A Safeguarding Adults Review concerning Rose commissioned by Royal Greenwich Safeguarding Adults Board

March 2019

Contents

1. Safeguarding Adults Review

Background to this Review

1.1 Rose was a 75 year old lady who had been admitted to Care Home B for respite. Following surgery to correct spinal problems in 2010 she had experienced numbness in her legs which resulted in a number of falls.

1.2 In 2013 Rose lost all use of her lower limbs and became wheelchair dependent. Rose received a care package four times a day from January 2013 to assist with her activities of daily living. The carers also used the hoist to transfer her using a full body sling.

1.3 Rose was referred to Care Home B on 8 February 2016 by the Joint Emergency Team (JET) for respite care due to her husband having some hospital treatment and him not being able to support her. Rose was assessed and then admitted to Care Home B on 10 February 2016 for a two week period of respite care.

1.4 On 12 February 2016 Rose complained of pain in her shoulders. On 14 February she was noted to have bruising to both breasts and arms. Rose's daughters discharged her home on 18 February 2016 because they had concerns.

1.5 On the evening of 18 February 2016 Rose started to choke at dinner time, and was taken by ambulance to the Accident & Emergency Department (A&E) at the Queen Elizabeth Hospital, Woolwich.

1.6 She was later diagnosed with aspiration pneumonia[1] as well as concerns regarding large haematomas on her breasts, torso and hips. A safeguarding alert was raised in respect of these bruises.

1.7 On the 1 March 2016 Rose's condition deteriorated and she sadly passed away.

1.8 The ownership and management of Care Home B has subsequently been taken over by a new provider.

Approach to the Review

1.9 This Safeguarding Adults Review follows the guidance of the Care Act 2014, Dept of Health & Social Care statutory guidance[2] and the London Multi-Agency Safeguarding Adults Policy and Procedures. The terms of reference for this review are given in full in Appendix A.

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1 Aspiration pneumonia is a complication of pulmonary aspiration. Pulmonary aspiration is when food, stomach acid, or saliva is inhaled into the lungs.

[2] Care and support statutory guidance; Updated 26 October 2018 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

1.10 Section 44 of the Care Act 2014 provides when a safeguarding adults review must be undertaken. It also provides a power to undertake a review in other situations. Section 44 provides (so far as is relevant):

> ***S. 44 Safeguarding adults reviews***
> *(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—*
> *(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and*
> *(b) condition 1 or 2 is met.*
>
> *(2) Condition 1 is met if—*
> *(a) the adult has died, and*
> *(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).*
>
> *(3) Condition 2 is met if—*
> *(a) the adult is still alive, and*
> *(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.*
>
> *(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).*

1.11 This review has been undertaken because of concerns raised about Rose's care, pursuant to the powers under Section 44 (4).

1.12 Safeguarding Adults Reviews[3] seek to determine what the relevant agencies and individuals involved in a case might have done differently that could have prevented harm or death of a vulnerable adult. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.[4]

1.13 The review was carried out by Donna Eldridge for Niche Health & Social Care Consulting (Niche), with expert advice provided by Dr Angela Hamblin, Consultant Haematologist.

1.14 The review team will be referred to in the first person in the report.

1.15 The report was peer reviewed by Nick Moor, Partner, Niche.

1.16 The review comprised a review of documents provided by Care Home B and the clinical teams caring for Rose, police documents and interviews with key

[3] *Care Act 2014 c.23. PART Safeguarding adults at risk of abuse or neglect http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted.*
[4] *Care and Support Statutory Guidance Section 14.168. 17 August 2017.*

staff. All records and interviews were requested through the Safeguarding Adults Board Manager, Royal Borough of Greenwich.

1.17 We used information from the following organisations:

- The provider of Care Home B
- General Practitioner
- Queen Elizabeth Hospital, Woolwich
- The Metropolitan Police
- Joint Emergency Team (JET)
- London Ambulance Service

1.18 As part of our review we interviewed the following staff:

- Care Assistant 1
- Care Assistant 2
- Care Assistant 3
- Care Assistant 4
- Care Assistant 5
- Care Assistant 6
- Care Assistant 7
- Regional Director
- Regional Support Manager
- General Practitioner
- Care Manager

1.19 Out of seventeen possible staff that were rostered whilst Rose was in Care Home B, only seven staff remain, employed as care assistants. Therefore police statements were obtained for the registered nurses who were responsible for Rose's care.

1.20 All interviews were recorded and then transcribed, with transcripts returned to the interviewees for review and signature.

Contact with the family

1.21 Contact with Rose's family was within an initial meeting with the Independent Chair of the Adult Safeguarding Board and the reviewer. We also held a formal interview with two daughters, with the offer of meeting the third daughter if they wished to do so.

1.22 We offer our deepest sympathies to the family of Rose. It is our sincere wish that this report does not contribute further to their pain and distress. We acknowledge how difficult this process must have been for them.

1.23 We received a history of Rose from her daughter as well as a resume of the family's findings within Care Home B.

1.24 Nick Moor, Partner, Niche Health and Social Care Consulting met with two of Rose's daughters on 9 January 2019 to explain the findings of the report and to hear and respond to any concerns.

Structure of the report

1.25 Section 2 provides background information about Rose.

1.26 Section 3 sets out the details of the care and treatment provided to Rose.

1.27 Section 4 examines the issues arising from the care and treatment provided to Rose and includes comment and analysis.

1.28 Section 5 provides a review of Care Home B internal investigation and reports on any progress made in addressing the organisational and operational matters identified.

1.29 Section 6 sets out our overall analysis and recommendations.

2. Background of Rose

2.1 Rose lived with her husband in Eltham, South East London and had three daughters. Rose is described as a caring person who was friendly and sociable and would do anything for anyone if needed.

2.2 Rose worked as a domestic cleaner for many years within Greenwich hospital, and then following a house move, she took up a position as a school cleaner and then worked as a domestic cleaner.

2.3 Rose suffered with lower back pain and on investigation in 2009/10, it was discovered that Rose had narrowing in her spinal cord and consequently had corrective surgery in October 2010.

2.4 Following this surgery Rose started to experience problems with her lower limbs. Rose started to experience numbness in her legs which resulted in a number of falls.

2.5 In 2011 due to Rose's physical problems she had to give up work. Rose was finding it difficult to walk unaided and went from using a stick to a 'Zimmer' frame. In 2013 Rose lost all use of her lower limbs and became wheelchair dependent.

2.6 Rose received a care package four times a day from January 2013 to assist with her activities of daily living. The carers also used the hoist to transfer her using a full body sling.

3. Care and Treatment of Rose

Referral and care planning by the Joint Emergency Team (JET)

3.1 The Joint Emergency Team (JET) is a crisis intervention team. It is a team consisting of both health and social care staff. The team has assessing officers, care managers and social workers, as well as nurses, physiotherapist and occupational therapists. The team deals with any crisis intervention that is required and deals with people who may need urgent care packages and any urgent safeguarding issues are followed up by the team.

3.2 In 2014 the JET set up a care package to support Rose. This was later increased to four times per day. The next input by the JET was on 8 February 2016 for the organisation of respite care for a period of two weeks as her husband needed to attend hospital and would not be able to care for her.

3.3 A 'Standard Care Plan' which is a document that provides both an assessment of needs and care plan, was completed by the JET, then faxed to Care Home B on 8 February 2016 requesting a period of two weeks respite care for Rose. The Care Act 2014 sets out, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support, focussing on the assessment on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve.

3.4 The Standard Care Plan outlined Rose's past medical history and the medication that she was on. The Standard Care Plan outlined seven needs to be met by services. These are as follows:

1. Transfers – to support with the safe transfer of Rose with appropriate equipment to ensure safety, dignity and respect.

2. Personal care – to ensure a good level of personal appearance and hygiene.

3. Fluids and Nutrition – to ensure a varied diet and adequate nutritional and fluid intake.

4. Toileting- To ensure Rose is supported in a safe and dignified manner with her toileting requirements.

5. Social contact/stimulation – To ensure that Rose is not socially isolated and receives appropriate simulation.

6. Medication – to ensure the secure keeping of Rose's medication and support in its administration as prescribed.

7. Domestic Laundry – to undertake the cleaning of Rose's room and communal areas and to ensure she has clean clothes and linen.

3.5 No information is provided on this care plan concerning Rose's mental capacity.

3.6 The JET's expectation was that following the faxed care plan, the care home would then complete their own assessment for suitability of a respite placement.

Assessment and Care by Care Home B

3.7 Care Home B provides personal care and nursing care to older people and those living with dementia. The service can accommodate up to 120 people in four separate facilities on the same campus. Rose was in a unit within Care Home B which was used for respite care at times but was also used for end of life care. There are three other facilities on the campus, which provide nursing and residential care and also cater for people with a dementia.

3.8 Rose was assessed on 8 February 2016 for the appropriateness of respite care by a member of staff from Care Home B.

3.9 This assessment took place in Rose's home.

3.10 The areas covered were:

1. Relationships/Community Involvement
2. Cultural/Spiritual/Religious practices
3. Promoting a Healthy Lifestyle
4. Wellbeing and Social Activities
5. Senses/Communication
6. Safety
7. Eating and Drinking
8. Personal Hygiene
9. Elimination
10. Skin integrity
11. Mobility
12. Sleep and Rest
13. Breathing/Circulation/Temperature control/pain
14. Future Decisions
15. Mental Health and Dementia care
16. Mental Capacity/Deprivation of Liberty

3.11 Although the assessment above appears comprehensive, with sections covering all the areas we would expect to be discussed, some of these sections were not completed in full. These were specifically the section on weight (under Eating and Drinking), Skin Integrity and Mental Capacity.

3.12 For the weight section, Rose's weight was not recorded, the section on recent weight loss was unchecked, and the recent MUST score[5] was left blank. Under the section on Skin Integrity, although it was noted that Rose had risk of pressure ulcers, and was reported to have sacral sores, her Waterlow score was blank.[6] Waterlow scores provide an assessment of the risk of pressure damage. Pressure damage to skin integrity is increased due to malnutrition or obesity, and immobility is a significant risk factor.

3.13 Under the section on Mental Capacity, although in the previous section it was noted that Rose had comprehension, the assessment of mental capacity (either 'full, variable or none') was left blank.

3.14 It would therefore be difficult to produce plans of care, for the key aspect of Rose's risk of pressure damage based on these assessments, although plans of care were not in fact developed either.

3.15 Although aspects of the supporting 'My Day, My Life, My Portrait' notes guide staff on key aspects of Rose's care, including how Rose needed to be helped to go to the toilet (*"she will need 2 staff with full body hoist to get on and off the toilet commode chair"*) and may need assistance with eating and drinking ('has upper limb weakness and so may need assistance') these do not tell the whole story, and some aspects are incorrect. For example, under 'Moving around' it states that she has osteoarthritis, and therefore uses electric wheelchair to move self around', whereas Rose was in fact immobile following narrowing in her spinal cord and corrective surgery. This would also be the more appropriate section to discuss how to support her mobility, and would have been improved if it had described the size of sling to be used.

3.16 The Mental Capacity Assessment section was not fully completed at this point, and the Future Decisions' section was for the most part blank, although the Mental Health and Dementia assessment section recorded that Rose had

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[5] Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan

[6] The Waterlow Score is a simple risk assessment tool that determines whether a resident is at risk of developing a bedsore or pressure ulcer. It is widely used in accident and emergency departments, hospital wards and residential nursing homes across the UK. The Waterlow Scorecard is an assessment of the seven risk factors known to contribute towards the development of pressure ulcers, including:

- *the resident's body mass index*
- *their sex and age*
- *their level of continence*
- *their skin condition (healthy or broken)*
- *the resident's appetite*
- *their level of mobility (fully mobile to bed-bound)*
- *special risk factors, including medication, surgery and trauma*

The resident is allocated a score against each of these criteria. The total score, in conjunction with the nursing staff's clinical expertise, places the resident into one of three risk categories:

- *a score of 10-14 indicates "at risk"*
- *a score of 15-19 indicates "high risk", and*
- *a score of 20 and above indicates "very high risk" of developing a pressure ulcer*

full orientation. The written notes also indicated that Rose was able to retain information.

3.17 Section 3(1) of the Mental Capacity Act 2005, provides the test of mental capacity as follows:

> *(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable–*
>
> *(a) to understand the information relevant to the decision,*
> *(b) to retain that information,*
> *(c) to use or weigh that information as part of the process of making the decision, or(d) to communicate his decision (whether by talking, using sign language or any other means*).

3.18 It also seems that there is a lack of understanding concerning mental capacity in other areas of documentation. Under the section 'Choices & Decisions over care' in the supporting 'My Day, My Life, My Portrait, it is noted that Rose has capacity, and able to make decisions over the care she receives. However, under the section on 'Future Decisions', it states that Rose's future decisions will lie with her family 'when she no longer has capacity to do so'. Whilst this would be appropriate if there was a Lasting Power of Attorney, we have seen no evidence of a Lasting Power of Attorney which would confer that power to her family.

3.19 Following on from this assessment Rose was then admitted to Care Home B on 10 February 2016 for a two week period of respite care. She was accompanied by one of her daughters.

3.20 Rose was admitted on a variety of medication and these were:

- Warfarin 1mg and 3mg
- Estradoil 1mg daily
- Levothyroxine 50mcg daily
- Quinine sulphate 200mg nocte
- Diazepam 2mg nocte
- Lansoprazole 15mg daily
- Mirtazapine 15mg nocte
- Atorvastotin 10mg nocte
- Amlodipine
- Aspirin 75mg daily
- Bisoprolol 2.5mg daily

3.21 The ‘Daily Notes’ for Care Home B record that shortly after admission Rose was transferred using a *“full hoist”* to the toilet and then was made comfortable in her wheelchair. That evening Rose was assisted to bed using a *“full body hoist”*.

3.22 From this point on within the notes there is reference to using a *“full body hoist”* for transferring her.

3.23 On the evening of the second day (12 February) of Rose’s admission she began to complain of pain in her arms. She was given pain relief for this (two paracetamol 500mg). Later that evening Rose’s daughter rang the unit to state that she wanted to discharge her mother as she felt that the care and treatment was not meeting her mother’s needs. This was due to her daughter believing that the slings on the hoist were the wrong ones and her mother stating that this was causing her pain and a lot of distress.

3.24 That night Rose was experiencing some distress and stated that she could not settle and felt unwell. Staff stayed with her throughout the night offering reassurance and taking her temperature.

3.25 She continued to state that she had pain under her arms. On 13 February Rose’s daughters brought in the sling that was used at home and the staff described this within the notes as a ‘toileting sling’. The sling which was brought in from her home was not compatible with the hoist used and a similar sling was then shown to Rose, which she agreed to try and was apparently happy with it.

3.26 On 14 February 2016 (fourth day of admission) it was noted by staff that Rose had bruising on both breasts and arms. It is recorded within the notes that she stated that this could have been due to a previous accident which she had at home but it does not state when this was.

3.27 Later in the evening the bruising appeared to darken and spread to her torso. An incident form was completed and Rose was seen by the clinical service manager who requested that the bruising be investigated further. Photographs were taken of the bruising.

3.28 On 15 February 2016, the bruising continued to spread down to her hip. The GP providing medical cover for the care home was called and reviewed her medication. Rose was prescribed paracetamol for her pain.

3.29 On 16 February a telephone consultation was held with Rose’s own GP who discontinued her aspirin as it was thought this could be one of the reasons for the bruising and advised that her warfarin required review when she returned home.

3.30 On 18 February 2016, Rose’s daughters discharged her home.

Queen Elizabeth Hospital, Woolwich

3.31 At home on the evening of the 18 February 2016, Rose started to choke at dinner time. An ambulance was called and Rose was taken to the Accident & Emergency Department (A&E) at the Queen Elizabeth Hospital, Woolwich.

3.32 The first concern from the medical team was that Rose may have experienced a stroke. This was ruled out following investigation, but there was concern in relation to her lung capacity and breathing.

3.33 Rose's daughters stated that whilst they were in A&E, that a nurse told them that Rose had dislocated shoulders and crushed ribs which they (the daughters) put down to the use of the wrong slings whilst she was in respite care at Care Home B. However, the statement as to dislocated shoulders and crushed ribs was never substantiated. A post mortem did not identify such injuries. We discuss this at 4.75 later in our report.

3.34 She was transferred to a ward for further assessment and investigations. Rose appeared to slightly improve, but the concerns that the medical team had were in relation to her breathing and the extensive bruising to her torso, breasts and hips. They were observing these as haematomas[7] in case they required draining.

3.35 Whilst on the ward Rose was seen by medical staff, speech and language therapy staff and physiotherapy. She was diagnosed with aspiration pneumonia[8] as well as concerns regarding the large haematomas on her breasts, torso and hips. A safeguarding alert was raised.

3.36 On the 1 March 2016 Rose's condition deteriorated and she sadly passed away.

4. Arising issues, comment and analysis

4.1 We have reviewed Rose's care from first contact with the Joint Emergency care Team (JET) through to her death on the 1 March 2016. We address each element of the terms of reference in separate sections, supporting our analysis with evidence as appropriate.

Referral processes

4.2 Rose's husband was her main carer. He required treatment in hospital which meant that he would not be able to care for her throughout this time. The family made a decision to ask for respite care for a period of two weeks.

7 A solid swelling of clotted blood within the tissues
8 Aspiration pneumonia is a complication of pulmonary aspiration. Pulmonary aspiration is when food, stomach acid, or saliva is inhaled into the lungs.

4.3 Rose was referred to the Joint Emergency care Team (JET) on the 5 February 2016 and a needs assessment[9] was carried out on the 8 February 2016. The assessment was completed by the care manager who felt that the respite would be appropriate. This assessment information was then used to provide a 'Standard Care Plan'.

4.4 A request was made to Care Home B and the Standard Care Plan documentation was faxed over. The 'useful information' section provided minimal information and did not outline any current or possible future risks. The past history was not detailed and there was no detail about Rose's need for transfer using a hoist, there was only a short sentence stating *"as a result carers use hoisting equipment to support [Rose] from bed to commode and wheelchair"*.

4.5 Rose's medication was outlined on the assessment but there were no dosages or timing evident. We were told by the care manager that they do not have any health training so would not know what the medication was for. However, to exclude any possible errors the dosages and timings should have been present.

4.6 There were seven needs identified for Rose on the Standard Care Plan completed by the JET Care Manager.

4.7 Needs identified in the Standard Care Plan included the following:

1. Need: Transfers:

Assistance to be provided with: to support Rose with all transfer requirements I.E. from bed to commode and chair.
Aim: to support with the safe transfer of Rose with appropriate equipment to ensure safety dignity and respect.

2. Need: Personal Care.

Assistance to be provided with: to support Rose with all aspects of daily personal care including washing, dressing and grooming.
Aim: to ensure a good level of personal appearance and hygiene.
Ensure support is provided in a dignified manner.

3. Need: Fluids and nutrition.

Assistance to be provided with: to provide Rose with all her meals, snacks and drinks (breakfast, lunch and dinner).
And support Rose with any eating and drinking requirements (has weakness in upper limbs).

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9 Section 9 of the Care Act 2014 provides that "a needs assessment must include an assessment of—
(a)the impact of the adult's needs for care and support on the matters specified in section 1(2),
(b)the outcomes that the adult wishes to achieve in day-to-day life, and
(c)whether, and if so to what extent, the provision of care and support could contribute to the achievement of those outcomes."
http://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted
See also "Assessment of adults' and carers' needs from Dept of Health & Social Care 'Statutory guidance: Care and support statutory guidance'; Updated 26 October 2018
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Aim: to ensure a varied diet and adequate nutritional and fluid intake.

4. Need: Toileting

Assistance to be provided with: to support Rose with her toileting and continence requirements.
Aim: to ensure that Rose is supported in a safe and dignified maner with her toileting requirements.

5. Need: Social Contact/stimulation

Assistance to be provided with: to ensure that Rose has the opprtunity to engage with staff and fellow residents and is provided with appropriate activities she can participate in if required.
Aim: to ensure that Rose is not socially isolated and received appropriate stimulation.

6. Need: Medication

Assistance to be provided with: to assist Rose to take any medication as prescribed.
Aim: to ensure the secure keeping of Rose's medication and to support with its administering as prescribed.

7. Need: Domestic and Laundry

Assistance to be provided with: to undertake the clieaning of Rose's room and communcal areas and to ensure she has clean clothes and linens.
Aim: to ensure a clean environment, clothes and bed linen

4.8 Transfer is the first need identified although it was explained at interview with the Care Manager assessing the needs that these were not necessarily listed in any priority order. The aim was identified as "to support with safe transfer of [Rose] with appropriate equipment to ensure safety, dignity and respect". This should have provided more detail on how Rose would need assistance for transfers and what sort of equipment should have been used. This was the key area that should have been detailed to ensure that the care home could accept and care for Rose appropriately.

4.9 We have similar concerns about the lack of information provided in the other areas. In general, there are no descriptions of how assistance is to be provided and in fact this section is stated as a general intention rather than a practical guide of how assistance should be given. For example, when discussing meals, would she require a soft diet or nutritional supplements? Does she require feeding? Information about swallowing would have been helpful at this point. Similarly toileting does not provide a description of how the assistance should be provided. There is no information about constipation or incontinence. For medication the assistance to be provided is simply to administer the medication as prescribed, when it would have been helpful to describe whether this is in tablet or liquid form, and if she needs to have the medication physically given to her, or simply reminded to take it.

4.10 The care manager stated that Care Home B would complete their own assessment, and although this is accepted, more information on the Standard Care Plan document would have been beneficial to Care Home B to properly guide them on Rose's needs when completing their own assessment.

4.11 There was no evidence of any form of risk assessment being completed for Rose on the JET Standard Care Plan. These risks would be for moving and handling of Rose and a 2 person hoist was required. Furthermore there is no space to provide information on a person's mental capacity should there be any concerns about this, and whether Deprivation of Liberty Safeguards should apply or have been applied.

Recommendation 1
The Joint Emergency Team (JET) to review their initial documentation to ensure a full assessment is completed when assessing for placement, this must include a risk assessment for care needs and assessment of mental capacity where there is any concern about mental capacity.

4.12 On 8 February 2016 a 'Pre-admission and Review' assessment was carried out by Care Home B at Rose's residential address. The pre-assessment outlined Rose's care needs as previously described.

4.13 Although this pre-assessment covered an adequate assessment profile, all sections were 'tick box' or yes and no answers. There was no in-depth description evident of any issues raised within it or identified where the information could be obtained, e.g. family, resident etc.

4.14 Within the mobility section it was identified that for transfers a full body hoist was to be used with a sling size of 'M'. However, it did not specify which make of sling was to be used or identified the equivalent 'M' to be used within Care Home B.

Recommendation 2
The provider organisation to assure itself that the pre-admission assessment process is fully completed; a full description of any issues raised to be completed in full with written text to enable a seamless handover for the resident when admitted.

Care planning and Core Assessments (Care Home B)

4.15 Rose was admitted to Care Home B, on 10 February 2016. A 'My Day, My Life, My Portrait' document was completed. This document appears to be a 'pen portrait' outlining the key areas of Rose's care needs.

4.16 This document largely correlates to the sections and headings identified in the 'Pre-Admission and Review' assessment documentation, although the headings differ slightly and there are fewer headings in 'My Day, My Life, My Portrait'.

4.17 The areas covered under the headings for assessment in the Pre-Admission and Review include:

- Relationships/Community Interests
- Well-being/Social Activity
- Cultural/ Spiritual/Religious needs
- Promoting Healthy Lifestyle
- Senses/Communication
- Safety
- Eating and Drinking
- Elimination
- Personal Hygiene
- Skin Integrity
- Mobility
- Breathing
- Sleep/Rest
- Future Decisions
- Mental Health and Dementia Care
- Mental Capacity Act and Deprivation of Liberty

4.18 Within the 'My Day, My Life, My Portrait' document the areas and descriptions covered were:

- Senses and communication – can communicate her need coherently
- Choices and Decisions – has capacity and can make decisions
- Lifestyle - watches TV in her wheelchair and needs socialisation
- Healthier Happier life - staff to provide activities for social inclusion
- Safety – requires bed rails whilst in bed
- Moving Around – has osteoarthritis and uses a wheelchair
- Skin Care – Rose has sacral wound according to (this section is incomplete within the assessment).
- Washing and Dressing - requires assistance
- Going to the toilet – requires two staff and use of full body hoist
- Eating and Drinking – may require assistance
- Breathing and Circulation – no problems but is on aspirin and Warfarin
- Mental Health and Wellbeing – in constant pain when moved
- Future Decisions – lays with the family when capacity is no longer evident.

4.19 Areas covered in Pre-Admission and Assessment and not covered in 'My Day, My Life, My Portrait' include:

- Well-being/Social Activity
- Cultural/ Spiritual/Religious needs
- Mental Health and Dementia Care
- Mental Capacity Act and Deprivation of Liberty

4.20 However, some of these areas may be covered in other areas, e.g. Well-being/ Social Activity and Cultural/Spiritual/ Religious needs could be covered by 'Lifestyle'.

4.21 The above list from 'My Life, My Day, My Portrait' outlines the main detail in each section. There is only one area that mentions the use of a hoist, that being for toileting. There is no further assessment information on transferring, detailing which sling to use due to Rose's lack of mobility. This could have been supported by more detail in the 'moving around' section.

4.22 Core assessments such as Mental Capacity, Risk Assessment, Moving and Handling, or Nutrition were not completed and care plans arising were not developed or implemented. Alongside this, key aspects of the partially completed assessments were wrong. For example a Waterlow assessment was completed for Rose on 11 February 2016. The Waterlow assessment did identify Rose as very high risk with an overall score of 22 and identified some sacral pressure sores. However, this assessment stated that Rose was restricted in mobility, scoring a 3 in this area. This should have been scored at the highest level of 5 which was chair bound/wheelchair bound. The assessment also stated that a care plan was commenced but there is no evidence this was properly completed or developed.

4.23 It would also appear that staff were using the wrong words to describe the wound, which they have noted as sacral, when the body map used by the Tissue Viability nurse identifies the wound on the buttocks. We note the daily record states that Rose refused to let the staff assess the wound on admission, and it is recorded that she told them they could see it tomorrow.

4.24 We found no evidence that any care plans were developed and implemented to address any of Rose's needs that had been identified at the pre-assessment stage or on admission. We did find evidence that through the My Day, My Life, My Portrait' documentation that there were attempts to describe the care needed. We have discussed where this could have been improved earlier in the report at 3.15 to 3.18.

4.25 The provider organisation has a moving and handling policy which clearly states that "following admission to the home the resident will undergo a specific moving and handling risk assessment and this should be completed within four hours of the resident moving in". It goes on to state that "the resident will have a moving around care plan written on the day of admission

which will offer clear direction to staff on what support the resident requires to move around safely, in accordance with the risks identified on the moving and handling risk assessment".

4.26 The policy also states that there are key responsibilities to ensure the safe moving and handling needs of residents are identified and that the right hoists/equipment is to be used. This should have been identified within the moving and handling assessment and care plan but these were never developed for Rose.

4.27 The provider organisation has a policy on care planning. It states that the format for residents is known as a personal plan and *"is essential in ensuring that service user's needs and wishes are clear to everyone involved in providing their care so that health needs are met, risks are identified and individuality is promoted"*.

4.28 The policy clearly states that the Care Home Manager is responsible for ensuring that staff are familiar with the care documentation system 'My Day, My Life, My Portrait'.

4.29 The policy also states that for short stay residents there is a set of short stay documents (short stay is considered as a stay no longer than twelve weeks). There are timeframes for completion, identified in the table below. We have also identified if these documents had been completed in Rose's records:

Document	Timeframe	Completed/ Incomplete/Not Completed
My Day, My Life, My Details	2-4 hours	Incomplete
Pre-Admission Assessment and Review	2-4 hours	Completed
Daily Notes	2-4 hours	Completed
My Day, My Life, My Short Stay – incorporated risk assessment	4-6 hours	Not Completed
My Day, My Life, My Short stay – Incorporated Plans	24 hours	Not Completed
Consent to access Care documentation	4-6 hours	Not Completed
Self-Medication Assessment	4-6 hours	Not Completed
Additional Plan of care or risk assessments (As Required)	48 hours	Not Completed

4.30 These documents were not all completed in Rose's notes. It is evident that there are clear breaches in the provider organisation's policies and processes for Rose which resulted in a lack of communication between the staff delivering care to Rose.

Recommendation 3
All assessments are to be completed upon admission for service users which must include full assessments of identified risks in a timely manner as outlined in the provider organisation's policies, and that these lead to robust care plans to meet the service user's needs.

Staffing issues and supervision

4.31 At the time of Rose's admission for respite care, there were a total of 19 members of staff on the duty rota to cover all shifts within that week. These staff completed a 12 hour day shift consisting of 8.00 am until 8.00 pm. There were night staff that completed 8.00 pm until 8.00 am. On a day shift there were a total of six staff on duty and four on a night shift.

4.32 At any one time there could be two registered nurses on a shift during the day, but we were told that due to a registered nurse shortage, usually there was only one registered nurse on shift. We were informed that any gaps in the duty rota were covered by their own pool of bank staff and if need be, staff would move around the different units to ensure adequate cover.

4.33 We were informed that there was a hierarchical chain of management for each unit. Going up the chain there are healthcare assistants and a number of senior carers, then registered nurses and the unit manager who is responsible for the whole unit. The unit manager is responsible for ensuring that staff supervision is completed. The unit manager would complete the supervision[10] for the registered nurses and then the registered nurses would complete the staff supervision for all healthcare assistants.

4.34 A Clinical Service Manager (CSM) was also in post. The CSM is responsible for supervising the unit managers as well as all clinical elements within the Units.

4.35 We requested copies of staff supervision notes or any records that would give evidence that supervision had taken place for all staff members on the Unit. We were told that these would have been archived and could not be provided. We are aware that some do exist, as a CQC inspection in November 2015 states that some of these records were reviewed although it does not state specifically for the staff on Care Home B.

4.36 Notwithstanding our comments at 4.32 concerning a shortage of registered nurse, at the time of Rose's admission there was no evidence that there was a shortage of staff and all shifts were adequately covered with both registered and unregistered staff.

Recommendation 4

[10] *Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual social care workers. As a result, this improves the quality of service provided by the organisation. Supervision is a vital part of individual performance management.*

The provider organisation to ensure that all staff have both management and clinical supervision as required by their policy that includes discussion of all training needs and shortfalls.

Staff Training issues

4.37 We requested a copy of the staff training records and we were provided with four out of a possible 19. We were told this was due to the other staff leaving and the records were no longer available.

4.38 The provider organisation's training and development policy states "*training and development is the responsibility of all employees and is not just a function of management*". The policy also states that it is the responsibility of the Unit Manager to nominate the staff to attend the rolling programme of the clinical training.

4.39 Out of the four training records submitted, three were in date with their moving and handling training and one had a date identified for their future training. All staff that were interviewed stated that they had received moving and handling training although there was some confusion amongst them as to whether this was annually or six-monthly.

4.40 The moving and handling policy clearly states that all staff receive moving and handling training upon induction and then on an annual basis.

Recommendation 5
The provider organisation to assure itself and the Royal Greenwich Safeguarding Adults Board that:

- all staff are fully aware of when they need to undertake moving and handling training;
- staff attend this training; and
- staff are competent to undertake moving and handling (including locum/agency staff).

Hoist and slings

4.41 The provider organisation has a very clear and concise policy on the moving and handling of residents. This states Care Home Managers are responsible for ensuring that all staff undergo Moving and Handling training on induction prior to moving residents, and on an annual basis thereafter.

4.42 Rose's pre-assessment documentation states that for transfer the sling size to be used is 'M' and to use a full body hoist. However, when Rose was admitted to Care Home B the documentation lacked detail in outlining the exact hoisting needs of Rose and no 'moving around' plan was formulated.

4.43 Within the moving and handling policy, there were four associated documents that were to be formulated. There were:

- Pre-Admission and assessment review
- Moving around plan
- Moving and handling Risk Assessment
- Falls risk assessment

Apart from the pre-admission and assessment review document there was no evidence of further assessments taking place.

4.44 When we interviewed care assistants there was confusion around the slings that were to be used for Rose. We showed a series of pictures of different slings that were received from the provider organisation following the incident. Some staff pointed to a 'toilet sling' and stated that it was a full body sling and vice versa. Only one interviewee was able to describe the slings correctly.

4.45 Rose's family, once aware that the wrong sling was used for transfer brought in the one that Rose used at home. Due to the different hoist that was used the fittings were not compatible. The staff stated that they used the equivalent sling for their hoist.

4.46 Rose's daughter was also asked to review the pictures of the slings submitted but was unable to confirm which sling was the full body sling.

4.47 During our interviews and in reviewing the documentation there was an abundance of different terminology used around slings and hoists and what constituted a full body sling. This would be very confusing for staff.

4.48 Within the moving and handling policy, it states that the organisation provides a number of different types of hoists to enable the safe lifting and movement of residents. The policy goes on to state that there are a wide range of slings available and different material sizes and connections, and that any sling used on a resident must be suitable because if the sling is too big, too small or not correctly attached, it can lead to the resident falling or sustaining injuries.

4.49 The policy also clearly states that the moving around plan must be routinely checked for any conditions that could alter the sling choice and moving and handling requirements. As previously noted, no such plan was in place for Rose.

4.50 The Health and Safety Executive (HSE) has issued clear guidance regarding the use of hoists and slings.[11,12]

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[11] *The Health and Safety Executive (HSE) is the body responsible for the encouragement, regulation and enforcement of workplace health, safety and welfare, and for research into occupational risks in Great Britain.*

[12] *Health and Safety Executive. "Getting to grips with hoisting people" Health Services Information Sheet No 3* http://www.hse.gov.uk/pubns/hsis3.pdf

4.51 The guidance clearly states “Sling sizes and coding varies between manufacturers. There is a risk of using an inappropriately sized sling if you make assumptions without checking the suitability of a specific sling for the individual. For example, two large slings from different manufacturers may be different sizes – the body of the sling may be a different length or the number of loop attachments may differ, resulting in a different lifting position. Additionally, sling designs can alter over time, so a new sling from a manufacturer may differ in size or attachment strap length from one previously purchased. Some slings come with a range of different length loops for attachment to the hoist. These can be used to increase the comfort of the individual or put them in a more reclined or upright position. However, you should take great care to choose the correct loops for the individual so that they are not at risk of slipping from the sling and to use the same loop configuration on both sides to reduce the risk of the person falling from the sling sideways”.

4.52 The use of slings and hoists in the Health and Safety Executive guidance on the moving and handling of residents states:

“Sling and Hoists safety
It is important that safe working procedures are followed during hoisting to avoid accidents that can result in serious or fatal injuries.

***Problems include**:*

- Selection of the wrong size sling – which can result in discomfort if the sling is too small, and/or the person slipping through if it is too large. Staff should be aware that sling sizes and coding vary between manufacturers.

- Wrong type of hoist or sling for the individual, or task – which can lead to inadequate support and a risk of falling. For example, toileting slings give a great degree of access, but little support.

- Incompatibility of hoist and sling can result in insecure attachment between the two. Follow the manufacturer’s advice and refer any concerns about sling/hoist design, supply, manufacturer’s instructions or compatibility to the Medicines and Healthcare products Regulatory Agency (MHRA), the regulator for medical devices.

- Failure of equipment due to lack of maintenance/inspection.

- Leaving a vulnerable person unattended in a hoist; or in a position where they might be at risk of falling.

Health and Safety Executive. “How the Lifting Operations and Lifting Equipment Regulations apply to health and social care” http://www.hse.gov.uk/pubns/hsis4.pdf

- Overturning of the hoist due to difficult surfaces, transporting an individual over a long distance on a hoist, or not following the manufacturer's instructions.

- Failure to use a safety harness, belt or attachment appropriately. Some slings come with different length loops for attachment to the hoist to increase comfort or the range of positions. You must choose the correct loops so that an individual is not at risk of slipping from the sling. Use the same loop configuration on both sides to reduce the risk of sideways falling.

The individual's risk assessment and care plan for hoisting should specify:

- which hoist to use for which task
- type and size of sling and any configurations of loops or leg attachments
- use of any additional safety devices such as safety belts
- number of carers needed to carry out the task
- any other relevant information specific to the person being hoisted.

You must communicate this information to staff and keep it accessible for easy reference. It is common practice to include assessments in individual care plans or profiles and provide an additional quick reference guide in a convenient place, e.g. on the inside of the resident's wardrobe door."

4.53 The terminology used within Care Home B was clearly confusing for staff. Within the documentation they referred to a hoist but were describing a sling and could not state how residents were measured for the correct sling.

4.54 The provider organisation provided an inspection report on the lifting equipment within Care Home B. This inspection took place on 11 January 2016 and 13 March 2016 and the equipment passed for these inspections.

Recommendation 6
The provider organisation to ensure that all residents must be measured for the use of the correct slings and the terminology used must be consistent to ensure the most junior staff are clear about the difference between a hoist and sling.

Communication systems

4.55 It is evident that when reviewing the documentation and interviews of staff, that there were significant gaps in communication from Rose's first

assessment with the Joint Emergency Team, the pre-admission documentation and Rose's respite care.

4.56 Detailed information concerning Rose's needs for support with transfers due to her mobility limitations and the use of appropriate slings was not adequately gathered or passed on.

4.57 We found that junior staff were not made aware of how to safely transfer Rose and which slings were appropriate to use due to there being no risk assessments and care plans formulated.

4.58 We found that Rose's family felt that they were not listened to by staff or that telephone calls by the family were not returned in a timely manner.

Recommendation 7
The provider organisation to review its communication systems ensuring communication between all agencies and family members is paramount and consistent. Documentation must be formulated to support this with the correct information.

Medical Treatment and bruising

4.59 Rose had an extensive medical history. Unfortunately we were not able to interview Rose's own General Practitioner (GP L) as he had left the surgery, however we were given a copy of all contacts that were made for Rose dating back to 1986.

4.60 We were also able to interview the GP partner at the medical centre (GP M) that was responsible for Rose's care whilst she was in Care Home B.

4.61 On admission to Care Home B, Rose's medication was prescribed correctly and we found no issues with the prescribing or administration of these.

4.62 Rose had regular blood testing for her warfarin levels, although we have seen no evidence that this occurred whilst she was in Care Home B. The last test occurred whilst she was in the Queen Elizabeth Hospital, Woolwich before her death. Prior to this Rose was seen by the anticoagulant clinic within the hospital that monitored her warfarin levels.

4.63 This GP practice had been contracted to provide GP medical cover for Care Home B for many years, and were providing this cover at the time under consideration for this review. However, this contract finished at the end of September 2017 and they are no longer the contract holders.

4.64 On 15 February GP M visited Rose at the request of Care Home B. GP M stated that at that time she was quite comfortable and she was not complaining of pain. The GP stated that "*[Rose] had bruising, which was quite symmetrical, like a girdle below her breasts and the breasts themselves, that went under her armpits*" the symmetrical pattern was, in the GP's opinion, suggestive of bruising due to pressure on that area. We were told that they

often see this in elderly people, due to them having very fragile skin which means they can bruise easily.

4.65 Bruising was noted by GP M just below her breasts, and not on her abdomen, and this was recorded. No other bruising to Rose's body was noted. GP M put the bruising down to pressure exposure and the likelihood for Rose to bruise more easily due to the warfarin.

4.66 GP M stated that he was informed of Rose's condition as he came into the building and that he was not going to Care Home B to see her specifically. He remembers the manager spoke to him in her office and said "*they have this case of this lady, she's quite bruised around her breasts, it looks as if this happened through hoisting, and could he have a look at her*". This implies that Care Home B had not contacted the GP specifically for Rose, however, if they did know that he was attending then this could be the reason that they did not call him.

4.67 GP M told us that nursing staff informed him that Rose had her warfarin levels checked regularly, and that the levels were fine. We have not been able to evidence that Rose had her warfarin levels checked whilst in Care Home B.

4.68 When GP M examined Rose, they could not find any other signs of bruising on her body other than that already mentioned, and there were no signs of spontaneous bruising which could have indicated warfarin overdosing. The GP stated that if Rose had bruising to other areas of her body, specifically her joints (elbows, wrists etc), they would have suspected overdosing of warfarin, and probably would have sent her to hospital. There was no suspicion that she had any shoulder or arm problems (although the X-ray on 22 February reported that she had degenerative changes to her acromioclavicular joints).

4.69 Care Home B nursing staff told us that Rose's family had stated that Rose had had similar bruising in the past and that the family stated that they had also seen it much worse.

4.70 On 16 February 2016 a nurse contacted Rose's own GP, asking them to review Rose's medication because of the bruising. On discovering that Rose was on both aspirin and warfarin, Rose's GP discontinued the aspirin because of the bruising. Within the nursing notes it is stated that Rose was complaining of pain in her shoulders and arms but this information was not passed to Rose's GP. The reason for the telephone call was for GP L to amend the prescription for the removal of aspirin, which was done. The Medicines Administration Record (MAR) sheet shows this prescription as discontinued on 16 February 2016. There was no further contact with either GP concerning Rose after this date.

4.71 GP M told us he was surprised that Care Home B did not contact him further following the spreading of the bruising. He stated that they often would ring for simple things, one little bruise on an elbow for example. He told us that *"If you looked at the residents, most of them have some form of bruise, because they bruise so easily, it takes even a small amount of pressure sometimes and they bruise, because of the fragility of the skin. They often called us for*

real minor stuff, I'm a bit surprised that they didn't call, or at least at night they could have called out-of-hours".

4.72 Following Rose's discharge home on the 18 February 2016, Rose had a choking episode and her husband dialled 999. Consequently Rose was transferred to the Emergency Department (ED) at Queen Elizabeth Hospital, Woolwich via the London Ambulance Service.

4.73 Whilst in the ED, the bruising was noted as a concern and an adult safeguarding alert[13] was raised with Royal Borough of Greenwich Safeguarding Adults team. Also whilst in the department Rose had a blood test which did not show any abnormalities and the warfarin levels were within the required international normalised ratio (INR) target range of 2-4.

4.74 Rose had a diagnosis of aspiration pneumonia and was admitted to a medical ward for older people. Whilst on the ward Rose was initially comfortable but unfortunately started to deteriorate and sadly passed away on the 1 March 2016.

4.75 The hospital notes states that on admission, she also had traumatic bruising bilaterally on her torso resulted from '*hoisting at respite placement*', although we are not clear where the evidence for this came from. She was treated for her aspiration pneumonia with amoxicillin,[14] metronidazole[15] and gentamicin.[16] Imaging showed a large right sided haematoma. The medical and surgical team advised 'conservative management' meaning a non-surgical approach to Rose's care.

4.76 The reviewer took expert advice from a consultant haematologist to discuss the effect of warfarin and bruising. We were informed that although warfarin is more than likely to cause spontaneous bruising, this would more likely be widespread and diffuse, and that trauma or force can cause the pattern of bleeding that occurred with Rose.

4.77 The consultant haematologist was able to review the photographs of Rose's bruising taken in A&E and was given access to blood results. The consultant haematologist noted that there was different ageing of the bruising and that the CT scan[17] would be able to pinpoint any possible dislocation.

4.78 We have identified that following the initial complaint, in the subsequent incident report by Care Home B it is recorded that Rose's daughters had

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[13] A Safeguarding Alert means reporting concerns, suspicions or allegations of abuse or neglect into the multi-agency safeguarding adults' procedures. Anyone can make a Safeguarding Alert. Within services that provide care and support, safeguarding alerts will usually be made by the manager of that service.

[14] Amoxicillin is a penicillin antibiotic that fights bacteria. Amoxicillin is used to treat many different types of infection caused by bacteria, such as tonsillitis, bronchitis, pneumonia, and infections of the ear, nose, throat, skin, or urinary tract.

[15] Metronidazole tablets belong to a group of medicines called anti-infective agents. They may be used to treat: infections, caused by bacteria of the blood, brain, bone, lung, stomach lining and pelvic area, following childbirth or in a wound following an operation.

[16] Gentamicin injection is used to treat serious bacterial infections in many different parts of the body. Gentamicin belongs to the class of medicines known as aminoglycoside antibiotics. It works by killing bacteria or preventing their growth.

[17] CT stands for computed tomography. The CT scan can reveal anatomic details of internal organs that cannot be seen in conventional X-rays. ... The CT scan is also known as the CAT (computerized axial tomography) scan.

raised that Rose's shoulders had been 'dislodged' due to using the wrong hoist. The reports states:

"On her [Rose's] first evening there she was actually hoisted using a upper hoist and subsequently this has led to internal bleeding in the upper part of her body and dislodged both of her shoulders."

4.79 This is later recorded in the incident report as 'dislocated shoulders'.

4.80 We reviewed the X-ray report provided by Queen Elizabeth Hospital, dated 22 February 2016. This report shows "XR Shoulder Both: No fracture or dislocation is seen. Early degenerative changes are noted at the acro-mioclavicular joints bilaterally".

4.81 No shoulder dislocations are recorded on the post mortem report.

5. Internal complaint investigation

5.1 On 14 February at 10.30 am an accident form was completed in Care Home B for the bruising that Rose had sustained. A body map was also completed at this time identifying the sites on Rose's body where the bruising occurred (breasts, arms and torso).

5.2 The accident form was completed by the unit manager and it stated that there was unexplained bruising to Rose's upper body spreading to her torso. There was a query as to whether or not this was old bruising, but in light that Rose had no bruising when admitted, and that from this point on the bruising appears to have started spreading this was not a valid query. It also stated that Rose had said that it could be from a previous incident. At this time photographs were taken of the bruising.

5.3 A formal complaint was raised by Rose's family and an internal investigation was carried out by the manager of Care Home B, and also at this time an adult safeguarding alert was raised with the local authority.

5.4 The internal investigation report covered the following areas:

- hoisting methods and practice during respite stay;
- bruising; and
- alleged dislocated shoulders (as reported by her daughters that they were told this in A&E).

5.5 Within the internal investigation report it states that on the first evening (10 February 2016) Rose was "hoisted using an upper hoist and subsequently this has led to internal bleeding in the upper part of her body and dislodged both of her shoulders". However, there is no evidence to substantiate that there was any dislocation of Rose's shoulders at this time. Also the report refers to

an “upper hoist” and it is not clear if they were describing the actual hoist or sling.

5.6 The report finding acknowledges that the wrong sling was used on the first evening of Rose’s admission which could have contributed to her bruising. It also stated that this could have led to the dislocation of Rose’s shoulder but as discussed above, there is no evidence that her shoulders had been dislocated.

5.7 The report findings also state that the significant bruising could be due to “*high levels of aspirin and warfarin*” but at no time during Rose’s stay in Care Home B were blood tests taken to substantiate this.

5.8 The report findings also states that Rose had a history of *“extensive bruising*” prior to admission but we could not find any evidence that this was the case. Although there is the earlier point made by nursing staff that according to them, Rose’s family had said she had bruised easily and had had worse bruising in the past.

5.9 The internal investigation report acknowledges that using the wrong sling would have caused pain and bruising, due to Rose’s osteoarthritis, although again it states that the wrong sling could also have caused dislocation of Rose’s shoulders.

5.10 The report stated that the *“hoist sling which was offered by the family, had material straps and the slings used by the home have clip on straps. By using the home’s system, this could have contributed as it may not have been as flexible as the clip on straps”*. Because this last sentence does not seem to make sense, we this sentence should say ‘*by using the homes system, this could have contributed as it may not have been as flexible as the material straps on the sling used at home’*. The straps would have no significant effect on the use of the hoist as it is the mechanism that fits to the actual hoist itself. Any effect would have been caused by the actual sling that was used and the size of the sling.

5.11 The conclusions of the internal investigation report are:

- Care Home B confirms that the wrong hoist sling was used on the first day of admission.
- Care Home B consulted with family and medical professionals re the extensive bruising of Rose in a timely fashion and all actions suggested were completed immediately.
- Nurses did give pain relief on several occasions to Rose and Care Home B confirm that further discussions regarding the pain and where it was should have been investigated further by nursing staff.
- Investigation cannot determine the previous incident that Rose stated she had prior to admission.

- The two staff who used the incorrect hoist sling were to be investigated under the disciplinary procedures of the provider organisation.

5.12 We acknowledge that the internal report tried to ascertain how and when the bruising happened, but although Rose allegedly stated that there was a previous incident prior to her admission, we could not find any evidence of this within any paperwork or within the synopsis provided by the family. Also when admitted, Rose had no bruising to any part of her body as a body map was completed and this only showed her sacral pressure injuries. We therefore concur with the internal investigation findings that Rose's bruising was most likely to have occurred as a result of having been hoisted in the wrong sling, and her increased propensity for bruising due to her taking regular warfarin and aspirin.

5.13 The internal report made the following recommendations:

- Re-training of staff in manual handling procedures to refresh knowledge and skills.

- Audit of those residents who currently use a toileting sling and consider the use in conjunction with any physical or medical conditions, e.g. osteoarthritis, brittle bones, upper limb weakness.

- Any new resident to the home and those existing residents on Warfarin will be seen by the Clinical Service Manager and appropriate risk assessments will be reviewed, e.g. risk of bruising, internal bleeding and medication review timings.

- For each new resident, especially those on respite, the Clinical Service Manager will liaise with the persons GP and ensure that all medical history, previous medications etc are available at the time of admission.

- Care Home B to provide 1:1 coaching to all nurses re pain for those residents with capacity and limited capacity and how to monitor (e.g. Abbey Pain scale etc) to ensure that if there are any underlying issues that they are addressed in a timely fashion.

5.14 When we interviewed senior management we asked for a copy of the home improvement plan that is formulated following any internal investigation. We have not been provided with this, and therefore we are not assured that one has been formulated and implemented.

5.15 It is also acknowledged that staff involved in the investigation had left the organisation and that due to the closure of Care Home B that documents had been either archived or destroyed.

5.16 Senior management stated that they would look into this but no home improvement plan was ever submitted. It is our conclusion that this had not been implemented.

Recommendation 8
The provider organisation to ensure that following any internal investigation, an action plan against the findings and recommendations must be formulated and implemented. This then should be recorded through their governance processes for assurance of implementation, minuted and archived for future evidence.

6. Conclusions and recommendations

6.1 The internal investigation by Care Home B identified areas of learning, which we support and expand on. We have made eight recommendations for wider systems learning, having had the advantage of reviewing the care provided to Rose.

6.2 In undertaking this independent review we have asked two key questions:

1. "Did Care Home B take all reasonable steps to ensure that the care and treatment needs of Rose were met?"

2. "Did they take reasonable steps to manage any known risks?"

6.3 We considered Care Home B's approach to Rose's care and treatment, and have concluded that she was not provided with the care that she should have had, in particular in relation to the use of the hoist and sling.

6.4 Core assessments such as Mental Capacity, Risk Assessment, Moving and Handling, or Nutrition were not completed and care plans arising were not developed or implemented. Alongside this, key aspects of the partially completed assessments were wrong. For example a Waterlow assessment completed for Rose on 11 February 2016 stated that Rose was restricted in mobility, scoring a 3 in this area. This should have been scored at the highest level of 5 which was chair bound/wheelchair bound.

6.5 We believe that Rose's care needs and risks should have been identified and care plans formulated to limit the risks and to properly meet her needs. This was not done.

6.6 We have concluded that if the correct sling was used on admission as identified within the pre-assessment forms, and if the documentation of risk assessments and care planning were in place for communication to junior staff, this should have minimised the risk of any injuries to Rose.

6.7 We believe, and therefore concur with the internal investigation findings, that the bruising on Rose's torso discovered on 12 February was as a result of the care home having used the incorrect sling in combination with Rose's propensity for bruising more easily due to her taking warfarin and aspirin.

6.8 The post mortem report findings state that:

"At autopsy the deceased was found to have pneumonia following aspiration of food particles. She had previously had a spinal injury which had been

operated upon in the lumber region but had left her paraplegic. She had bruising from a hoist used on her upper body to move her causing in my view restriction in her chest movement. In my view, aspiration of food particles together with contribution from restriction of chest movement resulting in eventual respiratory failure".

6.9 We note that the post mortem report identifies that the bruising caused restriction in her chest movement. It was the combination of aspiration of food particles together with the restricted chest movement which resulted in her eventual respiratory failure.

6.10 Although Rose's cause of death was due to aspiration pneumonia following her discharge to home and the ensuing choking episode she had whilst eating, Rose was reported to have been in pain in her shoulders from shortly after her admission to Care Home B, and had been given regular pain relief for this. It is not clear if the pain in her arms and shoulders was due to the bruising, or because of her underlying osteoarthritis (reported in the X-ray report of 22 February as "*degenerative changes are noted at the acro-mioclavicular joints bilaterally*").

Recommendations

6.11 Where issues have been identified we have reviewed practice against policies and best practice guidance, which clearly state the expectations in the various areas.

Recommendation 1
The Joint Emergency Team (JET) to review their initial documentation to ensure a full assessment is completed when assessing for placement, this must include a risk assessment for care needs and assessment of mental capacity where there is any concern about mental capacity

Recommendation 2
The provider organisation to assure itself that the pre-admission assessment process is fully completed; a full description of any issues raised to be completed in full with written text to enable a seamless handover for the resident when admitted.

Recommendation 3
All assessments are to be completed upon admission for service users which must include full assessments of identified risks in a timely manner as outlined in the provider organisation's policies, and that these lead to robust care plans to meet the service user's needs.

Recommendation 4
The provider organisation to ensure that all staff have both management and clinical supervision as required by their policy that includes discussion of all training needs and shortfalls.

Recommendation 5
The provider organisation to assure itself and the Royal Greenwich Safeguarding Adults Board that:

- all staff are fully aware of when they need to undertake moving and handling training;
- staff attend this training; and
- staff are competent to undertake moving and handling (including locum/agency staff).

Recommendation 6
The provider organisation to ensure that all residents must be measured for the use of the correct slings and the terminology used must be consistent to ensure the most junior staff are clear about the difference between a hoist and sling.

Recommendation 7
The provider organisation to review its communication systems ensuring communication between all agencies and family members is paramount and consistent. Documentation must be formulated to support this with the correct information.

Recommendation 8
The provider organisation to ensure that following any internal investigation, an action plan against the findings and recommendations must be formulated and implemented. This then should be recorded through their governance processes for assurance of implementation, minuted and archived for future evidence.

Appendix A – Terms of reference

SAR Methodology

The SAR will be based on the Root Cause Analysis (RCA) methodology and will be used to analyse the information gathered from IMRs, chronologies and reports/documentation. Interviews will take place with agencies involved in Rose's care as well as identified staff that had contact with Rose in the circumstances leading up the incident. The Panel will decide the most appropriate method for gathering information from each agency.

Root Cause Analysis is a retrospective multi-disciplinary approach designed to identify the sequence of events that led to an incident. It is a systematic way of investigating that looks beyond individuals and seeks to understand the underlying system features and the environmental context in which the incident happened.

Specific areas of enquiry

The SAR investigation (and by extension all contributors) will consider and reflect on the following:

- The care and treatment of Rose leading up to the incident (to include medical care)
- All documentation for Rose
- All core assessments undertaken within the home and for Rose
- Staffing issues including supervision
- Training issues
- Environmental factors
- An equipment review
- Communication systems with key stakeholders including GPs
- Referral processes for respite care

Specific areas of enquiry

- The SAR investigation (and by extension, all contributors) will consider and reflect on the following:
- The SAR should cover the time period 05/02/2016 to 01/03/2016.
- Agencies are asked to provide information detailing their involvement during this period within their chronologies and provide a summary of any relevant information that falls outside of this period.

  Chronologies and IMRs should not be anonymised initially, that will be undertaken at a later stage in the review process.

Timescales for completion

- This SAR will commence on 02/08/2017 and should complete within six months. However this may be affected by any criminal proceedings and the review may be suspended pending any court case and resumed when any trial is concluded. Everyone involved in the SAR process must be mindful of not jeopardising any criminal proceedings.

It has been agreed that the following organisations are to be asked to submit evidence to the SAR:

Organisation	Nature of the evidence to be submitted	Deadline
Royal Borough of Greenwich	Service user's records/ written evidence/ verbal evidence and policies and procedures.	End of August
Care Home B Nursing Home	As above	
Greenwich GP	As Above	
Bexley GP (Responsible for Care Home B nursing home)	As above	
Lewisham and Greenwich NHS Trust	As above	
London Ambulance Service	As above	

SAR report and publication
Donna Eldridge has been appointed to author the SAR report, the content of which is to be in line with section 7.14 of GSAB Procedure for SAR and multi- agency review and the London Multi-Agency Safeguarding Adults Policy and Procedures. It must contain the transparency of analysis necessary for others to scrutinise the findings.

It is expected that an anonymised version of the full SAR report or the executive summary will be published on www.greenwichsafeguardingadults.org.uk unless there are exceptional circumstances meaning this would not be appropriate. On completion of the report, the SAR panel will recommend to the GSAB how to publish the report, setting out clear reasons for the recommendation.

Timings for publication may be affected by any criminal proceedings and court case, and the SAR report may be held for publication until such time as the proceedings/ case has concluded it can be published. In the meantime, any lessons learned can be taken forward immediately.

Disclosure and confidentiality
Confidentiality should be maintained by all GSAB members and organisations involved in this SAR, in line with the confidentiality statement that forms part of these terms of reference.

However, the achievement of confidentiality must be balanced against the need for transparency and sharing of information in order for an effective SAR to be completed in the public interest, in line with Section 44 of the Care Act 2014, section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures.

All GSAB members and organisations involved in this SAR commit to co-operate in and contribute to this SAR, including sharing relevant information to support joint learning. Where it is suspected that critical information is not forthcoming, GSAB may use its powers under

Section 45 of the Care Act to obtain the relevant information.

The SAR Author may wish to review an organisation's case records and internal reports personally, request additional records and relevant policies/ guidance, or meet with review participants.

Individuals will be granted anonymity within the SAR report and will be referred to as an alias as agreed by this SAR Author.

Communications and media strategy
Communications advice will be provided and the communications approach managed by Royal Borough of Greenwich communications department. All media queries will be referred to Royal Borough of Greenwich, unless criminal proceedings are ensuing in which case all media queries will be referred to the Metropolitan Police Service.

Legal advice
Legal advice will be sought by the GSAB Manager as required from Royal Borough of Greenwich legal department to ensure the SAR process and final report complies with legal requirements and safeguards all parties.

Liaison with the police, criminal justice system and coroner

There are the following police or coroner's investigations on-going linked to this case: Police investigation Concluded- Coroner's inquest

The SAR Author in conjunction with the GSAB Manager will be responsible for ensuring appropriate on-going liaison with the Crown Prosecution Service, Coroner and the Police if and as required.

Links to parallel reviews

The SAR Author shall keep under review any links to other reviews of practice, such as domestic homicide reviews, serious incident reviews, Children's Serious Case Reviews or a SAR being conducted by another SAB, where known.

Funding and resourcing
It has been agreed that the funding of this SAR will be provided by GSAB

Review of Terms of Reference
In the light of information that becomes apparent, these Terms of Reference will be subject to review. Amendments to the terms of reference may be proposed as the SAR progresses but must be approved by the Chair of GSAB.

These terms of reference were approved at Safeguarding Adult Review Panel Meeting on 02/08/2017