NORTHUMBERLAND SAFEGUARDING ADULTS BOARD:

SERIOUS CASE REVIEW IN RESPECT OF MR. H

INDEPENDENT OVERVIEW REPORT

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MAY 2012

STRICTLY CONFIDENTIAL / RESTRICTED

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1) The purpose of a serious case review

Serious Case Reviews (SCRs) take place where there has been a death or potential life threatening injury or serious sexual abuse of an adult or adult at risk and abuse or neglect are known or suspected.

SCRs are a useful tool for reviewing more serious individual cases and to learn about the safeguarding process and its effectiveness and to revisit and amend/augment practices and procedures in the light of experience. They are designed to establish if lessons can be learned about the way local professionals and agencies work together to safeguard adults at risk.

The purpose of a Safeguarding Adults Serious Case Review (SCR) is

- To commission an overview report in relation to the highlighted case, bring together and analyse the findings of each of the relevant individual agency/organisation's significant case review reports submitted to the appointed SCR lead officer.

- To establish whether there are any lessons to be learnt from the circumstances of the highlighted case, specifically in relation to the way in which partner agencies and other allied professionals work together to safeguard the adult at risk.

- To facilitate a review of the effectiveness of individual organisations and their multi agency procedures

- To produce a series of recommended remedial actions with the aim of informing and improving inter agency practice

- To identify areas of particularly good practice and to share these.

2) Executive summary

2.1 Introduction

This overview report examines the circumstances leading up to the death in August 2010, of an eighty four year old man, Mr. H. This gentleman lived in Northumberland throughout his life and had worked in the local timber industry. He was widowed in 1987 and in 2003 moved to a sheltered housing scheme owned and managed by a housing association. He had never had any children. He had close relationships with two adult nieces, the daughters of his sister who died quite suddenly in 1989. His nieces live in Wales, but had frequent contact with Mr. H and visited him in Northumberland on a regular basis. They jointly held Enduring Power of Attorney (EPA) which covered issues relating to Mr. H's property and financial matters. This was an arrangement which Mr. H had put in place some years previously, purely as a contingency measure. The EPA was never used, until after Mr. H's admission to hospital in August 2010.

One of his nieces describes her uncle as having been *'…an extremely organised man who took care of his own affairs … a bright, happy and popular man with a dry wit, great interest in current affairs and a love of nature.'*

Mr. H had some long term physical conditions, including Dupuytren's contracture in both hands. This is a condition which causes one or more of the fingers to bend into the palm of the hand. He had also suffered, for some years, from a circulatory illness, resulting in intermittent claudication causing leg muscle pain when walking. This condition had gradually become worse, but Mr. H lived very independently, until the last few weeks of his life. He was able to walk to the local shops and back (latterly with some difficulty); do his own cooking, laundry, and other household tasks and attend successfully to all his daily self-care needs. There was no recent history of falls in the home, though some years previously he is reported to have fallen and suffered cracked ribs.

His landlords describe him as having been a *'model tenant'*. There was no formal care plan in place with the sheltered housing scheme, but they provided daily contact through the scheme's intercom system or visits from staff members. He employed a cleaning lady for two hours every fortnight, but kept his home in very good order, between these visits.

Mr. H enjoyed going to the local pub and is described by his nieces as a social drinker. He also drank wine and beer at home. In 2009, Mr H had been recorded by his GP as drinking an estimated 28 units of alcohol per week, which is higher than would be recommended for a man of his age and health status. However, there was no evidence to suggest that Mr. H's use of alcohol was causing significant problems with his self care, social functioning or behaviour towards others.

2.2 Basis of report:

The following section (2.3) is a brief outline of events leading to the decision to carry out a SCR. It is based on Individual Management Reviews (IMRs) completed for each of the organisations involved in his support, care and treatment during the period leading up to Mr. H's death on 8/8/10. These organisations are:

- The sheltered housing scheme where Mr. H was a tenant
- Mr. H's GP practice
- The nursing home where Mr. H was resident from 28/7/10 – 2/8/10
- The hospital to which Mr. H was admitted on 2/8/10 and where he died on 8/8/10
- The ambulance service which transported Mr. H from his home to the nursing home, from the nursing home to hospital and a return journey from the hospital and back (on the same day) for the purpose of having an MRI scan at another hospital.

In addition to the IMRs, the author of this overview report has seen written observations and copies of formal letters of complaint from Mr. H's nieces and spoken to them on the telephone on more than one occasion. Northumberland Safeguarding Adults Board is particularly grateful for the patience, cooperation and assistance of Mr. H's nieces during the course of the SCR process.

2.3 Summary of events leading to this serious case review:

Friday 23/7/10: Mr. H had what he described to a sheltered housing scheme staff member the following day, as *'a bit of a fall'* in his home. At this stage, he was not requesting any emergency or medical intervention and the sheltered housing scheme employee did not feel any such intervention was needed.

Sunday 25/7/10: Mr. H was in considerable pain and his out of hours GP service was contacted by a member of staff of the sheltered housing scheme. He subsequently received telephone advice from a doctor employed by this service. The advice included use of paracetamol and to contact his GP the following day, if there was no improvement.

Monday 26/7/10: Mr. H was still experiencing pain and was visited at home by his regular GP, Dr. B, following a further telephone referral from the sheltered housing scheme. At this visit Mr. H was described as 'sore, but mobile'. Dr. B diagnosed bruising to the ribs and a possible rib fracture. The GP believed that alcohol may have been a factor leading up to the fall and advised Mr. H on reducing his alcohol use.

Tuesday 27/7/10: Mr. H was in more pain and was visited again by Dr. B. He had 'stiffened up' and was described as having been 'stuck' earlier that day, but at the time of the GP visit he was able to walk about. Mr. H was prescribed Tramadol, which is a stronger pain killer than the over-the-counter medicines used up to that point.

Wednesday 28/7/10: Mr. H was visited by a different GP (Dr. A) from the same practice. At this stage he was found to be slightly confused and disorientated, which may have been an

effect of the prescribed medication. The GP's examination revealed multiple bruises, but no symptoms to suggest spinal cord compression or any other spinal injuries.

The medical assessment on 28/7/10 was that Mr. H's condition did not require hospital admission, but that he was not safe at home. On this basis, referral was made to a nursing home with which the GP practice had a local referral arrangement. An ambulance transfer was arranged and he was admitted to the nursing home later on the same day.

From his admission to the nursing home on **28 July** until his transfer to hospital on **2 August** (A stay of five nights duration) Mr. H's condition continued to deteriorate. On admission to the nursing home he was complaining of serious back pain. On 29th July his self-reported pain, on a scale of one to ten, was ten ('excruciating') whenever he tried to move. Similarly, on 31 July records show that he reported intensive pain when he moved in any direction.

However, there does not appear to have been a coordinated or effective pain management or treatment plan in place, due primarily to failures of communication between the GP practice and the nursing home. For example, the IMRs relating to the two agencies show that the GPs were advising staff to encourage and assist Mr. H to mobilise, even though he was reporting excruciating pain on movement. This was due, at least in part, to the GPs reportedly being informed that he had been voluntarily 'wandering' around the nursing home at night, apparently without major difficulty. It now appears that this information may have been incorrect. However, it has not been possible to establish with any certainty, whether this information was in fact false, or accurate. If it was false, this raises the question of why the GPs were misinformed about a factor which had clear implications for the diagnosis and treatment of Mr. H's condition. Unfortunately, the IMRs have not shed any further light on this issue, due in part to some poor quality recording, referred to below.

The nursing home has no written record of Mr. H being independently mobile at any point during his stay, or of the GPs being advised that he had been wandering at night. Similarly, none of the staff interviewed for the IMR could confirm making a statement about him being mobile or remember him wandering around, at any point during his stay. Mr. H's niece Mrs. R independently recalls that she was also told by nursing home staff that he had been walking about during the night, so there is little doubt that this information (or possible misinformation) was given to the GPs, in line with their own recollections and written case notes.

The IMRs show that written records kept by the nursing home and Dr. B were generally of poor quality, which could have contributed to failures of communication between the two agencies. This has also impacted on the ability of IMR authors to reliably establish all of the facts and the decision making processes, as they affected Mr. H's care and treatment during his stay in the nursing home.

Throughout his period in the nursing home, Mr. H's mental functioning appears to have deteriorated, and he was at times very confused about how long he had been resident there. However, there is no record to show that Mr. H's mental capacity was considered as part of the needs assessment or care planning processes.

As Mr. H's mental capacity and ability to consent to treatment was not identified as an issue, it followed that there was no automatic assumption that his nieces should be consulted about decisions relating to his treatment or care. They did, however, have a number of telephone conversations with members of the GP practice during Mr. H's stay in the nursing home.

Potential contributory factors to Mr. H's confusion were identified by GPs as pain; pain relief medication; urinary tract infection; dehydration and alcohol withdrawal symptoms.

Mr. H's niece visited him on 29th July and then twice daily throughout his stay at the nursing home. She was told by staff members that doctors were concerned that her uncle was having alcohol withdrawal symptoms. She can not recall the precise date on which this was first mentioned as a concern, but it was her clear impression that alcohol withdrawal issues were taking priority over his acute back pain. She was (and remains) firmly of the view that her uncle never had an alcohol dependency problem and felt that a focus on this issue was distracting attention from a need for urgent investigations into the cause of his back pain.

During Mr. H's stay in the nursing home, his niece had a telephone conversation with a senior partner of the GP practice. She expressed her concern that x-rays had not been arranged, despite the acute back pain reported by her uncle. She recalls being advised that x-rays were not needed, given that both of the GPs who had seen him were very experienced and were confident that Mr. H had broken ribs, which were being treated appropriately.

There is evidence to suggest that Mr. H suffered from dehydration during his stay at the nursing home. His niece states that, when she visited, he was always thirsty and needed help to take fluids. Subsequent hospital records stated that he looked dehydrated, immediately following his transfer from the nursing home.

Dr. A visited Mr. H at the nursing home on **30/7/10**. It was noted that he was still in pain and was confused. The medical assessment was that that he had a probable fractured rib, with confusion resulting from a combination of possible factors, including the Tramadol, alcohol withdrawal and infections. Blood and urine tests were taken, to investigate other potential causes of his confusion, including any urinary tract infection.

On **Sunday 1/8/10** Mr. H was visited at the nursing home by Dr. B, who found him to be in a condition of increased confusion and to have a urine infection (confirmed by the urine test) for which treatment was commenced. He was still experiencing severe back pain, which Mr. H said was stopping his legs from moving.

Dr. B visited again on **2/8/10**, when he noted that Mr. H was having more difficulty moving his legs. Following this visit, Dr. B arranged for Mr. H to be admitted to hospital.

Mr. H was transferred by ambulance from the nursing home into hospital on **2/8/10.** There is no record to show that his mental capacity to consent to treatment was considered by hospital staff, either on admission or subsequently, even though he had been admitted with an accompanying GP letter which outlined a recent history of increasing confusion. However, he was noted to be alert and orientated following admission to hospital.

On the evening of 2/8/10, Mr. H was describing excruciating pain (score of 10 on a scale of 1 - 10). However, pain control was put in place and his score had reduced to 6/10 by 12 noon on 3/8/10. By the evening of 3/8/10 the recorded score was 0/10 (no pain). From that point onwards until the evening of 6/8/10, his self reported pain level was recorded several times a day. On each occasion the recorded score was 0/10.

However, Mr. H's niece believes he was experiencing great pain during this period, and describes him on **5/8/10** as *'….crying out in pain, whenever he tried to move even a small amount'* and on **6/8/10** as *'…clearly still in great pain'*. She also describes an incident when he was being transferred onto a pressure relieving mattress and was screaming out in pain. She did not feel the nurses were carrying out this procedure with sufficient care or specialist equipment, particularly bearing in mind that this was after his spinal injury had been confirmed by an MRI scan.

There is inconsistency between the recorded pain scores of 0/10 and Mr. H's niece's observations. The probable explanation is that Mr. H was experiencing intermittent acute pain whenever he moved (or was being moved by nursing staff) but scores were recorded when he was stationary. It is certainly the case that communication became increasingly difficult for Mr. H as his condition deteriorated. Bearing in mind each of these factors and the observations of Mr. H's nieces, it is clear that the self reported pain scores of 0/10 do not reflect the levels of pain he was in for significant periods, during the last few days of his life.

On **3/8/10**, Mr. H had an MRI scan of his lower spine, which showed that he had a fractured vertebra, with spinal cord compression. Certainty about how and when this injury was sustained is not possible. Professional advice from the IMR carried out in relation to the GP practice suggests the most likely explanation is that Mr. H sustained an unstable spinal fracture when he fell on 23/7/10, but with no immediate spinal cord compression. Such a fracture could have precipitated a progressive condition, subsequently resulting in spinal cord compression. This explanation would be consistent with the extreme pain he reported following the fall and the initial absence of evidence of spinal cord damage. The possibility that he had another fall at some point after 23/7/10 cannot be ruled out as an alternative explanation, but there is no evidence to indicate that this occurred.

On the basis of specialist advice from a neurosurgery on call team, the decision was taken that surgical intervention for the spinal damage was not appropriate, due to the relatively late presentation of the injury.

On **6/8/10**, Mr. H was diagnosed with hospital acquired pneumonia and antibiotic treatment was commenced. Sadly, this treatment was not effective and Mr. H died in hospital, on 8/8/2010. The cause of death was recorded as bronchopneumonia and fractured vertebra with spinal cord compression.

2.4 Key Findings and Learning Points

Introduction

This section of the report asks a number of important questions about the care and treatment provided to Mr. H, from the date of his fall, until his death on 8/8/10. The questions, which all relate to the period from his fall on 23/7/10 until his death on 8/8/10, are guided by the terms of reference for the SCR and issues highlighted by the IMRs and the experiences and views of Mr. H's nieces. It is acknowledged that some of the questions are answered in terms of possibilities and probabilities, rather than reaching definitive conclusions. This is an inevitable outcome of reviewing events, communications and decisions which took place some considerable time ago and involved a number of different organisations, professions and family members. However, answering these questions as fully as the available evidence allows assists in drawing out key learning points to inform future policy, procedure and practice.

Question 1:
Were there any points at which different actions and decisions by care and treatment services could reasonably have been expected to prevent or significantly delay Mr. H's death?

As this SCR is concerned with the circumstances surrounding the death of a vulnerable adult, this is a question of fundamental importance.

Firstly, it is recognised that Mr. H was an elderly person with some significant health problems. He had a fall in his home, subsequently suffered complications, was later admitted to hospital and acquired pneumonia which did not respond to treatment. This is obviously a very distressing but not unusual pattern of events, which would not normally lead to a SCR.

However, in this case there are a number of issues of possible concern. Primary among these is the initial GP diagnosis that Mr. H only had bruised or fractured ribs, and the consequent judgement that an x-ray was not required. This judgement was actively questioned at the time by Mrs. R, based on her observations of the levels of back pain her uncle was describing and her knowledge of him as somebody who would not over-react to pain or discomfort. She expressed her concerns to nursing home staff and to a senior partner at the GP practice, but was advised that x-rays were not appropriate.

With the obvious benefit of hindsight provided by the MRI scan on 3/8/10, it can be said that an x-ray within the first few days after his fall may have identified a spinal injury. If this had happened, it is possible (but by no means certain) that action could have been taken to prevent or minimise subsequent spinal cord damage. It is also the case that he would not have been advised to try and mobilise, if an x-ray had shown evidence of a spinal injury.

On this basis, it can be surmised that an early x-ray could possibly have resulted in a more accurate and complete diagnosis, leading to more appropriate advice, nursing care and treatments, which could have prevented or significantly delayed Mr. H's death.

The professional advice from the IMR which considered the GPs' involvement is that the decision not to arrange an x-ray was correct, based on all of the clinical information available at that time. This information included the results of medical examinations and the nature of the fall described by Mr. H, which would not have indicated sufficient impact to suggest a spinal injury as a likely outcome. The IMR also notes that there were contra-indications for x-rays, including exposure to radiation and additional pain and discomfort from carrying out the procedure and transporting Mr. H to and from the x-ray site.

The IMR suggested that hospital admission for further assessment of possible spinal damage could have been considered as an appropriate option one day earlier than it actually occurred (on 1/8/10 instead of 2/8/10), but it is highly unlikely that this would have prevented or significantly delayed Mr. H's subsequent death.

Mrs. R's view that her uncle should have been x-rayed as soon as possible following his fall has proved to be well founded, based on what is now known about the nature of his injury. It is impossible to be certain whether or not this would have prevented his spinal cord injury and subsequent death, but there is at least a reasonable possibility that it would have done so.

The GPs did not have the benefit of hindsight from the MRI scan. Additionally, they had apparently been informed (or possibly misinformed) by nursing home staff that Mr. H was able to walk about, unaided. This information would have further reduced the possibility of the GPs considering a spinal injury as a likely diagnosis.

Key learning point 1A:

Knowledge and insight of family members and carers about their relatives should be carefully listened to by clinicians, with the understanding that ultimate responsibility for clinical decisions will remain with the medical practitioner. Although family members may lack medical knowledge and qualifications, they can often provide important contextual information about the patient. This contextual information can help to inform diagnoses, investigations and treatment plans.

Key learning point 1B:

Nursing staff observations about how patients present over a 24 hour period can significantly influence medical diagnoses, treatment plans and decisions about investigatory processes, such as x-rays. If significant observations are made (in this case that Mr. H was able to walk unaided) it is essential that these observations are reliable and properly recorded by the relevant member of nursing staff. In this case, the major issues are:

- As Mr. H's niece also recalls being given this information by member of nursing home staff, there seems little doubt that the GPs' records of having received this information are correct. However, the nursing home has no record to show that Mr. H was seen walking about or that the GPs had been informed of this happening.

- It is not clear whether or not the staff member(s) who passed this information on

were aware of how critical this could be in helping to ensure that Mr. H's condition was properly diagnosed, investigated and treated. This is a key learning point not only for the nursing home staff, but also for the GP practice, which did not provide written referral information or guidance about Mr. H's condition, or critical factors to look out for. This lack of referral information from the GP practice may have contributed to nursing staff being unaware of the potential importance of information about Mr. H's ability to walk unaided.

Question 2:
What were the key relevant points / opportunities for assessment of Mr. H, including risk assessment?
a) Were assessments of care needs carried out, and recorded in a professional manner?
b) Were care needs then reviewed and recorded, at appropriate intervals?
c) Did the care delivered meet Mr. H's needs?

The most critical issue related to medical assessments was the decision not to arrange x-rays, which has been addressed in response to question 1. However there are also some serious questions about the standard of assessment and review procedures at the nursing home. These concerns include the following:

- There was no written referral information from the referring GP.
- There was no written guidance from the GP about Mr. H's nursing needs, thresholds for contacting the GPs or emergency medical services.
- Basic factual information was missing from the initial nursing assessment.
- Other key issues were not addressed, including those related to personal care, diet, risk of falls, assistance needed with mobilisation.
- Despite a recorded pain assessment score of 10/10 (excruciating) there was no clear pain management plan in place and no decision was taken to seek external advice or emergency medical intervention.
- There was observational evidence that Mr. H was dehydrated, but no record to show that his intake of fluids was being effectively monitored, or that the care plan was actively addressing concerns about dehydration.

In summary, it is only possible to conclude that, for the period Mr. H spent at the nursing home, the answer to all three questions a), b) and c) is 'no'.

Once transferred to hospital, there is better documentary evidence of professional assessment of needs and risks, and of nursing and treatment plans which were informed by these assessments. However, it is of concern that a patient appeared to be dehydrated on admission from a nursing home, but this was not recognised or recorded as a potential safeguarding issue.

There is evidence that Mr. H continued to experience high levels of pain following hospital admission, but medical and nursing records reviewed by the IMR indicate that this was being actively monitored and managed, including appropriate use and regular review of pain control medication.

Question 3:
Was there adequate management supervision and accountability for assessment, care planning and decision making? What review procedures were in place?

The evidence of poor quality needs assessment and care planning documentation at the nursing home (see response to question 2) indicates that management, supervision and review procedures here were inadequate.

It is also of concern that there was no clearly identifiable key worker at the nursing home, which raises questions about accountability.

The IMRs for the other organisations involved in Mr. H's treatment and care did not identify any specific concerns or issues relating to management, supervision or accountability.

Key learning point 3:

As the IMR author observed, effective leadership from an accountable key worker could have ensured a full assessment of needs, care plans to reflect those needs and regular reviews to ensure that appropriate care was given and any changes identified an implemented.

Question 4:
Were there avoidable delays in arranging treatment or diagnostic interventions? If so, what were the causes and impacts of these delays?

The SCR has identified a number of factors which ultimately meant that the MRI scan, and consequently the diagnosis of spinal cord damage, was completed at a later date than may otherwise have been the case. Important factors include:

- The possible misinformation that Mr. H was able to walk unaided, meant that the GPs were less likely to consider the possibility of a spinal injury needing urgent investigation.
- Concentration by GPs on the causes of Mr. H's confusion (including, but not only, the possibility of alcohol withdrawal symptoms) caused some distraction from the need for more urgent consideration of a possible spinal injury.
- There was a delay in commencing treatment for the urinary tract infection, because a urinalysis result was not communicated to GPs until more than twenty four hours after the result was known. As the urinary tract infection was a potential factor in the confusion, this added further to the distraction referred to above.
- Mr. H was assessed as not needing to see a hospital consultant on the day of admission, although it is understood that an on-call consultant would have been available, if required. Having been seen by the consultant on the following morning, he was referred for an MRI scan which took place on the same day.

Taken in isolation, each of the above factors created relatively minor delays. However, the cumulative delay could have been in the region of three or four days. It is not possible to know whether or not an earlier MRI scan would have made a significant difference to the outcomes. However, an earlier diagnosis of Mr. H's spinal injury would at least have increased the possibility of more positive treatment outcomes.

Key learning point 4:

Delays were caused partly through inefficient communication within the nursing home and between the nursing home and the GP practice. Poor standards of recording of assessment and referral information were also contributory factors.

It is well documented that early assessment by a consultant following hospital admission is associated with improved patient survival rates. However, it is recognised that, Mr. H having a consultant assessment the following morning, is in line with current standard practice. It is most unlikely that seeing a consultant on the afternoon of hospital admission instead of the following morning would have made a significant difference to outcomes for Mr. H.

Although individual delays may have been relatively short, the cumulative impact could possibly have had a significant negative impact on the chances of successful treatment outcomes for Mr. H.

Question 5:
Did each of the services involved comply fully with the Mental Capacity Act, Deprivation of Liberty Standards and associated guidance and regulations? If they did not, what impacts did this have on Mr. H's care and treatment?

There were no concerns about Mr. H's mental functioning until the day of his admission to the nursing home (28/710) when his GP described him as being slightly confused and disorientated. On this basis, the sheltered housing staff acted reasonably and appropriately in allowing Mr. H to make his own decisions about family contact and referral for medical attention.

The available evidence from the sheltered housing scheme and the GP's description (28/7/10) of slight confusion and disorientation do not suggest that Mr. H lacked capacity to give informed consent to treatment, or to his admission to the nursing home. He had periods of increased confusion during his stay in the nursing home, but his niece has confirmed that he also was also quite lucid and able to communicate normally for significant periods of time. This pattern of intermittent confusion appears to have continued, as he was also described as having been quite lucid for much the time, following his admission to hospital.

The Mental Capacity Act Code of Practice makes it clear that, where people have fluctuating mental functioning (for example, due to the side effects of medication or a temporary condition such as a urine infection) they should not be treated as unable to make decisions about their own treatment or care. Rather, there is a clear principle that they should be supported to engage in decisions about their treatment and care, during those periods in which they are able to understand the relevant information and communicate their wishes. The available evidence from the IMRs and Mr. H's nieces suggests that this principle would have applied to Mr. H.

On this basis, the SCR has not found any evidence to suggest that Mr. H's admissions to nursing care or to hospital (or the care and treatment provided) happened without consent, or that there was any breach of the Deprivation of Liberty Safeguards (DoLS).

However, the IMRs did highlight the fact that neither the nursing home or hospital records made any reference to having considered possible issues of mental capacity or DoLS. In the case of the hospital admission and initial assessment, this was despite the fact that the GP referral letter made reference to increased levels of confusion and visual hallucinations.

Given that it seems unlikely that Mr. H lacked capacity in relation to decisions about his treatment and care, the fact that potential concerns about mental capacity were not specifically recorded in care and treatment plans may have had limited impact on how treatment and care was delivered. However, it is also noted that the care and treatment plans did not show how (or if) Mr. H was consulted about his care and treatment, although patient notes document that he informed staff of his condition on admission and was aware of his decreased mobility and increased confusion.

A closely related issue is the level and quality of communication and engagement by hospital staff, with Mr. H's nieces. Had there been closer consideration of possible concerns about his mental capacity, this may have prompted staff to also give closer consideration of the role his nieces could have, in helping to make sure that decisions about care and treatment were in line with Mr. H's wishes.

Key learning point 5A
Where there is evidence of confusion, nursing care and hospital services should proactively consider the possibility that the patient may lack capacity to make informed choices about their admission, care and treatment plans. It is correct that capacity should be assumed, unless there is clear evidence to the contrary. However, even where capacity has been assumed, it is good practice to record the basis for judgments about capacity.

Key learning point 5B
Patients who have mental capacity may still benefit greatly from professionals actively involving family members, to ensure that the patient's wishes are properly understood, recorded and acted upon. This is particularly true when there is evidence that the patient is experiencing periods of confusion and disorientation.

Clearly, there will be cases where the patient does *not* want family members to be informed or involved and such wishes must be respected.

The concern in this case is that there is little evidence to show that either the nursing home or the

hospital actively considered whether or not Mr. H wanted his nieces to be kept fully informed and involved in decisions about his care and treatment. At times they felt they were being excluded and that this was resulting in their uncle not receiving the best possible care and treatment.

Question 6:
Were all of the services involved sensitive to Mr. H's needs relating to his racial, cultural, and religious identity?

The IMRs provided very limited evidence on which to base an answer to this question. Mr. H's nieces have not raised any concerns in relation this aspect of the care and treatment delivered by any of the agencies involved. It was noted that the nursing home's initial assessment of need did not include any reference to spiritual or religious needs.

Question 7:
Were there organisational difficulties or lack of capacity in the organisation that impacted or may have impacted upon the care and treatment Mr. H received?

The SCR has found no direct evidence of lack of capacity or other organisational difficulties.

Question 8:
Did age discrimination contribute to any weaknesses in the care and treatment Mr. H received?

This question was raised by a member of the SCR Panel. The issue is whether decisions about medical investigations, treatment or care (including withholding interventions) were inappropriately influenced by the fact that Mr. H was an elderly man.

It is essential to recognise that there are often good reasons for ruling out medical interventions with an elderly and relatively frail person, where the same intervention could be expected to deliver good treatment outcomes with a younger and fitter person.

The SCR has found no evidence to indicate that age discrimination was an issue in this case**,** but it is important to note that the question has been asked. This is because studies have identified age discrimination as a significant factor which can impact negatively on the standards of care and treatment delivered to older people. [1]

<u>Key learning point 8</u>: Although there is no evidence to suggest that age discrimination was a factor in Mr. H's care and treatment, all care and treatment providers should have monitoring systems which can effectively identify and address any evidence of such discrimination.

Question 9:

[1] For example, see Centre for Policy on Ageing, Ageism and age discrimination in primary and community health care in the United Kingdom: A review from the literature, 2009.

Were there any problems in communication and information sharing between agencies, which impacted on the quality and effectiveness of the care and treatment Mr. H received?

There were very considerable problems in communication and information sharing between the GP practice and the nursing home, which included:

- There was no written referral information provided by the GP practice to the nursing home. This is a joint responsibility, because the nursing home should have insisted on this, as a condition of admission.
- At referral, the GPs gave no recorded advice on what was known about Mr. H's injury, signs and symptoms that nursing staff should look out for, instructions and contingencies related to pain management.
- There are serious questions about the accuracy of information which was shared, in relation to Mr. H's ability to walk unaided.
- There were delays in passing on key information, including urinalysis results.
- Nursing staff and one of the GP's failed to keep adequate written records.

The impacts of these problems on Mr. H's care and treatment have already been documented in response to other questions.

A major factor which contributed to these communication and information sharing issues appears to have been a very informal working relationship between the GP practice and the nursing home.

It is recognised that this close relationship provided some clear benefits, including continuity of primary health care for patients referred from the GP practice. Weekend cover was provided on a voluntary basis, indicating a genuine GP commitment to meeting patients' needs.

However, the evidence from the IMRs indicates that the informal nature of this inter-agency relationship contributed to staff being unclear about lines of communication and accountability between the two agencies. For example, the IMR into the GP practice makes the following observation about the informality of the arrangements:

"……it is unclear whether these (arrangements) impact on the willingness at a conscious or subliminal level of nursing staff to contact GPs with their concerns by altering their thresholds for making contact."

Key learning point 9:

Close working relationships, based on professional trust and respect between GP practices and nursing homes, deliver real benefits to residents and should be actively encouraged and supported.

However, such relationships should not become so informal that they come to rely exclusively on informal relationships between individuals, even where trust has been developed over a long period of time.

Formal procedures for referral, recording and sharing of information cannot by themselves guarantee the safety or welfare of patients. But they do provide an essential framework to ensure that each of those working with vulnerable adults have clarity about their accountability and responsibility for decisions and actions, or inactions.

Question 10:
Was practice consistent with policies at individual agency level, and with local and national multi-agency policies, procedures, guidelines and standards?

The issues and concerns already raised in relation to the nursing home and the GP practice indicate that practice was not consistent with the following Care Quality Commission (CQC) Essential Standards and Outcomes:

- **Outcome 4, care and welfare of people who use services:** People should get safe and appropriate care that meets their needs and supports their rights
- **Outcome 5, Meeting nutritional needs:** Food and drink should meet people's individual dietary needs
- **Outcome 6, Cooperating with other providers:** People should get safe and coordinated care when they move between different services
- **Outcome 16, Assessing and monitoring the quality of service provision:** The service should have quality checking systems to manage risk and assure health, welfare and safety of people who receive care
- **Outcome 21, Records:** People's personal records, including medical records, should be accurate and kept safe and confidential.

It should be noted that, as direct result of concerns raised in relation to Mr. H, the nursing home has now implemented significant improvements. They have since been inspected by CQC and found to be compliant with each the standards against which they were inspected.[2]

The IMR for the hospital found that the mandatory cognitive assessment was not undertaken on admission, although this should be done routinely for all adults aged seventy five years or older. Such an assessment is recognised by the hospital trust, as required clinical documentation for good patient care.

Question 11:
Were practitioners aware of and sensitive to the needs of adults at risk in their organisation? Were they knowledgeable of the indicators of abuse or neglect in such adults?

[2] All CQC inspection reports of registered services are published on their website: www.cqc.org.uk
The website also provides detailed guidance on each of the 16 Essential Standards and associated Outcomes.

A primary concern in relation to this question is the evidence that Mr. H was showing signs of dehydration, both during his period in the nursing home and on his admission from the nursing home to hospital. Despite this, neither the nursing home nor hospital staff appear to have recognised this as a possible safeguarding concern. Of particular concern was the absence of any documentary evidence at the nursing home to show that Mr. H's fluid intake was being actively monitored and managed.

The SCR Panel took the view that, on balance, they would not have expected hospital staff to make a formal referral under multi-agency safeguarding procedures, based on all of the information available to them at the time. However, had this at least been recorded as a possible cause for concern in relation to other residents of the nursing home, this would have been recognised as good safeguarding practice.

Question 12:
When and in what way were the wishes and requests of Mr. H and his family members ascertained and taken into account when making decisions about the provision of care and treatment?

There were many occasions on which Mr. H's nieces had contact with services and made their wishes and requests known. There are several good practice examples:

- The sheltered housing scheme responded to his niece's request to prepare food for him, even though this was beyond the formal responsibilities of a sheltered housing provider.
- A junior doctor at the hospital took very considerable time and care to explain Mr. H's diagnosis, following the MRI scan.
- Nursing staff at the hospital made considerable effort to enable Mr. H's niece to stay overnight with him in the hospital, following the diagnosis of pneumonia.
- The GP practice facilitated a good level of telephone contact with Mr. H's nieces during the period following the fall and whilst he was resident in the nursing home.

Question 13
Was there appropriate communication, information sharing and involvement between the organisations delivering care and treatment to Mr. H and his family members?

There were examples of good practice and appropriate communication, as outlined in response to question 12. However, there were also aspects of the engagement with Mr. H's nieces, with which they were very dissatisfied. While the GPs listened to requests to arrange x-rays, a clinical decision was taken that this was not appropriate. This is discussed in more detail at question one.

Another major concern of Mr. H's nieces was the decision by the hospital consultant to give Mr. H very distressing information that his legs were paralysed, apparently without considering the need for his nieces to be present to provide emotional support to Mr. H. The SCR has recognised that arranging for relatives to be present when imparting difficult information to patients can present a number of challenges, in the context of a busy hospital environment. This is further complicated by the fact that there can be no automatic assumption that the patient wants their relatives to be present.

However, none of the records seen in the course of the IMR indicate that Mr. H did not want his nieces (one of whom was his next of kin) to be fully involved and informed about his condition, treatment and prognosis. On the basis of the evidence available it is reasonable to assume that the reverse was true. In these circumstances, it would have been preferable to wait until his nieces were able to be present, before imparting this information**.**

Mr. H's niece also raised concerns that she was not informed by the sheltered housing scheme, as soon as they became aware that he had suffered a fall. While her distress and concern is very understandable, it does seem clear that the sheltered housing provider was respecting the wishes of their tenant. At that point there was no question about his mental capacity to make an informed decision about if and when he should contact family members. It may well have been the case that he did not want to cause what he thought was unnecessary worry or anxiety for his relatives.

Mr. H was mobile and had access to both a telephone and an emergency alarm system. When he decided he did need assistance he was able to contact his friend, who then alerted his niece.

2.5 Recommendations

2.51 Introduction:

The following recommendations include suggested actions to be taken by NSAB at the strategic planning and policy level, as well as actions to be taken at management and operational levels by the organisations which were involved in delivering care and treatment to Mr. H.

It is important to recognise that some of the management, training and operational service delivery recommendations have already been implemented, in response to immediate and urgent safeguarding concerns which were highlighted by Mr. H's nieces, following his death.

These concerns, which focused to a large extent on the nursing home service, were considered by a multi-agency strategy group, in line with NSAB policy and procedure. The nursing home engaged positively with this process and implemented an action plan to address highlighted concerns.

The purpose of publishing recommendations, some of which have already been implemented, is to ensure that the learning gained from the SCR is shared as widely as possible.

The SCR found no significant issues or concerns in relation to the roles of the sheltered housing provider or the ambulance service, so there are no recommendations specifically directed at these services.

2.52 Recommendations for the nursing home provider:
The following recommendations were made by the independent consultant who carried out the IMR for the nursing home and are fully endorsed by the findings from the SCR. It is understood from the IMR author that all of these recommendations have now been implemented or are in the process of implementation:

Recommendation NH1
Review induction process for all new senior staff / RGNs to explicitly include a component on conducting initial assessments with evidence of consultation with service users / family / advocates.

Recommendation NH2
Review the competency of all staff to carry out new assessments

Recommendation NH3
All senior staff to receive training on person centered care planning, to ensure that plans accurately reflect the needs of the service user and how the care should be provided, as directed by the service user.

Recommendation NH4
Care plans should be regularly reviewed by a designated senior staff member and feedback to individuals to form a standing item in all staff supervision sessions.

Recommendation NH5
Detailed written records of discussions of shift handovers should be kept, to provide an audit trail of information sharing, decision making, actions taken / actions which need to be taken.

Recommendation NH6
Review the key worker system, to ensure that each service user has a clearly identified and documented primary carer responsible for coordinating and overseeing health and care needs. They should be a pivotal contact point for all appropriate people.

Recommendation NH7
All relevant admission assessment information must be completed, for example, assessment records, risk assessments and care plans based on the outcomes of these assessments.

Recommendation NH8
Staff responsible for maintaining records must ensure that the information about all of their interactions with or about service users are fully and accurately documented. This is specifically pertinent to night duty staff.

Recommendation NH9
The initial assessment and care planning process must show evidence of consultation with the service user / family / advocates.

Recommendation NH10
There needs to be clarity for senior staff about the timescale for the completion of care plans from the point of admission and the initial assessment.

Recommendation NH11
As appropriate, healthcare evaluations need to be carried out for individual service users, on a regular basis.

Recommendation NH12
Senior staff must be confident of what to do in the event of a patient being unwell when it is out of hours.

Recommendation NH13
There must be formal policies and procedures and information referral forms, for admission to the care home.

Recommendation NH14
Review staff awareness and understanding of Mental Capacity Act and Deprivation of Liberty Standards.

2.53 Recommendations for the GP practice
The following recommendations were made by the doctor who carried out the IMR for the GP practice and are fully endorsed by the findings from the SCR. It is understood from the IMR author that all of these recommendations have now been implemented or are in the process of implementation:

Recommendation GP1
Improvements required in record keeping by Dr B. To be reviewed at next GP appraisal and incorporated into Professional Development Plan.

Recommendation GP2
GPs to provide clear safety netting advice for nursing home staff, following patient consultations and visits.

Recommendation GP3
Review on call arrangements at the nursing home, with externally facilitated discussion of cases, looking at thresholds for contacting GPs out of hours.

Recommendation GP4
Develop and implement a clear policy for recording of telephone calls and all patient contacts and failed contacts.

2.54 Recommendations for the hospital
The IMR for the hospital did not make any specific recommendations, but noted that action had already been taken in relation to alter documentation to prompt review of mental health state. This was as a result of lessons learnt from a previous serious case review. It also noted that documentation for mental health state and mental capacity are subject to annual audits and feedback to senior clinicians and managers.

The following are additional recommendations based on the findings from the SCR:

Recommendation H1:
The concerns raised by relatives about the imparting of distressing information to a patient, apparently without consideration as to whether or not relatives should be present, should be investigated as a formal complaint, within the Trust's complaints procedure. If the complaint is upheld, the Trust should urgently consider the need to review (and where appropriate to revise) policy, procedure, guidance and staff training on the issue of sharing potentially distressing information about diagnosis, treatment options and prognosis, with patients and family members.

Recommendation H2:
There should be a continuing review (and when appropriate revision) of guidance and training provided to relevant staff on the issues of safeguarding vulnerable adults, Mental Capacity Act and Deprivation of Liberty Safeguards. This review should include reference to the annual audits of documentation for mental health state and mental capacity, as referred to above.

2.55 Recommendations for Northumberland Safeguarding Adults Board

Recommendation SAB 1
The executive summary of this overview report should be circulated to senior providers of primary health care services; residential nursing care providers and hospital trusts throughout Northumberland, to ensure that learning can be shared as widely as possible.

Recommendation SAB2
The executive summary should be published on the SAB website.

Recommendation SAB3
The Care Quality Commission should have access to the full report, to help inform future inspections of the GP practice, the nursing home and the hospital.

Recommendation SAB4
The SAB should ask for reports from senior managers or commissioners of the nursing home, GP practice and hospital, detailing evidence of progress in meeting the recommendations at 2.2 – 2.4 above. This should be within a period of not more than 4

months from the date that this SCR overview report and recommendations are formally endorsed by the SAB.

Recommendation SAB5
The SAB (or training sub group) should carry out a review of multi-agency training needs arising from this report, its findings and recommendations. This should be with a view to commissioning training to meet identified needs.

Recommendation SAB6
The SAB should ensure that the lessons learned as a result of this SCR are effectively disseminated, locally, regionally and nationally. The Communications and Publicity Sub-Group should be asked to lead on this and to report back to the SAB on progress.

3) The Serious case review process

Northumberland Safeguarding Adults Board (NSAB) developed a multi-agency protocol for SCRs in 2010. This is the first SCR which has been completed under the protocol, which can be viewed at http://www.northumberland.gov.uk/default.aspx?page=1065. The SCR has been overseen by a multi-agency panel, in line with the multi-agency protocol. Panel membership includes each of the people who carried out IMRs into the involvement of those organisations which had responsibility for Mr. H's treatment and care, during the last weeks of his life. In line with the NSAB protocol, none of the IMR authors had any direct management responsibility for the services they were reviewing. In the case of the GP practice and the nursing home, the IMRs were carried out by independent consultants. Similarly, the author of this overview report is an independent consultant, with no prior involvement with any of the organisations involved.

Full Panel membership comprised:

- Senior Manager, Northumberland Care Trust (panel Chair)
- Strategic Safeguarding Manager, Northumberland Care Trust
- Independent overview report author
- Solicitor for Northumberland County Council
- Professional Lead for Mental Capacity Act and Deprivation of Liberty Safeguards
- Head of Extra Care Operations (IMR for Sheltered housing provider)
- Independent clinician (IMR for GP practice)
- Independent consultant (IMR for nursing home)
- Senior manager (IMR for ambulance service
- Head of Clinical Pharmacy Services (IMR for healthcare trust)

The full SCR Panel met for the first time on 28/11/11, when each of the five IMRs was presented by their authors. During the period from 28/11/11 to 20/2/12, the IMR reports were subject to detailed evaluation and analysis by the author of this Overview Report, Richard Corkhill. Mr Corkhill also had access to other relevant documentation, including written representations from Mr. H's nieces, who were instrumental in highlighting the concerns which led to the decision to carry out the SCR. A full list of documents seen by Mr Corkhill is provided at appendix 2.

During the period of analysis, further questions for clarification were raised with IMR authors and with Mr. H's nieces, via telephone contact and email correspondence. There was a further meeting of the Panel on 24/2/12, when an initial draft report was discussed and further clarifications provided by Panel members. A second draft report, including key findings and recommendations was discussed by the Panel on 12/3/12. A final draft was circulated to Panel members on 19/3/12 for final comments and amendments. The final report was agreed with the SCR Sub Group and endorsed by the full NSAB on 18/5/12.

4) Brief profile of Mr H and relevant contextual information

4.1 Family circumstances

Mr H. was born on 30/08/1925, and lived throughout his life in Northumberland. He worked in the timber industry in Northumberland, and had been a sales director for a well known timber merchant. He had also spent some time serving in the Royal Navy. He was widowed in 1987. He had no children, but had close relationships with his two nieces, the daughters of his sister who died in 1989. His nieces also originate from Northumberland, but now reside as adults in South Wales. His eldest niece Mrs ER. was named as his next of kin. She and her sister jointly held Enduring Power of Attorney for their uncle. This arrangement had been put in place, purely as a contingency measure, some years previously. The EPA covered property and financial matters. Mr. H. successfully managed all of his own affairs, until the fall on 23/7/10 which led to the events with which this SCR is concerned.

4.2 Housing

Mr. H had been a tenant of a housing association managed sheltered housing scheme, since 2003. His landlords describe him as having been a 'model tenant'. Residents are contacted on a daily basis, either by a visit from a member of staff, or through an intercom system. There is also an emergency on-call system. However, tenants of this scheme are generally quite independent, as was the case with Mr. H. There was no formal care plan in place with the sheltered housing provider, or any visiting care or support services. Mr. H had signed a disclaimer, indicating that he did not want a formal care plan. At this scheme, tenant's needs are reviewed annually. If the review does not result in an agreed care plan it is standard practice to ask the tenant to sign a disclaimer. This is commonly recognised as good practice and does not indicate that the sheltered housing provider has particular concerns about the tenant's decision not to have a formal care plan.

4.3 Medical history and mental capacity

Mr. H had some long term physical conditions, including Dupuytren's contracture in both hands. This is a condition which causes one or more of the fingers to bend into the palm of the hand. He had also suffered, for some years, from a circulatory illness, resulting in intermittent claudication causing leg muscle pain when walking. This condition had gradually become worse, but Mr. H lived very independently, as outlined at 4.5 below.

In 1999, Mr. H had two surgical interventions for bowel cancer, from which he made a full recovery. His niece stayed with him for a period following the surgery and recalls that it took several months for him to regain full fitness.

Mr. H had no known history of mental illness. There were no concerns about his mental capacity, at least up until the incident on 23/7/10. His niece describes him as having been a

'…bright, happy and popular man with a dry wit, great interest in current affairs and a love of nature'

There was no recent history of falls in the home, though some years previously he had reportedly fallen and cracked some ribs.

4.4 Use of alcohol

Mr. H enjoyed going to the local pub and is described by his nieces as a social drinker. He also drank wine and beer at home. In 2009, Mr. H had been recorded by his GP as drinking an estimated 28 units of alcohol per week, which is considerably higher than would be recommended for a man of his age and health status.

Mr. H had visited his GP in early July 2010, as he was concerned that he may have had a visual hallucination. He had seen a girl in a white dress running across a path. The GP's assessment of this incident was inconclusive. It may or may not have been related to alcohol, but no medical investigations were carried out at this stage. It is possible that there was in fact a girl in a white dress and no hallucination had occurred. No further incidents of this nature were recorded.

Blood tests carried out subsequent to Mr. H's fall on 23/7/10 showed evidence of impaired liver function. This impaired function is consistent with alcohol related liver damage, although a range of other possible causes can not be ruled out.

There was no evidence to suggest that Mr. H's use of alcohol was causing significant problems with his self care, social functioning or behaviour towards others. His nieces, who stayed at his home on a regular basis, saw no evidence of excessive or problematic alcohol use. His landlord's description of him being a 'model tenant' is further evidence that alcohol was not causing any problems with his day-to-day functioning.

In summary, the GP's records indicated that Mr.H had, for some years, drunk more than was medically advisable for a man of his age and general health status. However, there was no evidence (with the possible exception of his self reported experience of a suspected hallucination in early July 2010) to suggest that drinking had caused any significant problems with his daily functioning, self care, or management of his finances.

Whether or not Mr H had been drinking immediately prior to his fall on 23/7/10 is not known. It is clear that both of the GPs engaged in his treatment after the fall believed that alcohol was a possible causal factor. On the other hand, Mr. H's nieces are strongly of the view that alcohol was an unlikely factor, partly due to the fact that the fall is understood to have happened during the morning period. They do not believe their uncle was in the habit of drinking early in the day.

4.5 Social functioning and self care

Mr. H lived very independently, until he suffered the fall on 23/7/10. He was able to walk to the local shops and back (latterly with some difficulty); do his own cooking, laundry, and other household tasks and attend successfully to all his daily self-care needs. He employed a cleaning lady for two hours every fortnight, but kept his home in very good order, between these visits. Mr. H's niece reports that her uncle was:

'…..very fastidious….meticulously cleaned and stored way all his meal dishes….undertook his own ironing and even sorted out items for recycling.'

Mr. H had regular telephone contact with his nieces. Although they both live in South Wales, they did visit and stay with Mr. H quite frequently. Mrs ER (his older niece) had last stayed with him in March 2010 and stayed in his property again, following his admission to nursing care, after the fall.

Mrs. C's 17 year old son had also spent some time staying with Mr. H, prior to the fall. Her son returned to South Wales on 22 July, the day immediately proceeding Mr. H's fall. He apparently had found his great uncle to be in good spirits and functioning normally.

In summary, Mr. H appears to have been caring for himself quite successfully and safely, until 23/7/10. This was with a limited but appropriate level of monitoring and support provided by the sheltered housing scheme, combined with telephone contact and visits from his nieces.

5) Detailed analysis of events

5.1 Introduction

This section of the report considers the actions taken, individually and collectively, by the organisations involved in Mr H's care and treatment, from his fall on 23/7/10, until his death in hospital just over two weeks later, on 8/8/10.

Sections 5.2 – 5.6 focus mainly on decisions and actions taken at individual organisational levels; while the final two sections consider multi-agency issues and communication and cooperation with family members:

- 5.2 Sheltered housing scheme
- 5.3 G.P. practice
- 5.4 Nursing home
- 5.5 Hospital
- 5.6 Ambulance Service
- 5.7 Key issues and good practice examples for multi-agency working
- 5.8 Key issues and good practice examples for communication and cooperation with family members

This analysis has been closely guided by SCR terms of reference (appendix 2) and has sought to maintain a clear focus on:

- The care and treatment provided to Mr. H and the impact, positive or negative, this had on his quality of life between 23/7/10 and 8/8/10.

- Whether different actions by any of the agencies (individually or working together) could *reasonably** be expected to have led to better outcomes, including particularly those relating to physical pain, emotional distress and ultimately Mr. H's death on 8/8/10.

- If different actions would have resulted in better outcomes, what lessons can be learned by the individual organisations involved in Mr. H's care and treatment; other organisations which provide similar services; or those responsible for adult safeguarding policy, practice and quality management frameworks.

* The term *'reasonably'* requires careful consideration of the fact that the organisations concerned did not have the same benefits of hindsight, as have been available to the SCR panel.

5.2 Sheltered housing scheme

At mid morning on 23/7/10 Mr. H advised the Estate Manager (via the intercom system) that everything was fine. Around 24 hours later – mid morning on 24/7/10 - he received a routine visit from the Assistant Estate Manager. He reported that he had fallen against a stool and sustained some bruising, but did not want any action taken. This was the first point at which any of the agencies had any information about the incident.
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At the time of the Assistant Estate Manager's visit, he could not remember when the fall had happened, but he subsequently (on 25/7/10) advised the on call doctor that it had been Friday 23/710. It therefore appears that the fall happened after mid-morning and before midnight on the Friday.

After being told of the fall at her mid morning visit on Saturday 24/7/10, the Assistant Estate Manager made a note in the daily log, but did not call for any medical advice or assistance, or contact Mr H's nieces. The SCR Panel have noted that:

- At this stage, there was no cause for concern about Mr. H's mental capacity.
- He appeared to have suffered only minor injuries.
- He was not requesting any medical referral or family contact to be arranged on his behalf.
- He had a telephone and an emergency on-call system in his home and was able to use them, if necessary.
- There was no care plan in place, either with the sheltered housing scheme or any external care services.

Analysis
Bearing in mind all of the above points, the Assistant Estate Manager acted reasonably and appropriately. She respected Mr. H's stated wishes by not contacting any medical services, or Mr H's nieces. The note in the daily log would ensure that, whoever was next on the duty rota, would be prompted to prioritise contact with Mr H, ask about his injury and whether he was in need of any additional assistance.

On Sunday 25 July, the same Assistant Estate Manager visited Mr. H again. At this point he had a visitor. This was Mrs. A, a friend of his who lived around twenty miles from his address. He had telephoned Mrs. A earlier that day and told her about his fall and that he was in great pain. She had subsequently telephoned his niece in S. Wales (Mrs R) and they had agreed that Mrs A would visit him at home. This was the first time that Mr. H's nieces had any information that their uncle had suffered a fall.

At Mr. H's request, the Assistant Estate Manager called the on-call GP service, who were contracted to provide out-hours services on behalf of the GP practice.

The on-call doctor telephoned Mr. H and gave advice to take paracetamol and to call them again on the same day, or to contact his own GP the following day, if he had any concerns. No further contact was made with the on-call GP service.

Analysis

The fact that Mr. H telephoned his friend indicates that he was making rational and informed decisions and was able to seek advice and assistance, as soon as he felt he needed it.

The Assistant Estate Manager acted appropriately in contacting the GP on-call service, in line with Mr. H's request.

The IMR into the involvement of the GP practice also considered the actions of the on-call service and found that the telephone advice given was appropriate. On the basis of all of the information available to the service at that time, there was no indication to suggest that they should have arranged an urgent home visit. There is also no indication that such a visit would have made any significant difference, in terms of the eventual outcome.

On Monday 26/7/10, the sheltered housing scheme Estate Manager checked on Mr. H, having seen the record of events over the weekend period. Mr H was still in pain and the GP was contacted. (GP made home visit – see 5.3 below)

Also on Monday 26/7/10, the Estate Manager received a phone call from Mr. H's niece, requesting that they ensure Mr. H was eating. The sheltered housing scheme records show that food was prepared for Mr H, but it was left uneaten.

Analysis

Preparation of food for a tenant would not generally fall within the formal remit of a sheltered housing provider. The fact that food was prepared is an indication of a willingness to go beyond the strict limits of contractual expectations, acting in the role of 'good neighbour'.

That food was left uneaten for a limited period would not be a major cause for concern, provided that Mr H was able to eat and drink unaided, but had chosen not to, as appears to have been the case.

On Tuesday 27/7/10, the Estate Manager visited again and recorded that Mr. H was no better. She recalls that he drank a little tea and she made him some more sandwiches, but these were not eaten. The GP was contacted again (Further visit from GP - see 5.3 below)

Later that day, the Estate Manager visited again and found that Mr. H's neighbour was helping him to dress. In line with advice from the GP to try and mobilise, the neighbour and the Estate Manager helped Mr. H. to take a short walk around the garden.

Analysis

As there was no indication or GP advice that Mr. H may need any specialist help (e.g. occupational therapy) with mobilisation, the actions of the Estate Manager in helping him follow medical advice and take a short walk were appropriate, even though they were beyond her formal job remit or the recognised responsibilities of a supported housing provider.

On Wednesday 28/7/10 The Estate Manager visited again. Mr. H was in bed, in a distressed condition and in obvious pain. Mr. H's bed was wet. The Estate Manager contacted Social Services to request an emergency care package. The Estate Manager

was told by social services that the case would remain open for one week, in case more help was needed. Social Services also arranged for a District Nurse to attend on the same day.

The Estate Manager subsequently noticed the GP (Dr. A) leaving Mr. H's address. (This was following a visit from the District Nurse, who had then made a referral to the GP practice, due to her concerns about Mr. H's condition). Dr. A advised the Estate Manager that Mr. H was to be admitted to a local nursing home, later that day. The Estate Manager then made another visit to Mr. H and followed his instructions to prepare a bag of toiletries, pyjamas, etc. Mr. H was transferred by ambulance to the nursing home, later that day. He never returned to his home address, after 28/7/10. His niece arrived from S. Wales on 29/7/10 and stayed in his property until 2/8/10 so that she could make frequent visits to her uncle, at the nursing home.

Analysis

Mr H's condition had clearly deteriorated and the Estate Manager's decision to make a referral to Social Services was appropriate. Social Services and the District Nursing Service responded very quickly, in arranging a home visit on the same day. The District Nurse made an immediate referral to the GP practice, who also responded very promptly in arranging a home visit on the same day.

Social Services also acted appropriately, in assuring the Estate Manager that they would keep the case open, initially for a week, in case further assistance was needed. As Mr. H was admitted to nursing care later that day, there was clearly no reason to consider domiciliary or other care options, at that stage.

5.3 GP practice
Initial referral to GP practice, Monday 26/7/10
GP records show that Dr. B received a telephone call from one of Mr H's nieces on Monday 26/7/10, reporting her uncle's fall, commenting on his alcohol consumption and the possibility that this had been the cause of his fall.

Neither of Mr. H's nieces recalls having a telephone conversation with Dr. B on 26/7/10. The younger niece (Mrs C) is certain that she did not have any such conversation. His other niece (Mrs. R) says she has no record of such a conversation and that, if she had spoken to the GP she would never have suggested that alcohol was an issue, or a reason for her uncle's fall, as she had no reason to think it was. The sheltered housing scheme does have a record of contacting the GP practice on 26/7/10, to report Mr. H's fall. It now seems probable that this call was mistakenly recorded by the GP practice as having been from one of Mr. H's nieces.

Home visit by Dr. B on 26/7/10
At this visit, Dr. B noted that Mr. H had pain in his left lower ribs, but no spinal tenderness. Mr. H was sore, but mobile. Dr. B's assessment was that he had suffered a fall, possibly

secondary to alcohol and suffered badly bruised and possibly fractured ribs. There was no clinical suspicion of spinal fracture. Dr. B did not think there was any indication for an x-ray.

Dr. B discussed alcohol consumption with Mr.H. From this discussion he believed that Mr. H was drinking between a half and one bottle of wine per day. Mr H agreed he would reduce his alcohol intake.

Analysis

The IMR into the GP practice involvement found that Dr. B's records of this visit were incomplete, but that his conclusions appear reasonable.*

Dr. B responded very promptly to the initial referral, with a home visit on the same day.

The decision not to carry out an x-ray is in line with accepted practice for suspected rib injuries and Mr H's presentation at this point ('sore but mobile') would be extremely unusual for somebody with a serious spinal injury. Also, Mr H's description of the incident indicated a relatively minor impact, from which a serious spinal injury would be a highly unexpected outcome.

There was no further assessment of his falls and the view of the IMR author is that referral for assessment of falls would not normally be made after a single fall with a possible correctable cause.

**The issue of record keeping is discussed further at 5.7 below.*

Home visit by Dr. B on Tuesday 27/7/10

The GP practice was contacted by the sheltered housing Estate Manager. Dr. B visited around lunchtime. Mr. H was in more pain. He had 'stiffened up' and was described as having been 'stuck' earlier that day, but at the time of the GP visit he was able to walk about. Dr. B prescribed Tramadol, which is a stronger pain killer than the over-the-counter medicines used up to that point. There was no evidence of spinal tenderness or vertebral pain.

Dr. B recalls that a sheltered housing scheme staff member was present and said Mr. H should have no alcohol, but Dr. B advised that a little alcohol would be better.

Analysis

Again, the IMR report shows that Dr. B's documentation was incomplete. For example, there is no documentation of him listening to Mr H's chest in order to check for any lung damage which could potentially have resulted from a rib fracture.

The IMR confirms that the decision to prescribe Tramadol was appropriate, given the evidence of increased pain. Alternatives such as codeine may have been considered, but

this would be a matter of individual judgement and choice. There were still no presenting symptoms of spinal injury, to suggest x-rays should have been considered.

Home visit by Dr. A on Wednesday 28/7/10

The GP practice was contacted by the district nurse on 28/7/10 requesting a GP visit, as she was concerned about Mr. H, following her visit earlier on the same day. As Dr. A was the GP on call, she carried out this visit. Her notes show that she had been advised that Mr. H had soiled his bed earlier that day, though records from the sheltered housing scheme only refer to his bed being wet. Prior to the home visit she had a discussion with Dr. B. They had discussed the possibility that soiling of the bed could indicate spinal cord compression.

When she visited Mr. H, she found him to be slightly confused and disorientated and complaining of pain in the rib area. He had recently taken some Tramadol. Dr. A judged that Tramadol was the most likely cause of Mr. H's confusion and disorientation. The district nurse subsequently reported that there had been no sign of confusion when she had visited earlier that day, at which point he had not taken Tramadol. So this provided additional evidence that the confusion was caused by the pain relief medication.

In view of the concern about spinal cord compression, Dr. A checked Mr. H's anal sphincter, for any signs of loss of sensation which would have indicated a possible spinal cord injury. There were no such signs.

Dr. A concluded that Mr. H was not safe to be at home, but did not need hospital admission. She did not think he needed x-rays or any other investigation for possible spinal injuries, at this point. She made a referral to a local nursing home, with which the GP practice had a referral arrangement. Mr. H was transferred to this nursing home by ambulance, later on the same day. (See 5.4 for analysis of involvement of the ambulance service)

Dr. A does not recall giving any specific instructions to the nursing home regarding review, other than to let the GP practice know if there were any concerns. There is no written record of any such instructions or guidance given to the nursing home.

Analysis

The IMR found Dr. A's recording to be exemplary. It also found that there were still no indications of any need for x-rays, at this point.

That Drs. A and B took the opportunity to discuss Mr. H in advance of this visit was good practice, especially as Dr A had had no previous contact with Mr H. In this discussion they identified possible concerns about spinal injury. These concerns arose from the reported soiling incident, even though there is now considerable doubt about whether this incident was in fact soiling, or wetting of the bed. As either of these events could equally indicate a possible spinal injury, this apparent confusion would not have changed the actions or outcomes which followed.

Mr H's niece recalls being informed by the sheltered housing Estate Manager (in a telephone conversation on 28/7/10 following Dr. A's visit) that her uncle had begged for hospital admission, because of the pain he was in. This is contrary to Dr. A's recollection which was that, if anything, he was reluctant to go anywhere. Dr. A also recalls that nobody else was present during this home visit, so it may be that Mr. H spoke to the Estate Manager about going into hospital, but did not make such a request directly to the GP.

The decision to admit to the nursing home was entirely reasonable, based on the information available at the time, including the following:

a) As Mr. H was in increasing pain, confused and disorientated and his mobility was impaired, he could be expected to have serious difficulty with his self care, including eating, drinking, toileting and washing. These were not tasks which the sheltered housing scheme could be expected to assist with, on any formal or ongoing basis.

b) His pain control medication was thought to be contributing to his confusion. Nursing care and supervision could ensure that his medication was taken as directed and that the impacts of medication could be effectively monitored, and adjustments made, if necessary.

The lack of clear instructions from the GP practice to staff at the nursing home is identified as an area of significant concern. This is discussed further at 5.7

Visit to the nursing home by Dr. A on Friday 30/7/10
At this visit, Dr. A was informed by staff that Mr. H had been wandering around the building at night time, but during the day was staying in bed and in severe pain on movement. However, there is now significant doubt about the accuracy of this information. (This information was also given to Dr. B at his subsequent visit on 1/8/7 – see below)

She assessed that he had a probable fractured rib, with the confusion resulting from a combination of possible factors, including the Tramadol, alcohol withdrawal and possible infections. She took blood tests and requested nurses to arrange a urine test. The purpose of these tests was to ascertain other potential causes of his confusion, including any urinary tract infection.

Following discussion at a GP practice team meeting that day, it was agreed to change his pain control medication from Tramadol to Paracetamol and Diclofenac, in the hope that this would reduce his levels of confusion. Dr. A delivered the new prescription to the nursing home herself.

Dr. A has no recollection of the specific 'safety netting' advice she gave and nothing was written down in respect of this. Such advice could have included advice for staff on what to look out for and what actions to take in the event of specific events or changes in Mr. H's clinical presentation. She relied on the nurses to contact the GPs if they had any cause for concern.

Analysis

The IMR found that, at this stage, Dr. A implemented appropriate management of acute confusion, which is commonly multifactorial, as outlined above. She carried out a full examination and arranged for blood and urine tests, in order to investigate other factors which could potentially be contributing to Mr H's confusion.

There is evidence of good communication and discussion of Mr H's treatment plan within the GP practice team.

However, there is continuing concern about lack of effective communication and accurate information sharing between GPs and the nursing home and the possible negative impacts of this on Mr H's care and treatment. (See 5.7 below)

Telephone call from Dr. B to the nursing home, Saturday 31/7/10

The call was initially made to enquire generally about other patients at the nursing home, for whom the GPs provide out of hours cover. In the course of the call Dr. B was informed that Mr. H was still confused and in increased pain following withdrawal of the Tramadol. There was no request from the nursing home for an urgent visit or review. Dr. B advised he would visit on the following day, Sunday 1/8/10.

The IMR notes that during the course of this call, Dr. B encouraged nursing staff to get a urine sample.

Analysis

Unnecessary delay in commencing treatment for urine infection:

It is noted that Dr. B encouraged nurses to test a urine sample, though this had already been asked for by Dr. A on the previous day. The IMR for the nursing home shows that that a urine test had in fact already been completed at 7.20 am on Sat 31/7/10 (see 5.4 below) and that this showed signs of a urinary tract infection.

Had this information been given to Dr. B during the course of this call, treatment could have commenced immediately, but GP records show that the abnormal urinalysis result was not known about, or treatment commenced, until Sunday 1 August. This was an unnecessary delay. It may have impacted negatively on treatment outcomes, including the possible symptoms of confusion associated with such an infection. This is another example where poor communication between the nursing home and the GP practice appears to have resulted in Mr. H not receiving optimum levels of care and treatment.

Effective hand-over systems from nursing home night staff to day staff:

The above may also highlight an issue of internal communication, within the nursing home. If the 7.20 am urinalysis was carried out by night staff, this raises the question of whether or not systems were in place to ensure effective hand-over of information to day staff. If

not, this would explain why the result of the urine test was not passed on immediately to Dr. B.

It is of note that the information / misinformation about Mr. H walking about during the night also appears to have originated from night staff, which is further evidence to suggest that hand-over systems and practices between night and day staff is an area which needs an urgent review by nursing home managers.

Continued confusion and increased pain:
The report of continued confusion and increased pain following withdrawal of Tramadol would indicate that the treatment plan devised on the previous day – to take Mr. H off Tramadol, as it was suspected to have contributed to his confusion - had so far not reduced his confusion, but had resulted in increased pain. In retrospect, this was a poor treatment outcome.

However, as outlined above, dealing with multi-factorial confusion is not straightforward and removing Tramadol as a likely causal factor is recognised as having been a sensible and logical approach.

Thresholds for nursing home staff to contact GPs:
The arrangements between this GP practice and nursing home are unusual. They are based on a long standing arrangement, which does provide some benefits of continuity of GP care for nursing home patients.

This case has highlighted a lack of clarity around the arrangements for GP cover at the nursing home.

In particular, there was no clear guidance for nursing staff on the thresholds for contacting GPs, or the out of hours on call GP service. This was an issue, both in terms of general guidance, and the lack of any specific instructions or guidance in relation to Mr. H.

Visit by Dr. B to the nursing home, Sunday 1/8/10:
At this visit Dr. B found Mr. H to be confused and difficult to assess. He had a high temperature and an abnormal urinalysis, so treatment was commenced for a urine infection. Mr. H had back pain, which he said was stopping his legs from moving.

Dr. B recalls being told by a nursing home staff member that Mr. H had been wandering (walking around) during the night, but the IMR in respect of the nursing home has found no written record, either of Mr.H walking around at any point during his stay, or of the GPs being advised that this was the case. Similarly, none of the staff interviewed could recall either of these events having occurred.

There were significant issues of poor record keeping by both agencies and it has not been possible for the SCR to establish with certainty whether or not Mr. H did in fact walk about and what information was passed on to GPs about this. However, Mr. H's niece also recalls being informed that her uncle had been wandering about at night, which suggests that Dr.

B's recollection about being given this information is accurate. The medical evidence, including hindsight provided by the subsequent MRI scan, suggests this was unlikely. On the other hand, it is known that Mr. H was able to walk with assistance on 27/7/10, which was some four days after the accident.

Visit by Dr. B to nursing home, Monday 2/8/10:
Dr. B concluded that Mr. H was not moving his legs and arranged admission to hospital. Mr. H was transferred from the nursing home to hospital by ambulance on 2/8/10.

Mr. H's niece (Mrs. R) reports that she had a telephone discussion with Dr. B, on the day of Mr. H's admission to hospital. In this discussion, she recalls that Dr. B

'….did concede that maybe his pursuance of an alcohol withdrawal diagnosis had "clouded the issue" and Mr. H possibly had a back problem exacerbated by his moving about…'

Analysis

This reported discussion with Dr. B is an indication that the issue of alcohol withdrawal was, at this point in time, recognised as possibly having resulted in insufficient focus on Mr H's back injury.

5.4 Nursing Home

Brief background information about this service and recent Care Quality Commission findings
The nursing home is registered with the Care Quality Commission (CQC) as accommodation for persons who require personal or nursing care. The home is an adapted and extended building, with single room accommodation. Most of the rooms have en-suite facilities. It is situated in a residential area, close to local amenities. Two of the beds are allocated as 'GP' beds, for direct referral from the GP practice.

In 2011, (more than 12 months after the events which this SCR is concerned with) the service was reported to be compliant with the following CQC essential standards:

- Treating people with respect and involving them in their care
- Providing care treatment and support which meets people's needs
- Caring for people safely and protecting them from harm
- Standards of staffing
- Quality and suitability of management

There are currently no reported areas of non-compliance with CQC standards.

Brief factual summary of the nursing home's involvement:

The following summary is based on a review of the home's written records of their involvement with Mr. H, from his admission on 28/7/10 until his transfer to hospital on 2/8/10:

28/7/10: The 'Service User Needs Assessment and Care Plan' document completed on admission recorded that Mr. H:

- Had fallen backwards on 23/7/10
- Had a lot of back pain,
- Was at risk of falling
- Was in an agitated emotional state
- Was fully cognitive
- Often does not eat.

Records for the remainder of 28/7/10 report that Mr. H had a lot of back pain. They also refer to him being confused about how long he had been at the nursing home, at one point thinking he had been there for three days.

Analysis

There are a number issues arising from the nursing home's initial assessment documentation and subsequent recording on 28/7/10:

a) There was no GP assessment or any other referral documentation provided by the GP practice.

b) Consequently, there was no written record indicating the nature of the injury which was causing the back pain, though the RGN who conducted the initial assessment recalls that she was informed (she believes on the day of admission) that Mr. H had suspected cracked ribs.

c) There were a number of other important gaps in information recorded on admission, including:

- *Mr. H's weight and height*
- *Family and social contacts*
- *Spiritual and religious needs*
- *Signature and identity of the RGN who completed the assessment*

d) Although the initial assessment was that Mr. H was 'fully cognitive', later in the day he was showing clear signs of confusion. However, there is no record of any further enquiries being made, or of the staff member reporting this observation to the nurse on duty.

e) Given that Mr. H was clearly in pain on admission, a care plan should have been devised at the earliest possible stage, to guide staff on what action to take to support Mr. H and to manage the pain.

In summary, the initial processes of needs assessment and care planning on the day of Mr. H's admission to the nursing home were not carried out or recorded to a satisfactory standard. This was compounded by the fact that the referring GP did not provide any formal or written instructions regarding the diagnosis, treatment and care plan.

29/7/10:
Nursing home records refer to Mr. H staying in bed and complaining of 'excruciating pain' on movement. A Pain Assessment carried out confirmed a score of 10, though it was also noted that Mr. H appeared 'comfortable at rest'.

Further observations on 29/7/10 identified that Mr. H's urine output was 'very concentrated and poor' which was evidence of possible dehydration.

Analysis

Pain & pain control
The Pain Assessment confirmed that Mr. H was experiencing excruciating pain, but there was still no written care or treatment plan for pain control or management. The score of 10 should have alerted staff to seek further advice from the GP, or to have called an ambulance. ***This represents a serious gap between risk identification and action taken by the nursing home.***

Interviews with staff in the course of the IMR indicate that Mr. H was not showing any signs of extreme pain, such as agitation, but this was not documented at the time. Neither was there any record of investigation into this apparent contradiction between the pain score of 10 and an absence of visible evidence of extreme pain.

It should also be noted that Mr. H's niece who visited him twice daily throughout his stay at the nursing home describes finding her uncle as ***'….. always lying in bed and very distressed and clammy, in obvious great pain'.*** *This observation supports Mr. H's self assessment of his degree of pain as reflected in the Pain Assessment score and directly contradicts the view that he was not showing outward signs of extreme pain.*

Dehydration
There is no recorded evidence of any follow up regarding the potential dehydration indicated by the urine sample. For example, no fluid balance chart was devised and there was no written care plan for this area of need.

There is a record that Mr. H was subsequently encouraged to take good amounts of fluid. One of the nurses interviewed for the IMR recalls that, on 1/8/10 he was taking fluids and passing urine. However, Mr. H's niece reports that, on her visits to the home she found that he was 'always thirsty' and that she had to help him drink.

On his subsequent admission to hospital on 2/8/10, it was recorded that he looked dehydrated.

In summary, there are two areas of serious concern:
a) Mr. H experienced significant episodes of pain which he described as excruciating, but there was no recorded pain management plan and no immediate action was taken to contact his GP or emergency medical services.

b) Mr. H showed significant signs of dehydration whilst resident at the nursing home, evidenced by observations by his niece; poor and concentrated urine outputs; and subsequent observations by hospital staff immediately following his transfer from the home. However, the IMR found no nursing records to indicate that potential concerns about dehydration had been actively monitored or managed.

30/7/10:
Mr. H is recorded to have slept 'quite well, passing small amounts of urine in the commode'. Two care plans were completed. One was to 'prevent further falls and return to pain free mobility'. The other was to 'achieve pain control with analgesia'.

A Moving and Handling Assessment was carried out, highlighting that Mr. H was 'unable to weight-bear due to pain' with a risk factor score of 27, indicating a very high risk of falls. There was also a 'Pressure Ulcer Assessment/Waterlow Score carried out on 30/7/10, which recorded a score of 17, equating to high risk.

GP Dr. A visited and recorded fractured ribs and that Mr. H was not coping with the pain and was confused. This is the first time any diagnosis of the *cause* of pain was included in nursing home records. GP advice was given that Mr. H should be helped to mobilise.

Later, Dr. A telephoned to instruct that Tramadol should be discontinued as it was affecting Mr. H's behaviour.

Analysis

Care plan documentation
The IMR identified a number of concerns relating to the nursing home care plan documentation, including:

- While identifying 'goals' and 'actions' it did not provide clear and detailed information about what staff needed to do, in consultation with Mr. H, to prevent falls, or to encourage mobility.

- The documentation was not signed or dated by the person who completed it, or by Mr. H, even though he had been assessed at this point, as 'fully cognitive'.

- The care plan did not make any reference Mr. H's need (identified at initial assessment) with washing, though there are records which show that he was in fact receiving regular daily face and body washes

- Similarly, the care plan made no reference to any assessment or review of Mr. H's food intake, even though the fact that he 'often doesn't eat' had been noted at initial assessment. The Malnutrition Universal Screening Tool was not completed.

-The high risk score of 17 (Pressure Ulcer / Waterlow score) could have been an underestimate, because Mr. H's BMI was not calculated, as the initial assessment did not include height and weight measurements. Despite this (possibly under-estimated) high risk score, there was no record of a care plan or monitoring of this risk area, apart from provision of an air mattress

Mobilisation advice and guidance:
While the GP's advice was that Mr. H should be helped to mobilise, it was recorded by the nursing home that he was reporting excruciating pain when he tried to move and was unable to weight-bear, also due to pain.

***There is no record of discussion or guidance (either internally or between the nursing home and GP practice) on how staff should follow the GP's advice on mobilisation, when any movement was causing Mr. H severe pain**.*

31/72010
At 5am, it was recorded that Mr. H's bedding needed to be changed three times and there was no chance to dipstick (test) urine samples. It was tested at 7.20am and protein and leucocytes were visible, indicating a possible urinary tract infection.

Mr. H was still complaining of intensive pain, whenever he moved in any direction.

Analysis

Wet bedding
That Mr. H's bedding needed to be changed three times in one night is cause for some concern. Possible reasons for this occurring could have included:

a) That Mr. H was immobile. If this was the case, it would raise the question of why Mr. H he was not given any nursing assistance when he needed to urinate.

b) A spinal cord injury resulting in loss of sensation and bladder control.

c) A urinary tract infection.

The issue of primary concern is that the IMR found no evidence to show that nursing staff had considered or acted upon any of these possible factors, or discussed them with the GPs.

Pain assessment and control:
Despite Mr. H still complaining of intensive pain, there are no records of any formal Pain Assessment having been completed for 31/7/10 or 1/8/10.

Treatment for UTI:
There is no audit trail to show that information about the possible UTI was passed on immediately to the GP. This is despite that fact Dr. B telephoned later on the same day and in the course of this call encouraged to staff to carry out a urine test, presumably unaware that this test had already been completed. (See analysis of GP practice involvement for further comment on this)

1/8/10
Mr. H was visited by Dr. B who identified 'pain and muscle spasms; visual hallucinations; can move legs if prompted, but pain stopping further movement; UTI; alcohol withdrawal.'

Analysis

Suspected alcohol withdrawal symptoms
This is the first written record held by the nursing home which refers to possible alcohol withdrawal symptoms, although Mrs. R's impression from discussions with nursing staff was that, based on advice from the GPs, alcohol withdrawal symptoms were being treated as being of primary concern.

There is no evidence, from the IMRs or from Mr. H's nieces' observations, to suggest that either the GPs or nursing home staff took a judgemental attitude towards Mr. H. on the basis that his injury was seen to be possibly alcohol related.

Mrs. R witnessed her uncle being given a glass of sherry by a member of nursing home staff, though she does not remember the date on which this occurred. If Mr. H was experiencing alcohol withdrawal symptoms, allowing him to have limited measures of alcohol may have been a reasonable approach to lessen the impact of these symptoms. However, there is no record to suggest that giving him alcohol was part of a formal treatment plan; that his alcohol intake was being monitored; or that it had been discussed with his GPs. (See section 5.7 on multi-agency working)

GP records confirm that alcohol consumption was identified by the GPs as a potential causal factor for the original fall and that alcohol withdrawal symptoms were considered as one of a range of factors which could be contributing to Mr. H's confusion. Other factors considered included pain, pain control medication, and a urinary tract infection. The subsequent MRI scan on 3/8/10 revealed that Mr. H had multiple brain lesions which, with the benefit of hindsight not available to the GPs at the time, may well have been a significant additional factor.

An issue of major concern to Mr. H's nieces is that, during the critical days following his fall, (i.e. until after his admission to hospital on 2/8/10) they believe there was a disproportionate and inappropriate focus on the alleged affects of alcohol withdrawal, which resulted in his injury not being effectively investigated and treated, or ensuring that adequate pain control measures were in place. Evidence to support this view is from Mrs.

R's observations of her uncle; her recollections of discussions with nursing home staff and a telephone conversation with Dr. B, immediately following Mr. H's hospital admission.

The evidence from the IMR shows that the GPs considered a range of possible factors (or combinations of factors) which could have been contributing to Mr. H's confusion. This included the possibility that he was suffering from alcohol withdrawal symptoms, but other likely factors were also given appropriate consideration. There was an additional potential factor (i.e. the brain lesions) of which nobody had knowledge at that time.

In summary, the available evidence does not support Mr. H's nieces' opinion that an undue focus by the GPs on possible alcohol withdrawal symptoms distracted them from arranging more urgent investigations into a possible spinal injury.

However, it does appear that concern about his confusion (whatever its causes) resulted in less focus on the nature of the injury and levels of pain Mr. H was reporting.

2/8/10
Dr. B visited again, concluding that Mr. H was not able to move his legs. Admission to hospital was arranged. Mr. H was transferred to hospital by ambulance on 2/8/10.

5.5 Hospital
Mr. H was a hospital in-patient 6 days, until his death on 8/8/10. As the IMR was carried out over 12 months later, several hospital staff had limited or no memory of Mr. H. Therefore the evidence base is derived from those staff who could recall; reference to written hospital records and evidence from Mr. H's nieces' memories of events.

2/810
Mr. H was admitted to hospital at 14.05 on 2/8/10, accompanied by a letter from Dr. B, requesting assessment and providing background information on the date and circumstances of Mr. H's fall; suspected rib injuries; suspected alcohol dependency; increased confusion; decreased ability to move legs; inconsistent loss of sensation; recent UTI; treatment and progress at the nursing home; concern re possible subdural haematoma. The letter also made reference to the possibility of spinal cord lesion. It noted the following as differential diagnoses:

- Alcohol withdrawal
- Subdural haemotoma
- ?Spinal cord lesion*

(*? as presented in the hand written letter)

The IMR for the hospital confirms that Mr. H underwent a standard admissions procedure, which is used for all patients of this hospital trust. He was seen within 15 minutes by a triage nurse and assessed within three hours by a nurse practitioner. This included relevant observations, examinations and treatment decisions which were recorded in the admissions documentation, the medical record (i.e. details of relevant examinations / action

plans / treatment / investigations) and the nursing records, which include care plans and daily assessments.

It was noted by the IMR that, despite having a documented history of an earlier fall, there is no documentation on the 'body maps' which are included in standard admissions documentation.

The Malnutrition Universal Screening Tool was commenced on 2/8/10, but it was not possible to continue with this because Mr. H could not be weighed, due to problems with his spine and associated back pain. However, there is evidence of administration of intravenous fluids and the intake of drinks orally.

On medical review at 7.30 pm on the day of admission, it was noted that Mr. H looked dehydrated, but this was not recorded as a potential safeguarding concern. Possible acute renal failure was listed as a differential diagnosis.

There was no documented evidence to show that Mr. H's mental capacity was considered as a possible issue of concern, either on admission, or at any point following his hospital admission.

However, it was recorded that on the evening of 2/8/10, there was no confusion, and Mr. H was conscious, alert and orientated. There was no reference to hallucinations.

On the evening of 2/8/10, Mr. H was describing excruciating pain (score of 10 on a scale of 1 - 10).

Analysis

Referral letter from GP
It is noted that Dr. B provided the hospital with a letter of referral, which briefly summarised information about Mr. H's accident, his treatment and care to date, responses to treatment and possible concerns requiring further investigation and treatment by hospital. This was an example of good practice.

Mental capacity and mental health
The evidence available to the SCR does not provide a definitive answer to the question of whether or not Mr. H had the mental capacity to give informed consent to his hospital admission and the subsequent care and treatment plan. However, his nieces advise that he was able to talk to them about his financial affairs following his admission and they had no reason to doubt his capacity, at least until the final hours of his life. This, combined with the hospital record of him being 'conscious, alert and orientated' *suggest that he would have been assumed to have capacity, in line with the Mental Capacity Act and MCA guidance.*

However, it is of concern that there is no record to indicate that possible questions about Mr. H's mental capacity were considered, even though the GP referral letter described a recent history of increasing confusion and hallucinations. It is also noted that standard

procedure in this hospital requires a mental health assessment for all patients aged 75 years or over, but no such assessment was recorded as having taken place.

Had Mr. H's mental capacity been considered more carefully at this stage, this may have prompted nursing and medical staff to give closer consideration to the role of his nieces and the need to ensure that they were appropriately involved and consulted about his care and treatment plan. While this would not have changed the eventual outcome, it could have improved the quality of his experience of care during the final days of his life. It would also have helped to reduce the inevitable distress of his nieces, during this most difficult period.

Definition of 'vulnerable adult'

Staff interviewed as part of the IMR process stated that they could recall no aspects of the case that led them to consider Mr. H. to be a 'vulnerable adult'. Their views were apparently based on the fact that he was reported to have been living very independently, up to the day of his accident, some ten days prior to his admission to hospital. However the Northumberland inter-agency Safeguarding Adults Policy clearly defines vulnerable adults as:

> '….all adults who are aged 18 and over, who are receiving Community Care services, or who may be eligible to receive them by virtue of mental or other disability, age or illness and whose independence and wellbeing is at risk or would be at risk, if they did not receive appropriate health and social care support.'

There can be no doubt that Mr. H met this definition of a vulnerable adult. In fairness to the hospital staff, it is understood that they were not referring to this formal definition when they stated that they had not considered Mr. H. to be a vulnerable adult, but meant that they had not identified any specific concerns which required formal intervention under adult safeguarding procedures.

However, this confusion about terminology is an indication of a possible need for improved training and / or guidance to staff about adult safeguarding in hospital settings. A good starting point would be to recognise that almost any adult who has been admitted to hospital with a serious and life threatening condition is likely to meet the formal definition of 'vulnerable adult'.

Appearance of dehydration

That hospital staff noted that Mr. H appeared to be dehydrated on the day of transfer from the nursing home adds considerable weight to concerns about dehydration highlighted by the IMR for the nursing home and his niece's observations of him being continually thirsty whilst resident there.

The SCR Panel discussed at some length whether or not this should have triggered hospital staff to initiate a formal safeguarding alert under multi-agency safeguarding policy and procedure. This would have provided no direct benefit to Mr. H, but may have helped to ensure that any similar issues or concern around the care of other residents of the nursing home would be properly investigated and acted upon. The Panel noted the following factors:

a) There was an appearance of dehydration, but not a clinical diagnosis.
b) Signs of dehydration would not lead to an automatic assumption of failures of care at the nursing home.
c) There were no additional factors known to hospital staff which would have suggested failures of care at the nursing home.

Bearing in mind the above factors, it seems reasonable that no formal safeguarding alert was triggered.

However, it is of concern that hospital staff did not consider or record the possibility that Mr. H's appearance of dehydration, on admission from a nursing home, may be a ***potential*** *safeguarding issue. Mr. H's appearance of dehydration may have been seen as an isolated 'low level' concern, but there is a need to record and monitor such concerns, so that any patterns of similar concerns about a particular service are more likely to be identified and acted upon.*

This is an important learning point, because the failure to notice and act upon patterns of low level incidents or concerns is a very common theme of other SCRs and enquiries. These have often found that earlier interventions, in response to multiple low level concerns or incidents, could have prevented more serious abuse or neglect from occurring.

It should be emphasised that the foregoing is purely a general observation and learning point. It is ***not*** *based on any evidence of a history or pattern of low level concerns in relation to the nursing home in which Mr. H had been resident.*

Body maps
The absence of completed body maps had no direct impact on Mr. H's subsequent care or outcomes, but best practice would have been to complete this documentation.

Monitoring of Pain
That staff were systematically monitoring and recording Mr. H's pain levels is good practice. A reported maximum score of 10 would obviously have been major concern, but evidence from the IMR shows that appropriate pain control medication was provided and actively monitored and reviewed. Wider issues and concerns around pain management are discussed separately, below.

3/8/10
Mr. H was transported by ambulance to another hospital, in order to have an MRI scan. He returned later on the same day. The scan results showed that he had a fractured vertebra, with spinal cord compression. They also showed multiple brain lesions. Advice was requested from a specialist neurosurgery on-call team based in Newcastle. The advice given was that surgical intervention was not appropriate, given the relatively late presentation of the spinal injury. It was noted that conservative management and bed rest would be appropriate.

At around midday on 3/8/10, Mr. H reported that his pain level was 6/10, which was a significant improvement compared to 10/10 on the previous evening. On the evening of 3/8/10 he reported a score of 0/10. All subsequent scores were recorded at 0/10.

Analysis

Although Mr. H was admitted on 2/8/10, it was not until the following day that he was seen by his consultant, who then arranged an MRI scan on the same day. It is very unlikely that that a consultant assessment and scan on the 2/8/10 would have resulted in a different or better outcome for Mr. H. However, professional advice to the SCR suggests that, on the basis of what was known on 2/8/10, an urgent consultant assessment and a scan, on the day of admission, could have been considered.

4/8/10
Following a medical and nursing review, a pressure relieving mattress was requested and provided.

6/8/10
Mrs. R reports that on this date that she was informed by Dr. M (a junior doctor) of her uncle's diagnosis of a compressed spinal fracture. She was also informed that her uncle had been told, earlier on 6/8/10, that his legs were paralysed and that the plan was to rehabilitate him to life in a wheelchair. This information had reportedly been given to Mr. H by his consultant, in the course of a ward round.

Also on 6/8/10, a physiotherapist alerted nurses to marked signs of deterioration in Mr. H's condition. Following relevant observations they then alerted a doctor, who diagnosed hospital acquired pneumonia. This resulted in a treatment plan for administration of IV antibiotics, in line with standard hospital protocol for this condition.

Analysis

Informing Mr. H of his diagnosis of paralysis
Mr. H's nieces were understandably very distressed that their uncle received the information that his legs were paralysed; when they were not present to offer any emotional support.

On the other hand, they expressed appreciation for the time taken by the junior doctor, to explain their uncle's diagnosis as fully and sensitively as possible.

It is possible that there may have been an issue of patient confidentiality. However, none of the records seen in the course of the IMR indicate that Mr. H did not want his nieces (one of whom was his next of kin) to be fully involved and informed about his condition, treatment and prognosis. On the basis of the evidence available it is reasonable to assume that the reverse was true. In these circumstances, it would have been more preferable to wait until his nieces were present, before imparting this information.

Alternatively, he could have been told in private, but with his nieces outside the room and available to provide emotional support, as and when he requested their presence.

It is recognised that arranging for relatives to be present when imparting difficult information to patients can present a number of challenges, in the context of a busy hospital environment. This is further complicated by the fact that there can be no automatic assumption that the patient wants their relatives to be present.

If the normal procedure is that information is given to the patient by the consultant in the course of a ward round, it will clearly be very difficult to coordinate this, so that relatives can be present. However, if this is the case, it possibly highlights a need to review 'normal procedure' and ask whether a more flexible approach could deliver better outcomes for both patients and relatives.

In this case there is no record to indicate that the appropriateness or possibility of arranging for his nieces' presence was given any consideration.

Mr. H's nieces have referred to an unwillingness of some staff to share information with them about their uncle's care and treatment, following his hospital admission. They have also raised concerns about restrictions on times they were allowed to visit their uncle and about the fact that the consultant who was overseeing Mr. H's treatment plan did not speak directly with them, at any point during his stay in hospital. These issues have been raised in a formal complaint to the hospital trust. The IMR did not uncover additional factual information in relation to these issues, although some possible learning points arising from Mr. H's nieces' experiences are identified in section 5.8 which examines issues around communication and cooperation with family members.

Analysis

Pain control

On the evening of 2/8/10, Mr. H was describing excruciating pain (score of 10 on a scale of 1 - 10). However, pain control was put in place and his score had reduced to 6/10 by 12 noon on 3/8/10. By the evening of 3/8/10 the recorded score was 0/10 (no pain). From that point onwards until the evening of 6/8/10, his self reported pain level was recorded several times a day. On each occasion the recorded score was 0/10.

*However, Mr. H's niece believes he was experiencing great pain throughout this period, and describes him on **5/8/10** as '….crying out in pain, whenever he tried to move even a small amount' and on **6/8/10** as '…clearly still in great pain'.*

There is obvious inconsistency between the recorded pain scores and Mr. H's niece's observations. A possible explanation is that Mr. H was experiencing intermittent acute pain whenever he moved (or was being moved by nursing staff); but that when the scores were recorded he was not moving. It is certainly the case that communication became increasingly difficult for Mr. H as his condition deteriorated.

Bearing in mind all these factors and the observations of Mr. H's nieces, the self reported pain scores can not be seen as a complete record of the actual pain he was in for significant periods, during the last few days of his life. However, hospital records show that appropriate pain control medication was being prescribed, monitored and reviewed, in line with recognised good practice.

Moving and handling:
In addition to general concerns about pain control, Mrs. R has also reported that she witnessed a process when her uncle was being transferred onto a pressure relieving mattress. She reported that he was screaming out in pain. She did not feel the nurses were carrying out this procedure with sufficient care or specialist equipment, particularly bearing in mind that this was after his spinal injury had been confirmed by an MRI scan. Mrs. R has referred to this incident as part of a formal complaint. The IMR was not requested to seek additional evidence about this reported incident, as it is being investigated as part of a formal complaints process.

5.6 Ambulance service
The same ambulance service provided transport for Mr. H on three occasions:

- Admission to the nursing home on 28/7/10 (Journey 1)
- Transfer from the nursing home to hospital on 2/8/10 (Journey 2)
- Transport from hospital to MRI scan facility (another hospital site) and return to hospital on 3/8/10 (Journey 3)

The same two person patient transport crew attended for journeys 2 and 3, while a separate crew attended for journey 1. When interviewed for the purposes of the IMR, neither crew had a detailed recollection of Mr. H, due to the time lapse between the events and the interview. There were records to confirm that these journeys were completed and no problems or issues were reported.

Journey 1
The first ambulance request on 28/710 was from the GP who requested a 2 person ambulance with a wheelchair. There were no reported issues with this journey.

Journey 2
This request came from the GP practice receptionist who asked for an ambulance equipped with a stretcher to attend, within two hours. The crew could not recall with certainty whether a stretcher was used, but advised that as the nursing home has narrow corridors with tight bends, it is probable that a wheelchair was used inside the building, particularly if Mr. H had been sitting in a chair when the crew arrived. This would normally be the best option in respect of patient comfort. The crew would have taken advice from nursing home staff and had access to specialist stretchers for use in tight spaces, if needed.

Journey 3

This request was from the hospital. Mr. H was transferred to and from the MRI scan site (a return journey of around 60 miles) with a nurse escort. On this occasion a stretcher was used. No medical interventions were required on the journey and no untoward incidents were reported.

Analysis

All of the available evidence indicates that the ambulance service provided timely and appropriate responses on each of three occasions they were asked to transport Mr. H.

Each of the requests was for a non-urgent transfer and in this context there are no concerns about response times.

It is noted that the ambulance crew were given no explicit instructions by the GP practice or nursing home staff that a stretcher must be used, though the GP receptionist did ask for a stretcher to attend.

If, as seems likely, Mr. H was transferred from the nursing home to the ambulance in a wheelchair, this is arguably an area of concern, although it is very unlikely that this would have made any difference to his subsequent treatment outcomes. It is very possible that manoeuvring Mr. H on a stretcher would have caused more pain and discomfort than using a wheelchair and it seems reasonable that the crew would have exercised their professional judgement, with guidance from nursing staff on any specific risks or needs related to Mr. H's injury.

5.7 Summary of key issues and good practice examples for multi-agency working

The analyses at individual agency levels raise a number of issues and learning points for multi-agency working. Whilst these issues have already been referred to in 5.2 – 5.6 above, the following summary highlights the most critical learning points. It focuses to a large extent on communication and joint working between the GP practice and the nursing home, as this was the inter-agency relationship which had the most critical impacts on Mr. H's treatment and care during the period in question.

Key issues

a) Poor standard of recording by Dr B:

The IMR highlighted that medical notes kept by Dr. B were, in many cases, incomplete. This raises issues of potential concern for communication, both within the GP practice and between the practice and external agencies. In the event of Dr. B being unavailable, this would have impacted negatively on the ability of other members of the practice to provide continuity of treatment, or to communicate effectively with others (such as the nursing home and hospital) about Mr. H's nursing and medical needs.

b) Lack of clear communication between GP practice and nursing home:

This is a key area of concern, as it had significant impacts on the quality of care that the nursing home was able to deliver to Mr. H. Key issues include:

- Mr. H was admitted to the nursing home without any written information provided by the referring GP**.** Consequently, they had no written record of the nature of the injury which was causing his back pain. This absence of adequate referral information is the responsibility not only of the GP practice, but also the nursing home's registered manager, who should have required this information before accepting the referral.

- Following admission, there was no record of written guidance from GPs on specific safety netting advice, or any written instructions as to when GPs or emergency services should be contacted. This resulted in situations where Mr. H was reporting excruciating pain, but no immediate medical intervention was requested.

- There was a lack of clarity around GP out of hours cover at the nursing home. The informal arrangements between the GP practice and the nursing home delivered some undoubted benefits of continuity of care, but they also contributed to a situation where staff were unsure about thresholds for contacting the GPs.

- It is suspected, though not confirmed, that GPs were misinformed by nursing home staff about Mr. H having been walking about at night (seemingly without undue difficulty). Nursing home records show no reference at all, either to the alleged walking, or to GPs being given this information. Similarly, none of the nursing home staff interviewed have any recollection of Mr. H walking, or of telling GPs that this had occurred. However, one of Mr. H's nieces also recalls being advised by a staff member that he had been walking about during the night, which indicates that the GP's records of having been given this information (or possible misinformation) are probably correct.

- The (possibly incorrect) information that Mr. H was able to walk unaided would have had a significant impact, as it would significantly reduce the possibility that a spinal injury would be considered as a likely diagnosis, but could be consistent with the original diagnosis of bruised or fractured ribs. Had the GPs not been under the impression that Mr. H was able to walk unaided, it is possible that they would have made an earlier decision to admit him to hospital for investigation of a possible spinal cord injury. Unfortunately the SCR has not been able to establish all of the facts about this issue, partly due to incomplete record keeping by both agencies. This matter has since been further investigated by the Registered Manager of the nursing home, as part of the adult safeguarding process, but it has not been possible to substantiate that Mr. H was walking about, or to identify from whom this information originated.

- Another example of poor communication was the failure of nursing home staff to notify the GP of the result of the urinalysis taken at 7.20 am 31 July, until the following day. Consequently, there was an unnecessary delay of more that 24 hours in commencing treatment. This contributed to the focus on the possible causes of Mr. H's confusion, which in turn drew attention away from the possibility that he had sustained a very serious injury.

- An additional factor for both issues (i.e. the information that Mr. H had been walking about during the night and the delay in passing on results of the urinalysis) may have been poor internal communications between night and day staff at the nursing home.

c) Lack of a clearly identified keyworker at the nursing home
The IMR found no record to indicate that Mr H had a nominated keyworker. Effective leadership from an identified keyworker could have ensured full assessment of needs; care plans which reflected those needs and regular reviews to ensure that appropriate care was given and any changes identified implemented. A keyworker could also have taken a more pro-active role in coordinating communication and information sharing, including internal communications and those between the nursing home and the GP practice.

d) Failure by hospital staff to recognise that Mr. H was a vulnerable adult or to record potential safeguarding concerns relating to the nursing home
Although it is accepted that Mr. H's appearance of possible dehydration did not warrant an immediate adult safeguarding alert, the fact that this was observed in a patient who had been transferred from a nursing home should at least have been recorded as a possible cause for concern.

Such a concern was not recorded, partly because Mr. H was not recognised as being a vulnerable adult, which he very clearly was. This raises a question about the extent and effectiveness of adult safeguarding training for hospital staff.

This had no direct impact on outcomes for Mr.H, but reduced the possibility that any ongoing issues of sub-standard care at the nursing home would subsequently be indentified and acted upon. (This is a general observation only. The SCR has not looked at evidence other than that relating Mr H's individual care and treatment)

Good practice examples
In addition to the issues outlined above, the SCR has identified some examples of good multi-agency practice and communication, including:

- The sheltered housing scheme communicated effectively with social services; primary health care services, including the on-call GP service, the GP practice, district nursing and adult social care services.

- Adult social care services responded very promptly to the referral from the sheltered housing scheme and were prepared to provide community based care and support services, had they been needed.

- The GP practice provided prompt responses to requests for urgent home visits prior to admission to the nursing home.

- Case recording by GP Dr. A was of a very high standard.

- Dr. B provided the hospital with a letter of referral, which briefly summarised information about Mr. H's accident, his treatment and care to date, responses to treatment and possible concerns requiring further investigation and treatment in hospital.

- There was effective liaison between the hospital and the spinal neurosurgery on-call team, to ensure that Mr. H's treatment was informed by advice from an appropriate specialist.

5.8 Summary of key issues and good practice examples in communication and cooperation with family members

Firstly, it should be acknowledged that Mr. H's nieces have been the primary driving force behind the decision to carry a serious case review. They have highlighted a number of issues and concerns about the extent to which different agencies engaged with them, following Mr. H's fall on 23/7/10.

Sheltered housing scheme

Mrs. R has expressed the view that the sheltered housing scheme should have contacted her, as soon as they became aware of Mr. H's fall. However, the evidence suggests that, at this stage Mr. H was not experiencing any confusion and was quite able to contact his nieces by telephone, when he chose to do so. It would not have been appropriate for sheltered housing scheme staff to contact Mr. H nieces, without his knowledge and consent.

GP practice

The IMR for the GP practice noted the willingness of Dr. B to speak to Mr H's nieces as an example of good practice, and the available records show that there were a number of phone calls between the surgery and his nieces, during the period in question.

A central concern of Mrs. R is that, during her uncle's stay at the nursing home, she had asked on more than one occasion why x-rays had not been arranged, because her observations of her uncle's apparent pain levels led her to believe that he was suffering from something more serious than a fractured rib. This was contrary to the opinion of the GPs, and no x-ray was arranged.

The IMR for the GP practice has concluded that, on the basis of Mr. H's clinical presentation and known medical history at that time, a decision not to arrange x-rays was in line with recognised good practice.

However, it is not clear whether or not the GPs took sufficient account of Mrs. R's observations about her uncle's reactions to pain. She had witnessed her uncle's reaction to a broken rib when he fell on a previous occasion, some years ago. She also recognised that her uncle was not somebody who was prone to making an excessive fuss, or complaining unnecessarily. These were observations, which only a close carer or relative could make reliably, could help inform the clinical decision making process.

A closely related issue is that of the suspected alcohol withdrawal, which Mrs. R believes was given inappropriate emphasis, resulting in his back pain not being adequately

investigated. It is possible that some of Mr. H's reactions to pain were mistakenly identified as being the result of alcohol withdrawal. Again, Mrs. R was in a position to provide a fuller picture of her uncle's use of alcohol, even though there was evidence of a history of drinking more than was medically advisable.

The eventual outcome, with the obvious benefit of hindsight provided by the MRI scan, shows that Mrs. R's concerns about the cause of her uncle's physical pain were with good cause. It is possible, but by no means certain, that an x-ray at an earlier stage may have resulted more positive outcomes. This does not mean that the decision not to x-ray was clinically wrong, because the GPs did not have any benefit of hindsight.

The important learning point is that the knowledge and insight of family members and carers about their relatives should be valued and utilised, although it is also recognised that ultimate responsibility for clinical decisions must always remain with the relevant medical practitioner.

Hospital

Mr. H's nieces have highlighted a number of concerns about what they felt was poor quality of engagement and communication from some members of hospital staff. These are the subject of an ongoing complaint.

Correspondence about these complaints has been considered as part of the evidence base for the SCR, but it is not within the purpose or terms of reference for the SCR to investigate or adjudicate on individual complaints. However, on the basis of all of the evidence available, it is possible to offer the following analysis:

Analysis

Involving relatives when giving patients difficult or upsetting information:

The issue of whether (if / how / when) to involve relatives when imparting difficult or upsetting information to a patient, clearly has no simple 'one size fits all' answer.

However, there could be benefit in reviewing (and revising where necessary) existing procedure, guidance and training for staff, on how to manage situations such as this. The procedural review should consider whether or not it is always necessary or appropriate that difficult information is imparted by the consultant and whether this must happen during the course of a ward round. With Mr. H's nieces' permission, an anonymised case study based on their experience could provide a useful teaching aid.

It would seem reasonable to start with an assumption that the patient should, where possible, be given the option of having family members present. On the other hand, it is equally important to recognise and respect the confidentiality of patients who want to be given information in private, following which they can then decide whether or not this information may be shared with their relatives.

Visiting times and palliative care:

It is understood that relatives of palliative care patients at this hospital are made aware that they can visit any time, day or night, but may be asked to leave during direct nursing care

or meal times. This is recognised as good practice. However, part of the problem in this case seems to have been a lack of clarity – among staff and therefore between staff and Mr. H's nieces – about exactly when Mr. H became identified as a palliative care patient. If the reasons for this lack of clarity can be identified and addressed, this should help to prevent future conflicts or misunderstandings about visiting arrangements for this group of patients.

Good practice examples

- *Mr. H's nieces reported that the junior doctor who advised them of their Uncle's condition had an excellent manner and explained their uncle's diagnosis as clearly and sensitively as possible. It was also noted that this doctor's notes were exemplary.*
- *When it became clear that Mr. H was very seriously ill, facilities were arranged to enable his niece to stay overnight with him. This included arranging a private room and a folding bed for her sleep on.*

Appendix 1

STRICTLY CONFIDENTIAL / RESTRICTED

Serious Case Review Terms of Reference for adult B / Mr. H.

INTRODUCTION

Serious Case Reviews take place where there has been a death or potential life threatening injury or serious sexual abuse of an adult or adult at risk and abuse or neglect are known or suspected.

Serious Case Reviews are a useful tool for reviewing more serious individual cases and to learn about the safeguarding process and its effectiveness and to revisit and amend/augment practices and procedures in the light of experience. They are designed to establish if lessons can be learned about the way local professionals and agencies work together to safeguard adults at risk.

PURPOSE

The purpose of a Safeguarding Adults Serious Case Review (SCR) is

1. To commission an overview report in relation to the highlighted case, bring together and analyse the findings of each of the relevant individual agency/organisation's significant case review reports submitted to the appointed SCR lead officer.

2. To establish whether there are any lessons to be learnt from the circumstances of the highlighted case, specifically in relation to the way in which partner agencies and other allied professionals work together to safeguard the adult at risk.

3. To facilitate a review of the effectiveness of individual organisations and their multi agency procedures

4. To produce a series of recommended remedial actions with the aim of informing and improving inter agency practice

5. To identify areas of particularly good practice and to share these.

SERIOUS CASE REVIEW IN RESPECT OF ADULT B

1. At a meeting of the NSABs SCR sub group on 2nd February 2011 Adult B was considered to meet the criteria and a SCR was recommended to the NSAB Chair. It was recognised that Northumbria Police were investigating the case and that the outcome of those investigations would be awaited before proceeding further.

2. Northumbria Police's investigation was conducted by a Detective Chief Inspector who concluded in his report dated 13th March 2011 that his examination of the circumstances of Adult B's death had not identified that any criminal offences had

been committed. He concluded that a multi agency review of the case is the correct medium through which any issues can be identified and addressed and lessons learned.

TERMS OF REFERENCE

1. Please construct a comprehensive chronology relating to the involvement of your organisation/agency with Adult B from the beginning of 2010 to the end of 2010 (template attached)

2. Please summarise the provision of services that your agency/organisation provided in respect of Adult B.

3. Did your agency/organisation have in place policies and procedures for safeguarding and promoting the welfare of adults at risk? If so, please provide the name and location of those policies.

4. Was practice consistent with your policies and with national and local policies procedures, guidelines and standards? Please provide copies of any policies you refer to.

5. Were practitioners aware of and sensitive to the needs of adults at risk in their organization? Were they knowledgeable of the indicators of abuse or neglect in such adults?

6. When and in what way were the wishes/requests of Adult B and/or the family ascertained and taken into account when making decisions about the provision of services by your organization? How were Adult B's and/or the family's wishes assessed and recorded?

7. What policies/procedures do you have in place for the assessment of contextual capacity of an adult's ability to make a range of associated decisions and were the outcomes recorded?

   - If capacity was judged as lacking in any context, were appropriate decision makers for each assessment identified?
   - Were the principles of the Mental Capacity Act 2005 and the MCA Code of Practice followed in respect of the capacity assessment and decision making processes?
   - How was the assessment of mental capacity and the decision making process recorded?

8. What were the key relevant points/opportunities for assessment of Adult B in this case (including assessment of risk)?

- Do assessments relating to care management and decisions made relating thereto appear to have been carried out and reached in a professional and informed way?
- Were the appropriate services provided in accordance with the results of that assessment?
- How were the results of that assessment recorded?
- Did Adult B's care plan adequately reflect those assessed needs and was it regularly reviewed?

9. Were there any issues in communication and information sharing between your agency and other agencies/organisations, including at the point of transfer of Adult B between services?
   - Was the input of each agency properly coordinated?
   - Was sufficient information collated and shared between partner agencies within appropriate timescales/deadlines?
   - Was the information provided of the required depth and quality?

10. Was there appropriate communication/information sharing and involvement between your agency and Adult B's family members?
    - How was this communication recorded?
    - Was it conducted in a timely fashion?

11. Was your practice sensitive to the racial, cultural, and religious identity of the adult at risk?

12. Were there organisational difficulties or lack of capacity in the organisation that impacted or may have impacted upon Adult B's circumstances?

13. Was there adequate management supervision and accountability for assessment, care planning and decision making? What review procedures were in place?

14. As a result of your review which areas of good practice have you been able to identify? Please provide details

15. What do you consider are the implications from the lessons learnt for your future practice and what recommendations do you propose can be taken forward?

Appendix 2

List of documents reviewed for overview report:

1) Independent Management Review of involvement of the sheltered housing scheme. Prepared by a manager from the housing association which owns and manages the scheme.

2) Independent Management Review of involvement of the GP practice. Prepared by an Independent Clinician appointed by the relevant primary care trust.

3) Independent Management Review of involvement of the nursing home. Prepared by an independent consultant appointed by the nursing home.

4) Independent Management Review of involvement of the hospital. Prepared by a senior manager with the relevant healthcare trust. This was followed up with some further information and observations on records of pain relief management, as requested.

5) Independent Management Review of involvement of the ambulance service. Prepared by a senior manager from within the ambulance service.

6) GP case notes in respect of Mr. H, from 12/7/10 to 12/8/10 and a copy of referral letter from GP to the hospital, dated 2/8/10. These were forwarded to the independent overview report author by Mr. H's niece, with a covering letter (dated 10/2/2012). They had not been requested by the overview report author, as they had already been reviewed by the IMR author for the GP practice.

7) Document dated 6/12/10 from Mrs. R (niece of Mr. H) providing a detailed summary of events and consequent complaints about treatment and care provided to her uncle.

8) Copy of letter from the Chief Executive of the hospital trust to Mrs. R, dated 4/3/11

9) Letter of reply from Mrs. R to Chief Executive, dated 6/4/11.

10) Letter from, Patient Experience Manager to Mrs. R, dated 25/11/11.

11) Safeguarding Adults Planning Meeting minutes, 18/1/11

12) Safeguarding Adults review Meeting minutes 8/9/11