AM – Formerly resident at Homemead Care Home in the London Borough of Richmond- upon- Thames

Safeguarding adults peer review of learning arising from Safeguarding Adults Enquiry

Clive Simmons, Wandsworth Safeguarding Adults Policy and Development Manager

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1.0 Introduction

1. Mrs AM died on 6 November 2015 at Homemead Care Home in Teddington.

2. The circumstances at the time that Mrs AM died, and the decisions and actions of partner agencies in the months leading up to her death, led to the initiation of a Safeguarding Adults Enquiry on 6th November 2015. The enquiry is ongoing at the time of writing this report.

3. As the safeguarding adults lead for the London Borough of Wandsworth, I have completed a proportionate safeguarding adults peer review on behalf of the Richmond upon Thames Safeguarding Adults Board to ensure that multi-agency learning and actions are in place.

4. A proportionate safeguarding adults review is an appropriate response as AM was neglected at the time of her death and partner agencies could have worked more effectively to meet her needs and protect her in the months preceding her death. The purpose of the review is to determine what the relevant agencies and individuals involved with AM might have done differently that may have prevented her death, including a review of the effectiveness of relevant procedures, and to ensure that there is a commitment to act on this learning by developing best practice to minimise the risk of similar harm occurring again.

5. In completing the review I have considered the documentation held by LBRUT Adult Social Services Department in respect of the Safeguarding Adults Enquiry, and interviewed the following agency and family representatives between 22 February and 12 May 2016:

Christina M -	Daughter of AM
Andrew Laundy -	Senior Social Worker, LBRUT ASSD
Don Rainbow -	Acting Quality Assurance Manager, LBRUT
Abi Nimmo -	Community Occupational Therapist, LBRUT
Amy Clayton -	Community Occupational Therapist, LBRUT
Jeff Levine -	Assistant Director of Care, Central & Cecil Housing Trust
Yomi Ogunsola -	Service Manager, HRCH
Sandie Cox -	Safeguarding Adults Professional Lead, HRCH

6. This overview report, including learning points and actions, will be presented to the Richmond-upon-Thames Safeguarding Adults Board for endorsement on 23 May 2016.

2.0 Life story of AM

7. The following life story of Mrs AM has been provided by her daughter, Christina M.

8. Mrs AM was born in 1935, spent her childhood in Wiltshire, and was one of three sisters. She attended a Quaker school, although she was not a practising Quaker in adulthood. On leaving school, Mrs AM lived in France as an au pair and, on returning to England, worked for the BBC in London. She worked most of her life, including in the art and history department at Kingston University. Mrs AM married in 1960 and her husband, who was an artist, died in 2008. She had a strong academic, artistic and musical background, was an avid reader and a focal point in the wider family for advice.

9. Mrs AM and her two daughters noticed a deterioration in her memory during 2010 and 2011, leading to admission to Homemead in 2012. Her daughter feels that initially she looked out of place at Homemead as she was well presented and active. She was a very happy person in nature and was often laughing and singing throughout her life, including at Homemead. She was also very grateful for the support she received at Homemead and had a good rapport with staff.

10. Mrs AM's daughter noticed a decline in her mobility from 2014 and she feels that Homemead gave up too easily on encouraging her to continue walking. She also feels that there was a decrease in the level of communal activity, including singing and dancing; Mrs AM loved these activities and companionship.

11. Mrs AM's daughter also feels that agencies involved in assessments during the latter months of Mrs AM's life should have involved her more as a family member and discussed options with her for increased support, even if this would have included discussion of

transfer to a nursing home which she would not have wished to happen. In this regard, she is concerned that the continuing care assessment, which was received by her after Mrs AM's death, was not followed through and discussed with her.

12. She considers that her mother was isolated when in her bedroom as it was at the end of a corridor and staff tended to be reluctant to check on her. Mrs AM's daughter believes that the care home was short staffed on the final day of her life and should have contacted family if her mother was presenting as unwell, as had been the previous practice. She is not convinced that her mother would have chosen to stay in bed rather than have companionship, even if unwell.

3.0 Key events, decisions and actions

13. **Background to placement:** AM was a resident at Homemead, a care home in the borough of Richmond upon Thames with provision for dementia care, from November 2012. Homemead is not registered for nursing care and has capacity for 24 residents, most of whom have a diagnosis of dementia. Staffing is provided on a ratio of at least 1 member of staff to 5 residents and there are 4 staff on duty during nights. The home is reliant to some degree on agency staff, although with some consistency of staffing maintained.

14. **Increased dependency:** A significant decline in AM's mobility and transfers was evident from 2014 onwards to the point that she was no longer weight bearing. This coincided with a progression of her dementia. AM was supported with all personal care. She could express her needs, presented as content and had a positive relationship with staff.

15. **Homemead and Community Occupational Therapy:** Significant Occupational Therapy input was provided between 21 July and 13 October 2015. An OT assessment on 21 July recommended assistance of two carers and use of a passive hoist for transfers to bed in the evenings as AM was too fatigued to manage with a standing hoist at these times. Homemead carers had raised that they were experiencing increasing difficulty in providing care and a sliding sheet was provided to assist with bed positioning. Further OT visits were completed on 23 and 30 July, the latter joint with the Community Matron, and it was decided to dispense with the standing hoist completely due to AM receiving bruises to her shins from the equipment. OT visits were also completed on 12 and 20 August to provide a tilting armchair and to initiate a Personal Handling Plan reflecting manual handling requirements. On 26 August the Homemead Manager contacted the OT and discussed a bed system (sheets to use in turning on bed). The OT agreed to Homemead using the sheets (they had two spare sets) and considered that staff were managing manual handling competently before finishing her involvement on 27 August due to ill health and completing handover information on 5 September.

There was a gap in Occupational Therapy allocation between 27 August and 6 October. During this period the OT service was not contacted by Homemead to raise any concerns. A new OT was assigned on 6 October and visited Homemead on 13 October to demonstrate the bed system which had subsequently been delivered to the care home. The OT recommended 4 staff to complete turning on the bed (two staff either side) and Homemead raised a concern that this level of staffing was not available at night. Although not clearly recorded, the OT recalls stating that the procedure would be manageable but difficult with two staff attending instead of four. The OT discussed the use of pillows and wedges by staff in supporting AM in bed and, whilst this is considered to be acceptable practice, it was not an OT directive. The OT subsequently consulted with the previously assigned OT on using a slide sheet for moving and handling, which meant that the Personal Handling Plan was not provided, although the OT considered that staff were managing manual handling safely. The OT was due to visit AM again on 6 November 2015.

16. **Homemead and Hounslow and Richmond Community Health Care NHS Trust:** The District Nursing service was contacted by Homemead on 3 September and by the General Practitioner on 9 September 2015 to request a continuing health care assessment. The referrals were received at the single point of access in the borough. A Community Matron completed the District Nursing element of the assessment on 10 September and emailed this to the Homemead Manager on the same date, copied to District Nursing colleagues. There was a delayed response in part because the Community Matron was absent due to sickness from 14 September and subsequently left the post without a handover arrangement. The Homemead Manager emailed the Community Matron on 14 September to confirm that the Homemead element of the assessment had been completed and that the form had been forwarded to AM's daughter for her signature. This email was not seen by the Community Matron and other District Nurses were not copied into the communication. On 17 September the Homemead Manager again emailed the Community Matron (not seen and not copied to other District Nurses), confirming that AM's daughter had signed and returned the assessment form. On 22 September the Homemead Manager emailed the Community Matron (not seen) to confirm that the General Practitioner had signed the assessment, which was now complete. One month later on 21 October the Homemead Manager emailed the Community Matron (not seen), copied to AM's daughter, requesting an update on the assessment. The Homemead Manager did not widen or escalate communication about the delay. There was also no follow up by the District Nursing service to ensure that assessment documents had been forwarded to the Continuing Health Care Team. The Community Matron completing the assessment did not

identify a need for wider assessment or additional clinical input. On 2 November 2015 AM's daughter emailed the Community Matron (not seen), copied to the HRCH PALS service, requesting an update. AM died within a few days of this communication, before a decision on continuing health care was reached.

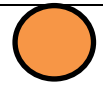
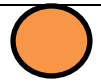
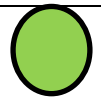
17. **Homemead and London Borough of Richmond upon Thames (LBRUT) Quality Assurance Team:** The Quality Assurance Team completed a light touch validation visit for compliance at Homemead three months prior to AM's death. There was a delay in producing the validation report. There was also a missed opportunity as the audit did not highlight a potential risk due to all care plans being updated onto electronic files, and reliance by staff on old paper care plans or incomplete files during the transition.

18. **Circumstances of death:** The care plan for AM included a requirement for positioning on her back in bed, which appears to have been an internal care home stipulation. On 5 November 2015, AM presented to Homemead staff as having a fever and remained in bed all day. There was no referral for medical assessment. She was cared for by two agency staff key workers who were familiar with AM and they made the decision, without consultation with any external agency and without recording the reason for this decision, to support AM on her side to minimise the risk of developing pressure ulcers. When the night staff came on duty, despite a visual check on AM by the Senior Care Assistant, the decision to support AM on her side was not questioned or changed. The bed system, which would have minimised the risk of rolling onto her face, was not used. It is possible that AMs arms were not positioned to prevent rolling. The responsibility for the provision of training to care home staff on bed positioning and skin integrity, as clarified by Occupational Therapy and HRCH, rests with the service provider.

    The care plan for AM included a requirement that night staff at Homemead would complete hourly checks and this did not happen on the night that AM died. The final check was at 21.45 on the night of 5 November and AM died at some point between then and when she was discovered at 6 am on the following morning, having apparently rolled onto her face and suffocated. It appears the record of check calls was later added to by the carer.

19. **LBRUT Adult Social Services Department:** There had not been social work input to review AM's needs, as this was a private placement, and there was no referral from partner agencies to trigger a reassessment of needs.

4.0 Learning Points & Actions

AGENCY	LEARNING POINTS	ACTIONS	EVIDENCE	LEAD OFFICER	TIMEFRAME		PROGRESS
SAB	Given the level of multi-agency input and concern from July 2015, there were sufficient grounds for involved agencies to trigger a multi-agency assessment, close communication and coordination in addressing high dependency care needs and risks. Agencies appeared to practice within specialist areas and largely in isolation.	Develop multi-agency trigger for reassessment of high dependency care needs and risks, via a communication protocol, and possibly using an agreed needs and risk matrix.	Development of communication protocol, briefings to staff, monitoring via SAB.	SAB	To be confirmed by SAB.		Recommendation to May SAB.
Central & Cecil Housing Trust-Homemead	Homemead should have requested a continuing care assessment at an earlier stage, and potential transfer to a nursing home, in view of the significant deterioration.	Clear procedure to request continuing care assessment when aware of high dependency nursing needs and difficulty in providing care.	Monitoring by Quality Assurance Team via validation visit before the end of July 2016 and then annually; also linking with CQC inspection when arranged.	Jeff Levine	July 2016		To be evidenced.
Central & Cecil Housing Trust-Homemead	Homemead should have escalated the concern to District Nursing on the delay in completing the continuing care assessment; and also to Occupational Therapy on raising concern about meeting the recommended staffing requirements at night.	Homemead – clear procedure to escalate concerns about agency responses.	Monitoring by Quality Assurance Team as above.	Jeff Levine	Completed		Escalation procedure introduced and shared with other providers.

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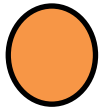
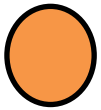
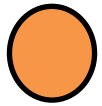
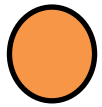
Central & Cecil Housing Trust- Homemead	Homemead should have ensured management oversight of practice standards, including that checks on residents at night were completed.	Homemead – CCTV installed in communal areas and regularly checked for compliance with caring responsibilities. Ad hoc monthly night checks by senior managers. Improved permanent staff recruitment and induction with increased emphasis on staff values. Prioritisation of supervision and appraisals. Emphasis on continuity of staff and induction of unfamiliar agency staff. Nurse call system installed in residents rooms to record presence of carer electronically. Night staff and senior staff checklists and floor walking checklist. Senior management sign-off on night check observation visits.	Monitoring by Quality Assurance Team as above.	Jeff Levine	Completed		All actions introduced as part of safeguarding adults enquiry response.

AGENCY	LEARNING POINTS	ACTIONS	EVIDENCE	LEAD OFFICER	TIMEFRAME		PROGRESS
Central & Cecil Housing Trust- Homemead	Homemead should have ensured that care plans, risk assessments and recording were up to date and that staff were familiar with care needs via induction, handover and communication; also checked with external agencies on changes to the care plan regarding positioning in bed.	Monthly resident of the day and review of care plan. Review of residents' care plans to ensure that they contain current care requirements and weekly auditing of care plans – part completed. Familiarisation with care plan and any changes both on induction of new staff and during handover between day and night shifts Improved factual recording by staff.	Monitoring by Quality Assurance Team as above.	Jeff Levine	Completed; except review of care plans, part completed.		All actions completed as part of safeguarding adults enquiry response, except review of care plans in progress, to be evidenced to Quality Assurance Team.
Central & Cecil Housing Trust- Homemead	Homemead should have ensured that staff are trained to an appropriate level in regard to skin integrity and positioning in bed.	Completion and evidencing of training to all permanent staff.	Monitoring by Quality Assurance Team as above.	Jeff Levine	Confirmation to QA Team of training arrangements by July 2016		For confirmation to Quality Assurance Team.

AGENCY	LEARNING POINTS	ACTIONS	EVIDENCE	LEAD OFFICER	TIMEFRAME		PROGRESS
HRCH	The District Nursing Service should have placed an out of office message and checked the emails of the departing District Nurse, in the absence of handover capability.	Out of office and checking emails of staff leaving or absent for prolonged periods.	Evidence of procedure and briefings to staff.	Yomi Ogunsola and Sandie Cox	30/06/16		A briefing has been provided to HRCH management and plans are in place to ensure that this is embedded in practice by all responsible team leaders by the end of June 2016.
HRCH	The District Nursing Service should have monitored the progression of the continuing care assessment and addressed the delay, in liaison with partner agencies.	Clear SAB and CCG procedure on monitoring continuing care assessments, overseen in practice by HRCH as part of continuing health care assessment role.	Evidence of procedure and briefings to multi-agency staff.	SAB	To be confirmed by SAB.		To be communicated within two weeks of an agreed procedure.
LBRUT Occupational Therapy	There should have been prompt provision of an updated Occupational Therapy Personal Handling Plan in the period from July to October 2015, underlining the advice that two care staff to support bed positioning was manageable but difficult.	Communication to staff.	Evidence of communication to staff.	Abi Nimmo and Amy Clayton	17/06/16		Communication to be drafted and approved by OT clinical lead.
LBRUT Occupational Therapy	Whilst the Occupational Therapy assessments from July to October 2015 indicated that staff were managing bed positioning competently, due to the high level of dependency it would have been preferable to have had continuity of OT support instead of the gap of one month which occurred.	Communication to staff.	Evidence of communication to staff.	Abi Nimmo and Amy Clayton	17/06/16		Communication to be drafted and approved by OT clinical lead.

AGENCY	LEARNING POINTS	ACTIONS	EVIDENCE	LEAD OFFICER	TIMEFRAME		PROGRESS
LBRUT Adult Social Services Dep. & Quality Assurance	LBRUT Quality Assurance Team should have completed the validation report promptly, and should have highlighted the risk during transition from paper to electronic support plans at Homemead of missing information, as part of a cohesive quality assurance framework.	Validation report action plans completed on providers to be circulated within a few days of audit. Introduction of peer reviews by care home managers.	Evidence of prompt audit action plans.	Don Rainbow	Completed		A draft action plan will be agreed and given to the provider at the time of the visit. An arrangement for a further validation visit to Homemead in July 2016 and annually thereafter is in place, and this will be alongside liaison with CQC.