment and had requested information from the GP he was registered with. There are inconsistencies about what information HNH received at the time, which could/should have helped inform the care plan and what the IMR author(s) had access to at the time of writing their reports. E.g. the HNH IMRv.1 & 2 report the knowledge that Mr AA had been seen whilst in hospital by the SALT team but neither state positively that they had a copy of the SALT discharge summary. IMRv1 says in its conclusions that the SALT guidelines were not available to staff and IMRv2 does have as an action on the action plan to develop “…a protocol for ensuring detailed information is received from the SALT team at the point of a resident’s admission…” which suggests not. The general 5-page discharge summary says Mr AA was on a pureed diet and nutritional supplements as advised by SALT.

5.25 Bupa have now confirmed that the SALT discharge summary was available to the home at the time and recommended syrup thickened fluids and “soft diet”. In the event HNH was giving soft foods and then changed to a pureed diet on 06.06.13, HNH was unable to establish the reasoning behind the switch. IMRv1 however, notes that on 10th or 11th (unclear from the documentation) June a request was made for AA to be seen by the SALT team as “Mr AA was unable to tolerate thin liquid and was coughing ++++”. Similarly, in an earlier record it states that the HNH medication care plan says that “Takes all medication with water”. In the context of the SALT discharge letter describing “overt aspiration signs when giving thin fluids” and asking that they “continue his prescription of Resource Thicken Up Clear powder and Resource Pre-thickened syrup drinks” the use of water and thin fluids was potentially dangerous.
5.26 The CHC team assessed the complexity of Mr AA’s health needs that established his eligibility for ongoing NHS funding and identified HNH as being able to meet those needs. Their IMR particularly references that their assessment documentation notes that Mr AA was unable to communicate severity of pain. The specialist TVN who reviewed Mr AA on 30.05.13 observed Mr AA to be in pain when his dressings were changed and asked for his pain medication to be reviewed by the GP. He had a long-standing prescription for paracetamol 500g PRN, which he was given on the evening of 29.05.13 but on no further occasions. Although the GP IMR does not record it, according to HNH, Dr L wrote a script for co-codamol on 03.06.13 but the first record of it being given (according to the SGNR) was 08.06.13. It is therefore possible to conclude that Mr AA may have spent at least 9 days in some pain and/or discomfort and could account for the reluctance and aggression he is recorded as having - displayed when attempts were made to turn him and give personal care. It is difficult to understand or defend this lack of pain management by HNH.

5.27 Mr AA had advanced dementia on admission. He also had committed and active support in Mr & Mrs O who acted as his NoK, as well as contact with Mr O’s brother. They had known him for 40+ years. Although they were consulted with about the move to HNH and visited prior to his admission, Mr & Mrs O reported at interview that no attempts were made to involve them in formulating and personalising his care plan. Good practice in dementia care requires their involvement where possible:

“Family, Carers and the person with dementia (where possible) should always be involved in developing a care plan based on person-centred care. Their knowledge and understanding of the person is extremely valuable to make sure the care plan is right for them.”

There is also no evidence of HNH informing the GP practice of Mr & Mrs O’s involvement as NoK, which contributed to them not being adequately informed and involved in Mr AA’s last 2 days.

5.28 There is no mention of consideration of a mental capacity act assessment, which could have led to a best interest’s decision in relation to undertaking personal care and turning, when Mr AA refused. Together with a personalised care plan drawing on the next of kin’s experience it could have provided support to staff when undertaking

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6 Alzheimer’s Society Factsheet: Treating behavioural and psychological symptoms of dementia: Person Centred Care.
these more challenging tasks as well as making Mr AA more comfortable.

5.29 The question of adequate hydration during Mr AA’s stay at HNH has been a contentious issue and pertains to the standard of care given. A detailed study of the case records from HNH including the fluid and food charts was undertaken as part of the SGNR. The details in the report were disputed by the author of IMRv1, who produced an alternative record. This author does not have access to the various records referred to or the clinical knowledge to form a judgment about their adequacy. The IMRv1 author acknowledges that the record keeping on such matters was not always complete and particularly in relation to mouth care. It is possible for someone in Mr AA’s situation to be adequately hydrated in clinical terms but still to have an uncomfortably dry mouth that needs help and support through other methods. The ready availability of a mouth care kit next to the bed is disputed between a couple of care workers interviewed by the independent nurse. It was also part of the complaint by the NoK, who found him on occasion with parched and cracked lips and in apparent discomfort. Additionally, on interview staff had different views about the amount of mouth care they had delivered. It is not possible from the available information to reach a conclusion about whether this aspect of Mr AA’s care had been adequate, but clearly as a minimum, HNH did not keep adequate records of this aspect of care.

5.30 There was an exacting requirement for turning Mr AA of 2 hourly by day and 4 hourly at night and that it would require at least 2 people to do this. It is stated by HNH that at times he refused to be turned. There should be turning charts to ensure this happens and these were not always completed, in particular records of when Mr AA is said to have refused. HNH state in IMRv1 that it was broadly a recording issue rather than inadequate turning frequency. This is at odds with the experience of the CTV nurse who was sent away on 11.06.13. She was unable to review Mr AA’s wound because she was told it now needed 3-4 staff to turn him as he was “difficult” and so it could not be done at that time. It seems extremely likely that during the last few days of Mr AA’s life at least, he was not being turned as often as his care plan required.

5.31 The presence of a care worker at the exact point of Mr AA’s death is another point of dispute between HNH IMR v1 and the SGNR. The former states a care worker was present, the latter states that a care worker informed her at interview that she had left the room to see
another resident. HNH’s IMRv2 suggests the member of staff did have to leave the room briefly to attend to another resident. It is not possible to say definitively which account is correct.

5.32 The dignity afforded to Mr AA immediately after his death is also in dispute. More than one member of staff recalled attempts to close Mr AA’s mouth after his death but that it would not stay shut, this can happen but can also usually be avoided. No detail is given in any account about attempts to close his eyes. Difficulties can occur with either if they are not carried out very soon after death but no definitive conclusion can be drawn from this observation.

5.33 The position of Mr AA’s body when the undertakers collected him and its subsequent impact is a further area of dispute and pertains to lack of dignity. Was his body not laid out properly thus it was almost in a “sitting” position as described by the undertakers to the independent nurse reviewer? If so was this a (further?) symptom of lack of personalised care and concern for dignity in death? Various possible explanations have been put forward. In IMRv1 it was suggested he was particularly tall and therefore could not fit into the carrying container consequently a member of staff had to accompany the undertakers to the van to hold the lid. It is unlikely the undertakers had equipment that did not allow for taller than average people and does not explain why this could result in the body appearing to be almost sitting. The author has also been able to ascertain from medical records that Mr AA was 171cms tall, which is not exceptional. IMRv2 points to the hospital discharge summary and offers a suggestion of pre-existing ankylosing spondylitis amongst a long list of problems identified in the review of a CT pulmonary angiogram. A physiotherapy and medical review of the hospital records suggest Mr AA was lying flat for the CT scan and therefore it was unlikely to have caused a significant problem in death. There is no previous reference to this condition in medical and clinical notes and it does not appear to have manifested visibly to those who knew him. On the balance of probability the explanation proposed in the SGNR is the most likely: that when a care worker attempted to flatten the electric bed that Mr AA was lying on at the time of his death, he was using a remote control. If it had accidently dipped the bed in the middle, it would have caused Mr AA’s bottom to be lower than his body resulting in the position described. When covered with a sheet it is entirely possible this would not have been noticed by other staff whom all reported Mr AA’s body to be laid out flat.
5.34 It is difficult to establish the facts about the concerns raised by Mr O relating to his contact with the home particularly the night before and the morning of Mr AA’s death. There was clearly, at best, a misunderstanding about how serious Mr AA’s condition was the night before he died. On a previous occasion when gravely ill in hospital Mrs O had sat all night with Mr AA, they did not wish him to die alone. It is therefore reasonable to conclude that the imminence of his death on the night was not adequately conveyed, or one or other would have attended.

It is also reasonable to consider that Mr & Mrs O, whilst not entirely surprised by the possibility and actuality of Mr AA’s death, would still have been affected by it. HNH purports to be experienced in end of life care and should be experienced in the support of NoK at such times, including their need on occasions to be angry. However, Mr O was not given the support he should have been able to expect when visiting the next morning. The member of staff who received him, although a qualified nurse, did not appear to have the appropriate skills to manage the situation well. It is not disputed that she inappropriately referred to “the body” on several occasions and had to leave Mr O to attend to someone else. She also did not prepare Mr O for seeing Mr AA’s body and the fact that his eyes and mouth were open, which was likely to be a shock for someone unprepared. The curtains being open and decorators working outside was a final straw. Understandably, Mr O having been left alone and feeling unprepared and unsupported left fairly soon after viewing Mr AA’s body and before the nurse’s return. It is of note that the HNH IMRv2 places some responsibility for Mr O not receiving appropriate support on Mr O, for leaving so quickly:

“The staff made every effort to return to Mr AA’s friend as soon as they had dealt with another resident, but within such a short space of time, Mr AA’s friend had left the home”.

The IMR does not consider that he may have left relatively quickly because he felt shocked and unsupported. Mr & Mrs O also reported receiving contacts from the home during the day, wanting to know when “the body” would be removed and what the plans were, which seems equally insensitive.

5.35 When analysing the circumstance around MR AA’s death it is impossible not to make observations on other more generalised indicators about care and dignity. As already stated there are 2 parts to the IMR(s) presented by HNH. One (IMRv1) is titled as a “timeline” and the author is not named though gives more opinion than a timeline
would indicate. It appears to have been written in response to what its author sees as an unfair report by the lead nurse for quality & assurance care homes for LBI and Islington CCG: the SGNR. It is extremely defensive and in places contradictory. At one point it states (in relation to the concerns about Mr AA’s open mouth following his death)

“The staff have acknowledged in statements that a number of attempts to close Mr AA’s mouth were made, but that all were unsuccessful and some have commented that he remained in death, as he did alive, with his mouth open”.

This is not suggestive of a staff culture of respect and dignity. That the author could see fit to write it, underlines that view.

5.36 The IMRv2 also has inconsistencies and inaccuracies that suggest the care and attention in wanting to learn from this experience may be limited, e.g. under a summary of Mr AA’s medical conditions it notes that he was “prone to aspiration and needed a soft diet with syrup consistency soft drinks”. However, it later cites as a good example of multi-agency practice that the home had made a referral to the SALT team for an assessment because of his “inability to take thin liquid”. The home already had clear advice not to give him thin liquids. Similarly it commends staff for securing a vacuum pump for his pressure care, when it had clearly been ordered by the hospital to the extent that his discharge was delayed for 4 days awaiting its availability. The report says that Mr AA was admitted for “palliative care” though this is not documented in any other reports or IMRv1. Palliative care is described in NHS Choices as:

“When there is no cure for an illness, palliative care tries to make the end of a person’s life as comfortable as possible. This is done by attempting to relieve pain and other distressing symptoms, while providing psychological, social and spiritual support. Carers and family are also offered emotional and spiritual support – referred to as a "holistic" approach to care.”

Had Mr AA truly been placed on a palliative care pathway, he and his NoK would have been better served.

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7 NHS Choices: Guide to care/end of life issues/ palliative care

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Key conclusions: HNH did not pay adequate attention to the discharge information they had in preparing his care plan which could have been dangerous (ref: types of fluids given). They did not involve his designated NoK in drawing up a care plan, which could have led to more personalised, and therefore, if implemented, more effective care.

At best, significant amounts of recording were inadequate and at worst, so was some of the care (ref: adequate turning frequencies, fluid intakes).

It is concluded that Mr AA was not afforded the dignity in death most people would want for their friends and family. It seems likely that he was alone at the point of death, despite the express wish of his NoK, who would have responded more positively if fully informed at the appropriate time. His body does not appear to have been treated with respect and his NoK not appropriately supported.

If, as asserted, the local palliative care team (who were not asked to assist with Mr AA) have commended HNH more generally for its palliative care, its skills in the case of Mr AA are not immediately apparent in this retrospective review.

Bupa posit that the SGNR, which reviewed the detailed care records and interviewed key staff, is inaccurate and that some of the care staff, with hindsight, do not agree with aspects of the records of their interviews and therefore have not signed them. The author is informed that the challenge to the SGNR was not made until 4 months after it was completed and shared. Whilst there are inevitably some errors in a 1:1 interview process, it is difficult to understand why an independent person would knowingly record fundamentally opposing recollections from a member of staff, to those said to have been given to their employer.

The GP care provided to Mr AA

5.38 The following observations and analyses need to be understood within the context of having received very scant information in the GP practices' “IMRs” and that NMC did not co-operate fully with the earlier safeguarding investigations. AMC did, up to a point, provide additional information in response to specific questions sent by the SCR author, the NMC when asked for information, did not. The reasons for this will be considered later but it means that some actions and decisions have
been noted from the IMRs and chronologies of others and some inferences drawn from that.

5.39 During the period under review Mr AA received GP care from 2 separate GP practices, both under a Locally Commissioned Service (LCS) specification with Islington CCG from April 2013 and prior to that Islington Primary Care Trust, for the provision of GP cover to Nursing, Residential and Intermediate Care Homes (see Appendix 1). This is in addition to the standard capitation fee for each resident registered.

The overall aims of the contract are set out as:

- Provide an additional level of care over and above that of the new General or Personal Medical Services Contract provided by all GPs.
- Provide a proactive, preventative service.
- Provide a single provider of GMS/PMS services to all patients in the named Nursing, Residential or Intermediate Care Home. All patients cared for within the home will be registered to the single provider on a permanent or temporary basis, unless the patient exercises choice in agreement with their existing GP provider. Such circumstances are expected to be exceptional.
- Improve the quality of care to older people in Nursing, Residential and Intermediate Care Homes, ensuring that all patients receive dedicated medical services.
- Minimise the risk and complications within this vulnerable group, which includes patients with highly complex needs by providing and monitoring a comprehensive programme of care.
- To provide proactive care in managing chronic disease and medicines including care planning especially around discharge and end of life care.
- To reduce reliance on Out of Hours for crisis management as well as reduction in inappropriate non-elective admissions, A&E attendances.
- To reduce inappropriate prescribing and wastage.

For LH, GP services were provided by the Archway Medical Centre and the contract required a minimum of 2 clinical sessions per week (a clinical session is the equivalent of 4 hours and 12 minutes).
5.40 Dr Z completed a “DNAR” order on 14.02.13 on Care UK headed stationary. The form asks for the “Reason for the DNAR and a clinical explanation of why it has been made” and Dr Z had written, “Pt has dementia and best interest decision made with staff.” It is not clear which member(s) of staff were involved in this discussion and the information as written could not be considered a mental capacity act assessment. The DNAR is not recorded on Mr AA’s GP medical record and nothing is recorded as to why it was raised at this point. The GP Practice summary record of GP contacts from 27.07.2011 was provided with the AMC IMR and there is no record of a formal mental capacity assessment from that date onwards. At interview Mr & Mrs O were unaware of this order and say they were not consulted. This is surprising as LH was very familiar with Mr & Mrs O and Mr O’s nominated involvement in complex care decisions (see para 5.18). This action is not in accordance with best practice as described in the End of Life Care Strategy 2008, End of Life Care LCS and Gold Standards Framework as set out in the Locally Commissioned Service Specification.

5.41 Dr Z was carrying out a routine “ward round” at LH on the 25.02.13, the AMC IMR strongly suggests that Mr AA was seen and the contemporaneous clinical note is ambiguous. Further clarification established that Mr AA was not seen on this occasion but an assessment based on a discussion with a member of staff who was described as the “clinical lead”. Care staff on the residential unit are not clinically qualified, so it is not clear if the discussion was with a member of the unit that was caring for Mr AA or one of the registered nurses from the other part of LH. The GP record as described in para 4.16 refers to there being no concerns from the patient or staff around the fall. It also describes the fall as having taken place a week earlier when in fact it was only 3 nights. There are a range of scenarios that could have caused the discrepancies and ambiguities around this consultation. When considering the GP care given to Mr AA in accordance with the terms of reference, this is an important area and could provide learning for both LH and the GP practice supporting its residents. It must be remembered this took place in the context of Mr AA having recently been in hospital including a period in ITU. Dr Y having seen Mr AA on 19.02.13 for a chest infection. A fall on the 22.02.13 that (in the care home staff’s words) had caused 3 new pressure ulcers and caused a district nurse to seek an urgent move to a nursing placement and express her concerns to LBI. Dr Z’s decision to DNAR Mr AA 1 week earlier. Dr Z’s assessment that Mr AA did not need to be seen was made on the same morning that the District Nurse
visited LH and was so concerned at his condition she sent him to A&E via the Ambulance Service.

There are a number of possible explanations that could have led to what appears to be an inadequately informed assessment including:

- Dr Z met with a registered Nurse from another part of the home for the regular medical review. The nurse was not well informed about Mr AA and his current state and gave false re-assurance to Dr Z.
- Dr Z met with a non-clinically trained member of staff from the residential care unit and accepted their view alongside being told that Mr AA (with advanced dementia) said he was ok and decided not to see him.
- Dr Z was not told about the skin damage that was said to have resulted from the fall.
- Dr Z was misinformed about the length of time since the fall.
- Dr Z was mistaken about the length of time since the fall when entering the clinical record.
- Dr Z did not have/use recent history and/or make sufficient enquiries to make an informed decision.

5.42 In view of the ambiguity the author took advice from an independent GP about the decision not to see Mr AA on this occasion. The response given was:

*It appears that the arrangement was that the GP visits the home, but only sees those patients there are particular concerns over. Mr AA’s fall was mentioned but the GP notes “no concerns”, which suggests that only limited information was sought / given. If a carer told me that a frail older person, had a fall a week earlier but was (in effect) back to their usual self, I would not feel the need to assess them. Assessment after a fall would mainly be about establishing whether there is a fracture or other serious injury, the sort that would have had some impact on his function a week later. If I had been told that this was one of several falls, I might have wanted to establish why he was falling or consider whether he needs aids.*

*In fact, this fall was actually only 2 days earlier (from what I can see of other notes). It also appears that Mr AA was unwell (as picked up by the DN), not due to the fall but possibly having caused it, but the care home staff had not noticed this or mentioned it to the visiting GP. It appears that the DN was unaware that there was a GP on site or perhaps the GP had left by then. If I had been told that Mr AA had a fall two days earlier, and now appeared unwell, then I would certainly have assessed him.*
Should the GP have assessed Mr AA because he had dementia? Is the implication that Mr AA may have had symptoms but not been able to express them to the staff? The GP perhaps should not assume or record the patient had no concerns on the basis of a third party report. However, I imagine there are several patients with dementia at these homes and one would have to use the information given by Carers before deciding who needs to be seen.

If taken at face value, the decision not to see Mr AA in person, given the likely belief the fall had taken place a week earlier and the reassurance by a member of the care home staff that he “had been well since”, was unremarkable. Given all of the wider contextual information it raises a number of questions/concerns for the GP practice, the Care Home and the CCG:

The nature of communication between LH and the GP particularly during “Ward Rounds”:

- Is the CCG aware that only a selected number of residents are seen on the routine GP visits? If so how are the more proactive components and the monitoring of comprehensive care plan requirements fulfilled?
- How does LH ensure the Member of staff engaging with the GP is fully informed about the health and welfare of all the residents?
- How does the GP ensure they are working with appropriately informed and trained care staff when they are informing clinical decisions?
- Is the visiting GP accessing all the relevant resident information when making an assessment?

5.43 Following his hospital discharge to HNH, the NMC GP practice assumed medical care of Mr AA. As stated in 4.29 the Nursing Home spoke to Dr L at the practice on 30.05.13 about DNAR. At this stage Mr AA had not yet been seen or assessed by anyone at the Practice and the home was very appropriately told that Dr L was unable to make a decision about DNAR. The same Dr visited the home the following day and Mr AA was seen and “clerked in” as part of a routine “ward round”. This was within the timescales required by the LCS contract. As well as noting his various medical conditions he was described as “comfortable” and the outcome was to “continue nursing care as per hospital discharge plan”. He was noted to have dementia but there was no formal mental capacity assessment. At that stage it was not necessarily required, as no instructions such as DNAR were issued.

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8 The LCS contract states: “...the Practice lead clinician or deputy should have appropriate records and details of the patients available and liaise with a member of staff from the care home to highlight concerns and actions. Where notes are not available, the practice should ensure that a full and comprehensive history is obtained.”
but would have provided a more rounded assessment and could have underpinned later actions/decisions. Although requested by the CTV nurse, there is no record of Mr AA’s pain medication being reviewed. It is not known whether or not this was because the HNH staff did not pass on this request, although it is noted in their records. According to the HNH records, Dr L subsequently prescribed co-codamol on 03.06.13, but this isn’t noted on the GP chronology.

5.44 Dr M was the next and last GP to see Mr AA on 12.06.13 as part of the routine “ward round”. It is not known on what basis an entry was made (erroneously on the CTV nurse care plan) that Mr AA was “under palliative care”. The author has found no record of a formal decision that palliative care was to be delivered, in some ways it would have been preferable for Mr AA and Mr and Mrs O if it had. It could/should have given access to the level of care described in the End of Life Care Strategy (DH 2008) as set out in the LCS contract.

5.45 The next role for the NMC was to certify Mr AA’s death. This took some 13 hours, which caused further distress to the NoK and meant it was not possible to transfer his body to the funeral home until after working hours. Although it caused additional distress, the delay was understandable, as current practice requires that a death certificate is signed by a GP who has attended the deceased person during their last illness or the involvement of the Coroner would be required. In Mr AA’s case that was Dr M. Dr M was out of the area that day and according to a letter from Dr L the home did not notify the GP practice of Mr AA’s death until 11:15. Dr M attended at 18:15 on her return to the area and according to the NMC IMR, when she was not officially on duty. The delay was unfortunate, but in the circumstances not unreasonable.

5.46 There was no contact between anyone from NMC and Mr & Mrs O from the point of Mr AA’s admission to after his death. When contacted by Mr & Mrs O who had questions about the care Mr AA had received at HNH, the practice refused to answer, as they didn’t recognise Mr & Mrs O as NoK even after he had died. Whilst with the hindsight of undertaking an IMR the practice now recognises this was an omission, there is no evidence of any enquiry being made about this at the time of or shortly after Mr AA’s death. The IMR does not identify that it should be a crucial element of the information and assessment at admission.
**Key conclusions:** Although the 2 practices were involved with Mr AA’s care for very different lengths of time, there are some commonalities about where practice could/should have been better. Despite Mr AA’s known dementia, the Mental Capacity Act was not utilised to protect Mr AA or indeed, the Doctors who made critical decisions about him, without a proper mental capacity assessment or the involvement with NoK that a proper assessment would have prompted.⁹

At some points it appears that Mr & Mrs O’s role as NoK was either not recognised or disputed. There are no “rules” about who can and cannot be a NoK and the phrase NoK has no legal definition or status in law. However, if before losing capacity, a person nominates someone as their NoK (as Mr AA had done with Mr O) who can be involved in discussions and complex decisions, this should not only be respected but can usually be a very helpful resource in contributing to planning someone’s care.

Both practices were attached to their respective care homes under a “Locally Commissioned Service Specification for GP Cover of Nursing, Residential and Intermediate Care Homes 2013/14”. The main aims of which are described at 5.34. It is difficult to match the GP care described in this review to some of the aims of the contract. In particular the following elements:

- Provide a proactive, preventative service
- Minimise the risk and complications within this vulnerable group, which includes patients with highly complex needs by providing and monitoring a comprehensive programme of care.
- To provide proactive care in managing chronic disease and medicines including care planning especially around discharge and end of life care.

Both practices employed the use of the term “ward round” in terms of planned routine visits to each care home but clearly decisions were taken in discussion with care home staff about who should be assessed face to face. This may be very appropriate in ensuring those

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⁹ The BMA Mental Capacity Act Toolkit offers clear and practical information for medical practitioners, which support this analysis.
in most need receive clinical interventions. However, this review highlights the need for comprehensive and accurate information being made available by the care home staff and the clinician being probing and curious in such discussions and not taking information at face value. This also has implications for the Clinical Commissioning Group:

- What is the understanding/expectation of a “ward round” in terms of patient contact?
- How are the LCS GP contracts monitored?

The next section will consider issues not necessarily asked for in the Terms of Reference but which need consideration by the Safeguarding Board.

5.48 **Safeguarding procedures** were not used when they should have been e.g. on the first admission to hospital, which may have led to a better assessment of Mr AA’s needs and an alternative discharge plan. When they were finally instigated (following a referral from the ED registrar and district nurse), they appear to have to some degree “lost their way”. The strategy meeting held on 04.03.13 appropriately identified the harm done to Mr AA and where and how it may have occurred. The actions call for further information/reports from the 3 agencies that were contributing to his care when the harm occurred. The actual purpose of the actions or indeed purpose of the strategy meeting is not explicit in the minutes. Was it to protect Mr AA? What were the continuing risks to him? Was it to protect others who may be deemed to be at risk as a consequence of the possible shortcomings in the services? There is no documented discussion about whether any other residents at LH were not having their needs adequately met. Nor for example was there a plan to follow up some of the discharges from the ward in question to assess the level of risk to others. The subsequent case conference on 05.03.13 went on to consider in more detail what went wrong in Mr AA’s care. It concluded that the 3 agencies involved should complete further reports outlining their learning and actions to address it within 2 weeks with a review meeting in 2 months to see how the actions have been implemented. It also determined that the LH report had not been of sufficient quality and depth.

5.49 Whilst the conclusions and actions don’t fall explicitly outside the multi-agency safeguarding policy and procedures, under the auspices of being a “protection plan”, they do have a feeling of trying to police the
constituent bodies. This feeling is not assisted by the “language” of safeguarding (not the responsibility of LBI)\textsuperscript{10} whereby an allegation has to be “substantiated, partially substantiated, not substantiated or not determined/inconclusive (in this case it determined “partially substantiated”). It is not difficult to understand how the case conference arrived at this position; there were clearly areas of concern and learning from a situation of harm to an individual having been caused. It may not have seen any other way of trying to do this but its mandate for this role is not clear. It is perhaps, not surprising that 2 of the 3 agencies were very tardy in providing their additional reports that meant the review meeting didn’t take place until 24.07.13.

5.50 Although not described in the chronology as it occurred after Mr AA’s death, a second safeguarding investigation commenced with a strategy meeting on 19.07.13, concerning allegations of neglect raised by Mr & Mrs O. They had also raised individual complaints with the NMC and HNH. A comprehensive audit of the nursing and care records on Mr AA held by HNH was commissioned as a consequence with the SGNR referred to above as an outcome. The same nurse who compiled the SGNR also established that care of other residents was adequate and they were not at immediate risk. It was also established that an unannounced inspection by CQC was planned for HNH. These last 2 points meant the function of ensuring the welfare of others in the same situation as the subject of the investigation, was fulfilled.

5.51 The NMC did not engage with the safeguarding process. LBI’s records suggest a sustained effort to engage them, which also involved the CCG. The reasons for non-engagement can only be speculated upon, but one reason given was that the matter was already the subject of a complaint. There may have been (an)other reason(s) but due to only minimal engagement with this Serious Case Review this has not been possible to establish. Given the very partial involvement in this Serious Case Review it will be important for NHS England\textsuperscript{11} to consider how to help GP practices understand from the outset that the safeguarding of adults at risk is not optional, including the processes and protocols that underpin it. At the same time it behoves the Safeguarding Adults Board to ensure that its processes are lean and fit for purpose (see 5.52 below).

\textsuperscript{10} The NHS Information Centre for Health and Social Care lays out definitions of safeguarding investigation outcomes.

\textsuperscript{11} NHS England is currently responsible for commissioning GPs.
In reflecting upon 5.49 it is possible to consider that, as with the first safeguarding investigation, in the absence of imminent or future harm to the subject, the safeguarding conference process was not sufficiently mandated to carry out the retrospective learning and action planning across a multi-agency forum. This may also have led to the decision by the case conference chair to request an SCR. In truth many of the issues/concerns identified by this SCR were also raised at stages of this second safeguarding investigation.

It may be that the Safeguarding Adults Board needs to identify and agree ways of identifying multi-agency learning that arises out of safeguarding alerts when the need for immediate protection planning has waned. This could be more productive and less cumbersome than having to use safeguarding procedures and less potentially resource intensive than a SCR. It would also fit with the direction of travel in the safeguarding elements of the recently published statutory guidance to the Care Act 2014.

GP Practices and safeguarding: the SAB and NHS England in particular, need to consider how to improve “buy in” to adult safeguarding amongst the GP practices it commissions. Whether or not the NMC considered a safeguarding investigation process appropriate, it was legitimately requested to contribute and did not. Similarly the contribution from both GP practices to the SCR process was very limited. It may be that individually a GP Practice is rarely asked to contribute to an SCR, but multiplied across London there could be a significant number in a year. A consultation/support process in completing IMRs and contributing to SCRs being available from commissioners could greatly assist their participation. It would also enable GPs to undertake their reflective practice about safeguarding issues that occur for them in a multi – disciplinary/agency context, which should lead to improvements in learning and practice.

Social work involvement in hospital discharges: It appears that there was no social work involvement in the first 2 discharges from hospital. A couple of times it was suggested that because Mr AA was funded by LBI, particular efforts should have been made to be involved. This is not an acceptable position. Self-funders can and are equally at risk in the circumstances that Mr AA was in and the responsibility for safeguarding applies equally. The LBI needs to consider how it can improve social work involvement in all relevant discharges.
5.56 **The Mental Capacity Act** has been a problem in its application and understanding in a number of areas of this review. If not already on the agenda the SAB should think about how it contributes to increasing the awareness, understanding and implementation of the Act across a range of settings.

5.57 **Palliative Care and End of Life Care** are terms that have occasionally appeared in documentation for this review. There is nothing in the discharge letter or in the Whittington Health (the Hospital) IMRs that states Mr AA’s move was for palliative care or end of life care. There is a set of expectations and responses as set out in the LCS contract and national strategies referred to earlier. If, as the NMC and HNH seem to be indicating in the information they provided, they believed Mr AA to be approaching the end of his life, the care pathway\(^\text{12}\) should have involved following steps:

- Identification of people approaching the end of life and initiating discussions about preferences for end of life care;
- Care planning: assessing needs and preferences, agreeing a care plan to reflect these and reviewing these regularly;
- Coordination of care;
- Delivery of high quality services in all locations;
- Management of the last days of life;
- Care after death;
- Support for carers, both during a person’s illness and after their death

There was a need for greater understanding and clarity between HNH and the NMC about the status of people in their care so that an appropriate care pathway could have been followed. The Safeguarding Board may want to consider if this is a wider issue in its area and/or may want to request the CCG to audit how GPs with care Home LCS contracts are implementing End of Life Care.

6 **Recommendations:**

Each agency undertaking an IMR was asked to identify actions for improvement where appropriate. Some agencies have identified a range of actions, others none. Where an agency has identified actions they are reproduced verbatim below under the agency’s name, as recommendations from the IMR. If this review has identified recommendations for improvement not already individually identified they appear next. These will be followed by recommendations for

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\(^{12}\) As set out in the DH End of Life Care Strategy 2008.
agencies not required to provide an IMR and finally any multi-agency recommendations.

6.1 **Lennox House:**

*Recommendations from IMR* – no formal action plan was submitted with the IMR but the following “learning points” were identified:

*Greater awareness of the safeguarding process and the need to involve the safeguarding team in concerns around harm caused to people whilst in hospital or as a consequence of a poorly managed discharge.*

*The need to ensure all residents receive a full and detailed assessment prior to admission/re-admission.*

*Improved communication with hospital units/wards to ensure changes in people’s (residents) conditions are fully understood and appreciated.*

*The need to work with the discharge team to produce an SOP aimed at ensuring smooth and successful discharges from hospital and avoidance of unnecessary re-admissions.*

**Recommendations from the overview report:**

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

6.2 **Archway Medical Centre:**

*Recommendations from the IMR:* No action plan or learning points identified.

**Recommendations from the overview report:**

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

6.3 Whittington Health-the Hospital:
Recommendations from the overview report:

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

6.4 Whittington District Nursing Service:
The confusion in referral processes that led to a serious delay in commencing district nursing in mid-February 2013 were addressed through the safeguarding investigation and conference the same year.

Recommendation from IMR:
A full review of the way in which district nurses assess and record the capacity and consent of a patient. i.e. assessing understanding when co-creating care plans, implied consent and specifically, under what circumstance do staff undertake formal mental capacity act assessments. Subsequent development (for the Whittington Health) of a Standard Operating procedure to support this review.

6.5 Whittington Tissue Viability Service

Recommendation from IMR: Appropriate management and supervision of the individual tissue viability nurse.

Recommendations from the overview report:

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

Islington Safeguarding Adults Board
6.6 **London Borough of Islington:**

*Recommendations from the IMR:* Although the LBI added a number of detailed actions these followed difficulties identified through the 2 safeguarding investigations and relate to many of the difficulties establishing multi-agency engagement in that process rather than actions specific to LBI. To an extent these are superseded by this review but it is proposed the Safeguarding Board consider the LBI IMR recommendations and decide if it wishes to pursue any.

*Recommendations from the overview report:*
- Review thresholds for “acceptable risk” in care settings and disseminate/train accordingly.
- Work with Whittington Hospital to optimise social work input to hospital discharges.

6.7 **Highgate Nursing Home:**

*Recommendations from the IMR:* The IMR contains a number of actions shown verbatim below, which as the wording implies, HNH assess as having been completed.

“A new procedure has been established for all staff at The Highgate in relation to hand over arrangements when a resident is admitted to the Home from either hospital or hospice. This procedure is now incorporated into the pre-admission assessment to remind the person responsible for the assessment of the information required.

A protocol within the Home has been established to emphasise the need for all registered nurses to be familiar with each resident’s CPR status. This has been cascaded to staff during training sessions.

A protocol for ensuring detailed information is received from the SALT team at the point of a resident’s admission has been developed and cascaded to the nursing staff within the Home.

This protocol includes the need for all information to be shared with care staff. Instructions for the inclusion of all SALT recommendations have been issued and are being used as an aid memoir to all staff in terms of recording the procedures that need to be followed.

All staff have been reminded of the need to complete in detail their input in respect of fluid recording where it has been determined as being necessary for a resident. This has been shared with all staff, and has been documented.

All staff have received a written reminder of the procedure to follow when any intervention is required in terms of managing a resident’s
hydration. This includes confirmation that the Home does not have the responsibility or authority to carry out certain types of hydration methods.

All staff have been reminded of Bupa’s mandatory requirements to completed certain Information where appropriate for each resident within the first 72 hours of their admission to the Home.

A new guideline has been developed to support the nursing staff when implementing End of Life care with specific reference to individual staff when supporting a resident at the time of their impending death.

Procedures for staff regarding the expectations of towards residents and their relatives at the time of death have been circulated to all staff.

Competency assessments have been carried out for each of the nurses involved in the care of Mr. AA.

All staff have been reissued with the Bupa protocol on Care of the Dying.

A thorough review and assessment was carried out by Bupa’s Quality Department, who work independently of the Home, to assess working practices and procedures that were in place at the time of Mr. AA’s admission.

A service development plan was established by Bupa’s Quality Department.

An independent review of the complaint received, issues raised and staff involvement was carried out by Bupa’s Customer Relations Manager, following a meeting with the complainant. This review resulted in a time line being developed and a subsequent response was issued.”

Recommendations from the overview report

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

6.8 **Northern Medical Centre:**

*Recommendations from the IMR:* No new actions identified but the IMR states in that section:

“We already had adult safeguarding training (4th March 2013)”

“Regular multi-disciplinary meetings (Patients at risk meeting) – most recent one was 10th June 2014”.

**Recommendations from the overview report:**

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

The following recommendations are for organisations not directly involved in Mr AA’s care:

6.9 **Clinical Commissioning Group:**

- Review the implementation of the Locally Commissioned Service Specification for GP cover to Residential, Nursing and Intermediate Care Homes, with the Archway Medical Centre and Northern Medical Centre.
- Sample other GP practices with the Locally Commissioned Service Specification to ensure practice is compliant with the same specification.

6.10 **NHS England (London)**

- Issue very clear written advice to all GPs about their responsibilities in respect of the full spectrum of safeguarding
from alerts to Serious Case Reviews/ safeguarding Adults Reviews (SARs).\textsuperscript{13}

- Consider making available an advisory/support service for GPs when involved in Safeguarding investigations and serious case reviews, to enable timely and informative contributions to keeping people at risk safe and/or mutual learning.

The following recommendations are for the collective attention of the Safeguarding Board:

6.11 **The Islington Safeguarding Adults’ Partnership Board:**

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

Jane Ashman  
Independent Overview Author  
08.01.2015

This review does not rely on hindsight, and tries not to use hindsight in a way that is unfair. It does use hindsight where that promotes a fuller understanding of the events and their causation.

\textsuperscript{13} SCRs become known as Safeguarding Adults Reviews under the Care Act 2014.
Appendix 1

Locally Commissioned Service Specification for

GP COVER OF NURSING, RESIDENTIAL, and INTERMEDIATE CARE HOMES 2013/14

A local enhanced service between Islington CCG and member GP practices

1. Introduction and Background

All GP practices provide services to older people, either within the GP premises or in the patient’s home. However, this service specification acknowledges that patients who are residing in Residential, Nursing and Intermediate Care Homes have a greater degree of need and unmet need, than that of the general population. This service specification aspires to meet the goals of national and local strategies to improve physical, mental and social care of service users who are resident in Residential Homes, Nursing Homes or Intermediate Care Homes in each borough of North Central London.

Nationally it has been stated that the goals of health and social care policy are to anticipate and respond to problems recognising the complex interaction of physical, mental and social care factors which can compromise independence and quality of life (NSF Older People, 2001; Standards for Better Health, 2004; End of Life Care Strategy, 2008; End of Life Care LCS; Gold Standards Framework [See Appendix III for links]).

The specification of this enhanced service lies outside the criteria for essential and specialised services and does not replace the contractual obligations laid out in Practices’ GMS/PMS Contract.

This LCS is open to all Practices, except those practices under remedial process and those who have a private contract with a home to provide care.

2. Aims

The aims of the Local Commissioned Service are to:

- Provide an additional level of care over and above that of the new General or Personal Medical Services Contract provided by all GPs
- Provide a proactive, preventative service
- Provide a single provider of GMS/PMS services to all patients in the named Nursing, Residential or Intermediate Care Home. All patients cared for within the home will be

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registered to the single provider on a permanent or temporary basis\textsuperscript{14}, unless the patient exercises choice in agreement with their existing GP provider. Such circumstances are expected to be exceptional.

- Improve the quality of care to older people in Nursing, Residential and Intermediate Care Homes, ensuring that all patients receive dedicated medical services.
- Minimise the risk and complications within this vulnerable group, which includes patients with highly complex needs by providing and monitoring a comprehensive programme of care.
- To provide proactive care in managing chronic disease and medicines including care planning especially around discharge and end of life care
- To reduce reliance on Out of Hours for crisis management as well as reduction in inappropriate non-elective admissions, A&E attendances
- To reduce inappropriate prescribing and wastage.

### 3. Eligibility and exclusions

The specification for the LCS will be made available to all practices and all existing practices currently providing the service will be asked to reapply. This is to ensure that practices sign up to the new specification and to demonstrate via application how the new specification will be delivered.

For practices to provide the services outlined in this LCS, they will need to complete the application form.

The Care Homes LCS is only applicable to the definitions outlined below:

**Nursing Home**

“Nursing home” means any premises used or intended to be used for the reception of and the provision of nursing for, persons suffering from any illness or infirmity but does not include:

- Hospitals
- Children’s Homes
- Sanatoriums provided at schools or educational establishments
- First aid or treatment rooms provided at employment premises, sports grounds, show grounds or places of public entertainment
- Premises used by doctors, dentists or occupational health practitioners
- Private dwellings
- Other premises.

\textsuperscript{14} Temporary Residents must be registered with the Practice within 5 working days of the home informing the Practice of the patient
Residential Home
“Residential Care Home” means a home, other than a hospital, a nursing home, a children’s home or a university, college or school which provides residential accommodation with both board and personal care for any of the following:
- Old age and infirmity
- Disablement
- Past or present dependence on alcohol or drugs or
- Past or present mental disorder.

Intermediate Care Homes
"Intermediate Care Home” means a home which provides active rehabilitation for, usually, up to six weeks to help someone to regain daily living skills that may have been lost during a period of ill health. (Intermediate care may also be provided where a period of assessment is needed to establish someone’s longer term needs).

4. Service Specification
The Practice is required to work to the following service specification for Nursing and Residential Homes:

All patients in a care home will be registered with the GP practice commissioned to provide the care home LCS for that care home, except the rare exception where a resident chooses to register with a different GP and is accepted by that GP.

Practices should have signed up to the EOLC LCS. However there will be a separate After Death Analysis and action plan specifically for review of deaths of care home residents. This should be discussed and agreed with the care home manager.

The practice must have done the online assessment under the Deprivation of Liberty Act which safeguards adults who lack the mental capacity to make decisions without aid.

The practice must have completed Safeguarding Adults training.

Review meetings with the Care Home Manager will need to be attended as required.

A nominated lead clinician or nominated deputy will provide an enhanced level of clinical care, to the registered patients on a regular basis to the Home, including routine and emergency visits. Minimum clinical sessions:

<table>
<thead>
<tr>
<th>Number of beds</th>
<th>Minimum Clinical Session*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-25</td>
<td>1 per week</td>
</tr>
<tr>
<td>26-50</td>
<td>1 per week</td>
</tr>
<tr>
<td>51-75</td>
<td>1.5 per week</td>
</tr>
<tr>
<td>76-100</td>
<td>2 per week</td>
</tr>
</tbody>
</table>

*A clinical sessions is the equivalent of 4 hours 12 minutes (based on Camden LES) and is based on block of 25 beds
Conduct an initial review for all patients upon admission to the Home within 5 working days of being informed which will include:

- Initial physical and mental health assessment
- Medication Review
- Information Gathering
- Initiation of a joint care plan and also offer option of an Advance Care plan if their health deteriorates in the future including their preferences of End of Life care. Establish resuscitation status of the resident and document in the notes as per EoLC strategy.
- Liaise and/or meet with relatives.

On completion of the initial assessment, the Practice will determine with the home the frequency of future non urgent visits, ensuring that previous medical records are available.

A comprehensive Medical Review – for all patients within a maximum of one month of their admission to care home including:

- Full Medical History
- Physical and Mental Health Assessment
- Documentation of a care plan and advance care plan including preferred place of care if dying and resuscitation status.
- Liaise with other Health and Social Care Professionals where relevant, including acute medical services, primary care services and social care.

On completion of the initial assessment, the Practice will determine with the home the frequency of future non urgent visits, ensuring that previous medical records are available.

Following the first comprehensive assessment, some patients will require routine medical monitoring whilst some will require a comprehensive intense period of review. It is anticipated that some patients following admission have minimal medical needs but may develop more complex or new medical problems which require more intensive medical input. The increased level of medical input may be temporary or permanent, the latter possibly leading to terminal illness. The Practice will prioritise the review period for each patient and agree with the home the frequency of medical review. However, it is agreed that the Practice will carry out a comprehensive medical review at least every six months for each patient, or more often if indicated, including around any admission (planned or unplanned).

Dementia should be sought out at the reviews and a basic Mental Capacity assessment (e.g. GP-COG) should take place.

On a 6 monthly basis have reviewed all patients medication, with Pharmacist support where available and discussed and acted upon or responded to the recommendations from the adviser.

Offer vaccination against flu and pneumococcal to all residents in line with GMS contract.

Out of Hours (OOH) cover is provided by Borough OOH provider and practices providing the service will complete hand over forms for all residents after their major
review, and send this to LAS, OOH provider and where relevant other providers such as OOH community nursing and Specialist Palliative Care team. Once the CMC register is up and running this can be updated via the CMC register.

Practices providing the service will provide a practice policy covering:

- The day/s and time/s of any visit/s, that will be attended by a clinician.
- A named clinician to ensure the service specification is met and a deputy.
- The development and production of an up to date register of home patients.
- A named administrative person responsible for prescription requests, communications, requesting medical records and maintaining practice held patient records. The process for this work should be detailed.
- A named person responsible for ensuring the home are made aware of changes to a patient’s case management inc medication changes. The process for this work should be detailed.
- The process for home staff, residents and families/ carers to raise concerns and make referrals to the enhanced services provider.
- The timeframe for prescription requests.
- Roles and responsibilities in dealing with an incident and a process for incident reporting to Islington Clinical Commissioning Group (ICCG) and care home.
- The practice’s policy for dealing with complaints and ascertaining learning.
- The practice’s role in challenging discrimination, promoting equality and respect and human rights, and treating patients, their relatives, and carers with dignity and respect.
- A contingency plan for named clinician absences

The Practice also agrees to:

- Respond to urgent visit requests the same day it is reported
- Ensure that routine visits are not made during patient meal times
- Ensure that adequate contingency arrangements are in place to provide full cover for the LCS should planned or unplanned changes in service arise
- Give reasonable notice of any planned or unplanned changes in visit times to allow Home staff to inform relatives who may have made an appointment
- Share management of the care plan with the patient, the patient’s relatives, home staff and other professionals as appropriate.
- Meet QOF standards (if appropriate, avoid unnecessary tests in very elderly or demented patients)
- Issue repeat prescriptions within one week of the request
- Provide a medical report, if requested, when a client is presented to a complex care panel or community care panel
- Liaise with the Nursing Home and NHS NCL Primary Care Contracting team where concerns arise (see appendix I for NHS Islington Incident and Serious Untoward Incident Policy, December 2008)

In preparation for the visit to the home, the Practice lead clinician or deputy should have appropriate records and details of the patients available and liaise with a member of
staff from the care home to highlight concerns and actions. Where notes are not available, the Practice should ensure that a full and comprehensive history is obtained.

This LCS is open to all Practices, excluding practices under remedial process and practices that have a private contract with a home to provide medical services.

Attendance at a 6 monthly Care home training event which would include discussing the audit results on antiphychotic prescribing, review of admission audit and after death analysis and any other learning from the Locally Commissioned Service. The Practice agrees to work in line with the minimum standards set out in the NSF Older People, 2001, Standards for Better Health, 2004, End of Life Care Strategy, 2008, End of Life Care LCS and Gold Standards Framework.

The Practice agrees to give Islington Clinical Commissioning Group a minimum of six months’ notice in order to terminate their agreement to provide care under this LCS.

The practice will need to link in with the role of the Community Geriatrician. This role is currently being developed and further information will follow.

**Service Specification: Intermediate Care Homes**

The Practice is required to work to the following service specification for Intermediate Care Homes:

All patients in a care home will be registered with the GP practice commissioned to provide the care home LCS for that care home, except the rare exception where a resident chooses to register with a different GP and is accepted by that GP.

Practices should have signed up to the EOLC LCS. However there will be a separate After Death Analysis and action plan specifically for review of deaths of care home residents. This should be discussed and agreed with the care home manager.

The practice must have done the on line assessment under the Deprivation of Liberty Act (details of this will be included in the final pack).

The practice must have completed Safeguarding Adults training.

Practices must complete questionnaire prior to Care Homes monthly quality assurance meetings with any comments/concerns they have. Monitoring/Review meetings will need to be attended as required.

A nominated lead clinician, and nominated deputy when not available, to provide an enhanced level of clinical care to the registered patients on a regular basis to the Home, including routine and emergency visits. *Minimum* clinical sessions:

<table>
<thead>
<tr>
<th>Number of beds</th>
<th>Minimum Clinical Session*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-25</td>
<td>0.5 per week</td>
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<td>1.5 per week</td>
</tr>
<tr>
<td>76-100</td>
<td>2 per week</td>
</tr>
</tbody>
</table>

*A clinical sessions is the equivalent of 4 hours 12 minutes (based on Camden LES) and is based on block of 25 beds.
The Practice must provide care to all patients admitted into the home, regardless of the patient’s length of stay. Practices are still obliged to provide care if the patient is only staying in the home for a few days and is not registered with the Practice.\(^\text{15}\)

In preparation for the visit to the home, the lead clinician or deputy should have appropriate records and details of the patients available and liaise with a member of staff from the care home to highlight concerns and actions. Where notes are not available, the Practice should ensure that a full and comprehensive history is obtained.

The Practice agrees to work in line with the minimum standards set out in the End of Life Care Strategy 2008 & Gold Standards Framework.

The Practice also agrees to:

- Agree the visit timetable with the Home so that a mechanism can be established for concerns and issues raised by staff and relatives to be addressed
- Ensure that routine visits are not made during patient meal times
- Give reasonable notice of any planned changes in visit times to allow Home staff to inform relatives who may have made an appointment
- Respond to urgent visit requests the same day it is reported
- Share management of the care plan with the patient, the patient’s relatives, home staff and other professionals as appropriate.
- Support the Nurses and contribute to the management of complex cases.
- Issue repeat prescriptions within one week of the request
- Ensure that the resuscitation status of a resident is established and documented and reviewed on a regular basis
- Provide a medical report, if requested, when a client is presented to a complex care panel or community care panel
- Liaise with the Nursing or Care Home and NHS NCL Primary Care Contracting Team where concerns arise (see Appendix I for NHS Islington Incident and Serious Untoward Incident Policy, December 2008)

Initial Admission Period

- The Home will inform the practice of an intended admission using the standard template. As per CSCI regulations, the Home is required to assess and confirm that they can meet the needs of the client.
- Lead clinician or nominated deputy to be involved with the management of the admission process
- Agreement to be reached between the lead clinician or nominated deputy and Home manager on the repeat prescription procedure, to meet the Home’s need.

\(^\text{15}\) Temporary Residents should be registered with the Practice within 1 working day of the home informing the Practice of the patient
Initial Assessment

The Practice will carry out an initial assessment, if required, for all patients upon admission to the Home within 5 working days of being informed. The initial assessment, based on the information available, will include the following:

- Initial physical and mental health assessment
- Medication review
- Arrange required investigations necessary
- Information gathering and review of medical history
- Initiation of joint care plan for future management of the resident and demonstrating this has been discussed with the patient and their relatives/carers.
- Complete one month’s FP10
- Liaise and/or meet with relatives (unless otherwise indicated)
- GP to liaise with REACH therapists for provision of rehabilitation where indicated
- Establish resuscitation status of the resident and document in the notes

Routine Management of Patients

On weekly visits the lead clinician or deputy from the Practice should provide the following:

- All patients will have a routine examination and review of medication every three to four weeks
- Physical and Mental Health assessment, where relevant
- Liaise with other Health and Social Care Professionals where relevant, including acute medical services, primary care services and social care
- Liaise with senior qualified nurses for nursing homes or the senior carer in residential homes
- Liaise and or meet with relatives (unless otherwise indicated)

Subject to Consultant advice, the lead clinician or deputy from the Practice will be required where appropriate to:

- Be available to attend Consultant reviews and case conferences
- Liaise with the appropriate Consultant for advice as applicable

Attendance at a 6 monthly Care home training event which would include discussing the audit results on antipsychotic prescribing, review of admission audit and after death analysis and any other learning from the Locally Commissioned Service.

Please note, Patients residing in an immediate care bed for longer than 6 weeks should be cared for as if in a Nursing/Residential Home.

The Practice agrees to give Islington Clinical Commissioning Group a minimum of six months notice in order to terminate their agreement to provide care under this LCS. The practice will need to link in with the role of the Community Geriatrician. This role is currently being developed and further information will follow.
5. Payment Schedule

Each practice commissioned to provide the LCS will be reimbursed on the rates below:

- Quarterly payments in arrears - £450 per bed per annum for nursing and residential home
- Quarterly payments in arrear - £1400 per bed per annum for intermediate home
- Year end payment on submission of audit and action plan and attendance at the care home GP training event equating to
  - £150 per bed per annum for nursing and residential home
  - £600 per bed per annum for intermediate care home

6. Monitoring

<table>
<thead>
<tr>
<th>The Performance Measure</th>
<th>Method i.e. Monitor, Audit or Portfolio</th>
<th>Frequency</th>
<th>Responsibility of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of ADA audit for those patients that were cared for in a Nursing, Residential or Care Home.</td>
<td>Completion of ADA template and action plan to be submitted to CCG. This must be agreed at a meeting with the Care Home Manager and EoLC facilitator.</td>
<td>Annually</td>
<td>Practice</td>
</tr>
<tr>
<td>Review of medication for patients in line with prescribing protocol.</td>
<td>Action plan from medication review to be submitted to CCG office</td>
<td>Six monthly</td>
<td>Practice</td>
</tr>
<tr>
<td>Review of all non-elective admissions from a care home using previous fiscal year data.</td>
<td>Completion of action plan to help reduce non-elective admissions</td>
<td>Annually</td>
<td>Practice</td>
</tr>
<tr>
<td>Reduction in non-elective admissions from a Care Home</td>
<td>Monitoring of SUS/SLAM data</td>
<td>Quarterly</td>
<td>Islington CCG</td>
</tr>
</tbody>
</table>

Development of a care plan and where appropriate of advance care plan including preferred place of care if dying. Practices will also be given audit templates for each audit as well action plan templates and dates in the diary for the two Care Home GP training events.

7. Review of the Service

The LCS proposal has been development by Islington CCG team working closely with colleagues and clinical leads for End of Life Care across the Boroughs. It will be managed by the CCG Primary Care Team. The LCS will be monitored quarterly looking at non-elective admissions data and A&E attendances from the homes and will be fed back to the provider.
8. Variation/Termination of Agreement

NHS NCL will also give a minimum of 14 day notice period to practice, but where possible this will be extended to a maximum of 3 months notice.

9. Protecting Patient Confidentiality

All patient level data should be sent to pbc.secure@nhs.net as per Caldicott Guardianship principles.

Contract

Acceptance of Terms: Service Specification for GP COVER OF NURSING, RESIDENTIAL, and INTERMEDIATE CARE HOMES 2013/14 LCS.

Practice Code…………………… Name of Practice:

By signing this document the practice agrees to provide the LCS according to the specification. This document will become part of the contract documentation between the ... [commissioner] and ... [provider] to provide Locally Commissioned Services. The Locally Commissioned Service the practice has contracted to provide will also be included in the relevant schedule of your contract.

I hereby confirm my acceptance of the terms of this service. Please sign and date below to confirm acceptance:

Signed on behalf of the [provider] by…………………………………………………………

Print name………………………………………… Date: ..........................

Practice Stamp:

Commissioners should use this section to detail any responsibilities they will sign up to here

Signed on behalf of [Commissioner]…………………………………………

Print name………………………………………… Date: ..........................
Appendix 2

Response from Mr and Mrs O (next of kin) to the Serious Case Review report

a) 4.3 - date is incorrect, it should be 31/1/13.

b) 4.7 – they are very concerned that the GP at AMC appears to have signed a DNAR form without seeing the patient (they note this issue is also currently in the news).

c) 4.14 – they acknowledge the action taken by the DN, but feel that if she had observed signs of infection, this should have been flagged up with the GP. The DN should also have initiated a safeguarding alert.

d) 4.16 – they are concerned about the inaccuracy in record keeping by the GPs. Also raised the issue about competency in relation to blisters being described as pressure ulcers rather than as wounds resulting from a fall. Even if they were believed to be pressure ulcers, why was this not discussed with TVN?

e) 4.27 and 4.31 are linked. This is in relation to HNH following SALT guidance. 4.27 notes that he was prescribed thickened fluids. The HNH IMR notes that he was referred to SALT as he couldn’t tolerate thin liquid. They question whether he also had aspiration pneumonia at the point of death.

f) 4.30 – the lack of pain management is something they are very concerned about. It is evident that no analgesics were administered after 8/6/13. They do not feel that the issue of pain management is sufficiently reflected in the report.

g) 4.34 – this shows that HNH were not following the care plan in relation to being turned regularly.

h) 4.35 – HNH seem to have informed the GP that he was ‘under palliative care’ and the GP recorded this on the Home’s CTV pressure ulcer care plan. The hospital was clear at discharge that Mr AA was not for palliative care. When was the decision ‘under palliative care made’? Furthermore, why was a DNAR decision made after 2 days of him moving to HNH?

i) 4.37. They would like to point out that when they came to HNH having been informed of Mr AA’s death, it was not about not getting a cup of tea. Nobody called them to inform them that Mr AA had died. When he went to the Home, no humanity or respect was shown either to him or to Mr AA. In their view nobody was with Mr AA at the point of death or after as rigor mortis had set in (eyes and mouth open). Mr O would also like it noted that he was at the Home for over an hour.

j) 4.38 – they believe that Mr AA was not laid out flat as described by HNH. They note that the undertakers are a respected business who have been based in Islington for a considerable period of time. Mr and Mrs O spoke to the undertakers themselves and were informed of the above.
k) 5.25 – they query why the concerns raised about the use of water and thin fluids is not reflected in the executive summary.

l) 5.28 – they note that HNH said they couldn’t shave him. He had always been clean shaven.

m) 5.34- Mr O would like to re-iterate he didn’t leave quickly; he was there for an hour. They had no idea how long he stayed.

n) 5.44- prior to this GP visit; he was only seen by the GP on 31/5/13.

o) 5.45 -They would like it noted that the GP was not notified until 6 hours after his death. They also do not feel that it was acceptable for Mr AA’s body to be left at the Home for 13 hours waiting to be certified. As Mr AA was cremated a second GP was needed to sign the death certificate. The second GP was so concerned about the situation that she contacted Mr and Mrs O. She wanted to see if they had any concerns. Mrs O raised with her that she felt that dehydration played a part in his death.
## Appendix 3

### Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMC</td>
<td>Archway Medical Centre</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CHC</td>
<td>Continuing Health Care</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>CT</td>
<td>Computerized Tomography</td>
</tr>
<tr>
<td>CTVS</td>
<td>Community Tissue Viability Service</td>
</tr>
<tr>
<td>DNAR</td>
<td>Do not attempt resuscitation</td>
</tr>
<tr>
<td>DNS</td>
<td>District Nursing Service</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HNH</td>
<td>Highgate Nursing Home</td>
</tr>
<tr>
<td>IMCA</td>
<td>Independent Mental Capacity Advocate</td>
</tr>
<tr>
<td>IMR</td>
<td>Individual Management Review</td>
</tr>
<tr>
<td>ITU</td>
<td>Intensive Therapy Unit</td>
</tr>
<tr>
<td>LAS</td>
<td>London Ambulance Service</td>
</tr>
<tr>
<td>LBI</td>
<td>London Borough of Islington</td>
</tr>
<tr>
<td>LCS</td>
<td>Locally Commissioned Service</td>
</tr>
<tr>
<td>LH</td>
<td>Lennox House Residential Care Home</td>
</tr>
<tr>
<td>NoK</td>
<td>Next of Kin</td>
</tr>
<tr>
<td>NMC</td>
<td>Northern Medical Centre</td>
</tr>
<tr>
<td>PRN</td>
<td>(pro re nata) “as needed”</td>
</tr>
<tr>
<td>SALT</td>
<td>Speech &amp; Language Therapy Team</td>
</tr>
<tr>
<td>SAB</td>
<td>Safeguarding Adults’ Board</td>
</tr>
<tr>
<td>SCR</td>
<td>Serious Case Review</td>
</tr>
<tr>
<td>SGNR</td>
<td>Safeguarding Nurse Report</td>
</tr>
<tr>
<td>TVN</td>
<td>Tissue viability nurse</td>
</tr>
</tbody>
</table>