WAKEFIELD & DISTRICT safeguarding adults board

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Safeguarding Adults Review in respect of Derry & Joyce

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Contents

1. Foreword

1.1. The Wakefield & District Safeguarding Adults Board has today published this Safeguarding Adults Review in respect of Derry and Joyce.

1.2. The purpose of a Safeguarding Adults Review is not to reinvestigate or to apportion blame but to establish where and how lessons can be learned and services improved for all those who use them and for their families and carers.

1.3. This is the first SAR that the Wakefield and District Safeguarding Adults Board has undertaken since the Care Act 2014. I want to thank Clive Simmons the author of this review for his thorough and professional approach in exploring the information available to him, his care when working with Derry and Joyce's family and friends, his consideration when working with staff involved and his support to the Board on this journey.

1.4. I want to thank the agencies and practitioners involved in this review for their willingness to be frank and open and to accept that there is much to learn when reflecting on the care of Derry and Joyce. I am pleased to see that agencies have already commenced improving key areas identified within this review.

1.5. I want to apologise on behalf of the Wakefield and District Safeguarding Adults Board and the agencies involved in this review for the areas identified where things could have been done so much better for both Derry and Joyce. I personally promise to ensure that the recommendations within the review will be converted into a robust action plan and that the Board will do everything within its power to make sure this leads to real positive change and improvements.

1.6. Last but not least I want to thank the family and friends of both Derry and Joyce for their expert input into this review ensuring that the readers of this report know who Derry and Joyce were as people. As you read the report you will find out that Derry is described as a 'ladies' man, an able dancer with the ability to play jazz piano by ear. We find that Joyce was a bus driver, rode a motorbike and had a 'heart of gold'. The input from friends and family has played a vital role in ensuring that we fully understand how we need to improve to ensure that circumstances are not repeated in the care of others.

Diane Hampshire
Independent Chair Wakefield and District Safeguarding Adults Board

2. Introduction

2.1. The Care Act 2014, Section 44, requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review when certain criteria are met. These are:

- When an adult has died because of abuse or neglect, or has not died but experienced serious abuse or neglect, whether known or suspected, and;
- There is a concern that partner agencies could have worked more effectively to protect the adult.

2.2. The Safeguarding Adults Board, Safeguarding Adults Review Panel, met in July 2022 and requested further information relating to health care needs.

The panel met again in October 2022 and decided that the criteria to undertake a statutory Safeguarding Adults Review was met in respect of two people, Derry and Joyce. Both were living in the same Care Home and died in March 2022. The panel considered that neglect had contributed to the death of Derry and Joyce, and that agencies had not worked effectively together to safeguard them. Derry had lived at the Home for 25 days and died there on 14/03/22. The cause of death was end stage renal failure, related to dehydration, with chronic conditions.
Joyce had lived at the Home for 8 months, deteriorated and died in hospital on 24/03/22. The cause of death was sepsis, cellulitis and peripheral vascular disease. In view of the similarities in the experience of Derry and Joyce, the panel decided to commission a joint review.

2.3. Safeguarding Adults Reviews are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership and accountability.

2.4. The aims of the Safeguarding Adults Review are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy to the person, comfort to family and friends, and support to professionals.

2.5. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations.

2.6. The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer has chaired an initial panel meeting to agree the review terms of reference; conducted research by critically analysing information provided by involved agencies and by interviewing representatives; culminating in a planned Safeguarding Adults Review Learning Workshop and presentation of this overview report to the Safeguarding Adults Board.

2.7. The Independent Reviewer has involved families and significant others in the review. For Derry, this involved meeting with GN and RD, sister and close friend. For Joyce, this involved meeting with KR, niece (informal). They contributed positively to the review and provided considerable insight into the experience of Derry and Joyce, also contributing to the agencies' learning. GN has expressed her wish, as a review outcome, that the Care Home improves and that GPs visit the Home regularly. RD would like joined-up thinking by agencies to improve. KR asks the SAB to ensure that improvements are reviewed within an agreed timeframe to ensure that they are actioned and embedded.

2.8. The Independent Reviewer met with the following representatives of relevant agencies, either face to face or online, and acknowledges that all contributed positively to the conduct and outcome of the review:

- Home Manager; Quality Assurance Manager; Regional Manager – Care Home (anonymised)
- Service Manager, Joint Commissioning; Service Manager, Integrated Intermediate Care & Support; Service Manager, Community Social Care & Safeguarding; Social Worker; Care Coordinator – Wakefield Council, Adult Social Care

- GP; Operations Manager – GP Practice (anonymised)
- Safeguarding Lead GP; Safeguarding Lead Nurse – Local Care Direct, West Yorkshire NHS Trust
- Designated Professional for Safeguarding Adults – Wakefield & District Health & Care Partnership, NHS West Yorkshire Integrated Care Board
- Clinical Team Leader – Continuing Health Care Team, NHS West Yorkshire Integrated Care Board
- Head of Safeguarding; Named Nurse Adult Safeguarding – Mid Yorkshire Hospitals NHS Trust
- Named Professional for Safeguarding – Yorkshire Ambulance Service NHS Trust
- Detective Inspector – Wakefield Safeguarding Adults, Domestic abuse, Partnership, West Yorkshire Police

2.9 The review is independent of an overlapping Coroner's inquest process.

2.10 A learning workshop has been held in June 2023, with participation by families and a wide range of involved agencies, to discuss taking forward key recommendations. This was a very positive and proactive forum and will inform the action planning process arising from the review.

3. Circumstances leading to the review

3.1. **Derry** was a 65-year old man who had lived at the Care Home on the general nursing unit, following a lengthy hospital stay. His medical conditions included rheumatoid arthritis, diabetes and chronic kidney disease. A Continuing Health Care Review on 09/03/22 identified that he was not well and the Home was asked to request a face-to-face GP visit. A GP review took place on the following day, but this was by telephone with staff. After significant concerns were expressed by Derry's sister, following her visit to him on 13/03/22, a face-to-face GP visit did take place on 14/03/22. The GP found Derry to be very unwell and requested that an ambulance be called for him. He died before the ambulance arrived.

3.2. **Joyce** was an 89-year old woman who lived at the Care Home on the dementia nursing unit, following hospital discharge. She experienced a series of falls in quick succession from 15/03/22 to 18/03/22 and was admitted to hospital on 21/03/22, due to an infected wound to her arm that was sustained during one of these falls. She died in hospital on 24/03/22.

3.3. The scoping period for this review is from 15/07/21, the date of the first significant contact regarding Joyce, to 24/03/22, when she died. Relevant decisions and actions relating to Derry also fall within this timeframe. The Independent Reviewer has also considered contextual information from May 2020, to support an understanding of the circumstances.

4. Key Themes identified for this review

4.1. The following key themes were identified in the terms of reference and evolved in the course of the review.

4.2. How safe was the hospital transfer of care, with particular attention to:

- Discharge pathway and documents
- Patient Safety Incident Response Framework

4.3. How effective was the quality of care whilst living in the Care Home, with particular attention to:

- Previous care in the community
- Specific nursing and care standards at the Care Home
- Improved care standards
- External support and multi-agency communication
- Improved Care Home monitoring

4.4. How timely was medical attention and hospital admission, with particular attention to:

- GP ward rounds
- Out of Hours GP service
- Yorkshire Ambulance Service

4.5. How effective were safeguarding adults responses to concerns?

4.6. How effective was the consideration of mental capacity and actively listening?

4.7. How did environmental and resource issues impact on service delivery?

4.8. How compliant were agencies with key statutory requirements?

5. Pen picture of Derry

5.1. Derry had a close relationship with family and friends and lived his entire life in Wakefield. On leaving school, he worked with his father, then attended college and became an accomplished joiner. Due to rheumatoid arthritis, Derry retired early. He had a leg amputated below the knee due to diabetes and had chronic kidney disease. Derry lived in his own bungalow and then moved in with his mother. On moving to a Care Home in February 2022, he had planned to live with his twin sister, who was preparing a room for this purpose.

5.2. Derry is described by his twin sister as an extrovert and a 'ladies' man'. His close friend, RD, knew him since they were aged 11 or 12 and recalls that he was very popular, always meeting someone on nights out together. Derry played football in the Sunday league until his 30's and travelled abroad regularly with friends. He played jazz piano by ear and was a very able dancer.

6. Pen picture of Joyce

6.1. Joyce lived her entire life in the Wakefield area. She is remembered fondly by KR, her niece and close friend who she knew for 26 years and lived with on a farm before moving to her own bungalow. She was divorced and her ex-husband died in his 30's. Joyce survived a brother and sister, neither of whom lived locally, and she had no other family.

6.2. Joyce is described by her niece as having a 'heart of gold' and in many ways she was unconventional. She worked as a cleaner and then as a bus driver, rode a motorbike and

later played bingo with her close friendship group.

6.3. Joyce was involved in a road traffic accident in 2018 and her health deteriorated from that time. Her niece recalls that the onset of her memory loss seemed to be fairly sudden around 2019.

7. Summarised Chronology

Prior to March 2022

7.1. Derry's circumstances from May 2020: Derry fell at home in May 2020 and was found 12 hours later by a neighbour. He felt that support for his health conditions was less attentive due to Covid and that this may have contributed to his fall. Derry was admitted to hospital from 17/05/20 to 25/05/20 and discharged home with reablement support, arranged by the Hospital Social Work Team, which stopped after a few days because he felt that he was managing. He was readmitted from 24/08/20 to 05/09/20, due to low blood sugar and collapsing, and was again discharged home with support, which stopped after 10 days for the same reason.

7.2. Derry had a further hospital admission from 02/11/20 to 04/12/20 and his right leg was amputated below the knee, due to gangrene. A safeguarding concern was raised on the ward regarding a category 3 pressure ulcer and related pain. He was discharged to a Care Home in January 2021 and to his mother's home in March 2021 with a package of care. His mother was unwell, he was low in mood and had concerns about his care package, with poor compliance at times. Carers, who visited 4 times daily, reported that Derry was not eating appropriately in view of his diabetes, was refusing care at times and was refusing hospital admission when unwell. Community Nurses visited 3 times daily, incorporating insulin administration, and his sister feels that they were attentive to his nursing needs. His friend, RD, recalls that he was not encouraged by carers and nurses to leave his bed, or to mobilise, and that he was not motivated to do so as he was in considerable pain due to arthritis. He also believes that Derry was not receiving physiotherapy support. RD recalls that there was inconsistency in carers attending, meaning that it would have been difficult to have developed a rapport. Some contacts, including with the dietician, were virtual due to Covid and he believes that Derry would not have relayed concerns. RD noticed a significant deterioration in his condition and motivation around July 2021 and feels that there was not a sense of agencies working to a common plan in supporting him.

7.3. From March 2021 to February 2022, Derry had 6 hospital admissions, all due to diabetes mismanagement and infections. This included admission from September to November 2021. He moved to a different Care Home on discharge to receive nursing care, due to his complex diabetes management. A Transfer of Care (TOC) form on discharge reported that he was bedbound through choice. A Hospital Social Work 'Adult Interim Care Plan' was completed and clearly outlined his medical conditions and the need for encouragement to reduce his dependency. It was also noted that he needed an assessment to determine his long-term care needs. A Social Worker visited Derry in the Home, noting that he was encouraged to leave his bed and to mobilise, but that he was not fit enough for an assessment at that time. His friend, RD, recalls offering to encourage him in getting up and mobilising. Derry acknowledged that he did not like living in a Home. Low mood was documented, he had no interest in sitting out, he could be non-compliant with medication, and he had a poor dietary intake.

There were two contacts with the Ambulance Service in November 2021 and January 2022, due to diabetes mismanagement, general weakness and 'challenging behaviour', with hospital admission on the first of these.

7.4. On hospital readmission in February 2022, due to constipation, Derry was mostly confined to bed and continued to disengage with his treatment and care. His sister found a placement at another Care Home (the main Home covered in this review) and he moved to the general nursing unit on 17/02/22.

7.5. Joyce - initial contact from March 2021: Joyce received periods of Community Nursing support from March 2021, Phlebotomy from February 2021 and a Tissue Viability Nurse (TVN) attended from December 2021. A Community Nursing referral to Adult Social Care (ASC) on 25/03/21 raised a concern about self-neglect. Also, her niece contacted ASC in April 2021, as Joyce was experiencing difficulty in managing her health and domestic needs. Joyce was ringing her up to 30 times a day, anxious about moving indoors as she had experienced falls. There were 7 contacts with the Ambulance Service from April to June 2021, for a range of concerns but most notably breathlessness. From these, she was admitted to hospital on two occasions, initially from 18/04/21 to 29/04/21, due to cellulitis. She was discharged home with the reablement service and was awaiting a memory clinic appointment, with concerns raised in May 2021 regarding her level of confusion. A TOC form was completed prior to discharge and a care package was arranged by a Social Worker. This was due to commence in June 2021 when Joyce was at home, but she was admitted to hospital again on 19/06/21 due to a breathing difficulty, before this was put in place, and was discharged to the Care Home on 15/07/21. The placement was located by a Social Worker and was in close proximity to her niece.

7.6. Joyce admission to the Care Home on 15/07/21: Joyce was assessed by both Social Work and Health practitioners as having 24-hour care and support needs on transfer to the Care Home. Prior to hospital discharge, a TOC form was completed. This was limited in scope, with mainly medical and mobility-related information included, and the Independent Reviewer acknowledges that the purpose of the form is to provide an overview of the patient's needs. However, the combined documentation did not provide robustly holistic information.

There was communication within the Hospital Discharge Team, including Social Work, on discharge needs.

7.7. The Care Home contacted the Rapid Access Service (South West Yorkshire Mental Health Trust) for support on 12/08/21, due to Joyce's presenting behaviour, with a concern that there may be an emerging, undiagnosed dementia.

A mini-ACE cognitive impairment test was completed. The team referred Joyce to the GP Practice on the same date and to the Memory Service on 24/08/21 for a diagnostic appointment. Her niece was not made aware of an assessment and dementia diagnosis having taken place at any time and it is notable that Joyce was deemed by involved agencies to have mental capacity relating to her care needs.

7.8. Joyce was admitted to hospital on 06/10/21, following a fall. After discharge, a Social Work review meeting was held at the Care Home on 11/10/21, involving Joyce, her niece and a Social Worker, which led to her transfer to the dementia nursing unit on 14/10/21 and confirmation of a permanent placement. The Social Worker advised that a referral

should be made to Community Nursing, due to an infection risk with weeping sores to her legs. Funded Nursing Care (FNC) was agreed at a Decision Support Tool (DST) virtual meeting on 17/11/21, to be reviewed after 3 months. This was due in mid-February 2022 and delayed, presenting a potential lost opportunity to review long-term nursing needs with Continuing Health Care support. The GP contacted the Rapid Access Service on 26/11/21, whilst Joyce was open to the Memory Service, as the Care Home were requesting specific support with challenging behaviour. There had been Social Work communication with the Care Home on 13/12/21 and no further contact until March 2022.

7.9. The Care Home contacted the Rapid Access Service again on 05/01/22, to request a medication review. The GP had terminated Trazadone anti-depressant medication because it was not effective and Joyce continued to present agitated behaviour, including hitting out. A Speciality GP telephone review (not a visit due to Covid) was completed on 12/01/22, with a change in medication. There had been no recent significant falls. The same Doctor visited Joyce on 03/02/22, recommending follow up by the Memory Nurse. A GP letter on 25/02/22 referred to a likely background of severe vascular dementia.

7.10. The care plan in February and updated in March 2022 noted a need for staff to sit and talk with Joyce and to keep her bedroom door open, due to her agitation and calling for help, and to explain tasks as she was agitated by staff touching her. She had double incontinence and was not remembering to use the call bell due to her cognitive impairment. A skin integrity care plan was in place and she was assessed as being at high risk of developing pressure sores. There was regular contact with the GP and TVN regarding Joyce's leg ulcers between December 2021 and March 2022. A referral for TVN support was received on 01/02/22. Joyce received antibiotics and the GP maintained contact with the Care Home, advising TVN contact when informed by the Home on 14/02/22 that there had been little improvement. The TVN rang the Care Home on 16/02/22, but there were no nursing staff available at the Home to discuss a plan of care for the leg ulcers.

The TVN and Care Home liaised on 23/02/22 and the TVN requested photos (which were sent on the same date), with a plan of care provided by the TVN.

7.11. Her niece recalls that, on visiting, she would generally hear Joyce screaming as she approached, her bedroom door would be closed and no carer would be in attendance, and that her call alarm was out of reach when she sat in her bedroom chair.

The care plan and life story were not shared with KR (although it is noted that Joyce was deemed to have capacity relating to her care needs), who feels that staff did not encourage her to spend time in the lounge. She also recalls that she would find Joyce with a large amount of urine on her skin, on her chair and on the floor, which she believes was the accumulation of more than one spillage. She put name tags in clothes as requested by the Home, but they would still go missing and she always found Joyce wearing other residents clothes. This was particularly significant as she had an attachment to her cardigans. KR also recalls an occasion when Joyce had an eye infection and staff were unaware. She recalls that staff were generally not approachable, that information was not reliable and staff morale appeared to be poor.

7.12. Whilst at the Care Home, there were 7 calls to the Ambulance Service from October 2021 to March 2022 (prior to the call leading to the only hospital admission in this period) for a range of concerns**,** including unwitnessed falls on 4 occasions. A referral was made to the My Therapy Service for a falls assessment in February 2022**.** Although the details are

unclear, a Doctor visited Joyce on 03/03/22 and diagnosed vascular dementia. There were 5 GP contacts with the Home in February regarding Joyce, all relating to a rash on her leg.

7.13. Joyce: Safeguarding Adults Concerns November 2021 to February 2022: There were 5 Safeguarding Adults concerns raised regarding Joyce within this 3 month period, all by the Care Home. On 4 of these occasions they were related to falls, mostly unwitnessed in her bedroom. These did not lead to Safeguarding Adults Enquiries, as either the threshold was not met or there was a medical or risk management response outside the safeguarding adults procedure.

7.14. Derry: admission to the Care Home on 17/02/22: Derry was admitted to the nursing care unit, due to the instability of his diabetes, and was registered on the same day with the GP Practice. The hospital discharge letter focussed on medical information. This indicated that a Darbepoetin injection (treatment for anaemia due chronic kidney disease) should be administered on 02/03/22. On 22/02/22, a nurse from the Hospital Kidney Unit rang the Care Home and advised that the injection should be administered on a monthly basis, but the prescription was not received or followed up. The Transfer of Care (TOC) form outlined a need for encouragement, that at times he would refuse insulin as he said that he knew his own body. He remained in bed all day and was generally non-compliant with care. The previous Adult Interim Support Plan was updated by the Social Worker, who noted that he was confined to bed, there were no cognitive concerns, and a further assessment would be needed whilst at the Care Home. The Home also completed a pre-placement assessment in hospital and therefore had a range of transfer information on the extent of his medical concerns and the need for encouragement with self-care. There was no communication between the Care Home and the Hospital Social Work Team after he was discharged. Derry expressed a wish to apply for an independent living scheme when his health improved.

7.15. Derry's friend, RD, comments that both he and GN spoke to a nurse at the Care Home about encouraging him to mobilise, but that she felt there was insufficient muscle strength to work with. He spoke to Derry about trying to mobilise in order to go home, but he was in too much pain due to arthritis.

There was no specific care plan in relation to diabetes, but his nutritional care plan made reference to a diabetic diet. Daily monitoring of blood sugar levels is evidenced, although the timings and knowledge of the staff in interpreting and responding to the readings is unclear. RD comments that the Home initially tried to cater for his diet, but were inconsistent and this fell away when it was not working. His previous GP surgery submitted a referral for a Diabetic Nurse on 21/02/22, which remained on the system as awaiting information. Documentation at the Care Home indicates that he was regularly offered food and fluid throughout the day, with alternatives provided when he declined menu items. The amount eaten was not always recorded. Fluid charts indicate that Derry was offered at least 1 litre of water a day, although he regularly declined. The care plan was not discussed with family, whilst it is acknowledged that he was deemed to have capacity relating to his care needs. RD did not have a sense of there being a clear hospital discharge plan or holistic approach to Derry's care, or that staff were handing over information on his condition between shifts.

March 2022

7.16. Initial concerns for Derry at the Care Home: A GP telephone review was completed on 03/03/23, as Care Home staff suggested that he was unlikely to comply with a video

conference. His friend, RD, understood from the Home that the GP was due to visit and that he and Derry's sister could attend, as they wished to relay their concern that his physical health had seemed to significantly deteriorate in the past couple of weeks. On attending, they were told that the review had already been completed by the GP and nurse by telephone. He was advised that only pressure ulcers were discussed, when he had expected his overall decline, diet and medication to have been covered. On raising his concern with the Home Manager, they visited Derry together, with the Manager confirming that he would check on him daily. RD accompanied GN to the GP Surgery to speak to a GP and relayed their concern in detail to a receptionist.

They were advised that they would need Derry's signed authorisation before they could see a GP, as they were not his next of kin (and he was also deemed to have capacity in this regard), which they completed at the Home and, on returning, were advised that there were no appointments. The receptionist consulted with a GP at one point and said that they would have to make an appointment on the next available day. It is not clear whether the specific concerns were relayed to the GP.

7.17. A referral was made by the Care Home on 07/03/22 for Diabetic Nurse involvement, due to high blood sugar readings, and on 08/03/22 it was noted that the Diabetic Nurse would ring on the following day. Readings were significantly above the target for a person in Derry's circumstances, with a risk of hyperglycaemia.

Care Home records indicate that he more regularly declined food and fluids from this date onwards.

7.18. Derry's CHC review on 09/03/22: A virtual Continuing Health Care (CHC), Decision Support Tool (DST) meeting was held on 09/03/22 to decide on health funding. The meeting was postponed to arrange a face-to-face meeting, as Derry's health was not sufficiently stable for an assessment to be undertaken. It was attended by Derry, his sister and friend, the CHC Nurse Advisor, a Hospital Social Worker and a Care Home Nursing Associate.

The Nursing Associate was unable to provide comprehensive information on his condition and needs, although the Home state that she was familiar with the resident. At the meeting, concerns were raised about poor food and fluid intake, loose stools, pressure sores, low mood, a large number of medications, missed injections, pain and diabetes management. The Nursing Associate was asked to request a face to face GP visit and contact was made with the GP Practice on the same day. She was also asked to arrange support from a Dietician, the Speech and Language Team (SALT) and a Tissue Viability Nurse (TVN). The CHC Nurse Assessor noted the missing injection and asked the Nursing Associate to liaise with the Hospital Kidney Care Team, but there is no record of this taking place and the impact of this omission is unclear. It was agreed that the CHC Nurse Assessor would follow up on 16/03/22 that recommendations had been actioned, but Derry died before this follow-up could be actioned. There is a record at the Home that he was not eating and that two blood sugar level readings were generally within the expected range. RD recalls relaying information about Derry's diet and general condition, as the Care Home Nursing Associate was not fully informed.

7.19. Derry's GP review on 10/03/22: A GP telephone review was completed with the Care Home, recorded by the GP Practice as arranged due to Derry being a new patient and not that there was contact from the Home. It was discussed that he was more regularly declining food and fluids and the GP agreed to refer him to the Renal Team. A referral was

sent to SALT and Fresubin nutritional supplement was prescribed, but did not arrive until the day he died. His family recall that previously he either had paracetamol or no medication to relieve the pain of arthritis. As an outcome of the review, he was prescribed Co-Codamol pain relief. The GP attempted to converse with Derry by video, but he was not willing to engage, and rang GN to provide an update. It was decided that a review would take place a week later. There is no record of contact being received from a Diabetic Nurse or being actively followed-up, or of any external support relating to his diabetes. On the following day, Derry declined his insulin and blood sugar monitoring and a high reading was taken on 12/03/22. On 11/03/22, the TVN introduced a plan and advised the Home to request a full lower limb assessment by the GP, which was put on the list for 1 week later. RD recalls visiting Derry on this date and felt that he was more alert and talkative.

7.20. Derry's sister and friend visit on 13/03/22 and 14/03/22: GN visited Derry on the afternoon of 13/03/22 and was very concerned about his presentation. RD visited him on the following day and was concerned that he was motionless, his breath was shallow and he was cold, with only his legs covered by bedding.

As RD was distressed at his appearance, he spoke to the Home Manager and nursing staff, but felt that there was no clarity about his condition or intention to take any action.

7.21. GP visit to Derry on 14/03/22: The care plan was updated on this date and continued the expectation to offer a varied diet and to ensure availability of fluids. A further 2 blood sugar level readings were taken. Derry's sister rang the GP Practice on the morning of 14/03/22 to raise her concern about his presentation, including significant weight loss, and to request a GP visit. She recalls that the receptionist and GP initially said that there was no space and then agreed to a GP visit by the end of the afternoon.

GN also recalls saying that she thought her brother was dying. The GP rang the Care Home and was advised that his condition had deteriorated since the review 4 days earlier. A Bank Staff Nurse said that she was unfamiliar with Derry's usual condition in order to determine whether he had deteriorated. He was diabetic, not eating or drinking, and his blood sugar level was not being regularly checked. The GP visited at 16.15 and found Derry to be jaundiced, exhausted, very unwell and asking for hospital admission. She rang 999 at 16.41 and requested an ambulance to convey Derry to hospital. This was the first contact with the Ambulance Service whilst at the Care Home. He was described as not eating or drinking in recent days, dehydrated and it was not known if he was in an end of life phase. A 1 hour response time was requested, rather than immediate emergency admission, and the call handler explained that the response time could not be guaranteed as the service was extremely busy. The GP advised a nurse at the Care Home to call 999 again if Derry deteriorated before the ambulance arrived. The service was at this point operating under level 3 (level 4 is the highest) of a Clinical Safety Plan, which is an operational management decision when demand is greater than the availability of ambulances and crew.

7.22. Derry died at the Care Home on 14/03/22: He was found dead by a Healthcare Assistant at 17.45, before the ambulance arrived at 19.26. Contact was made by the Care Home with the 111 service at 18.13 to advise that Derry had died. The cause of death was recorded as end stage renal failure, related to dehydration.

7.23. Joyce experienced falls from 15 to 18/03/22: Joyce experienced a series of falls in quick succession. She had a witnessed fall on 15/03/22 and sustained a skin tear to her right elbow, following which the Home's falls protocol was implemented. On the following day,

regular basic medical checks and wound care were undertaken. On 17/03/22, Joyce declined the administration of cream for skin care on three occasions. The care plan, which was reviewed in March 2022, recorded that Joyce does not lack capacity (a general comment), so it can reasonably be assumed that she was considered to have had capacity to decline this care. On the same day, around 22:15, she was found on the bedroom floor, close to her chair. She had leaned forward in her chair to reach a drink on her table, slid out and caught her arm on the table. Two skin tears to her right wrist and lower arm were observed and the wounds were dressed. The plan was for hourly checks, cleaning and dressing every 3 to 4 days or sooner, and to call the GP Practice if there were signs of infection. There was no apparent head injury on observation.

7.24. Joyce - Out of Hours GP contact on 18/03/22: A registered nurse at the Care Home rang the Health 111 line at 12.40 am on 18/03/22, in relation to the fall at 22.15 and the skin tears. An Out of Hours GP returned the call, advising continued physical observations. The falls protocol was followed, with checks undertaken, but Joyce was unsettled, shouting and declining observations, so was supported from her bed to her chair at 3:00 am. Joyce had a further unwitnessed fall at around 6.30 am and was found on the bedroom floor next to her chair with a bump to the front of her head. A further call was made by the registered nurse to 111 at 07.28 and the Care Home received a call from a regular GP, having received the Out of Hours GP information. It was decided that there was no need for the GP to see or assess Joyce, unless there were further concerns. It is unclear whether the GP was aware of the second fall, or that the Out of Hours GP had not seen the wound or head injury. Her niece, KR, visited on this date and viewed pictures of the wound.
Basic medical checks and wound care were undertaken throughout the day on 19 and 20/03/22, new photos of the wound were taken and the wound record was updated. It is unclear whether wound care and monitoring were always undertaken by a registered nurse and there was no record of progression.

7.25. GP visit to Joyce and hospital admission on 21/03/22: A Carer at the Home, not a registered nurse, rang the GP Practice on 21/03/22 regarding Joyce's arm, as she was concerned that the wound might be infected. The GP asked for a photo of the wound to be sent and, on receiving this, rang the Home and asked the staff member to ring for an ambulance, as the arm appeared to be infected. The Independent Reviewer understands that the wound was in a particularly poor state and that sepsis was indicated. It is not clear when the infection started and medical/nursing contributors to the review confirm that, whilst the onset can be in quick, it is unlikely to have presented within a matter of hours.
The Carer rang 999 at 10.00 am and said that Joyce's arm appeared to be infected and her blood pressure was low, that her GP has advised hospital admission for assessment. The call handler advised that, as the service was busy, a clinician would call back within 2 hours to triage further. It was understood that Joyce was unwell but not deemed to require immediate admission. A second 999 call was made by the same Carer at 11.01, to query the decision for further triage, as her manager was requesting an ambulance to attend. The Carer was advised that the GP should arrange hospital admission and a timeframe would be agreed, as it was local policy that all non-health care professionals when calling 999 are taken through the triage process. The Yorkshire Ambulance Service (YAS) log of the call reads that the Carer said she was "doing a nurse's job as they had no nurses." The same Carer rang the Surgery again at 11.20 regarding the ambulance not being sent and was given the healthcare professionals number to request an ambulance. She rang this number and was advised that the line was only for use by healthcare professionals (medical or nursing qualified practitioners). The YAS clinician rang the Care Home at 11:53, within the stated timeframe, and medical triage was undertaken. An ambulance was dispatched, which arrived at the Home by 12:59 and Joyce was conveyed to the Hospital

Emergency Department by 14:16.

7.26. The Care Home case notes on 21/03/22 mention a referral to the My Therapy Service regarding a mobility assessment. The notes also refer to an assessment and diagnosis of vascular dementia.

The Home Manager had contacted the Community Social Work Team on 22/03/22 to advise that the GP had undertaken a medical review and had 'made a few changes', due to a number of falls. The care plan was updated on this date, regarding falls prevention; including the planned purchase of socks with grips on the soles and a non-leather chair, increased safety checks when administering medication, to refer to the continence care plan, and to encourage Joyce to spend more time in communal areas.

7.27. The Hospital admission notes state that Joyce had experienced multiple falls, had skin tears to her right forearm and elbow which appeared to be infected, and had cellulitis and oozing bandages on her legs. The assessment record for 21 and 22/03/22 refers to right forearm cellulitis. On responding to a Hospital Doctor's request for information, a Care Home staff member said that Joyce called out all the time and that this was 'normal' for her.

7.28. Joyce died in hospital on 24/03/22: The cause of death was recorded as sepsis, cellulitis, peripheral vascular disease and vascular dementia. A Safeguarding Adults concern was raised by the GP concerning a delay in the Care Home seeking medical attention, but this was not progressed as Joyce had died.

8. Analysis & findings

Overview

8.1. It should be recognised that professionals and agencies were functioning within a difficult period due to the impact of continued austerity and the Covid pandemic. Within this context, there is some evidence of attentive and personalised practice in responding to the complex needs and risks presented by Derry and Joyce. However, it has been correctly acknowledged by the Safeguarding Adults Board that they experienced neglect and they were let down by the services they depended on to provide quality care and safety. In the view of the Independent Reviewer, Hospital discharge planning was not adequately coordinated, streamlined or holistic; as discharge services were not coordinated and some essential services were not in place, the complex care and engagement needs for both Derry and Joyce were not conveyed (also whilst in the community), and the documentation was not sufficiently joined-up or comprehensive. Care and nursing needs were not adequately met or coordinated by the Care Home and external agencies. There were delays in securing medical attention and hospital admission. Also, there was not a sense of professional curiosity and active listening to reach an in-depth understanding of their lived experience, which was necessary to enable fully personalised care. The Independent Reviewer acknowledges the open and positive contribution of agencies' representatives, as well as families and a close friend, in learning the lessons to reduce the risk of similar circumstances arising in the future. Significant improvements have been made, as recognised in this report, and ideas for further improvements have been raised and committed to in discussion.

8.2. How safe was the hospital transfer of care?

8.3. Overview: It is evident that there are established, comprehensive arrangements for hospital discharge planning, involving the safe transfer of patients from hospital to care home and community settings.
These arrangements are overseen by a large, integrated Hospital Discharge Team, which incorporates close working between a Discharge Coordinator, Nurses and Social Workers. However, these arrangements seem to be less effective in meeting complex and rapidly worsening needs on discharge; in terms of providing coordinated, holistic assessments and streamlined transfer documentation, as viewed and discussed by the Independent Reviewer. The gaps relevant in this review concern the commissioning and checking of the delivery of essential services, as well as the communication of good practice in response to worsening conditions and poor engagement by residents. They also concern follow-up by the Care Home and external agencies after discharge.

8.4. Discharge pathway and documents: Medical and nursing staff on hospital wards plan discharge from the point of admission and, when ready for discharge, the patient is considered to 'have no reason to reside'. There is a 'discharge to assess' arrangement that is used when it is considered that this meets patients needs, if the patient is eligible for care home admission and the long-term funding plan is unclear. Health and Social Care agencies have up to 4 weeks to conduct an assessment on discharge to the home. At this stage, part 1 of a Transfer of Care (TOC) form is completed and transferred to the Hospital Social Work Team.

The Social Work Team visits the patient on the ward to complete an initial assessment, an interim support plan (a quick snapshot) and part 2 of the TOC form which is shared with the home and any relevant others. The patient is transferred out of hospital with a view to receiving a full Care Act needs assessment by the Hospital Social Work Team, followed by 3 monthly reviews. This system has clear merits in preventing delayed discharges when patients are medically fit to leave hospital, and when discharge needs are relatively straightforward. Also, discharge can be delayed if there are safeguarding concerns and information can be shared at MDT meetings and ward 'huddles'. A discharge letter is also completed by Medical and Nursing staff on the ward and is forwarded to the GP Practice and any relevant others.

Whilst hospital discharge concerns can be related to both Derry and Joyce, this report will focus on Derry in this aspect of care, as there was a considerably shorter timescale from discharge to rapidly worsening health.

8.5. Derry: In circumstances of complex and rapidly changing needs, as experienced by Derry, it may be beneficial to consider earlier Hospital Social Work involvement and a comprehensive, holistic assessment and care plan either before or immediately following discharge.
Information on specific support needs, such as diabetes and TVN follow-up and encouragement to mobilise were relayed. However, services were not confirmed before discharge and a clear and coordinated plan was not in place; also involving full consideration of aspects such as effective pain relief and actively listening to Derry's concerns. A Hospital Social Worker attended the Decision Support Tool (DST) meeting for Derry at the Care Home on 09/03/22, by which stage his health had declined rapidly. The discharge letter was timely and provided reasonably detailed information to the Care Home and GP Practice on medical treatment and nursing needs.

It was not, however, specific about actions for the Care Home and the GP Practice to take, including accessing diabetes and TVN support, and it was not holistic in regard to wider needs concerning his motivation, low mood and poor engagement. The TOC form is not shared with the GP Practice and, for Derry, it did not refer to his lack of engagement, low mood and services to be followed-up by the Care Home. A monthly kidney disease injection was not received or followed-up on hospital discharge. Derry was seen on the ward by a Care Home representative, which was good practice. It seems that care homes assessing patients on wards has reduced and ensuring that this is a priority when there are complex needs would also make discharge planning more rigorous. The Care Home intends to prioritise this practice.

8.6. Patient Safety Incident Response Framework (PSIRF): It may be beneficial to consider a more streamlined, holistic and coordinated discharge documentation in circumstances of complex and rapidly worsening conditions. The Hospital Trust is considering the adoption of a new form, which will amalgamate the TOC form, interim care plan and discharge planning letter, as well as taking account of the trusted assessor role.

8.7. **How effective was the quality of care whilst living in the Care Home?**

Previous care in the community: Both Derry and Joyce received a comprehensive community care package, involving community nursing and domiciliary care support. However, their families were concerned that services were not sufficiently coordinated or personalised. They had key strengths in terms of their characters and it is possible that spending time to understand their experiences of low mood and anxiety may have led to an improved understanding of how to encourage their engagement and a slower decline.

This learning could have been shared with the Care Home and other agencies to reduce the increasing disengagement of Derry and the distressed calling out by Joyce. Whilst Derry and Joyce experienced rapidly worsening conditions when in the Care Home, concerns about physical health needs and engagement were apparent before admission.

8.10. Specific nursing and care standards at the Care Home: It has been established that the care and nursing needs of both Derry and Joyce were neglected whilst they were resident at the Care Home. There was not a sense that the Home had a grasp of the rapidly worsening conditions affecting the two residents; due it seems to deficits in nursing awareness and handovers, alongside deficits in communication between involved agencies. There were concerns about the availability of nursing staff with an awareness of residents, about the morale of staff, and about communication by staff with each other and with residents.

8.11. Derry: Concerns about care involved insufficient encouragement with mobilising, insulin administration and eating and drinking, as well as not following-up the provision of a diabetic nurse and care plan, and kidney disease injections.
There were also gaps in the recording of blood sugar monitoring.

Derry's sister recalls visiting on one occasion when he was soiled by faeces, which he said had been for two hours, and a staff member responded to her request for support that he would have to wait as she was busy. She felt that there was generally a limited number of staff on duty, including registered nursing staff at night, and that some staff did not seem

to be familiar with his needs; although they initially tried to encourage him. He was in considerable pain due to rheumatoid arthritis over a prolonged period, including before his admission to the Care Home, and painkillers were not increased to Co-Codamol until a very late stage. It is the view of his sister and friend that pain was a very significant factor in his declining support with mobilising and it is unclear why increased pain relief was not an earlier consideration. However, it should be noted that Derry resided at the Care Home for a short period when he was very unwell, with limited opportunity to develop a rapport and to encourage engagement and compliance with care and treatment, and it seems that staff were initially more attentive and caring.

8.12. Joyce: An internal investigation by the Care Home in March 2022 acknowledged that there were concerns regarding the delivery of care. These mainly related to the prevention of falls, that Joyce should have been provided with non-slip socks and a non-leather chair, more encouragement to spend time in communal areas, a medication review and wound care planning. It seems that a referral to the My Therapy Service for a falls assessment was made in February 2022. A Tissue Viability Nurse (TVN) was engaged and there was some attention to skin and leg ulcer care. However, there was a delay in the TVN service starting in response to the referral. The Independent Reviewer acknowledges that there are no key performance indicators in terms of a timely response and that the service provides support and advice, with an expectation that staff in nursing homes possess the knowledge and skills to care for wounds. It also seems that nursing staff were not always available to follow the guidance received. Her niece recalls that staff were not responsive in following up concerns about her skin condition and in supporting her with cleaning due to urinary incontinence.

Joyce preferred to remain in her bedroom, was at significant risk of falls from her chair and regularly shouted for support due to an anxiety about being left alone and possibly about falling, which was also evident before admission. Whilst her needs were complex, there was a tendency to regard her shouting as the norm, rather than attempting to understand and allay her anxiety and to adequately encourage stimulation. It seems that an assessment regarding vascular dementia did occur in March 2022, following a trail of referrals to the Memory Service and intervention since May 2021, although the details of this are unclear. The Rapid Action Team may also have been engaged to provide support with addressing the underlying causes of her shouting, but there was not a clear plan to address this area of concern. Her niece also recalls that Joyce was generally not provided with her own clothing, which was important to her sense of self.

8.13. Improved care standards: The Care Home has acknowledged that there were shortfalls in practice and the Regional And Quality Assurance Team Managers, along with a new Home Manager recruited in May 2022, state that they have introduced root and branch improvements within the Home; working alongside Local Authority Commissioners.

They confirm these as including overall management oversight; staff performance measures to ensure that the entire team is on the same journey, with improved communication and morale; handovers between all shifts; a flash meeting every morning to discuss all residents; daily monitoring, management oversight and escalation arrangements when residents decline food, fluids or care; medication audits; additional clinical support to staff in identifying changes in residents conditions and escalating concerns; electronic recording; Quality Assurance Team audits of falls and accidents; floor walking by managers several times a day; life stories with all residents; resident of the day; as well as the aforementioned improvements in their relationship with the GP Practice and

weekly face to face ward rounds. The managers state that they have as yet to finalise improvements in supervision and core training, which have been raised by the Commissioners. They intend to embed and sustain these improvements.
It is also noted by the Home Manager that the Care Home is now in a much better staffing position, with regular Nurses and Care Practitioners working across both general nursing and dementia nursing areas. The managers wish to have an opportunity to apologise personally to the families of Derry and Joyce for the care having fallen short of reasonable standards and to give assurance of improvements in place to meet the needs of current and future residents.

8.14. External support and multi-agency communication: There was also not a sense that involved agencies collectively had a grasp of the rapidly worsening conditions for Derry and Joyce, whilst they were residing at the Care Home, as there was limited scrutiny of developing needs, engagement with the Home and the two residents, and communication with each other in fulfilling post- discharge assessment responsibilities. These were missed opportunities to have observed the rapidly worsening conditions in the absence of receiving Care Home information.

8.15. Improved Care Home monitoring: The Local Authority Commissioning Team has a continuing 'enhanced surveillance' arrangement in place to monitor improvements at the Care Home.

On a wider basis, there is also a multi-agency Quality Intelligence Group, which is a sub-group of the Safeguarding Adults Board and meets every 6 weeks to discuss concerns about providers, although not individual residents.

8.16. **How timely was medical attention and hospital admission?**

8.17. Overview: There was an unreasonable delay in securing medical attention and hospital admission for Derry and Joyce, due to a range of contributory factors. These primarily involved a lack of awareness about worsening health conditions, a delay in escalating concerns to the GP, medical reviews conducted over the telephone and virtually, and not actively listening to the concerns of families and a close friend.

8.18. Derry: An internal investigation by the Care Home concluded that a significant decline in Derry's health was evident from 26/02/22 and that this should have been escalated to the GP surgery at the time. There was a further noted deterioration and missed opportunity to escalate concerns on 03/03/22, when Derry was eating and drinking less and his general presentation was worsening.

The Care Home did not discuss his deterioration during a telephone review with the GP Practice. The Practice had not yet seen Derry directly and, whilst acknowledging that there were Covid restrictions, it was felt that Derry would not engage with a virtual review. His sister and friend were unable to relay their concerns to the GP because neither were next of kin and there was no available appointment, but these reasons should not have prevented the disclosure of information and consideration of proportionate action. It seems that a reliance on nursing staff at the Care Home who were not familiar with Derry and possibly a breakdown in handovers between staff may have limited the awareness of worsening health conditions. At the virtual Decision Support Tool (DST) meeting on 09/03/23, the CHC Nurse Assessor asked the Care Home representative to escalate concerns to the GP and agreed to follow up a week later. Whilst the Independent Reviewer acknowledges that this was good practice, there was an opportunity for attending agencies

to escalate known concerns about deteriorating health directly to the GP Practice (thereby enabling engagement between the Practice and the Home). On the following day, a GP telephone review was conducted, as Derry would not engage with a virtual review, and the Care Home raised Derry's deteriorating condition for the first time. This led to some follow-up medical actions and a decision to review in a week. There seems to have been grounds for the Home to have requested an emergency ambulance on 13/03/22, when there was a significant deterioration in his presentation, and the current Home Manager states that staff would contact 999 if a resident's health deteriorates and this is appropriate. The GP visit and call for an emergency ambulance on 14/03/22 were prompted by family rather than the Care Home, by which time Derry was acutely unwell and his body was effectively shutting down. The ambulance response time was category 3, not an acute emergency response, and the GP was advised that the ambulance may not arrive within the requested 1 hour period, due to pressure on the service.

Derry died within about an hour of the call and it is not possible to conclude whether a swifter response may have led to a different outcome. It is not within the remit of the review to question whether the ambulance should have been requested on an emergency basis.

Also, whilst meeting ambulance response times is a national concern and is highlighted by this report, it is not within the remit of the review to directly impact this resource issue.

8.19. Joyce: When Joyce fell from her bedroom chair on 15 and 17/03/22, receiving skin tears to her arm, it seems that appropriate wound management (cleaning, dressing and monitoring) was provided, although it is unclear whether this was always by a registered nurse and the records did not indicate whether healing was progressing. There was also an escalation of concern about the wound to the Out of Hours GP service on 18/03/22 (although indicating that this was a routine contact) and about possible infection on 21/03/22, albeit in the latter case by a non-nursing member of staff. However, it seems clear that the infection would have deteriorated to such a poor condition over a matter of days and should have been noticed earlier, that photos should have been requested by and sent more promptly to the GP Practice, and that hospital admission was unreasonably delayed. The GP Practice were unaware of the previous falls in recent days and of the extent of the wounds.

There was a delay in arranging ambulance attendance, due to a non-nursing member of staff making the call and triage initially being offered. The triage was provided within the confirmed two hour window and an ambulance was dispatched. It is unclear if this was significant in health terms. The Independent Reviewer understands from the Yorkshire Ambulance Service that it is agreed practice for healthcare professionals to call 999 via the healthcare professional (HCP) route when requesting an ambulance.

The Home Manager, in relation to the skin tears, has identified a need for comprehensive details to be recorded by the Home on wounds, signs of infection and a robust escalation process. On a positive note, the falls protocol had been followed and the GP contacted, the falls risk assessment and care plans had been updated appropriately and promptly, and staff had been proactive in taking photos of the wound and evidencing these on the body map.

8.20. GP ward rounds: There have been weekly ward rounds by the GP Practice at the Care Home for many years. However, it seems that in the timeframe of March 2022, these were conducted virtually due to Covid restrictions. Subsequently, an arrangement of face to

face weekly ward rounds has been put in place. The Home draws up a list of residents requiring review and can also request visits on other days as necessary. The GP Practice has further decided to ensure that all new residents are seen face to face at the ward round immediately following their admission, there will be an initial checklist and review, a welcome leaflet will be provided to patients and families with contact details, a priority line will be set up for care homes, and a line will be set up for an hour a day for families to relay concerns (additional to the general service). The Independent Reviewer acknowledges that these are positive initiatives that should benefit residents and relatives.

8.21. Out of Hours GP Service: The service completed face to face visits, as necessary, throughout the period of the Covid pandemic. On receiving contact from the Care Home on 18/03/22, after Joyce had fallen and received wounds, advice was given on wound management. However, the task to the GP practice, that no action was needed, lacked clarity as the intention was to say that the Home could manage rather than there being no need for the GP to review.

As a pending improvement, the outgoing messages from the Out of Hours service to GP practices are under review and will be updated to highlight when specific further intervention is required. It is also notable that there are two systems for relaying information; most practices use SystmOne, which has a shared element but receiving primary care staff will only filter information if they know it has been sent, and some use EMISS, which has no shared element.

8.22. Yorkshire Ambulance Service: As highlighted, meeting ambulance response times is a national concern, related to resource provision and outside the reach of this review. The recognised response times are category 1 (immediate), category 2 (arrival within 18 minutes) and category 3 (arrival within an agreed timescale up to 4 hours). Category 5 covers a clinician call-back to triage within 1 hour. A Clinical Safety Plan is in place, allowing for delayed response times when there is excessive demand on the service. Within this context, it does appear that the Ambulance Service responded correctly to calls relating to both Derry and Joyce.

An emergency response was not requested and, for Joyce, the caller was not a recognised healthcare professional. In 2019, the Yorkshire Ambulance Service introduced the national framework for GPs and other Health Care Professionals who request urgent or emergency ambulance transportation. This incorporates standards, including equity of access for all seriously unwell and injured patients.

There seems to be an understanding among some participants that the Ambulance Service grades response times for residents in care homes as a lesser priority than residents living in their own homes, even though there is no access to onsite medical intervention.

However, the Ambulance Service representative has clarified that location is not a consideration in categorising response times. She states that the service uses the Advanced Medical Priority Dispatch System (AMPDS), a unified system used to dispatch appropriate aid to medical emergencies, including systemised caller questions and pre-arrival instructions. This ensures that responses are made according to the clinical need of the patient regardless of the location.

8.23. How effective were safeguarding adults responses to concerns?

8.24. Overview: There were opportunities to raise safeguarding concerns regarding both Derry and Joyce, whilst living in the community and at the Care Home, which may have provided the impetus for a coordinated, multi-agency, risk management response. These related to neglect and self-neglect. However, self-neglect may not have been a consideration if there had been a more personalised approach and a proportionate safeguarding adults response was not dependant on adopting a formal enquiry. On the occasions that safeguarding adults concerns were raised, these were not followed up as safeguarding.

8.25. Derry: When Derry was living in the community during 2020 and 2021, he was at times declining insulin treatment, food and drink, and he was also not motivated to mobilise. Whilst these circumstances could have triggered a safeguarding response due to self-neglect, a multi-agency risk management response that considered potential root causes of these circumstances, such as pain management and understanding the reason for non-engagement, did not require a formal enquiry. When in hospital during November 2020, a safeguarding concern was raised regarding pressure ulcers, but this did not progress.

8.26. Joyce: In March 2020, Community Nursing raised a safeguarding concern regarding self-neglect, which did not progress to an enquiry. However, Joyce transferred to the Care Home the following year, where her needs could be met in terms of registration requirements. The Care Home raised 5 safeguarding alerts between November 2021 and February 2022, mainly regarding falls, which were potential missed opportunities for a multi-agency risk management response. The GP Practice raised a safeguarding concern in March 2022, regarding the delay in seeking medical attention, which was not progressed when Joyce died.

8.27. How effective was the consideration of mental capacity and active listening?

8.28. Mental Capacity: Whilst it does not appear that a Mental Capacity Assessment was undertaken in respect to Derry or Joyce, there is evidence of agencies risk assessing whether there was a need for a statutory assessment.

For Derry, there is a GP record in August 2021 and a Yorkshire Ambulance Service record in November 2021, both stating that he was deemed to have decision-specific mental capacity.

The Yorkshire Ambulance Service has a two stage procedure, with a risk assessment followed if appropriate by a statutory assessment. His friend, RD, believes that he had mental capacity to make informed decisions about his care needs. It is unclear whether Derry may have lacked the mental capacity to make decisions about his care in March 2022, when his health had significantly deteriorated, but he was accepting of hospital admission.

For Joyce, the Ambulance Service deemed that she had decision-specific mental capacity in March 2022 and she was also accepting of hospital admission.

8.29. Active listening: Although it is difficult for agencies to engage with service users who have fully or partially disengaged, there was not a sense of professionals sitting with Derry to discuss and reach an in-depth understanding of his concerns about his deteriorating health and his loss of functioning and independence; or of his potential areas of

motivation. This personalised and strengths-based approach, if adopted when Derry was living in the community and in the Care Home, may have supported staff in encouraging him to accept help in improving his health and well-being. Instead, his non-engagement was considered to be his norm and a presentation of challenging behaviour. There was an over-reliance on virtual communication, due to the restrictions imposed by the Covid pandemic, which further restricted meaningful engagement. This constraint has in large measure been removed. Both his sister and friend recall that he was motivated to return home, but that he was frustrated, giving up to a degree as he realised that his health was not improving, experiencing low mood and possible depression, which was not formally assessed. There is an indication that his low mood emerged by late 2020 and increased during the following two years. His friend believes that he may have declined food to reduce the impact of bowel incontinence. Both Derry's sister and friend were persistent in raising concerns with the Care Home and GP Practice, without their voices being promptly heard and without knowledge of other avenues to raise their concerns. It is also possible that further attention to pain relief may have led to Derry feeling more disposed to accepting support and to mobilising. For Joyce, there was not a sense of professionals sitting with her to understand her anxiety about being touched, being left alone and falling. Instead, her calling out was regarded as her norm and considered to be challenging behaviour. It is also a concern that a nurse, on contacting the Out of Hours GP to report that she had fallen, seemed to be routinely following a protocol rather than actively seeking medical attention. There is a risk that professionals can become desensitised and detached through exposure to the needs of older, disabled and unwell service users, thereby potentially developing an ageist approach to caring. Sharing care plans with relatives has been raised as a concern in this review and, whilst both Derry and Joyce were deemed to have capacity relating to their care needs, the current Home Manager states that relatives are encouraged to be part of the care planning process, as long as the resident is consenting to this.

8.30 **How did environmental and resource issues impact on service delivery?**

8.31 Environment: There were concerns about the care received by Derry and Joyce in both community and Care Home settings. Their care needs could have been met in the Care Home, respectively in the general nursing and dementia nursing units, along with the support of external agencies. It does appear that the Covid pandemic had some negative impact on the delivery of care to Derry and Joyce, as there was a tendency towards virtual contacts in circumstances that required close engagement.

8.32 Resources: There is a continuing impact of austerity on the resources available to Local Authority, Health and Independent agencies, which undoubtedly affects staffing levels and the provision of services. However, a lack of services has not been raised as a contributory factor for any specific gap in services or practice standards for Derry or Joyce.

8.33. **How compliant were agencies with key statutory requirements?**

8.34. Legislation: The Care Act 2014, section 9, requirement on the Local Authority to provide care needs assessments and to meet eligible needs was met in respect to the delivery of care packages to Derry and Joyce in the community and in arranging Care Home provision. Health funding was sourced as appropriate. Agencies were also generally compliant with the requirements of the Mental Capacity Act 2005 and the Equality Act 2010. However, multi-agency service provision and practice standards did not have a sufficient focus on personalisation, adequately meeting needs and risk management.

9. Recommendations

9.1. Overview: These recommendations are based on the specific learning in this review, with some consideration of learning from national reviews. It is recognised that significant improvements have already been implemented by agencies and the emphasis is on an assurance that these are embedded and effective, alongside the further agreed recommendations. The Safeguarding Adults Board should have oversight of sustained improvement.

9.2. Safe hospital transfer of care: The Hospital Trust should consider a review of the safe transfer of care pathway and documentation to ensure that it provides oversight through a lead professional of a coordinated, holistic, assessment and care plan; with services in place and all agencies aware of expectations at the point of discharge. This may be aligned to the current consideration of a new coordinated form. The review should specifically cover expected standards; including the arrangement of essential services before discharge and checking that they are in place post-discharge; care home representatives visiting prospective patients with complex needs before discharge as a matter of course; sharing of vital information on individual needs such as effective approaches to encouraging receipt of care and treatment; and for patients with complex needs (including concerns about worsening health conditions and engagement) to either receive a full assessment in hospital or within a short period after discharge.

9.3. Meeting care needs: The SAB should seek assurance of the Care Home improvements relating to care needs from the Home and Local Authority Commissioning Team. This should be aligned to reassurance that arrangements for monitoring safeguarding and quality concerns in care homes are robust, either as a component of the Quality Intelligence Group or as a separate arrangement.

9.4. Access to records: There should be consideration by the Integrated Care Board (ICB) of the feasibility of consistent access to the SystmOne primary health care records across all GP practices, as well as the Continuing Health Care (CHC) Service.

9.5. Multi-agency communication and risk management: There should be consideration by the SAB of the establishment of a Multi-Agency Risk Management (MARM) panel to consider risk assessment and management in complex circumstances. This may be accompanied by risk training, to include professional curiosity. The Primary Care Network, which has the capacity to fund non-medical posts, might also be the basis for considering the development of an underpinning practitioner-level risk management structure.

9.6. Timeliness of medical attention and hospital admission: The SAB should seek assurance of the improvements made and intended improvements by the Care Home, GP Practice and Out of Hours GP Service, most notably on awareness and escalation of worsening conditions and on regular face to face visits which meets a family desired outcome. The improvements should also be considered by the Care Quality Commission (CQC) and both Adult Social Care and Integrated Care Board (ICB) Commissioners, as appropriate, in undertaking regulatory and contractual responsibilities.

9.7. Safeguarding adults concerns: The SAB should seek assurance from partner Agencies that staff have been provided with safeguarding adults training at an appropriate level, to

include the interface with risk management arrangements.

9.8. Mental Capacity Assessments: The SAB should seek assurance from partner agencies that staff have been provided with Mental Capacity Act and Deprivation of Liberty Safeguards (Liberty Protection Safeguards) training at an appropriate level.

9.9. Active listening: The Local Authority and Health Commissioners should consider the provision of an information leaflet to new care home residents and their families, including contact details to raise quality and safeguarding concerns.