Confidential

Report on the Independent Management Review into the circumstances surrounding the care and treatment of Mrs X who died in April 2014.

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1. Introduction

This review has been commissioned by the London Borough of Enfield Safeguarding Adults Board, following a recommendation by the Serious Case Review Panel who expressed concerns that there may have been failings in the care and support of Mrs X.

Mrs X was a 92 year old lady who had a long history of rheumatoid and osteoarthritis. She lived in an Enfield residential care home for the last three years of her life where she was supported by her daughter who took an active interest in the care of her mother.

Mrs X received regular district nursing support and during the end stage of life palliative care was also given. She initially declined to be admitted to hospital or transfer to a nursing home despite the significant challenge of controlling her pain in the residential setting. She received a considerable number of medical visits and treatments until her death in April 2014

2. Terms of reference

The purpose of the review is to:

- Establish what lessons can be learnt from the circumstances of the case,
- Review the effectiveness of its procedures and processes within these specific circumstances
- Inform and improve local inter-agency practice
- Improve practice by acting on learning (developing best practice)
- Commission an overview report to bring together and analyse the findings of the various reports in order to make recommendations for future.

This review shall have the following terms of reference:

1) To review all relevant documentation leading up to the death of Mrs X
2) To review communication and information exchanges between key professionals, actions taken and the levels of communication
3) To review the way health professionals worked together to safeguard their patients
4) To obtain detailed chronologies of involvement with Mrs X by referring to notes, records and files from the following :

   - The London Borough of Enfield
   - The Royal Free Hospital
   - Tissue Viability Nurse
   - District Nurse Team
   - GP services
   - Significant others, who may be identified during the course of the review.

5) To collate all the investigations and reports that took place as part of the Enquiry in respect of the above organisations and suggest any further investigations if required.
6) Deliver an oversight report with recommendations to the London Borough of Enfield's Safeguarding Adults Board
7) Identified how lessons can be shared between health and social care organisations, contribute to a round table discussion event with constituent agencies as to how such incidents may, as far, as possible be avoided in the future.

3. Medical and Capacity Profile of Mrs X provided by Ms Q, daughter of Mrs X

Mrs X was a court dressmaker, although her apprenticeship was cut short by the war. Her embroidery, dressmaking and knitting were second to none in their quality, attention to detail and, indeed, perfection. Her obsessive perfectionism (everything from measuring the folds of the net curtains, to straightening the tassels on a carpet with a fork as the very first act after spending 7 months in hospital, to attempting to hand paint - with a child's paintbrush - every 2inch square on the wallpaper because she didn't like the colour) was a fundamental part of her identity. Disability and dependence presented real challenges to her as she was no longer able to control her physical surroundings or easily manage the resultant anxiety. The managers at Mrs X's care home deserve enormous credit for both understanding this quality and doing all they could to ensure that Mrs X enjoyed as much independence as was possible within her limited circumstances - and to continue to do so even as her limitations became more acute in the months before her death.

Mrs X was very disabled and her needs complex. She had both rheumatoid and osteoarthritis going back some 45 years, complicated by a LHS Girdlestone hip, itself the result of a failed hip replacement procedure at King George's hospital, Redbridge in 2004, which left Mrs X with one leg some 5 inches shorter than the other. At the same time, a fall in the hospital required a second hip replacement of the right leg. During this 7 months stay at King George's Mrs X survived two bouts of Clostridium and a period of anorexia. She was fed, finally, by a naso-gastric tube.

Furthermore shortly after discharge she was, following routine tests to pave the way for the administration of the anti-inflammatory drug Humira for her rheumatoid arthritis, found to have Hepatitis B, suppressed successfully by daily Lamuvidine. Advice from the Hepatitis B Association was that this was almost certainly hospital acquired, particularly since extensive examination of Mrs X's history and lifestyle revealed no other possible cause.

In 2012 Mrs X was admitted through A&E to Chase Farm hospital for septicaemia resulting from grade 3 pressure ulcers. She needed treatment for the ulcers and intravenous antibiotics. In an extended period leading up to the admission she had been seen by the district nurses who had been treating her for a sore sacrum. Her experience in the hospital was stressful as the nurses were not equipped (or in some cases willing) to deal with her

special needs regarding toileting e.g. the need to put on her orthopaedic shoe before using the commode and not leaving her on the commode for extended time or indeed not responding to the buzzer; leaving her food inaccessible. The hospital dealt satisfactorily with the infection and the pressure sores.

Unsurprisingly given this history, Mrs X had an acute fear of being admitted to hospital.

Until the very last month or two of her life Mrs X remained alert, she watched the news, TV drama (Foyle's war, and TV sport, the Olympics, Wimbledon, all of which she loved to discuss as both she and her husband had been keen on sport throughout their lives. She had a good memory and rarely forgot anything, much to her family's frustration at times.

Mrs X was fastidious in her appearance and cleanliness and did everything she could to maintain her independence. She took responsibility for her own medication, had her hair dressed every week, despite the discomfort of having her hair washed, and carefully put on her gold necklace every day.

Her disability and arthritis meant that she got stiff and achey joints, hence every hour, on the hour she went through a routine of neck, shoulder, wrist exercises and got on her feet to stretch her legs. This she had done for decades, religiously. She felt it worked. It probably did. The wounds and dressings on her feet made it very, very difficult to perform this routine. As did going to bed, which to her was the ultimate sacrifice of what little independence and control she had. The lack of independence caused her considerable anxiety. She developed obsessions, acted compulsively and became very, very anxious and subject to panic attacks as she became more and more limited.

Due to her medical conditions Mrs X was under the care of the Rheumatology team at Chase Farm Hospital. District nurses visited the care home twice monthly for prescribed injections of Humira[1]. She also had skin problems which responded to daily vitamin C tablets if they had the sufficient dosage.

From the end of Sept 2013 onwards, whilst resident in the care home, a history of leg and foot ulceration, which deteriorated significantly was diagnosed, treated and recorded. She had specially fitted orthopaedic shoes which were noted to rub her foot, however she was reluctant to stop wearing them as they enabled her to mobilise. In addition she was disinclined to spend time in bed to elevate her legs following advice from the General Practitioner (GP) and District Nurses (DN) because she felt this diminished her independence and made it difficult to exercise and mobilise her joints. The leg ulcer began with a small abrasion in Oct 2013, a maggot infestation developed and subsequently weekly and twice weekly treatment by DNs took place during which time the ulceration deteriorated dramatically from small abrasion until by Feb 2014, Mrs X was identified in

[1] HUMIRA is a prescription medicine used to reduce the signs and symptoms of moderate to severe rheumatoid arthritis (RA) in adults. HUMIRA can be used alone, with methotrexate, or with certain other medicines. HUMIRA may prevent further damage to your bones and joints and may help your ability to perform daily activities.

various reports as having pressure ulcers on her sacral area, her right leg, right toe, right dorsum of her foot, left lower leg

By the beginning of February 2014 three grade 2 sacral pressure ulcers were identified by the DN and care home staff. Following an assessment by the TVN, Mrs X was transferred to the Royal Free hospital (RFH) for a Deep Vein Thrombosis on her leg. During her admission the sacral ulcer was assessed as grade 3. As per the NHS Pressure Ulcer Policy, this was reported to London Borough of Enfield via a safeguarding alert with the potential allegation of neglect against the care home.

A subsequent safeguarding investigation found that the care home had acted accordingly, and indicated that the concerns involved multiple health agencies. After a presentation to the Serious Case Review panel, this Independent Management Review (IMR) was commissioned.

Within the varying reports submitted by health professionals, a number of inconsistent and unchallenged assumptions are made in regards to Mrs X's capacity, personal hygiene and behaviour. Examples such as the GP record which notes that 'she was reluctant to be washed or bathed thus increasing her risk of infection' (there is no mention of this in the care home or the Barnet Enfield and Haringey Health Trust (BEH) report). The Royal Free Hospital (RFH) had recorded that Mrs X has dementia which was untrue however they did not make a referral to memory services or consider that the pain, anxiety and discomfort that Mrs X experienced may have masked her capacity No mental capacity assessments were referenced in any reports. There is an expectation that if services are making statements such as those above that the necessary test of capacity would have been completed or requested.

4. Methodology

The focus for this independent management review is to assess the relevant information collated during the safeguarding process and collate this into one overall report. Reference to professional knowledge and policy will be included. It is not within the scope of the review to re-interview or interview relevant professionals or the next of kin.

The following documentation and reports from these service areas were assessed:

- London Borough of Enfield (LBE). Safeguarding and Care First information.
- Barnet, Enfield and Haringey NHS and Mental Health trust (BEH). Report from the community nursing team
- Royal Free London NHS Foundation Trust (RFH). Report from the hospital safeguarding lead.
- NHS Enfield CCG/ Mrs X's GP Surgery. Report from Mrs X's GP
- Mrs X's Care Home

- Ms Q, daughter of Mrs X

5. Pressure Ulcers, Risk and Reporting

Unlike nursing homes, residential care settings are not required to have nursing staff. When a resident requires nursing intervention it is provided by a community service such as a district nurse, arranged via the GP. Residents who require more frequent or intensive nursing care are usually transferred to a nursing home. However if a person wishes to remain in what is now considered their home, more intensive health support can be provided including tissue viability, care home and treatment services and palliative care.

Pressure ulcers are caused by sustained pressure being placed on a particular part of the body which interrupts the blood supply to the affected area of skin. Once an ulcer has developed, it can become infected by bacteria. Adults considered to be at high risk of developing a pressure ulcer will usually have multiple risk factors (for example, significantly limited mobility, nutritional deficiency, inability to reposition themselves, significant cognitive impairment) identified during risk assessment with or without a validated risk assessment tool. Adults with a history of pressure ulcers or a current pressure ulcer are also considered to be at high risk (Nice Guidance pg 179 Chp 1)

It is estimated that over 700,000 people are affected with pressure ulcers every year (2014: Statistics from NHS Safety Thermometer data) and evidence indicates that the majority of pressure ulcers are preventable and could be avoided through simple actions by staff, patients and carers. (http://www.nhsiq.nhs.uk/improvement-programmes/patient-safety/pressure-ulcers.aspx)

In June 2010, NHS London determined that all Grade 3 and 4 pressure ulcers must be reported as Serious Incidents (SIs). In addition a safeguarding referral should be made if there is evidence that the damage could be preventable. Pressure Ulcer management and the maintaining skin integrity has been a key priority for the NHS. In 2013 pressure ulcers became one of the 4 reportable harms, (the NHS Safety Thermometer CQUIN).

"The issue is pressure ulcers and the impact of them on patients, families, carers, staff and organisations is huge. The lifestyle of a person who has suffered a pressure ulcer is changed forever, their ability to lead a pain-free, risk-free life in the future is affected" (Reflections on Pressure Ulcer November News – Dr Ruth May 10 December 2014 - 13:22, NHS England)

6. Timeline / Chronology (see appendix 1)

This chronology will focus on the time span from Mrs X's 2nd period of skin integrity concern, first noted at the end of September 2013 to the time of Mrs X's death in April 2014.

Reports cross referenced for this section have been taken from:

- Mrs X's GP
- Care Home Operations Manager – with supporting evidence of the Care Homes (CH) recording of the medical visits and District Nurse (DN) progress notes kept at the home.
- Service Manager - Adult Community Nursing Enfield (chronology from the Trust electronic patient record which included the District Nurses, TVN and Dietetics entries).
- Head of Safeguarding, Royal Free Hospital (RFH)
- Ms Q – Daughter of Mrs X - Report of supporting evidence for safeguarding investigation.

The safeguarding investigation report compiled by the social worker and safeguarding minutes have not been included in this section as it was concluded prior to key partner reports being made available. Her interim outcomes were based on the care home and family reports which have already been included. The initial allegation of neglect against the care setting was not upheld by the social worker, who felt this should be redirected at health professionals in charge of her medical care. Her recommendation was to refer the concerns to the serious case review panel for consideration.

7. Analysis of Chronologies: Findings and Recommendations

Mrs X had been a resident at the care home since 2011 until she passed away in April 2014. She considered the care setting to be her home.

The overriding concerns emerging from this report are the effective management of pain, both pre and post pressure ulcer dressing and the managerial oversight of Mrs X's care and treatment plans. The chronology highlights that there was limited pain management in place until Mrs X's daughter raises this at the start of 2014.

To observe a relative in severe pain and discomfort is an extremely distressing experience for any family member as well as for the person themselves and the people caring for the person, as is evidenced from Mrs X's daughter's detailed and contemporaneous account.

The next section is broken down by outcome themes or service areas. Where concerns, inconsistencies or problems for Mrs X are noted (from the submitted documentation) this is highlighted as an example. The recommendations at the end of each section are mostly recommendations for service areas to take forward to aid learning and improve practice to prevent these concerns occurring again. (A few relate specially to Mrs X where confirmation /actions is required)

In addition each service area has also included their own learning recommendations which have been included within the action plan at the end of this report.

7.1 *The Role of the District Nurses:*

The main external professionals to have oversight of Mrs X's care and treatment was the district nursing service[2]. District nurses are experienced at pressure ulcer management and should be expected to have kept up to date with pressure ulcer treatment plans.

NHS England is clear that organisations should have their own pressure ulcer prevention and management guidelines. These should always include an up to date Waterlow Risk Assessment; (Pressure Ulcer Risk Assessment (PURA) and a Malnutrition Universal Screening Tool (MUST) for patients at risk of, or with pressure harm. In addition the taking of pressure ulcer photographs (with the relevant consent) is the best way to understand the effectiveness or not of treatment plans.

The district nurses would have been responsible for the completion and review of these risk assessment tools, photograph consent with evidence of progression of treatment (or decline) as per their trust protocols.

It is of concern therefore that the TVN noted on her first visit in Feb 2014 that there was no leg ulcer assessment form in her notes, no photographic evidence or recent Waterlow Score (last score seen was 2011). This resulted in the inability to track and verify the varying accounts of the numerous visiting nurses who at times appeared to contradict previous pressure ulcer opinions, (for example: the wound is healing one day then wet with skin loss the next time) and were not following trust procedures. [3]

There were three recording methods for when a DN visited Mrs X in the care setting which are referred to within the chronology:

- The BEH community nursing report which is an electronic office based system (RIO),
- Health progress notes kept in the home by the district nursing service
- The care home 'Record of Medical Visits' form.

Upon cross referencing the three methods it is noted that at times there were inconsistencies, for example: On Sunday 22nd Dec 2013 the progress notes and care home record indicate that a swab of the ulcer is required for Monday 23rd. The BEH report makes no indication of this on the 22nd entry but makes reference to a swab being taken the 24th Dec (no health visit occurred on this date) [a later Q to BEH notes this was a handwriting mistake]. The swab is finally taken Friday 27th Dec (although there was no entry of this date recorded in the BEH report)

[2] Working in partnership with the multidisciplinary team the District Nursing service delivers nursing care to clients in their homes, residential homes, and in clinics. District nurses have a pivotal role as patient assessors, care co-ordinators and team leaders. At the end of life, patients and their families have the re-assurance that the district nursing service is committed to supporting them throughout this time and to achieving a peaceful and dignified death.

[3] The BEH trust has an extract from their pressure ulcer prevention protocol:- *"Skin damage has a number of causes, some relating to the individual person, such as poor medical condition and others relating to external factors. It is recognised that not all skin damage can be prevented and therefore each case should be reviewed on an individual basis."* (Service Manager - Adult Community Nursing Enfield)

Mrs X's daughter kept detailed records of her discussions and experiences with various health professionals and email correspondence with the care home to evidence her growing concerns over her mother's deteriorating health and wellbeing. It highlighted the differing opinions and decisions with health professional recording, creating anxiety for family and care home staff. In addition these discrepancies could lead to allegations of neglect by professionals.

It is likely that DNs update the electronic systems at a different time frame from those in the care setting. The disparity of data between recording methods can give room for doubt as to whether a visit or a treatment took place or not. Accurate recording is especially important to ensure the persons care and wellbeing is maintained. It also allows family members to access the records in the residents file as a communication aid and to monitor treatment progress and ongoing actions.

Recommendations:

- Nursing staff must complete the relevant risk and nutritional assessments and review when a change of circumstances is noted. These should be kept with the DN notes and a treatment plan(s) should be developed.
- Significant events or changes should be entered correctly across all recording methods.
  Treatment plans and referrals should be discussed clearly with patients and their families to avoid confusion and allay fears. These should be kept in the residents file and made available to family members so they can reference the information at anytime.

7.2 Pressure ulcer damage

Mrs X's medical history and age would have identified that there were significant warning indicators that she was at high risk of skin damage and therefore the appropriate risk assessments and management plans should have been in place at the first sign of oedema in Sept 2013. By Feb 2014, Mrs X was identified in various reports as having pressure ulcers on her sacral area, her right leg, right toe, right dorsum of her foot, left lower leg and a left leg skin tear which occurred through a hoisting incident at the RF Hosp. The lack of detailed nursing body map within the review documents made it impossible to interpret/compare which ulcer was which and when it occurred.

As identified earlier there were no Waterlow[4] assessments or similar evidenced during this report, neither were there any pain assessments or charts (other than a care home plan).

[4] The **Waterlow** pressure ulcer risk **assessment**/prevention policy tool is, by far, the most frequently used system in the U.K. and it is also the most easily understood and used by nurses dealing directly with patient/clients. Intended for use by nurses, healthcare professionals and carers

These should have been completed by community nursing staff and they would have assisted in identify the risks, treatment plans and referral/advice to a TVN when necessary. There was only one community nursing plan found which had been completed at the end of Jan 2014. An updated plan and relevant risk assessments in place from the onset could have predicted and reduced Mrs X's pain, offered a visual structure to the treatments given and provided reassurance to the family.

There is no evidence to support the allegations that the sacral ulcer developed from a grade 2 into a grade 3, either at the care home or in the hospital. It was wrongly graded as a 3 at the RFH A&E

Recommendation:

- Early identification of risk factors should be considered when a person presents with previous and potential damage. Assessments should be completed by the DN for residents in Care Homes and reviewed accordingly.
- Pain management assessments should also be used to gauge a person's pain threshold with regular reviews and planned pain relief once identified that pain had become unmanageable.
- Community nursing treatment plans should identify the lead professional. Documents must be kept in the relevant care home file with review dates.
- The use of a body map and photograph evidence to chart the progress of treatment would have been helpful and could have been used to assist the GP in recommending antibiotic and follow on treatment which could include a timely referral to the TVN or other relevant service.

7.3 Managerial Health Oversight

The report finds that Mrs X received a significant level of medical intervention/visits during in the last months of her life. However with at least 26 health professionals involved there was evidence that the lack of a structured treatment plan created disjointed care and treatment actions.

There was no named professional with overall responsibility for the coordination and direction of treatment for Mrs X. An identified lead person would have ensured that the relevant risk assessments were completed and timely specialist referrals made including consideration of pain management, particularly for pre dressing preparation.

This type of joined up approach with planned responses and actions would have eased the pain and discomfort for Mrs X and may have promoted healing.

Recommendation:

- A named lead professional is allocated to oversee the care and treatment for residential care home and high risk community patients.

- These leads should meet with the patient, involved next of kin and GP at least once to discuss the roles and responsibilities of each professional, assessment and review outcomes and treatment plans.
- Mental capacity should be considered at key stages throughout involvement to ensure patients are able to weigh up and retain decisions pertaining to unwise decision making or treatment refusal.

7.4 Dietetics and Nutrition

One of the key recovery aids to assist the healing of pressure ulcer damage is a diet high in protein and nutrients. Community nursing staff should have completed an accredited screening tool such as the 'Malnutrition Universal Screening Tool' (MUST) to assess the person's risk of malnutrition at the onset of pressure damage and make a referral to Dietetics where required [5]. There is no evidence that Mrs X had a MUST assessment nor does there appear to be any nutritional charts used within the care setting to capture her nutritional intake when it became obvious that her diet was compromised. The GP did eventually make a referral and a dietician visited in April 2014 however she was already receiving palliative care at this stage.

Recommendation:

- Community staff/ DNs should complete the relevant assessment tools and provide the care home manager and staff with relevant nutritional charts and food fortification advice.
- The care home should record all nutrition and provide a weekly summary to DN and GP to assess. If the resident continues to lose weight then a timely referral to the Dietetic service should be made with the evidence collated as supporting documentation.

7.5 Tissue viability nurses

BEH trust report clarifies the role and duties of a TVN as: 'Education and training for registered nursing staff in: wound management, pressure ulcer prevention and management, leg ulcer assessment and management, skill development in Doppler and compression bandaging, product selection and nurse prescribing and current topical subjects related to wound care' including:

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[5] Dieticians are degree trained health professionals who translate scientific information about food into practical dietary advice. The service provides nutritional assessment and dietetic support for oncology/palliative care patients.

- Advanced patient assessment with recommendations and care planning for future treatment
- Specialist advice and training to staff working in General Practice including GPs and Practice Nurses
- Audit of practice within District Nursing

In Mrs X's situation it seems that the threshold for this type of support early on in her treatment was warranted. It appears from the DN progress notes that there were several occasions where the visiting nurse suggests referring to a professional. There were two vascular referrals noted from the GP report, one on the 7th Jan with a chase up letter on 16th Jan 2014. No further follow up actions in regards to these requests were found.

On the 4th Feb the care home medical visit report makes reference to a TVN referral made by the GP. This is not recorded in the GP report. The TVN did not visit Mrs X until mid Feb where an urgent transfer to hospital was sought. This visit date varies across each service record: The TVN records in the DN progress notes and assessment form that she visited on the 12th Feb. The care home and Mrs X's daughter record this as the 13th Feb and the GP as the 14th Feb.

Recommendations

- A referral for advice and support should be sought by district nurses when it becomes clear that the treatment is not responding as it should.
- An early specialist referral should be considered if a person has a particular presentation which may have a factor in the development of and recovery of ulcers (strong willed, very particular, specialist footwear). Evidence of this referral must be kept in the residents file at the care home for staff and family to refer too.
- To consider further investigation into why the original referrals in Jan 2014 did not come to fruition and why there was at least an 8 day delay between the TVN referral being made and the visit occurring given the level of pain and discomfort.

7.6 Royal Free Hospital (RFH)

Mrs X was sent to the RFH as a planned urgent admission for suspected DVT / Vascular investigation in mid February 2014. She was received in A&E rather than onto a ward. Given her advanced age, frailty and pressure damage it would have been advantageous to have her admitted directly to a ward.

There was disparity on grading of ulcers within the hospital departments. A grade 3 was assessed in A&E however this was reassessed later as a grade 2 on the ward. (Notes completed both prior to and after discharge record the ulcer as a grade 2). The hospital also recognises that when a lack of clarity with pressure ulcer gradings is found a referral to the hospital tissue viability team should be made.

It seems that the community TVN leg ulcer assessment form was sent with the patient to hospital as per Mrs X's daughter notes. There is no reference to sacral ulcers on this form and as there was no care home transfer summary to indicate pre-existing pressure damage, a safeguarding alert was made by A&E in regards to possible neglect by the care home.

Whilst in A&E Mrs X suffered accidental damage to her left leg whilst being hoisted onto a toilet. The RFH report confirmed this was reported as a Datix (required incident reporting form with internal oversight by the ED matron) and was seen by a doctor and then dressed by the nurse. The RFH report notes that a verbal apology was given to both Mrs X and daughter.

The RFH discharge summary in February 2014 provided limited information which did not include details or treatments for the sacral ulcer nor the injury sustained to the left leg. A diagnosis of dementia was also included on the RFH discharge summary with a recommendation for referral to memory services. Dementia is not noted in other documentation and no professional challenge was found or referrals made.

Although A&E is a busy place, consideration should be given to a personalised approach for frail older people. Mrs X was fearful of hospitals from previous visits and due to sacral ulcers and arthritis found it difficult to sit and move. Her preferred method of moving was with a lifting belt which was not available in A&E. Hospital staff should have the appropriate moving and handling equipment and ensure training is given on its use throughout the service.

Mrs X's daughter noted the vast differences between the competence and organisation skills of the two wards her mother stayed on. The first had a competent and understanding ward manager and the ward exuded competence, calm and organisation. The other was chaotic and disorganised. Royal Free management should ensure that the standards on 7 East A are replicated across other wards.

From the time spent in the ambulance through to Mrs X's admittance into a hospital ward, Mrs X remained on a trolley for over 8 hours. Given her history of pressure damage it would be imperative that this is kept to a minimum and transfer to an appropriate mattress made as quickly as possible. The hospital report states Mrs X was transferred to a hospital bed with appropriate mattress at 18.00 hours. *Disparity still exists between the daughter's notes and RFH as to when Mrs X was transferred to an appropriate pressure mattress and bed. This requires further explanation by RFH.*

Mrs X's daughter also raised a number of concerns in her report, in particular staff indifference to Mrs X's suffering, the hydration of her mother during the period she was in A&E and the treatment of her mother's leg wounds, lack of pain management pre and post dressing and the delay in redressing. However these where not raised with the hospital at the time of the safeguarding investigation and hence RFH have not had the opportunity to

reply. A meeting between the family, RFH staff and safeguarding to discuss these concerns is recommended.

Recommendations:

- A&E staff must keep patients and family updated with treatment plans and equipment provided, i.e. reassurance that patient is on a pressure relieving mattress for those at risk of or with pressure damage.
- The categorisation of ulcers to improve grading consistency must be recorded throughout the hospital using a tool such as the European Pressure Ulcer Classification System (2009)'' or standardised information as recommended by http://nhs.stopthepressure.co.uk/, with referral to the hospital TVN service where disparity between wards is noted.
- Given her past experiences and fear of hospitals the care home and community nursing staff could have developed a hospital passport with Mrs X to use in this instance, stating her fear of hospitals and particular moving and handling requirements etc.
- Future discussion between community staff and the ward post discharge is required when an unexpected diagnosis is noted (such as Dementia).
- Include all areas of damage and treatments given should be included on the discharge summary with adequate pain relief prescribed.
- Meet with family to review outstanding concerns/discrepancies not covered in this report.

7.7 Care Home/ Family support

The safeguarding alert initially alleged that the care home had been responsible for the sacral pressure ulcers. The investigation found this to be incorrect with the care home providing extensive documentary evidence to prove otherwise. The care home staff summarise all health visits on the 'record of medical visit' form however did not provide a transfer summary for Mrs X's emergency admission to the RFH which may have assisted in the care of Mrs X.

As an earlier preventative measure the provision of a rising/reclining chair may have been appropriate given Mrs X's reluctance (understandably) to become bedbound. This would have given her a level of control and independence at the early stages and would have reduced the oedema in her legs to aid healing and prevent further pressure damage.

The care home notes that Mrs X's nutritional intake was limited. A daily nutritional log sheet was not seen as part of the evidence provided by the care home and as such is assumed to not be in existence. This is a missed opportunity to evidence the decline of her nutritional intake and could have been used to prompt the DNs to complete the MUST tool

and make an earlier referral to the Dietician. Food fortification is not evident in the reports provided by care home (nor in the follow up questions which were requested) however Mrs X's daughter confirmed that the care home provided fortified food and Ensure drinks.

Mrs X's daughter was very involved in the care of her mother, visiting most days and expressed confidence in the abilities of the care home to look after her mother. She was able to attend the hospital with her mother and give support and pain relief which she brought with her from the care home. **Pain relief for Mrs X was a huge concern which the district nurses and hospital staff failed to respond too in a timely manner leaving Mrs X in considerable discomfort**.

The roles and responsibilities of each profession in regards to pressure ulcer management were not explained to the family leading to concern and confusion on who was responsible for treatment and pain relief.

Care Home Recommendations:

- To look at alternative / innovative methods of elevation and discuss with family or others if purchases are required at the earliest point possible.
- Ensure that any community nursing services update the care home on the necessary risk assessments. Care Home to remind nurses that these are required to ensure that their resident is cared for appropriately.
- Complete nutritional charts (can request from dietetics service) to record a residents dietary intake. Ensure that these charts are evaluated and reported to the relevant health professional when weight loss (or extreme gain) is evidenced.
- Ensure that a transfer document is sent with the resident to hospital, including body maps or assessments of pressure damage. These should be faxed if not available at the point of transfer to A&E. To request further information and details if ward discharge summary appears incomplete on return from hospital

7.8 General practitioner (GP)

There were a number of visiting GPs who attended the care home regularly. By their own admittance, their role in pressure ulcer management is limited, usually to seeking or providing advice from relevant nurses and specialists and the prescribing of antibiotics where an infection is indicated. Timing a GP and DN visit to coincide with the re-dressing of a wound is difficult, resulting in a possible delay in the identification of a deteriorating wound. The use of photograph evidence would have been an invaluable aid.

An earlier review Mrs X's medication should have been undertaken. HUMIRA which Mrs X took for arthritis is a TNF blocker medicine that can lower the ability of your immune system to fight infections. It was noted that this medication was stopped during the 2012 injury. An assessment which weighed up the risks of improved healing against the possibility of an arthritis relapse at an earlier stage should have been undertaken. This was not considered

until late in her decline when the removal of the drug would have had limited impact on healing process.

On October 23rd 2013 DN informed the GP that the right foot ulcer was ‘clearing and improving’. DN did not think it was infected however the GP notes on this day that results from a swab (most likely taken on the 17th Oct) suggested the wound was contaminated with pseudomonas bacteria. It seems that no treatment was prescribed at this point as it was felt to be improving however the DN was advised to report back if things changed. The next visit Mrs X receives from a GP was 7 weeks later on the 10th Dec 2013. The foot ulcer had not healed over this time and an earlier assessment should have been made.

The GP report also details that Mrs X disliked being washed and bathed which may have increased her risk of infection. This was an incorrect entry as this was not highlighted in any other reports that were made available for this review. If a similar situation was seen in another person then a timelier TVN intervention and test of capacity would have been required (under the Mental Capacity Act 2005).

Recommendations

- It would have been helpful to have a multi -agency management plan prepared prior to or at the first sign of skin damage given Mrs X’s unique condition and high risk factor.
- GPs should request photographic evidence (if consent given)
- Medication should be reviewed at the earliest point to check for any medication contradictions and side effects.
- Consider re testing ulcers infected with contaminants at regular stages to track colonization
- When dementia or memory loss is evident, discussion with family and care home staff should have been considered throughout her treatment and appropriate assessments and referrals made when indicated.

8. Report conclusion

This review highlighted a number of outstanding questions or further investigations required i.e. why first referral for TVN went missing. However given the length of time the investigation covered it was agreed with Mrs X’s daughter that it would probably not uncover any additional learning, with the exception of Mrs X’s experience and concerns raised by her family in relation to the Royal Free Hospital. A resolution and sharing of good experiences will be organised by the London Borough of Enfield safeguarding team for the family to feedback.

Preventing pressure ulcers is an essential aspect of patient safety. The process of prevention begins with a risk assessment incorporating evaluation of identified risk factors and skin

inspection.[6]. Whilst many health staff supported and cared for Mrs X during her last 7 months there was a delay in seeking professional support and timely pain relief. Only after the request by the care home manager, did the palliative care team become involved. Once the syringe drive and correct medication was given Mrs X's pain was better managed (although it is noted by Mrs X's daughter that the nurses did not set up the syringe driver correctly on several occasions causing pain and distress for Mrs X) There were also problems obtaining emergency medication out of hours.

Although there was not a deliberate act of neglect by health (the staff did not intend to cause pain and harm) the report finds that the pressure damage and pain management could have been avoided or reduced had the nursing staff followed their trust protocols and used compassion to treat Mrs X. As such, this lack of oversight identifies that there were neglectful practices found which require immediate action and improvements. Each health service undertook an internal investigation as requested by the SCR panel chair and identified areas for improvement and learning. These have been included in the action plan below, along with the recommendations identified during this review for implementation and monitoring by the Safeguarding Adults Board.

Mrs X's wish to remain in the residential care home was realised and following the implementation of an end of life plan, she died in the home in April 2014.

Her death certificate records that she died from: 1a) Cardiopulmonary degeneration, 1b) Old age 1c) Decubitus leg ulcers and rheumatoid arthritis.

Mandy Oliver: Independent Reviewer

March 2016

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[6] Unavoidable pressure ulcer definition.
In summary, a pressure ulcer can be deemed unavoidable when: ● All risk assessments and preventive care have been implemented and re-evaluated, yet a pressure ulcer still occurs; ● A life-threatening event may have occurred; ● A patient may have end-of-life skin changes; ● A patient with mental capacity may have refused preventive interventions; ● A patient may have been in a collapsed state, unknown to health professionals. Source: Bedfordshire and Hertfordshire TVN Forum (2010); NPUAP (2010); DH (undated)

9. Recommendations and Action Plan into the Circumstances Surrounding the Care and Treatment of Mrs X

	Area of improvement and learning	Recommendation	By whom	Time Frame	Progress to date	RAG
1	**Baseline assessments must be completed and reviewed when a person presents with previous and potential damage within the community**	▪ Waterlow ▪ MUST- nutritional recording ▪ Community Nursing Plan ▪ Pain Management plan ▪ Gold standard - End of Life ▪ Test of capacity	BEH			
2	**A lead clinician is allocated to oversee the care and treatment for residential care home and high risk community patients**	▪ Clinical management plan completed with a named contact for patient, family and care provider, kept in patients notes	BEH			
3	**Mental capacity should be considered at key stages when concerns are indicated.**	▪ Ensure patients are able to weigh up and retain decisions pertaining to unwise decision making or treatment refusal ▪ Personalisation of prevention and treatment plans must be evidenced	All			
4	**Pressure ulcer management**	▪ Clear treatment pathway with professional escalation process (kept with patients notes) ▪ Body Maps and photographic evidencing ▪ Benchmarking example of wound progression ▪ Audit of protocol compliance, implementation and review	BEH/RFH			
5	**Improved communication**	▪ Defined professional roles and responsibilities identified at early stage. ▪ Significant events or changes discussed and entered correctly	All			

	Area of improvement and learning	Recommendation	By whom	Time Frame	Progress to date	RAG
		across all recording methods. ▪ Transfer summaries/ hospital passport or pen picture models to be agreed and implemented. ▪ Audit of multi agency communication, compliance and outcome.				
6	**Outstanding concerns and observations**	▪ RFH trust meet with family and Safeguarding rep to discuss remaining concerns.	RFH & SGD			
	Individual Service Area Recommendations and Learning Arising from Internal Investigation (Where duplication is found these are included above)					
a)	Five Part time GPs attended the home on a regular basis	Reflecting on this case we have developed a monthly rota rather than a weekly one so that, for continuity, the same GP attends the home for a month at a time.	GP			
b)	Palliative Care	Additional learning suggests an earlier referral to palliative care would have been appropriate to ensure more effective management of the pain	GP			
c)	DN Capacity and case loads	The district nursing service is in negotiation with commissioners regarding increased substantive funding to improve capacity and reduce individual nurses caseloads	BEH			
d)	The care home assessment team	Extend this provision to all 47 residential and nursing homes in Enfield	BEH			
e)	Pressure ulcer prevention	The tissue viability nurse consultant leads a monthly pressure ulcer prevention forum for all relevant ECS teams	BEH			

	Area of improvement and learning	Recommendation	By whom	Time Frame	Progress to date	RAG
f)	Tissue viability link nurse scheme	A tissue viability link nurse scheme is re- launching in June 2015 to maintain and develop up to date knowledge and competencies.	BEH			
g)	Multi disciplinary work	Integrated locality teams comprising district nurses, community matrons and intermediate care staff now work with social services and GPs by way of multi-disciplinary meetings to plan care for frail elderly people in Enfield.	BEH			
h)	Initial A&E handover	ED staff should ensure any information given from the care home or family members is recorded.	RFH			
i)	Care home transfer	To ensure this information is made available to ED staff	RFH/CH			
j	Improvements in documentation required	To ensure all actions are recorded	RFH			
	Wound management	TVN team to be involved for patients with infected or deteriorating leg ulcers.	RFH			

Key:
BEH: Barnet Enfield and Haringey Trust, includes notes from-District Nurses (DN), Tissue Viability Nurses (TVN) Palliative Care and The Care Home Assessment Team (CHAT)
GP: GP
RFH: Royal Free Hospital