

Significant Incident Learning Process

Case Review

Subject

Mr Z

OVERVIEW REPORT

Final Version May 24th 2016

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1 Introduction to SILP

- 1.1 SILP is a learning model which engages front line staff and their managers in reviewing cases; focussing on why those involved acted in a certain way at the time. This method of reviewing is encouraged and supported by national development for both children and adults.
- 1.2 The SILP model of review adheres to the principles of:
- Proportionality
 - Learning from good practice
 - The active engagement of practitioners
 - Engaging with families
 - Systems methodology
- 1.3 SILP's are characterised by a large number of practitioners, managers and Safeguarding Leads coming together for a learning event. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again to study and debate the first draft of the Overview Report.
- 1.4 Central Bedfordshire Safeguarding Adults Board have requested that the SILP model of review be used to consider the circumstances of Mr Z, in order to learn lessons about the way that agencies in Bedfordshire work together to safeguard adults.
- 1.5 This review has been undertaken in a way that reflects the principles of a systems methodology; wherever possible seeking to review organisational factors and not individual blame.

2 Introduction to the Case

- 2.1 Mr Z died in the Luton and Dunstable (L & D), Hospital on the 20th January 2015 from pneumonia and prostate cancer which had spread to his bones. In the three months prior to his death, Mr Z had been admitted to the L & D on five separate occasions and in that time he had been diagnosed with the advanced cancer that was causing spinal cord compression and additional pain to his knee joints, a pulmonary embolism, a chest infection and suspected stroke. Mr Z and his wife had felt unable to cope at home due to Mr Z's limited mobility which prevented him from caring for himself and restricted his independence. Because of this, during Mr Z's third admission in December 2014, Mr and Mrs Z asked for help to rebuild his strength before returning home. In response, professionals assessed Mr Z's suitability for such support and it was established that he had potential to become more mobile. In December 2014, he was discharged to the care of a specialist 'Step Up Step Down unit', based within Greenacres Care Home, with the aim of improving his mobility so that he felt ready to return home but sadly, Mr Z deteriorated quite quickly whilst in residence at Greenacres and died in the L&D before he had the opportunity to return home. His rapid deterioration was unexpected by his family and there had been no consideration of an alternative provision of palliative care by professionals.
- 2.2 This review is seeking to examine the role of agencies concerned in the care of Mr Z to establish if there are any lessons to be learned in relation to the professional understanding of the overall serious nature of Mr Z's illness and from the information and

decision making processes that led to Mr Z being transferred to, and remaining at, Greenacres. It will also review separate safeguarding alerts that were made concerning Greenacres in December 2014 and January 2015 and how this impacted on Mr Z and his family and future service provision at Greenacres.

3 Mr Z

- 3.1 Mr Z was a husband and father of two daughters. He was 80 years old at the time of his death and lived with his wife in the family home in Bedfordshire prior to a placement at Greenacres Care home. Mr Z was very close to his family and his daughters lived nearby and provided support to their parents. Mr and Mrs Z had a strong and long marriage. His family describe him as having been an 'amazing Husband and Dad'. Mr Z was very proud to have been social worker before retirement.
- 3.2 Before he died, Mr Z expressed how he felt about his placement at Greenacres Care Home to his family and to his Social Worker. He described feeling very let down and being very sad when living there. He stated that he known the purpose and aims of a 'Step Up, Step Down' unit he would not have agreed to a placement because he received the wrong treatment and did not receive enough care. Mr Z and his family always wanted Mr Z to return home and they are very sad that he wasn't able to die at home.

4 Terms of Reference

- 4.1 The detailed terms of reference and Project Plan appear at Appendix 1 which details the purpose, framework, agency reports to be commissioned and the particular areas for consideration of the review.
- 4.2 It was agreed that the scoping period for this review should be between October 2014 and the 21st January 2015 initially, but it was found from discussion at the Learning Event that there was useful learning to be gained by extending the scope to May 2015 to incorporate the safeguarding alerts and subsequent safeguarding investigation undertaken to ensure service improvements at Greenacres.

5 The Process

- 5.1 Mr Z's wife and two daughters met with the review Chair at their home on the 1st March 2016. The family's views and information have been incorporated into this review.
- 5.2 An initial scoping meeting was held on the 11th December 2015 and agency representation, terms of reference, scoping period and the project plan agreed.
- 5.3 A meeting for Authors of individual agency reports was held on the 7th January 2016 where the SILP process and expectations of the agency reports was discussed. A full day learning event followed on the 2nd March 2016 with the agency reports having been circulated in advance. Most of the agencies involved were represented by both the report author and staff, including managers, who had been involved during the scope period.
- 5.4 At a Recall Event on the 16th May 2016, participants who had attended the Learning Event considered the first draft of this report. They were able to feedback on the

contents and clarify their role and perspective. It is of note that a representative from the Community Nursing Team did not attend the Recall Event; however, all those involved had the opportunity to contribute to the conclusions about the learning from this review. The final version of this Overview Report was presented to the Central Bedfordshire Safeguarding Adults Board on the 24th May 2016.

- 5.5 The review has been chaired by Donna Ohdedar, an independent safeguarding consultant with no links to Bedfordshire Safeguarding Adults Board or any of its partner agencies. The report has been written by Carolyn Carson, an independent safeguarding reviewer, who is also independent of the Bedfordshire Safeguarding Adults Board.
- 5.6 The process has been efficiently administered by Emily White, Safeguarding Lead for Central Bedfordshire Council

6 A brief background prior to the scoped period

- 6.1 Prior to the scoping period, Mr Z had been under the care of his GP and Community Nurses whilst living at home and from the 22nd August 2014, was also supported by a self-funded domiciliary care package. The care package provided assistance to dress/undress; catheter and continence care; and a full body wash daily because Mr Z could no longer manage these tasks himself.
- 6.2 Mr Z's medical history indicates that he was diagnosed with hypertension in 2002, osteoarthritis in 2002, prostate cancer in 2007 and type 2 Diabetes Mellitus in 2012. Mr Z received medication for the arthritis, blood pressure and diabetes and in addition was on several other medications including oral steroids and strong morphine based pain killers and laxatives.
- 6.3 Central Bedfordshire Council took control of Greenacres Care Home from BUPA on the 1st August 2014. Central Bedfordshire Council owned the building and at this time the contract with BUPA had come to an end and BUPA instigated a policy decision not to renew care home contracts for buildings they did not own. In this way, Central Bedfordshire Council acquired a further six care homes from BUPA at this time. There were no concerns about how Greenacres had been managed prior to the transfer to Central Bedfordshire Council. Mr Z was resident there from December 24th 2014 until January 18th 2015.

7 Key Practice Episodes

7.1 Early Treatment and Care Package - October 2014 to December 11th 2014.

- 7.1.1 Between October 2014 and admission to Greenacres, Mr Z lived at home and was supported by a self-funded Domiciliary Care package in which he received two care visits; one in the morning for 30 minutes and a 15 minute evening call. This had been arranged by Social Care who conducted an initial assessment and again prior to both discharges home from hospital in October and November 2014. The evening visit was cancelled by the family on the 20th October 2014 because they were concerned about cost and usefulness in that it required Mr Z to be made ready for bed at 6.30pm.
- 7.1.2 GP and nursing records show Mr Z to have received frequent care when living at home. The Community Nurses managed a pressure ulcer and other care requirements as required. It was noted that Mr Z slept in a reclining chair due to not being very mobile.

The Community Complex Care Matron reviewed Mr Z and in July 2014 commenced an on-going vulnerable adult care plan, which highlighted medication reviews, care needs, mobility and occupational therapy needs and family discussions. The plan was linked to a government scheme that sought to review all adults over the age of 75, with a view to avoiding hospital admissions where possible. There was no recording of any palliative care options or wishes as to hospital admissions, but all updates to the plan were recorded on System One and able to be seen by the District Nurses (where they have access), and all Community Nurses.

- 7.1.3 GP records indicate being aware of Mr Z's prostate cancer and a co-morbid condition of diabetes. Post his November admission to the L&D, the GP was also aware that Mr Z could not be cured and had a poor prognosis due to the spread of cancer to his bones and that he had a pulmonary embolus. The GP visited Mr Z at home on the 4th December for diarrhoea contracted in hospital and the Out of Hours GP saw him on the 10th December, fully aware of the spread of cancer and prescribed antibiotics for a urine infection.
- 7.1.4 Mr Z was admitted to the L&D on two occasions in this period. Firstly on the 22nd October for one day's duration due to worsening knee pain, and secondly on the 11th November owing to a further increase in pain. On this occasion Mr. Z remained in hospital for 15 days and was subsequently discharged home on the 26th November.
- 7.1.5 The October admission noted that Mr Z was waiting for knee surgery, had previously had knee and hip replacements, and noted the Prostate cancer and a grade 2 pressure ulcer¹ on his buttocks. Mr Z was treated by an Orthopaedic Consultant who diagnosed an exacerbation of pain due to knee degeneration, and seen by the Urology team for his cancer who noted an increase to his prostate specific antigen (PSA) reading. He was also assessed by an Occupational therapist who noted an improvement in pain management post admission. Mr Z was discharged home with a reassessed care package which continued his existing domiciliary provision and his family had been informed about his care whilst in hospital.
- 7.1.6 During his November admission, Mr Z received treatment from the Orthopaedic team, Urology team and the Occupational Therapist. A discussion took place between Orthopaedics and Urology with hormone therapy being agreed to be commenced on the 12th of November. A specialist Urology Macmillan Nurse reviewed Mr Z on the 13th November and noted that as he was already subject to hormone therapy the latest treatment wasn't required, and advised Mr Z that his enhanced pain may be due to his prostate cancer. Mr Z was tearful and in a low mood and expressed that he didn't feel he was being kept up to date and that he wanted to ensure his wife was updated too. This was relayed to the ward and a family discussion took place later that day but there is no record as to what extent Mr Z was aware of the advancement of his cancer and there was no information recorded concerning consideration for palliative care.
- 7.1.7 Later that day a CT scan indicated that Mr Z's cancer had spread to his bones and his PSA had risen. The ward had some discussion with him and his wife about this but it is not clear from records how much the family were told and if they understood the seriousness of Mr Z's condition at this time which in reality was a poor prognostic diagnosis; but they were told that Mr Z's case was due to be discussed at a multi-disciplinary Team meeting (MDT) to optimise management and treatment.

¹ Pressure Ulcers range in severity from grade 1 (superficial), to grade 4 (full thickness tissue loss with bone or tendon exposure) NHS grading chart available at: <http://nhs.stopthepressure.co.uk/docs/PU-Grading-Chart.pdf>

- 7.1.8 On the 14th November, Mr Z was diagnosed with a Pulmonary Embolism and began treatment with daily injections of Tinzaparin to thin his blood and dissolve the clot. Mr Z's family were informed and on the 20th November further advised that a knee operation was now too risky because of the increased risk factors but that it would be reviewed in six weeks time.
- 7.1.9 On the ward, MR Z was assessed by the Occupational Therapist on the 12th November where it was noted that he had not mobilised in months, and again on the 17th where an improvement in mobility was noted. The therapist recorded that Mr Z would require an increase in care package once discharged home.
- 7.1.10 Prior to discharge on the 26th November, Mr Z's care package was reviewed by the Social Work team and his existing Domiciliary Care was to continue at home. Mr Z did not wish to have this extended and he had full capacity to make the decision. He was reviewed by the Orthopaedics Team and Occupational Therapist who assessed him as suitable for discharge; and reviewed by the Urology team who recorded the intention of arranging a follow up outpatient appointment, although the date had not been set at this time.
- 7.1.11 Overall through this admission phase, there is evidence of the family being regularly updated with information but it isn't clear if they were able to understand the full extent of Mr Z's illness at this time. An overarching care plan was not put in place and he was not discussed at a MDT meeting prior to discharge as expected, although he was discussed at a MDT on the 2nd December post discharge, and seen again at Oncology clinic on the 6th December. There is no record that professionals considered Mr Z's potential for palliative care and/or a 'Continuing Health Care', (CHC), checklist during this phase

7.2 Discharge Planning from hospital to Greenacres Care Home in late December 2014 - December 11th to December 24th 2014.

- 7.2.1 Mr Z was admitted to the L&D on the 11th December for increased abdominal pain and diarrhoea, and remained until discharge on the 24th December to the 'Step Up Step Down' unit at Greenacres from where he did not return home again. It was noted that Mr Z had a grade 4 pressure ulcer due to sleeping in his chair and not being mobile, and this was assessed by a specialist Tissue Viability Nurse on the 15th December.
- 7.2.2 During this admission, Mr Z's Surgical Consultant requested a CT scan on the 13th of December which showed that his cancer had potentially spread to his bones. He was seen in Oncology on the 13th and reviewed by Acute Oncology on the 15th which indicated that there may also be spinal compression requiring a MRI scan. On the 17th December, the Surgical Consultant considered Mr Z to be medically fit for discharge with further investigations to be continued by Oncology and in response, on the 17th December, the specialist Oncology team at Mount Vernon stated that Mr Z must not be discharged because he needed an MRI to confirm the spinal compression. The ward examined Mr Z's spinal compression and found the findings to be normal and dismissed suggested treatment. This prompted an e-mail from Mount Vernon on the 18th December categorically stating that Mr Z should not be discharged and needs an urgent MRI. The MRI was then undertaken which confirmed the spinal cord compression along with numerous Vertebral Metastasis; a firm indicator of a poor and worsening prognosis requiring palliative emergency treatment in the form of radiotherapy to prevent paralysis, and this commenced the same day.
- 7.2.3 The hospital social work team were responsible for collating and assessing Mr Z's overall care needs in preparation for discharge and they commenced this on the 12th

December. The unclear situation regarding Mr Z's suitability for discharge required the Social Worker to query suitability for discharge three times. On the 17th December, Mr Z told the Social Worker that he did not feel ready to go home because he was concerned about his level of pain and needed to rebuild his strength. In response the Social Worker considered respite care as an option and the hospital Discharge Officer considered Mr Z's suitability for a NHS funded rehabilitation bed, which would include physiotherapy, but on the 18th December, found that a rehabilitation bed was not suitable because Mr Z was not mobile enough.

7.2.4 The Social Worker then commenced an assessment of suitability for Mr Z to attend an alternative placement, this being a 'Step Up Step Down'² unit, based within Greenacres care home. From information available, the assessment was completed on the 22nd December and forwarded to Greenacres for them to make the decision as to suitability for a placement in the unit. Mr and Mrs Z agreed with this placement because he wasn't ready to go home and needed rebuilding, with his wife explaining that at home he was 'hard to manage'. The Social Work assessment reflecting the family's wishes was sent to Greenacres supported by a 'Part 5'³ report completed by a senior Occupational Therapist which outlined Mr Z's health issues in detail, including the metastatic nature of his cancer at that time, and provided an opinion that he could improve mobility with a frame; an opinion supported by two further physiotherapist assessments. Greenacres accepted Mr Z and he was discharged to the 'Step UP, Step Down' unit on the 24th December. However, an overarching care plan had not been put in place across practitioners to inform the assessment and records show that there had been no consideration for palliative care or a 'Continuing Health Care', (CHC), checklist which may have provided an option to return home with added community support, or to receive a more suitable nursing placement given his poor realistic prognosis.

7.2.5 Having been discharged, Mr Z was seen at Greenacres on the 24th December by the Community Nurse and care plans set up for catheter changes, daily Tinzaparin injection, and wound care for a grade 2 pressure ulcer. Mr Z was assessed as being at point 14 on the 'Waterlow Scale'⁴ at this time but pressure relieving equipment was not in place for him post discharge and nor was it considered by Greenacres or the Community Nurses on admission to them.

7.2.6 During this admission, overall there are no records that ward staff, or Oncology, spoke to the family about Mr Z's worsening condition. Discussions happened between the social worker and Mr Z in relation to his care needs but there is no record that the seriousness of Mr Z's condition was discussed with the family by any professional. The family had been expecting a potential knee operation and expecting his return home after respite and so there was no obvious reason for them to suspect the reality of Mr Z's prognosis at this time.

7.3 Re-admission to hospital - 29th to 31st December 2014

7.3.1 On the 29th December at Greenacres the Occupational Therapist (OT), noticed a rectal bleed whilst assisting Mr Z to toilet. The ambulance was called and Mr Z admitted back to the L&D for a fourth time. Ambulance records indicate they noted an extensive bleed

² Greenacre is the location for the 'Step Up Step Down' residential reablement service. This service has 8 places and provides older people who normally live in the community with intensive support in a residential setting for a period of up to six weeks either to prevent them being admitted to hospital ('step up') or to enable them to return home after a hospital stay ('step down').

³ Specialist assessment form

⁴ Waterlow Scale is an indicator of how much at risk a person is from pressure ulcers.

and noted that it had occurred two days previously, but it is not known if Greenacres staff had been aware. On admission, a grade 3 pressure ulcer and moisture lesions were noted, a clear deterioration from discharge previously. Two further bleeds occurred during admission and were diagnosed as having been caused by the Tinzaparin injections. There is no record that side effects had been anticipated or planned for.

- 7.3.2 On the 31st December the Hospital Discharge Officer noted that Mr Z wanted to return to Greenacres and notified the hospital social work team of Mr Z's admission and requested a reassessment of care needs. This was the first time the Social Worker was notified of Mr Z's readmission and his assessment for discharge was commenced. The Social Worker noted the hospital had made a Safeguarding Alert due to Mr Z's presenting pressure ulcer, and established that the alert was concluded as not requiring further investigation because the ulcer was assessed as being suitably treated at Greenacres under the care of the Community Nurses. Greenacres were able to accept Mr Z back to their care and he was discharged back to the 'Step Up, Step Down' unit on the 31st December, and his wife informed.
- 7.3.3 There were no recorded discussions with family during this admission phase or consideration of an overarching care plan to manage further complications or deterioration in the future.

7.4 Events leading to re-admission to hospital on the 18th January 2015

- 7.4.1 On the 1st January 2015, Mr Z was seen by the Community Nurse at Greenacres and a full holistic assessment undertaken. It was noted that he had a grade 3 sacral ulcer and an additional grade 1 ulcer to his elbow. His Waterlow scale was assessed at 24 and in response the nurse ordered a specialist pressure relieving mattress because one had not been arranged prior to either discharges from hospital. Community nurses continued to visit daily for injections and pressure ulcer care until he left Greenacres, but no family discussions, further interventions, or consideration for palliative care, (a core role for Community Nurses), are recorded.
- 7.4.2 On the 2nd January 2015 Mr Z was assessed by the Occupational Therapist (OT), with his wife and daughter present. Symptoms discussed included: bowel bleeding; prostate cancer which had spread to his bones requiring radiotherapy; and restricted knee flexion for which his wife reported the wait for a knee operation. The objective for therapy was to improve Mr Z's mobility and increase his independence with toilet transfers, so that he could return home with support from a suitable care package. Again, there is no record of discussion about alternative potential palliative care with the family.
- 7.4.3 Between the 5th and the 9th January, the OT saw Mr Z regularly and it was noted that there was an improvement in mobility, with Mr Z managing a frame and some exercise on a pedal cycle, but that he was easily out of breath and had knee pain. On the 5th January, a routine MDT meeting was held with Social Care, (who were linking in to support re-ablement goals), where the OT advised that Mr Z would require an enhanced care package when returning home. Concerns were raised that he was not progressing and a referral was made on the 6th January to the Leighton and Buzzard Older Persons Team and a Social Worker allocated to reassess Mr Z's care needs.
- 7.4.4 On the 7th January, the OT noted that Mr Z had a persistent cough, as did his family and this was reported to Greenacres staff in the unit. The OT notified the social worker that Mr Z needed assistance with all personal care tasks, transfers and mobility, and a meeting was agreed to be held on the 15th January with Mr Z and his family to progress support. It is noted from records that Mr Z's pressure relieving mattress was delivered to Greenacres on the 7th but there is no record as to subsequent use available.

- 7.4.5 The review has established that an Out of Hours GP visited Mr Z on the 8th January but there is no record of that visit on GP systems or further information available. It has also been established that Mr Z had not been registered for a local GP whilst resident at Greenacres.
- 7.4.6 On the 9th January, Mr Z felt unwell but managed 3 to 4 meters with a frame and 4 lengths on the parallel bars. The OT saw Mr Z again on the 12th January after a weekend break and Mr Z reported being very tired and chesty. It was noted by the OT that Mr Z had persistent coughing; his transfers were steady but slow; and he had reduced mobility.
- 7.4.7 Mr Z attended an Oncology appointment on the 13th January where he reported being 'miserable' at Greenacres, but there is no record of any discussions or consideration for alternative options in a different environment.⁵
- 7.4.8 On the 14th January the social worker received a call from Mr Z's family expressing concerns about Mr Z's care at Greenacres and they also raised the possibility that Mr Z may have had a stroke with staff at Greenacres, but no action is recorded as having been taken.
- 7.4.9 On the 15th January an evening MDT was held with the social worker, the OT and family but without a representative from the 'Step Up, Step Down' unit as the Team Leader was not available. Mr Z's spinal compression was noted and as he had deteriorated over the last three days, it was agreed that his needs could not be met at the unit and a nursing placement was necessary. The family were very distressed and upset at this meeting and reported Mr Z sleeping in a chair as unable to get to bed and coughing loudly, but that a GP had not been called when requested. The social worker ensured Mr Z was not left in a chair by arranging the use of a reclining chair that he had been more used to at home, and escalated the family's concerns to a line manager the following day to ensure they were actioned but didn't immediately raise a safeguarding alert because the family and Mr Z specifically asked them to wait until he had left due to feeling intimidated at the home.
- 7.4.10 The review has established that an Out of Hours GP saw Mr Z on the 15th January but again there are no records of that visit recorded on GP systems.
- 7.4.11 On the 16th January the OT noted that Mr Z had been deteriorating and sleeping much. The OT could not wake him and alerted the Team Leader in the unit who reported that Mr Z had commenced a course of antibiotics the previous day and although did manage to wake him, Mr Z did not respond. The OT expected a GP to be called, but records show that a GP was not called.
- 7.4.12 On the 16th January, following receipt of a report from Mr Z's Oncology visit on the 13th January, Mr Z's original GP from his home address telephoned Mr Z at his family home but was not able to get a reply. Mr Z's GP had not been directly informed that he was now resident at Greenacres and records show that an alternative GP had not been registered for Mr Z which should have been the practice at the unit.
- 7.4.13 On the 18th January, Mr Z's daughter insisted that Greenacres called the Out of Hours GP due to concerns her Father had suffered a stroke. In consequence, an ambulance attended Greenacres but could not gain access for 5 to 10 minutes. Mr Z was found to

⁵ Awaiting further info from the L&D re Oncology involvement

be FAST⁶ positive and admitted to L&D hospital where he was found to be very unwell and suffering chest pain.

7.4.14 Mr Z very sadly deteriorated further and died on the 21st January 2015. The cause of death is recorded as Pneumonia and Prostate Cancer with spinal cord compression. During this last admission, Mr Z and his family did receive appropriate end of life care and his family were involved in decision making.

7.5 Safeguarding Alerts January to July 2015

- 7.5.1 The first safeguarding alert was raised by the L&D on the 29th December due to the presenting grade 3 pressure ulcer and Mr Z had said that his bedroom door was closed at night inappropriately. The alert was reviewed by the Safeguarding Team who concluded that no further investigation was required because the pressure wound was being suitably treated at Greenacres by the community nurses.
- 7.5.2 The second alert was raised by the East of England Ambulance Trust on the 18th January after Mr Z reported he had woken that morning with weakness to his left side but the staff at Greenacres would not listen. His family had visited and being very concerned had insisted on assistance. Mr Z also stated that his water jug was not topped up and the family relayed that Mr Z had been taken to hospital appointments in just a tee shirt despite him having a chest infection. The Ambulance was also concerned about Mr Z's pressure ulcer.
- 7.5.3 On the 20th January, CQC received third party information regarding Mr Z's care at Greenacres. They raised a safeguarding alert on the 22nd January and undertook a comprehensive inspection of Greenacres between the 23rd and 30th January, identifying serious neglectful practices by staff and management, some of which were directly witnessed by CQC. Following the inspection, they issued a general safeguarding alert to Central Bedfordshire Council due to the poor standards of care identified generally, but at that time they had no legal powers to directly investigate the care of Mr Z specifically.⁷
- 7.5.4 The Leighton and Buzzard Older Persons Team allocated the safeguarding alert to the lead social worker involved with Mr Z's family and who had attended the MDT on the 15th January at Greenacres. On the 21st January, the lead social worker contacted the L&D and learnt that Mr Z had died and on the 22nd January, visited Greenacres and established that records at Greenacres had been inadequately kept and lacked relevant information, and also that the nursing records had been removed. The family were visited on the 23rd January and provided the opportunity to voice their concerns about Mr Z's care.
- 7.5.5 A strategy discussion took place on the 28th January and investigative actions agreed. An initial case conference was planned for the 11th February but this was delayed until the 16th February because of the difficulty in attendance by agencies. The subsequent case conference evidenced many concerns and actions were agreed to be undertaken and completed for a further case conference to be held on the 17th March.
- 7.5.6 The case conference was held on the 17th March and the investigation was substantiated. However, the investigation has been found to be inadequate, with many actions not having been completed, and pertinent agencies not represented. In particular, although the concerns raised by Mr Z's family on the 23rd January were

⁶ FAST – an indicator test of likely stroke symptoms

⁷ In April 2015, legislation changed which now places the prosecution of individual cases where there was avoidable harm within the regulatory framework of CQC.

provided to the conference on the 16th February, there was no internal investigation into those specific concerns within the overall investigation. In addition, a risk protection plan was not put in place for Greenacres because it was felt that it was no longer required due to Mr Z having died; thereby leaving other residents potentially at risk.

7.5.7 Following the case conference on the 17th March, the Greenacres Home Manager was suspended. Following a series of monthly performance monitoring meetings in February and March a 'Serious Concerns'⁸ process was instigated. A formal meeting was held on 22nd April 2015 between the Head of Safeguarding for the local authority, Head of Contracts, Assistant Director of Commissioning and CQC. An action plan was instigated and shared with staff and customers and family members spoken to and their views incorporated.

7.5.8 The raised action plan included work to address issues pertinent to Mr Z's care; namely the assessment undertaken prior to admission; general attitude and recruitment of staff; how to recognise signs of a stroke; and the obtaining of medical care when needed. It concluded that care fell short of the standard required and formal meetings continued monthly until it was felt that sufficient improvements had been made and the action plan could be lifted, which occurred in July 2015.

8 The voice of Mr Z's family

8.1 Mr Z's wife and two daughters had an opportunity to speak to the review Chair on the 1st March 2016. They outlined what they felt had gone well for them; what did not go so well; and how they felt services could improve.

8.2 In terms of what went well, the family outlined that;

- They were impressed with their initial domiciliary care package and visits between August and November because it eased some pressure and they found the carer to be empathetic and very good.
- They were happy that the L&D moved Mr Z from a side ward, where he didn't wish to be, to a main ward.
- The Occupational Therapist was very good at Greenacres and identified that Mr Z needed a different bed and he was realistic in what Mr Z could achieve.
- Their family GP was very good and accessible.
- The lead social worker allocated to them at Greenacres was really good; making it clear she was available to them at any time; providing clarity; and seemed to understand their situation.
- The Paramedics who attended on the 18th were amazing and really made Mr Z feel at ease.
- The stroke admission at the L&D was lovely and provided dignity.

8.3 What was not so good:

- When at home, the family did not know who to go to for advice about matters such as how to get a more appropriate bed for Mr Z.
- It would have been helpful to know if there was any opportunity for respite care to have been available together with his wife.
- They were concerned that the hospital was telling Mr Z more than they were telling his family.
- The family were not clear about Mr Z's prognosis. They agreed that Greenacres

⁸ Brief outline of role and purpose, hierarchy etc

would be good to build up Mr Z but it was unrealistic to have expected Mr Z to care for himself e.g., he was expected to wash himself with a flannel when he had not done so for two years at home.

- The family do not feel they were involved with the hospital assessment in December. They did not understand the full extent of his terminal condition or they would not have opted for Greenacres but instead ensured he died at home.
- The family do not know the outcome of the safeguarding investigations and don't know what has happened about Greenacres. It is their wish to understand that change has taken place and that it's a better place to be.

8.4 Specifically in relation to Greenacres:

- Whilst Mr Z had a chest infection he was sent to hospital wearing only a tee shirt.
- Mr Z was left without water to drink.
- He had an eye infection that was not treated and requests for a GP were ignored.
- On Christmas morning when the family visited at 10am, Mr Z was not ready and was wearing only a grubby tee shirt.
- On telephoning Greenacres there would often be no reply.

8.5 How could services improve?

- Families should be more involved in assessment and discharge planning and be informed about treatment that is planned ahead. In Mr Z's case, the family outlined that they learnt suddenly after discharge that Mr Z was due to undergo five bouts of radiotherapy that they weren't prepared for.
- Families should be fully informed as to prognosis. In Mr Z's case they had been told about the differing issues, such as back pain and knee pain, but they weren't aware of the overall terminal nature of his illness.
- Record keeping should be clear and accurate. In this case, Mr Z's family are aware that a letter sent from the L&D outlined that the neurology team had believed Oncology had had full discussions with the family, but they hadn't.

8.6 Mr Z's family have been offered the opportunity to go through the conclusions and recommendations of this report with the lead reviewer at the end of the review.

9 Analysis by theme

9.1 The analysis section of the review will consider the information above, which was gained from Agency Reports and Learning Event, thematically. All analysis leads to lessons that need to be learned from this review. The themes to be addressed are:

- Identification of suitability for 'End of Life' Palliative Care
- Suitability for placement in the 'Step Up, Step Down' facility
- Multi-agency Communication, Decision Making and Teamwork
- Family Involvement in Decision Making
- The wider picture at Greenacres including Safeguarding Alerts

9.2 At the end of each section of analysis the lesson learned will be stated, along with a recommendation where required. These will be reiterated in the specific sections towards the end of the report.

9.3 Identification of suitability for 'End of Life' Palliative Care

- 9.3.1 The Bedfordshire Clinical Commissioning Group provides advice and guidance to professionals in support of management of end of life care through their 'Partnership for Excellence in Palliative Support Coordination Centre' (PEPS) approach.⁹ Where identified, a palliative care package can be provided and potentially also a 'Continuing Health Care Package', (CHC)¹⁰, which removes costs from the patient and families. Good practice for accessing end of life care, as outlined in the PEP's approach and the National Institute for Clinical Excellence (NICE), Gold Standards guidance¹¹ is that a patient may receive end of life care within the final 12 months of life where there is no cure available, an identified terminal diagnosis or a degenerative illness from which it is unlikely the patient will survive for 12 months. There is not, however, a definitive specific assessment of palliative or end of life need generally, it being a subjective process relying on professionals to assess and trigger the need and have discussions with the patients or families as to treatment options and wishes.
- 9.3.2 In Mr Z's case, the need for palliative care had not been formally identified, which given his poor realistic prognosis and the fact that he could not be cured and may reasonably be expected to deteriorate within 12 months, he should have been provided with. The fact that he received an emergency palliative treatment in the form of radiotherapy was a key indicator but there is no evidence that professionals recognised this. In consequence, Mr Z did not receive consideration for on-going palliative care or consideration of a CHC assessment at any point. This review will analyse if there were opportunities for Mr Z to have been assessed as suitable for palliative and/or end of life care in advance of his final admission to the L&D on the 18th January 2015.
- 9.3.3 Mr Z's malignant cancer was known about from 2007 but it wasn't until he was admitted to the L&D in November 2014 that a scan showed that his cancer may have spread. During that admission, Mr Z was further diagnosed with a pulmonary embolus and in response Mr Z was seen by the ward Orthopaedic team, Oncology (including a Urology Macmillan nurse), the OT and assessed by the hospital social work team for his future care needs. All conditions were being managed as presented but without information known to his GP, (as recorded on System One), being considered, i.e., Mr Z's existing co-morbid conditions of Diabetes Mellitus, Hypertension and arthritis, or the information contained within his vulnerable adult care plan. Unfortunately a planned MDT did not go ahead during the November admission which could have provided a wider discussion and opportunity for Mr Z's palliative needs to have been identified at an early point and an overarching plan to be considered and put in place to manage Mr Z's holistic clinical needs and assist with discharge planning.
- 9.3.4 What was known without the benefit of a MDT, was that Mr Z's cancer had spread, he had developed a pulmonary embolus, he was physically struggling, he had not been mobile for a long time and he was in a great deal of pain with the specialist nurse noting that his increased pain may be due to his cancer spreading. During the review Learning Event, professionals assessed that Mr Z had been in a serious condition at this point and unlikely to be cured. However, there were differing opinions as to whether Mr Z was suitable for end of life care at that time owing to differing professional perspectives and understanding of the thresholds and triggers to instigating palliative care. A key factor is that there had been no formally recorded medical need for palliative care to

⁹ [http://www.gpref.bedfordshire.nhs.uk/referrals/speciality/palliative-care/partnership-for-excellence-in-palliative-support-coordination-centre-\(peps\).aspx](http://www.gpref.bedfordshire.nhs.uk/referrals/speciality/palliative-care/partnership-for-excellence-in-palliative-support-coordination-centre-(peps).aspx)

¹⁰ <http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/nhs-continuing-care.aspx> This is not automatic; to be eligible a patient must be professionally assessed as having a 'primary health need'.

¹¹ <https://www.nice.org.uk/guidance/QS13>

commence and there was no indication to professionals that Mr Z may die imminently. All agreed that a decision to commence palliative care is subjective and without the need for a palliative plan being formally put in place, not easily triggered by individual professionals.

- 9.3.5 Following discharge back home and before Mr Z's next hospital admission on the 11th December, Mr Z was seen in the community by his GP, an Out of Hours GP, Community Nurses and a Community Complex Care Matron who updated the vulnerable adult care plan. The GP records show that Mr Z's cancer had spread and records indicate a good exchange of information between the surgery, out of hours GP and the nurses, but there is no record that Mr Z's advancing condition was discussed directly with him or his family, and this was a missed opportunity for the family to understand the seriousness of Mr Z's illness whilst managing at home. In addition, practitioners at the learning event felt that the GP could have considered a referral to a Specialist Palliative Care Macmillan nurse at this point.
- 9.3.6 A key indicator of Mr Z's incurable cancer was in the L&D on December 18th after an MRI scan showed clear vertebral metastasis with a spread to his bones and spinal compression requiring emergency palliative treatment. This is accepted to be a palliative condition with a very poor prognosis, but again there is no record that on-going palliative care was identified and no overarching future care plan considered at this point, which impacted on the assessment for Mr Z's future care needs and the family's choices for future care. The reasons for a lack of identification of palliative need appear to be because Mr Z was being managed for different elements of his illness and needs, as presented, by different professionals and there were no joint discussions undertaken to provide an overall strategy, nor was there a clear single individual with overall responsibility to do so. This situation is highlighted with the differing approaches to Mr Z's need for an MRI scan and the confusion that caused the social worker in relation to suitability for discharge. An MDT meeting whilst on the ward in December may have assisted this but one was not planned or convened. Interestingly, at the Learning Event, hospital staff were confident that had an MDT taken place in the November, palliative care would have been considered and put in place. However, an Oncology MDT did take place on the 2nd December and there is no record that on-going palliative care was considered and no on-going plan put in place that fed into the subsequent December admission.
- 9.3.7 Professionals at the Learning Event agreed that Mr Z had been very seriously ill in December, with a GP perspective that he had months or weeks to live because bone metastasis is not curable and an observation that Mr Z had been deteriorating at each hospital admission. Spinal cord compression also yielded a very poor prognosis and there was agreement that skin ulcers are also an indicator of deterioration. Again though, there are differing opinions as to thresholds for palliative care and whether he was eligible for consideration even at this point. Some felt that he was and that this should have happened whereas some felt that the thresholds for eligibility for a CHC checklist are the marker to receive services. Another viewpoint was that, in hindsight, Mr Z's presenting symptoms met the threshold as a 'Primary Health Need'¹² and as such should have been considered for a CHC checklist by individuals regardless of whether a palliative plan was in place or not. Overall, it was agreed that a significant requirement for a trigger to commence palliative or end of life provision is the need for a formal identification to be recorded and shared, and that without this it is a subjective view and although everyone acknowledges their responsibility to discuss future care with Mr Z and his family, the need to do so is not easily identifiable by individual professionals without a specific future plan being in place. This varying approach to thresholds, together with a lack of any formal identification of palliative need, is a significant barrier to longer term

¹² Threshold requirement for consideration of a CHC package

end of life care being instigated in advance of a critical situation. The consequences of being admitted to the 'Step Up, Step Down' unit without a palliative plan or holistic 'Advanced Care Plan' that encompassed family wishes, impacted directly on Mr Z's health and wellbeing whilst resident at Greenacres and prevented the family having an opportunity to contribute to decisions regarding where Mr Z received future care, including a request not to return to hospital for treatment, or to receive resuscitation, if that was their wish.

- 9.3.8 Mr Z went to Greenacres on Christmas Eve and returned to the L&D on the 29th December as a result of his Tinzaparin medication causing rectal bleeds. His bed ulcer was a problem, now being categorised as a grade 3 pressure ulcer (deteriorated from a category 2), and an appropriate safeguarding alert made. However, there is no record of any consideration for future general care, including the need for vigilance with deteriorating symptoms or potential for palliative care, being considered at this point either. The L&D explained at the Learning Event that a presentation for rectal bleeds could be seen as a new condition due to existing medications and not easily recognisable as an end of life stage, highlighting the need for an advanced care plan that seeks to identify deterioration and likely future medical and care needs.
- 9.3.9 The social worker was made aware of Mr Z's admission once ready for discharge on New Year's Eve in order to conduct an assessment of need on discharge. The ward stated that Mr Z wanted to return to Greenacres and as they could accommodate him, he went back there. This was an undoubted late referral to the social work team and again there had been no formal identification of the need for palliative care to inform and alert the assessment despite the added concerns for Mr Z's health from the bleeds, and deterioration of, and concern for, his pressure ulcer. This should have been an opportunity for discussion with Mr Z and his family and an opportunity to consider Mr Z's need for pressure relieving equipment.
- 9.3.10 Whilst at Greenacres, Mr Z attended an Oncology appointment on the 13th January in which it is recorded that he told staff that he was 'miserable' at Greenacres and it was noted he had deteriorated. This was an opportunity for Mr Z's care to have been directly discussed which may have triggered a palliative care package but sadly, a routine update letter was addressed to Mr Z's previous GP, due to Mr Z not having been re-registered at Greenacres, and the information from Oncology was not able to contribute to the work being undertaken by the team at Greenacres. It is not clear to what extent Oncology assessed Mr Z's condition to be terminal and/or their expectation of the role of his GP to instigate any palliative processes on receipt of their letter, but it is clear that Oncology did not actively contribute to wider palliative care.
- 9.3.11 Whilst at Greenacres, Mr Z deteriorated in health steadily. The purpose of his stay was to build his strength and increase his mobility so that he could return home and this was the focus of the home's interventions. The 'Step Up, Step Down' unit at Greenacres did not plan for a palliative condition because although metastasis was recorded on the OT 'Part 5' form, and spinal cord compression noted on the referral, this had not been adequately assessed by them or the need for palliative care identified by the social work assessment. Concerns were raised about Mr Z's health and welfare by the OT and family and there were two MDT meetings held on the 5th and 15th January. Whilst these meetings were routine and good practice, they were inadequate to meet Mr Z's needs because no medical assessments were considered, either from a GP or Oncology. This may have been hindered by the fact that Mr Z now lived away from his registered GP, who had received the Oncology update but been unable to support him and Greenacres not re-registering him for a local GP, but his medical background and current clinical condition was lost to the discussions. Whilst it is noted that Mr Z received two visits from out of hours GP's to treat individual complaints of persistent coughing for which he received anti-biotics, these were provided in isolation of an overarching care plan and did not result in a contribution to the team at Greenacres or an assessment for

palliative care. The out of hours GP service did not communicate their consultations to Mr Z's GP, which had they done so, would have alerted the GP to the fact that Mr Z was resident at Greenacres with an increasing need for medical intervention, and could have prompted a reminder to the home of their duty to re- register with a local GP.

9.3.12 Mr Z received daily care from the community nurses at Greenacres but they were working to their own care plan based on the hospital discharge notification and their holistic assessment but because the discharge notification did not record a palliative plan or note that Mr Z was near to the end of his life, the nurses did not consider an assessment for palliative care need or apply vigilance in noting deterioration. Community Nurses have a core role to manage palliative need and they were aware of the spinal cord compression and therefore this was a missed opportunity for a palliative assessment. Following the MDT on the 15th January, a Nursing home placement was considered as an alternative to Greenacres and this would have greatly helped Mr Z, but overall whilst at Greenacres and observed to be deteriorating, palliative care should have been considered as an option. The lack of a formal palliative plan and/or near end of life diagnosis was a factor in preventing this due to no trigger being available for professionals, and which without, left the need for palliative care as a subjective decision by individuals who without that prompt simply did not consider it as an option, even at this late stage when deterioration was apparent.

9.3.13 On his final admission to the L&D on the 18th January, it was obvious to hospital staff that Mr Z had deteriorated considerably and at this point, discussions were had with his family in line with NHS England's five priorities for care¹³.

9.3.14 **Lesson 1**

End of life palliative care for Mr Z was not routinely considered by professionals because there had been no formally recorded palliative need to prompt professionals to consider them and nor were professionals vigilant in on-going assessment of deterioration.

9.3.15 **Lesson 2**

Professionals in this case believe the need for palliative thresholds to be subjective and have different perspectives for when to consider palliative care, or commence a CHC checklist. There was a lack of awareness that palliative care may be appropriate within the last 12 months of life where there is no cure and not just when end of life is imminent.

9.3.16 **Recommendation 1:**

Central Bedfordshire Safeguarding Adults Board should assure itself that there is multi-agency training and awareness raising in relation to national and local guidance on end of life care and associated palliative care and CHC checklist criteria.

9.4 Suitability for placement in the 'Step Up, Step Down' facility.

¹³NHS England *Five priorities for care*¹³

Experts have agreed that there are five important priorities for the care and support that you and your carers can expect to receive in the last few days and hours of life.

- 1. You should be seen by a doctor regularly and if they believe you will die very soon, they must explain this to you and the people close to you.*
- 2. The staff involved in your care should talk sensitively and honestly to you and the people close to you.*
- 3. You and the people close to you should be involved in decisions about how you are treated and cared for, if this is what you want.*
- 4. The needs of your family and other people close to you should be met as far as possible.*
- 5. An individual plan of care should be agreed with you and delivered with compassion.*

- 9.4.1 Mr Z had been assessed for suitability to attend a 'Step Up, Step Down' facility at Greenacres as an alternative to going home on discharge from the L&D on the 24th December 2014. At that point, Mr Z and his family did not feel they could cope with Mr Z at home and they asked that he be able to build up his strength before returning home. Also, the family expressed reluctance to spend more money on an extended care package which they felt did not meet their needs. Mr Z had full capacity to make that decision and the social work team assessing his needs showed that he had been listened to by seeking an intermediate care placement for him.
- 9.4.2 In support of the social work decision to consider the unit at Greenacres, the OT's on the ward were aware of Mr Z's metastasis but all agreed that he was suitable for physical rehabilitation and could improve his strength and mobility; and their Part 5 report recorded this. Professionals at the Learning Day also agree that an OT can make those decisions and even when an individual is terminally ill, it can be appropriate to set those goals. However in Mr Z's case, this review will consider if this was an appropriate choice for Mr Z given the overall reality of his physical situation and poor prognosis at that time and if the assessments that supported the move were sufficiently thorough.
- 9.4.3 Fundamentally, the assessment of suitability for Greenacres was flawed by the lack of identification of the need for palliative care being recorded prior to discharge and a lack of discussion between professionals about the reality of Mr Z's clinical needs, his future needs and his potential for rapid deterioration. Without this information the social work assessment did not consider palliative care, or a CHC assessment and possible care package, as an alternative option and this reduced the options the social worker did have, especially as the Discharge Nurse had stated that a nursing option with physiotherapy was not possible because Mr Z was not mobile enough. This, on the face of it, left the choice of going home or to the unit at Greenacres to build up his strength and given the family's wishes, the social worker felt there was no option but to refer to Greenacres.
- 9.4.4 The purpose of the 'Step Up, Step Down' unit was to reach goals aimed at greater mobility and so is an obvious choice in these circumstances and Mr Z did show some improvement in mobility. He was also able to receive help with pain relief and management of his bed ulcers whilst resident, but the unit it is not a nursing bed option and the reality of such a placement is that Mr Z would be expected to wash himself and move between bed and wheelchair by himself. It is important to note the unit is sited within Greenacres care home but is a separate facility with its own Team Leader and it does not provide the nursing care available in a different section of the building. Mr Z's physical abilities were not adequately assessed during the assessment for suitability and so consequently, Mr Z, who had not washed himself or been mobile for a considerable time, was not able to perform these tasks and this caused him and his family anxiety. And although he did improve his mobility, he was very ill at the time with multiple conditions and he became ill with a chest infection quite quickly. Therefore it is questionable how realistic his goals were at the time despite the good intentions. Unfortunately because Mr Z went to Greenacres without a palliative overlay, his interventions were aimed solely at increasing his mobility and this had a detrimental effect on his deteriorating illness whereas a palliative approach would have realistically assessed what he was capable of. Added to that was his need to attend Oncology appointments and undergo radiotherapy, the physical effects of which were not taken into consideration during the assessment of suitability either. A thorough assessment by the social work team would have looked more widely at Mr Z's condition and potential for deterioration and side effects from his treatments but it did not include consideration for his longer term medical conditions and so wasn't realistic for him, overall.

- 9.4.5 A further assessment was completed for Mr Z on New Year's Eve prior to discharge. Given his deterioration in illness with the rectal bleeds and increased pressure ulcers, this was an opportunity for direct planning between medical staff, community nursing and Greenacres to consider renewed goals. However, the social work team was only told of Mr Z's admission once he was declared medically fit for discharge and there should have been more time available to complete it thoroughly. In particular, had a CHC checklist been considered this takes some days to complete. The social worker was aware of the safeguarding alert and made checks as to its conclusion and was aware that the hospital discharge officer had contacted Greenacres and knew they could accept him back. The Learning Event established that it is normal practice for a Discharge Officer to deal with a transfer from a care setting to another care setting and Mr Z had full capacity to request that he return to Greenacres. The role of the social work assessment is to review to see if needs have changed and to be sure that the existing service could still meet his needs. Having checked the safeguarding outcome it was felt that the pressure ulcer was being managed and therefore Mr Z was safe to return there and no changes were considered necessary to his discharge plan. In discussion at the learning event, the L&D expressed an opinion that no-one should be discharged if a safeguarding referral was in place or where a social work assessment was required, as in this case. Professionals agreed that a full assessment, because of the bank holidays, would not have been possible until well into the New Year and as such the L&D opinion was that MR Z should not have been discharged on New Year's Eve.
- 9.4.6 A hospital admission is intended as an acute phase and there is pressure on wards to discharge quickly to community services where possible. In addition to that, at the Learning and Recall Events, professionals expressed their concerns about a perceived pressure to discharge patients even more quickly over Christmas or New Year, especially during the winter of 2014/15 during the flu epidemic, and concerns were raised that this may have impacted on the quality of the assessment in this case.
- 9.4.7 Although the social worker referred Mr Z to the unit at Greenacres on both occasions, it was Greenacres responsibility to assess Mr Z's suitability for acceptance from the information provided to them. The Part 5 form clearly indicated metastasis of his cancer and other medical conditions such as spinal compression but this was not considered by them as part of their future care planning within the unit. As a result, they expected Mr Z to wash and dress himself when he wasn't able to and focused on mobility without consideration of his wider medical needs or consideration for renewed planning after he had been admitted to the L&D with the complications of rectal bleeds. They accepted Mr Z to their unit without understanding, or reviewing, exactly what his overall needs were, although this wasn't helped by Mr Z's overall medical needs not having been adequately assessed in the social workers assessment originally or again on New Year's Eve. The situation regarding Mr Z's medical condition whilst at Greenacres was compounded by the fact that they did not re-register him to a local GP and his own GP did not know where Mr Z was now residing.
- 9.4.8 It was established at the Learning Event that the social work assessments were conducted by paper without any direct discussion between the social worker, ward, nursing or the home and as such there was no jointly agreed approach. This situation was not helped by the lack of an Advanced Care Plan recorded on the notes prior to discharges. The social worker did show the discharge plan to the ward however and clarified that Mr Z was fit to be so discharged, but what was missing was an assessment which incorporated a clear plan between the hospital and the unit at Greenacres which assessed his immediate goals but also had realistic expectations suitable for his condition at the time.

9.4.9 **Lesson 3:**

The purpose of a 'Step Up, Step Down' unit was not fully understood by professionals and the assessment to place Mr Z at a 'Step Up, Step Down', unit was flawed due to not having a palliative overlay or sufficient shared information about his poor prognosis and potential to deteriorate and although well intentioned, was not a realistic one given his wider clinical issues and specific purpose of the unit.

9.4.10 **Lesson 4:**

The assessments were note based without any professional discussions having taken place and relied on the quality of record keeping. A lack of professional discussion prevented a jointly discussed holistic approach that may have better understood expectations and provided a more realistic goal, or placement, for Mr Z.

9.4.11 **Lesson 5:**

Mr Z's admission in late December was notified to the social work team just prior to discharge and not when first admitted and this impacted on the time the team had to prepare an assessment. There were also added pressures on the assessment from a discharge decision having already been made by the Discharge Officer and the pressure to discharge quickly that professionals perceive to be enhanced over the Christmas and New Year's Eve period.

9.4.12 **Recommendation 2:**

The Luton & Dunstable Hospital and hospital social work teams should undertake a joint review of the quality of discharge and care plans and report to the Central Bedfordshire Safeguarding Adults Board upon its completion.

9.5 Multi-agency Communication, Decision Making and Teamwork

9.5.1 Mr Z had complex medical and care needs requiring support from many different professionals. Whilst at home Mr Z received treatment from his GP, Community Nurses and Complex Care Matron. At the L&D, Mr Z was treated on the ward on four occasions, seen by the OT's and separately by Oncology. Throughout the scoping period Mr Z was also under assessment for his care needs by Social Care. Once he moved to Greenacres he received treatment from the Community Nurses, Oncology, the Out of Hours GP service, his OT's, Greenacres care home staff, and he remained under assessment by Social Care.

9.5.2 At home, Mr Z received care from his GP surgery for cancer, hyper-tension and arthritis, and this was well co-ordinated between the GP, Community Nursing and the Complex Community Care Matron which also provided a vulnerable adult's plan. At no point through pre-discharge or assessment planning was Mr Z's GP consulted which, given that the surgery had provided much support whilst in the community and was well placed to do so again in the future, was a missed opportunity for discussion with the GP that may have prompted a revised care plan in light of his deteriorating condition.

9.5.3 On his admissions to the L&D, Mr Z was reviewed and treated according to his presenting conditions, which for the October admission were pain management and appears straightforward. In the November admission, Mr Z's condition became more complex because his PSA had risen, a scan indicated a spread of his prostate cancer and he developed a pulmonary embolus. Prior to discharge a planned MDT did not take place which was a missed opportunity for a specific diagnosis and Advance Care Plan to be put in place; the impact of which prevented other professionals directly considering

palliative care albeit professionals have responsibilities to assess patients' on-going needs. An Oncology MDT did take place on the 2nd December but there is no record that advanced care was considered and notes were not shared or made available for the later admissions.

- 9.5.4 During Mr Z's December admission, there was a difference of opinion concerning Mr Z's treatment for spinal cord compression whereby the ward team did not agree with the specialist Oncology diagnosis and did not heed the advice and guidance provided by them. This resulted in a delay for a formal diagnosis of metastatic cancer and confirmed spinal cord compression requiring emergency palliative care for Mr Z and provided a very confused picture for the social worker and family. The Learning Event discussed this and the L&D opinion was that it is not uncommon to see differences in decision making and this can be confusing for families, but in this case, Oncology's advice had been sought and the MRI should have happened at the first opportunity. Such confusion could have been allayed by a MDT meeting and a clear plan of immediate need, underpinned by underlying issues, which would also have been an opportunity for an Advance Care Plan, together with a formal assessment of his clinical condition and associated palliative care needs.
- 9.5.5 On discharge from hospital, it is the responsibility of the hospital to ensure that all appropriate professionals managing Mr Z are informed and updated accordingly; in particular they are required to notify the GP and Community Nurses, and send a 'transfer of care' letter (separate to the social work assessment), to the unit at Greenacres. In this case, the ward sent discharge letters to Mr Z's GP after discharge appropriately; however they were lacking detail and after the December discharges failed to inform the GP that Mr Z had been transferred to Greenacres. Unfortunately Greenacres also failed to re-register Mr Z with a local GP and this caused a big gap in Mr Z's medical history being available. Due to the complexity of Mr Z's situation, practitioners at the Learning Event felt that the L&D could have considered a complex patient meeting prior to discharge on the 24th and/or the 31st December. This would have been an opportunity for future care needs to have been better understood and shared prior to discharge. Professionals at the Recall Event outlined the complexities of discharge decisions in that the Discharge Officer is not a trained medical professional and the L&D discharges patients across two different local authorities with differing policies and care pathways. This presents many different options for patient care at discharge and as such it is not a straightforward process but there was agreement that professional discussions would enhance the process.
- 9.5.6 The transfer of care letter to Greenacres raised the fact that Greenacres requested a pressure relieving mattress for Mr Z but this was not actioned and caused a delay in him receiving one. The community nurses upon accepting Mr Z back into their care should have also identified that pressure relieving equipment was required when they first assessed Mr Z and although they did so at their later assessment, Mr Z's pressure ulcer had deteriorated in that time. Practitioners at the Learning Event believe that this should have been actioned by the hospital district nurse but they weren't certain who should take responsibility for this. It was further discussed at the Recall Event where it was noted that the social work assessment should note the need for equipment and then co-ordinate the facilitation by the district nurses. CQC noted that all professionals have a responsibility to ensure specialist equipment is provided where needed and that legislation has since changed which provides a duty to prevent 'avoidable harm' and so enhances the need to ensure such equipment is considered.
- 9.5.7 A discharge notification was sent to the Community Nurses but was inadequate because it did not provide any future care planning, or identification of the need for palliative care. In consequence, the community nurses at the unit at Greenacres were not alerted

to look for signs of deterioration, although they do have responsibility to holistically review patients for themselves. The Community Nurses have access to System One, where trained and can access it, on which is held information known to the GP but this information was not sought by them in this case. On completing a holistic assessment on the 2nd January 2015, the nurses identified the high risk for pressure ulcers for which they ordered specialist pressure relieving equipment. This is the only intervention the nurses made; at the Learning Event they explained that they were managing a situation in which they had not been told of Mr Z's full prognosis or that he needed palliative care. Also, different nurses went in every day preventing a relationship being formed with Mr Z and his family. There were no discussions with Mr Z or his family about his condition and choices because it wasn't raised by the family and the nurses hadn't identified a need based on what they believed they were managing. This situation identifies why an advanced plan on discharge is so vital; the nurses are in a unique position to observe and assess Mr Z every day but in this case they were working in isolation and not part of a multi-agency team approach and they were not vigilant in seeking to identify deterioration and changing care needs.

- 9.5.8 In terms of accuracy of record keeping, the notification made to the community nurse's on the 31st December, indicated that Mr Z had been admitted and discharged on the same day. This indicates poor record keeping and if forwarded inaccurately to System One records, could result in community nurses not being aware of a patient's admission date and potentially miss a discharge; although in this case, the nurses appear to have received a discharge letter and notification of the move to Greenacres because they visited the next day. At the Recall Event, professionals stated that there is no definitive process for notifying admissions to social workers, they do so when the need to inform them is identified, as in this case for a pre-discharge assessment. On this occasion the social worker felt that the decision to discharge had been firmly made before their assessment and there was little requirement for them to conduct a longer assessment because 'he was going'.
- 9.5.9 Oncology continued Mr Z's care in January 2015. One important appointment was on the 13th January where they recorded him to be 'miserable' at Greenacres and noted deterioration. In response, Oncology sent a letter to Mr Z's GP but because the GP had not been informed of the move to Greenacres, when he tried to contact Mr Z to plan his care at home, he was unable to do so. It has not been able to establish Oncology's intentions at this point but records show that no other contact was made by them to consider a co-ordinated approach and nor did they facilitate wider palliative care at that time. Therefore it indicates that Oncology were also working in isolation and not part of a wider team approach.
- 9.5.10 Overall in this case, whilst Mr Z was being treated by the hospital, there is no evidence that any one person took overall responsibility to convene a multi-disciplinary meeting. The acute hospital setting was managing Mr Z's presenting conditions but without consideration of his underlying conditions and there was no acknowledgement of Mr Z's poor prognosis and consideration for palliative care throughout the scoping period. By the point of the Oncology appointment on January 13th, the need had become critical. There had been opportunities for multi-disciplinary meetings between medical teams and social care but they didn't happen in the November admission and weren't considered in the December admission and on-going Oncology appointments. This had a direct impact on Mr Z's future care and prevented him from having the opportunity to receive more suitable palliative care. This was discussed at the learning event and generally it was felt that the social work assessment had overall responsibility to co-ordinate care and convene a meeting to ensure an effective assessment was made. However, all professionals have a responsibility to consider holistic care needs and identify where palliative care is appropriate and this situation was not helped by differing

approaches to thresholds as to when end of life care is appropriate, based upon individual needs and wishes. The benefits of a MDT meeting were discussed at the Recall Event where it was agreed that such meetings are very important and provide an opportunity to assess if a service is right for an individual's needs and they also ensure that future goals can be agreed and how they are to be achieved.

9.5.11 At Greenacres, the social worker contributed to two routine specific weekly MDT meetings held by the unit and specifically on the 15th January ensured highlighted concerns were raised and shared. This was a positive step, especially as the family attended and was able to share their concerns about Mr Z's care which were noted and actioned by the social work team. This shows the value of multi-disciplinary meetings; however, in terms of identifying Mr Z's critical medical condition, the unit MDT's had limited value because there had been no medical input due to the GP or nurses not having attended or contributed. Although the outcome of the meeting on the 15th did ensure that a nursing home placement was considered for Mr Z because it was clear the 'Step Up, Step Down' unit was not meeting Mr Z's needs, it did not identify his deteriorating critical condition or prompt discussion with the family about alternative palliative care. This was discussed further at the Recall Event where the social worker involved outlined that the unit itself had not acknowledged that Mr Z was so ill and had not informed the social worker of his medical condition and it wasn't until attendance at the unit in advance of the MDT that the social worker realised that Mr Z was so ill. The role of the GP was discussed and agreed that the GP should have oversight and identify a need for hospitalisation. However in this case, the out of hours GP did not communicate their consultation and there was no GP registered for him at the home. This review has not been able to establish specifically who had been invited due to no records of the MDT being available but there was no GP or Community Nurse representation.

9.5.12 The role of a Macmillan nurse was discussed at the learning event and it was noted that thresholds for referrals were misunderstood by professionals in that many believed that a Macmillan nurse could be referred to for all cases of cancer. In fact, specialists emphasised that it is not an automatic referral and explained that a Macmillan nurse's role is to provide specialist care, including palliative care, where universal services cannot provide the service.

9.5.13 **Lesson 6**

An overarching Advanced Care Plan was not created for Mr Z because professionals worked independently without coming together or accessing relevant information from other key professionals by meetings or other face to face contact, and this prevented the agency network from working together to plan, and manage Mr Z's needs or to recognise his palliative needs.

9.5.14 **Lesson 7**

The hospital discharge letters did not provide advice for on-going care and were inaccurate in detail.

9.5.15 **Lesson 8**

A lack of clarity as to who was responsible for arranging specialist pressure relieving equipment pre-discharge contributed to a deterioration of Mr Z's pressure ulcers.

9.5.16 **Recommendation 3:**

The Central Bedfordshire Safeguarding Adults Board should hold an event to disseminate

key messages from this review to as many practitioners as possible. Those messages should include, but not be limited to:

1. The need for those undertaking assessments to consult with key staff engaged with the individual;
2. The consideration of complex patients meetings prior to discharge from hospital;
3. The importance of more detailed and accurate record keeping which includes the views of service users and their families and identifies responsibilities for on-going care;
4. The need to fully explain the current situation and future treatment options to families.
5. Professionals understanding of specialist discharge options such as a 'Step Up, Step Down', unit.

9.5.17 **Recommendation 4:**

Central Bedfordshire Safeguarding Adults Board should assure itself that effective MDT meetings are in place for patients with complex care needs.

9.6 **Family Involvement in decision making**

- 9.6.1 Whilst living in the community, Mr Z's family felt supported by their GP and Domiciliary Care. They were able to make choices as to the extent of the domiciliary care and chose to reduce it to mornings only due to cost and perceived effectiveness for them.
- 9.6.2 During Mr Z's November hospital admission, ward records indicate that Mr Z and his family were well informed about each diagnosis; i.e. developing cancer; likelihood of a knee operation; and pulmonary embolus, but record keeping is not that detailed and it cannot be shown exactly what the family were told or, importantly, their level of understanding. Following Mr Z reporting concerns that his wife needed to be updated, this did happen and therefore, some discussion did take place but it cannot be said to what extent because of the lack of detail in the records. At this point the family believed Mr Z's knee pain was due to a degenerative condition, but the Urologist nurse had told Mr Z that his pain could be due to his cancer so there is a difference in explanation to the family at this point. The family feel strongly that they were not told of the seriousness of Mr Z's cancer in November or that he could be not be cured and had a poor prognosis. This is supported by the fact that nowhere in records does it indicate at any point that Mr Z required palliative care and also the family believed Mr Z was to be considered for a knee operation in six weeks time. At the Learning Event, the social work and ward staff feel strongly that they informed Mr Z and his family of his condition and consulted them in decision making before discharges. However this is not clear from records and if family involvement is not recorded, it cannot be evidenced that it took place.
- 9.6.3 The family received much less information during the December admission. At that time, the ward and Oncology were in disagreement about Mr Z's condition and there are no records on the ward or Oncology notes to record that Mr Z or his family were updated at any time throughout this stay. The family have since established that the L&D had thought that the neurology team believed the Oncology team had had full discussions with the family when this hadn't been the case and so poor record keeping is a factor here too.
- 9.6.4 Contact with the family through the December admission was by the social worker when completing the pre-discharge decision planning, and this shows that the family were consulted regarding Mr Z's return home and separately about an option to go to Greenacres. The social worker clearly took the family's wishes into consideration by

seeking to find an alternative to going home due to them not feeling they could cope. Again though, the detail of the family discussions were not well recorded and as established, no consideration existed at this time of Mr Z's need for palliative care and this supports the family's assertion that they did not realise the reality of Mr Z's poor prognosis when choosing Greenacres. The family feel strongly that had they known this, they would not have agreed to the plan to build his strength at Greenacres but instead would have made a decision to take him home to die. In addition, the family would not have agreed to a placement in which Mr Z would be expected to do things for himself, such as washing, when he hadn't been able to do so for a long time. At no point were the family offered the opportunity for a CHC checklist assessment and given that the cost of additional domiciliary care had been an issue for the family, being aware that financial assistance, if assessed as being suitable, provided through a CHC care package may have provided alternative choices for the family.

9.6.5 During Mr Z's late December admission, there are no recorded discussions with family by ward staff concerning his clinical situation and no discussions concerning care needs by the social worker. As established however, the social work assessment did not have much time to be completed, with a decision to discharge having been made by the Discharge Officer based on Greenacres being able to accept Mr Z back and his wish to return there and no changes or variation identified by the ward that prompted the need to change Mr Z's plan. As such, there had been no perceived requirement for discussions with Mr Z's family during this discharge process but it is noted that in hindsight through reflection in this review that the L&D feel that a discharge should not have been made so quickly and Mr Z's deteriorating clinical condition should have prompted further agency discussions for future care planning which should have involved discussions with Mr Z and his family.

9.6.6 At Greenacres, the family developed rapport with the Occupational Therapist and Social Worker and this is reflected in their ability to raise concerns about Mr Z's care and deteriorating condition, which was positive. Despite this, the family still did not know Mr Z's poor prognosis, and although they were included in the MDT meetings, they were not sufficiently aware of Mr Z's medical condition because this had not been fully discussed, thus preventing effective decisions even at this late stage. The family had been very upset at the MDT in relation to Mr Z's care and steps were taken to find Mr Z a more suitable placement but the lack of a thorough medical overlay resulted in Mr Z's family not understanding his clinical condition and not having a choice to take him home instead. In consequence, the family were very shocked at his condition when he was admitted to the L&D on the 18th January and very shocked that he died so soon before he had the opportunity to return home, as they had planned.

9.6.7 Another issue raised by the family was that they weren't told about Mr Z's future medical needs in terms of requiring radiotherapy and it was difficult for them to manage and support him through the appointments and treatments that they hadn't planned for. They were also not aware that such treatment was an emergency palliative treatment.

9.6.8 **Lesson 9:**

Mr Z's family had not been made aware of Mr Z's poor prognosis and although they were included in some assessments, their choices were limited by the information they were provided with and options presented to them.

9.6.9 **Lesson 10:**

Record keeping in relation to information sharing with families was not sufficiently detailed, or not recorded at all, and there was confusion as to who had been updating

the family.

9.7 The wider picture at Greenacres including Safeguarding Alerts

- 9.7.1 Central Bedfordshire Council became responsible for Greenacres Care Home on the 1st August 2014 and received safeguarding alerts between Christmas 2014 and April 2015. However, it is important to note that there were no outstanding safeguarding alerts prior to Mr Z's admission.
- 9.7.2 Following Mr Z's death and subsequent protective action, many of the staff in post at that time have since left and there has been no Greenacres representatives available to attend the Learning Event. Much information relating to Greenacres has been obtained from available records, albeit poorly recorded, and records from professionals who had involvement with Mr Z's case at that time, including a CQC inspection.
- 9.7.3 In relation to Mr Z's first safeguarding alert made by the L&D on the 31st December it was noted on the SWIFT¹⁴ database that the pressure ulcers were known about and being treated by the community nurses and enquiries made with Greenacres indicated the nurse's intervention and that he was on two hourly bed turns. As such, a safeguarding investigation was not deemed to be necessary at that time. In fact though, the reality was that Mr Z had been discharged previously without specialist equipment and had been treated by the Community Nurses already but in a short time, his pressure ulcer had deteriorated. He was subsequently discharged again, the same day, without specialist equipment and in consequence Mr Z's ulcer was not likely to improve, especially as he then slept in a chair. A more proactive approach may have ensured protective factors were instigated.
- 9.7.4 Mr Z's family raised their concerns about Mr Z's care at the home to the social worker on the 14th January 2015 and outlined their concerns again at the MDT on the 15th January 2015 but the family did not want to raise a formal complaint at that time as they were very concerned that Mr Z may be subject to intimidation. The social worker left the home after office hours and reported the concerns the following day, escalating them as 'care quality' concerns to a senior manager. A safeguarding alert was not made at the time and at the Learning Event the social worker explained that the family had full capacity and the focus had been on Mr Z's future needs and he insisted he wanted to leave first, and steps were taken immediately to ensure Mr Z no longer slept in a chair. In line with Central Bedfordshire Council Safeguarding policy, this should have been a safeguarding alert with the decision made to do so by the social worker and not influenced by the family. A discussion with the safeguarding team may have prompted a threshold for investigation, supported by an explanatory discussion with the family that may have led to action that ensured a move from Greenacres sooner for Mr Z and the earlier detection of his stroke symptoms.
- 9.7.5 Mr Z's admission to hospital on the 18th January triggered a formal safeguarding investigation as a result of the Ambulance Service reporting their concerns, including their inability to get into the home. The safeguarding investigation was raised and allocated and a further report concerning care standards was received by CQC shortly afterwards which prompted a further safeguarding alert by them, and a full CQC inspection of Greenacres.
- 9.7.6 The CQC inspection identified serious concerns at the home and in response to their findings and safeguarding alerts, the Central Bedfordshire Council instigated their 'Serious Concerns' process and initiated an action plan, managed at a very senior level,

¹⁴ Social care information system

to improve the care provided by the home.

- 9.7.7 The safeguarding investigation has been subject to scrutiny by this review and it has been established by the Author of the Central Bedfordshire Council Older Persons Team report, and through discussion at the learning event, that the safeguarding investigation itself was not conducted to a high standard. The main points are summarised within Appendix 2.
- 9.7.8 One area of concern established in relation to the quality of the safeguarding investigation was the difficulty in arranging an 'interim case conference' due to key staff not being available to attend. This was discussed at the Recall Day and professionals who work across different local authorities outlined that often they receive invites for case conferences from the different authorities on the same day and are therefore unable to attend both, as was the case for the L&D in Mr Z's investigation and they would ask that this is noted for future invitations.
- 9.7.9 It was noted that the Police did not participate in the safeguarding investigation nor send a report to the initial case conference outlining why they didn't see a role for themselves in the enquiry. This was discussed at the Learning and Recall Events and it is not expected that the police routinely participate in such safeguarding investigations, and on this occasion, the police were not informed about the investigation at all. However, the investigation substantiated the concerns and, together with this review, has established that Mr Z suffered neglect at Greenacres. Whilst this review is not able to state that such neglect was wilful and suitable for a criminal prosecution, it does highlight the fact that a routine decision that there is no role for the police in safeguarding investigations at an early stage, before information has been fully shared and concerns identified, does not appear to be good practice.
- 9.7.10 As a result of the safeguarding alerts received by Central Bedfordshire Council during January 2015, there were a total of three safeguarding investigations undertaken, including Mr Z's as above which was substantiated. One of the other investigations was also substantiated and a third is still under review, but all were positively managed to improve service.
- 9.7.11 At the end of January the Council took steps to prevent any new admissions to Greenacres and monitored the home through the 'Serious Concerns Process'. The associated action plan ensured quality was monitored and improved, and the manager replaced.
- 9.7.12 **Lesson 11:**
- A complaint was made by Mr Z's family to Social Care which should have prompted an initial safeguarding alert but which didn't happen because the decision not to raise an immediate alert was unduly influenced by the wishes of the family.
- 9.7.13 **Lesson 12:**
- The safeguarding enquiry was not investigated thoroughly, sufficiently represented or managed robustly at an appropriate level.
- 9.7.14 **Recommendation 4:**
- Central Bedfordshire Council should refresh its messages around the Safeguarding Adults policy to ensure a full understanding of practitioners' roles and responsibilities regarding reporting and participating in a safeguarding enquiry.

10 Conclusions

- 10.1 This review process has established that Mr Z received services from a wide range of professionals across many agencies but that they did not consult together, or form into a multi-agency team, to plan for his holistic care. Mr Z had been very seriously ill and not able to be cured from November 2014 and was therefore able to be provided with the Gold Standard for palliative care but this did not happen because there was no multi-agency Advance Care plan considered for him and no identification by any professional of his need for palliative care. This formal identification is an important step needed by professionals for them to identify palliative and/or specialist end of life services.
- 10.2 Professionals in this case have differing perspectives as to when palliative end of life care is appropriate; thresholds are an issue with some needing to be informed that palliative care has been identified, recorded and included in a plan, to others that would consider them but only at a point where there has been sufficient deterioration to indicate that end of life is imminent. There had been sufficient opportunities whilst in the community, hospital and Greenacres for Mr Z to have been considered for palliative care and this should have happened for him from either November 2014, or most definitely from December 2014 once the MRI scan confirmed the suspicions that his bone cancer had metastasised requiring emergency palliative treatment; a situation that professionals are aware has a very poor prognosis with no cure.
- 10.3 The impact of Mr Z not having been assessed as requiring palliative care or considered for the opportunity to receive a CHC checklist, contributed to a well intentioned but inappropriate placement at a 'Step Up, Step Down' unit. The unit was not able to realistically meet Mr Z's needs at that time due to his clinical situation and the purpose of the unit not having been fully understood by professionals.
- 10.4 The assessment for that placement was inadequate and relied on hospital notes and reports which did not have an Advanced Care plan recorded, rather than professional discussions, and a complex patient meeting, or MDT meeting, was not considered when it would have been appropriate to do so. The fact that Mr Z was discharged on Christmas Eve and New Years Eve may have impacted on the speed at which he was discharged and the depth of information gathered for the assessments, but accuracy of recording and a professionals meeting would have ensured relevant information was considered and an holistic plan considered that realistically met his future needs.
- 10.5 Greenacres did not assess Mr Z's needs adequately before accepting him to their unit and failed to notice his cancer and complex medical situation. The 'Step Up Step Down' unit is not a nursing option and is intended for patients that are able to undertake some tasks for themselves, such as being able to wash themselves and wasn't suitable for Mr Z's physical abilities. Greenacres did not register Mr Z for a GP and coupled with not adequately assessing his condition, failed to consider his medical needs.
- 10.6 The lack of an overarching care plan was significant for Mr Z at Greenacres because with no GP oversight and the Community Nurses and Oncology not contributing, the social work assessment was not able to adequately assess his current medical condition and identify alternative palliative care.
- 10.7 Whilst at Greenacres, the social worker and Occupational Therapist raised concerns about Mr Z's treatment and contributed to appropriate multi-agency meetings which were due to have Mr Z moved to more appropriate nursing care but because they, and

others, had not identified a need for palliative care, his very poor prognosis was still not recognised even at this late stage, and this prevented him being moved sooner. Also, had the safeguarding alert been made on the 15th January, this may have provided an opportunity for him to be moved sooner.

- 10.8 Mr Z's family were not well enough informed before choosing to accept Greenacres as a placement for him. They were not aware that he could not be cured and needed palliative care and nor were they provided with the opportunity to be considered for a CHC assessment and possible care package that may have reduced their concerns about the cost of additional domiciliary care and allowed them to consider alternatives, such as nursing care or a return home with additional support in the community. It is very unfortunate that Greenacres was not well run at that time, but professionals did not know that before he was placed there. Sadly, as a result Mr Z's placement at Greenacres, he suffered unnecessary harm from neglect by staff and this has caused Mr Z's family much additional distress.
- 10.9 Once safeguarding alerts came to light, Central Bedfordshire Council acted and instigated three safeguarding investigations and instigated their serious concerns process. CQC also conducted an assessment of the home which resulted in a finding of being inadequate. An action plan for improvement was implemented and monitored at the highest level of seniority to ensure changes were made and service improved.

11 Lessons Learned

11.1 Lesson 1

End of life palliative care for Mr Z was not routinely considered by professionals because there had been no formally recorded palliative need to prompt professionals to consider them and nor were professionals vigilant in on-going assessment of deterioration.

11.2 Lesson 2

Professionals in this case believe the need for palliative thresholds to be subjective and have different perspectives for when to consider palliative care, or commence a CHC checklist. There was a lack of awareness that palliative care may be appropriate within the last 12 months of life where there is no cure and not just when end of life is imminent.

11.3 Lesson 3:

The purpose of a 'Step Up, Step Down' unit was not fully understood by professionals and the assessment to place Mr Z at a 'Step Up, Step Down', unit was flawed due to not having a palliative overlay or sufficient shared information about his poor prognosis and potential to deteriorate and although well intentioned, was not a realistic one given his wider clinical issues and specific purpose of the unit.

11.4 Lesson 4:

The assessments were note based without any professional discussions having taken place and relied on the quality of record keeping. A lack of professional discussion prevented a jointly discussed holistic approach that may have better understood expectations and provided a more realistic goal, or placement, for Mr Z.

11.5 Lesson 5:

Mr Z's admission in late December was notified to the social work team just prior to

discharge and not when first admitted and this impacted on the time the team had to prepare an assessment. There were also added pressures on the assessment from a discharge decision having already been made by the Discharge Officer and the pressure to discharge quickly that professionals perceive to be enhanced over the Christmas and New Year's Eve period.

11.6 **Lesson 6**

An overarching Advanced Care Plan was not created for Mr Z because professionals worked independently without coming together or accessing relevant information from other key professionals by meetings or other face to face contact, and this prevented the agency network from working together to plan, and manage Mr Z's needs or to recognise his palliative needs.

11.7 **Lesson 7**

The hospital discharge letters did not provide advice for on-going care and were inaccurate in detail.

11.8 **Lesson 8**

A lack of clarity as to who was responsible to arrange specialist equipment pre-discharge contributed to a deterioration of Mr Z's pressure ulcers.

11.9 **Lesson 9:**

Mr Z's family had not been made aware of Mr Z's poor prognosis and although they were included in some assessments, their choices were limited by the information they were provided with and options presented to them.

11.10 **Lesson 10:**

Record keeping in relation to information sharing with families was not sufficiently detailed, or not recorded at all, and there was confusion as to who had been updating the family.

11.11 **Lesson 11:**

A complaint was made by Mr Z's family to Social Care which should have prompted an initial safeguarding alert but which didn't happen because the decision not to raise an immediate alert was unduly influenced by the wishes of the family.

11.12 **Lesson 12:**

The safeguarding enquiry was not investigated thoroughly, sufficiently represented or managed robustly at an appropriate level.

12 **Good Practice and What's Changed?**

12.1 Mr Z and family felt well supported by their domiciliary care package and reported a good rapport with their carer. They also felt supported by their family GP.

12.2 During Mr Z's November admission to the L&D, both he and his family were kept well

informed by the ward and social worker. Also when Mr Z expressed his concern to the Urology specialist that his wife be updated, this was recorded as having been done later the same day.

- 12.3 During Mr Z's December admission, Mount Vernon persisted in ensuring that Mr Z was not discharged and received an MRI scan which definitively identified his metastatic cancer and spinal cord compression, and provided emergency palliative treatment that prevented his paralysis.
- 12.4 The Occupational Therapist and lead Social Worker at Greenacres developed a good rapport with Mr Z's family, and they felt they had been listened to. The Therapist also realised that Mr Z's goals could not be met and ensured a discussion took place with the social work team for his needs to be reassessed.
- 12.5 Mr Z received a very good service from the L&D during his last admission, with the family reporting they had been treated with dignity. The L&D ensured the family were well informed and had discussions concerning resuscitation and the L7D also reported the presenting safeguarding concerns.
- 12.6 The Community Nurses report that their service have implemented the following to develop their recording procedures and enhance their practice:
- Clinical Records are audited using peer review template monthly to ensure that clinical records contain all of the relevant information; with feedback given where gaps are identified. Also, themes are identified and shared across the wider teams.
 - Induction process for new staff has been reviewed to ensure that new starters receive the necessary training on SystemOne (Electronic records).
 - SEPT¹⁵ have identified face to face record keeping training which is cascaded to the wider teams for learning.
 - Palliative care training has been identified and training opportunities are now accessible for all staff.
 - SystemOne training has been delivered to all staff and refresher training will be routinely offered to ensure that staff are maintaining their knowledge.
 - Live laptops have been issued to all community staff enabling them to have access to SystemOne when out with their patients which will enable inputting to be contemporaneous.
- 12.7 Bedfordshire CCG is currently reviewing Out of Hours/111 provision as part of the Integrated Care procurement process. Sharing Out of Hours consultation information with GP Practices is considered essential and providers therefore will be required to demonstrate assurance that this is being undertaken.
- 12.8 A review of the way that MDT's are managed is currently being undertaken locally. The Head of Service is reviewing how the hospital social work discharge team service and support MDT's and terms of reference to be delivered and clarity around professionals' responsibilities.
- 12.9 The hospital social work discharge team are reviewing their referral and assessment criteria for hospital discharges and improving more realistic goals.
- 12.10 Central Bedfordshire Council are re-provisioning specialist 'Step Up, Step Down' units away from nursing care settings and as such are closing the unit at Greenacres having

¹⁵ Community Nursing Team

established that it is not a suitable venue for it.

13 Recommendations

13.1 Recommendation 1:

Central Bedfordshire Safeguarding Adults Board should assure itself that there is multi-agency training and awareness raising in relation to national and local guidance on end of life care and associated palliative care and CHC checklist criteria.

13.2 Recommendation 2:

The Luton & Dunstable Hospital and hospital social work teams should undertake a joint review of the quality of discharge and care plans and report to the Central Bedfordshire Safeguarding Adults Board upon its completion

13.3 Recommendation 3:

The Central Bedfordshire Safeguarding Adults Board should hold an event to disseminate key messages from this review to as many practitioners as possible. Those messages should include, but not be limited to:

1. The need for those undertaking assessments to consult with key staff engaged with the individual;
2. The consideration of complex patients meetings prior to discharge from hospital;
3. The importance of more detailed and accurate record keeping which includes the views of service users and their families and identifies responsibilities for on-going care;
4. The need to fully explain the current situation and future treatment options to families.
5. Professionals understanding of specialist discharge options such as a 'Step Up, Step Down', unit.

13.4 Recommendation 4:

Central Bedfordshire Safeguarding Adults Board should assure itself that effective MDT meetings are in place for patients with complex care needs.

13.5 Recommendation 5:

Central Bedfordshire Council should refresh its messages around the Safeguarding Adults policy to ensure a full understanding of practitioners' roles and responsibilities regarding reporting and participating in a safeguarding enquiry.

Appendices

Appendix 1: Terms of Reference and Project Plan

Bedford and Central Bedfordshire Safeguarding Adults Board



SAFEGUARDING ADULTS REVIEW

TERMS OF REFERENCE & PROJECT PLAN

SUBJECT: Mr Z

Version 2: 15.12.2015

1. Introduction:

1.1. This Learning Review is commissioned by Bedford and Central Bedfordshire Safeguarding Adults Board in response to the death of Mr Z in January 2015. The review is being conducted in accordance with the Bedford and Central Bedfordshire Safeguarding Adults Board Safeguarding

Adults Review Procedure. The aim being to establish whether there are any lessons to be learnt about the way in which local professionals and agencies worked together to prevent and reduce abuse and neglect of adults.

1.2 During December 2014 to January 2015 three safeguarding alerts were received by Central Bedfordshire Council from the L&D, ambulance trust and CQC, raising concerns about care for Mr Z at Greenacres care home. The alerts stated that staff did not recognise Mr Z had suffered a stroke and that he had untreated pressure areas. The family initiated calling the doctor when he appeared unwell. The alerts stated Mr Z was left cold and was taken to hospital inappropriately dressed. They also state that family concerns were ignored, and suggest general neglect.

1.3 Mr Z had been living at home with his wife until his admission to hospital on 11.12.14 with abdominal pain. Mr Z was discharged from the L&D to Greenacres rehab unit on 24.12.2014, readmitted to the L&D on the 29.12.14, discharged on 31.12.14, readmitted again to the L&D on 18.01.15 and passed away on 21.01.15. Mr Z's cause of death was pneumonia and metastatic spinal cord compression secondary to prostate cancer. Mr Z had been diagnosed with prostate cancer before these hospital admissions.

1.4 A safeguarding response was initiated prior to Mr Z's death and enquiries undertaken by Central Bedfordshire Council Leighton Buzzard Older Persons Team. The safeguarding concerns about Greenacres response to Mr Z appearing unwell were substantiated. In a parallel process, in response to this and other safeguarding concerns, the Council initiated its serious concerns process.

2. Legal Framework:

2.1 The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In addition to the above SABs might select cases for either of the reasons noted in the statutory guidance:

1. Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults
2. To explore examples of good practice where this is likely to identify lessons that can be applied to future cases

2.2 The purpose of the SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

2.3 In the case of Mr Z, the purpose of this safeguarding adults review is to provide insight into the way organisations are working together to prevent and reduce abuse and neglect of adults.

2.4 Central Bedfordshire Council's serious concerns procedure was initiated in respect of concerns at Greenacres care home. The original safeguarding enquiry in January 2014

substantiated the concerns relating to the response of care staff at the home. It is not intended that this safeguarding adults review re-investigate the concerns about quality of care at the home, but will focus on the wider inter-agency learning about working together to safeguard people.

3. Methodology:

3.1. This Review will be conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focussing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.

3.2. This model is based on the expectation that Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3.3. The SILP model of review adheres to the principles of;

- Proportionality
- Learning from good practice
- Active engagement of practitioners
- Engagement with families
- Systems methodology

4. Scope of Review:

4.1. Subject Z:

4.2. Scoping period: from 22.10.15 [increased pattern of hospital admissions] to 21.01.15 [date of Mr Z's death]

4.3. In addition agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of this adult. This could include a significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

5. Agency Reports:

5.1. Agency Reports will be requested from:

- Domiciliary Care Agency Prime Care Support Ltd
- East of England Ambulance Service
- GP (Leighton Buzzard)
- SEPT Community Nursing Service

- Central Bedfordshire Council Leighton Buzzard Older Persons Team
- Central Bedfordshire Council Hospital discharge Team
- Central Bedfordshire Council Occupational Therapy team
- Luton and Dunstable Hospital
- Care Quality Commission
- Central Bedfordshire Council Greenacres Care Home

5.2. Agencies are requested to use the attached Report Template.

6. Areas for consideration:

- 6.1 Were the original assessments of Mr Z's needs by the L&D hospital ward team and Central Bedfordshire Council hospital discharge team adequate in terms of:
- a) identifying a rehab unit as a suitable discharge destination?
 - b) providing the care home with sufficient information to manage Mr Z's needs including the provision of equipment?
 - c) offering alternatives such as a discharge home rather than to a care home?
- 6.2 Could communication and discussion about Mr Z's diagnosis and care needs have been improved during his hospital admissions so that he and his family could better understand his prognosis and make informed decisions about discharge and care?
- 6.3 A number of professionals were involved in supporting Mr Z during his stay at Greenacres. Were they in a position to identify concerns about quality of care and if so what prevented them from raising concerns?
- 6.4 Was sufficient information provided to Mr Z and his family and at the right points so that they knew who to contact about their concerns with the care at Greenacres?
- 6.5 What were the barriers to the network having sufficient opportunity to consider the case including use of the safeguarding process to identify learning?
- 6.6 Identify examples of good practice, both single and multi-agency.

7. Engagement with the family:

- 7.1 A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. BSAB has already informed the family that this Review is being undertaken. The independent lead reviewers will follow up by making contact with Mr Z's wife and two daughters.

7.2 Further contact will be made to invite them to participate in the form of a home visit, interview, correspondence or telephone conversation prior to the Learning Event. Their contribution will be woven into the text of the Review Overview Report and they will be given feedback at the end of the process.

8. Timetable for the Review:

Scoping Meeting	11 December 2015
Letters to Agencies	17 December 2015
Agency Report Authors' Briefing	7 January 2016 at 1.15pm
Engagement with family	Begin January 2016 once authorised
Agency Reports submitted to BSAB	19 February 2016
Agency Reports quality assured	9 – 24 February 2016
Agency Reports distributed to participants of Learning Event	24 February 2016
Learning Event	2 March 2016
First draft of Overview Report to BSAB	30 March 2016
Recall Event	7 April 2016
Second draft of Overview Report to BSAB	14 April 2016
Presentation to BSAB Sub Group/Board	24 th May 2016

Appendix 2: Concerns highlighted in the Safeguarding Investigation:

- The investigation commenced on the 20th January but the initial strategy discussion was not held until the 28th January; outside of the required target of 5 days;
- The strategy discussion was held between the lead social worker and their line manager and did not encompass wider agency members when it is clear from Mr Z's background that a wide range of professionals had been involved with him prior to his death. Importantly, it did not include consideration of specific issues raised by Mr Z's family when spoken to on the 23rd January, nor did it consider a risk assessment or protection plan for Greenacres to assess if there were any immediate concerns that needed to be addressed, such as easy access to the home by the emergency services, or if other residents needed immediate protection;
- An 'interim' case conference was planned for the 11th February but due to difficulties in getting attendees together, it was delayed until the 16th February. The interim conference tasked attendees to investigate their agencies involvement and to report back at the next case conference. As such, it was more appropriately a strategy meeting rather than a case conference of early finding and this built an unnecessary delay into the investigation, preventing early findings being actioned more quickly. Terminology and understanding of process is an issue here because it is not usual to convene an 'interim' conference; the term 'strategy meeting' would have been more helpful.
- The interim conference was chaired by a team manager rather than an Operations Manager in line with procedure, although senior managers had been consulted in that decision;
- Information provided at the conference confirmed an extensive list of concerns about Mr Z and more widely, about the management of the home. However, information gained from Mr Z's family was not provided to the conference and no action was set for an internal investigation to be made at Greenacres for these issues to be addressed;
- Attendance of relevant agencies was an issue in that Greenacres' manager had been invited when the manager had been mentioned as a potential issue for Mr Z's family and thus liable to investigation; the Occupational Therapist had been invited but not the Occupational Manager and no action was set for the role of Occupational Therapy to be examined;
- Clarity of actions set was reviewed and it has been found that an ambiguous action was set for the L&D hospital in that they were tasked to review their hospital notes by three different persons; namely the hospital social work manager, the hospital safeguarding lead and lead social worker in the investigation. Also, the action itself did not specify a review of pre-discharge assessments and processes to ascertain the rationale for the move to Greenacres. Additionally, it wasn't clear as to agreed timescales for completion, or submission, of reports because this was not recorded in the conference minutes.
- In consequence of the ambiguous action set for the L&D neither the hospital social work manager nor the L&D Safeguarding representative attended but instead sent a report that was inadequate because it did not cover the critical element of Mr Z's December admission and discharge periods. The Report Authors opinion is that there was confusion as to roles and responsibilities which prevented attendance, the task was not adequately specified which prevented critical information being provided and that it was inappropriate for the lead social worker to have been tasked, their role more appropriately should have been to co-ordinate that task;
- It has been established that the Clinical Manager for the Community Nursing team, although tasked, did not attend the subsequent conference and nor did they send a report. Nursing records had been removed from Greenacres before the investigation commenced and as such weren't available for the lead social worker, or investigation, to review. Therefore key information was never made available in relation to the management of Mr Z's pressure sores, the obtaining of blood tests and who had responsibility to ensure Mr Z's specialist pressure relieving equipment should have been ordered prior to discharge from the L&D in December;
- A subsequent case conference was held on the 17th March 2015 to receive feedback from actions

set during which attendees received an outcome summary of the family interview held on the 23rd January but because no actions had been set to investigate these concerns at the previous conference, there was no feedback available to the conference;

- The family attended the second half of the conference and were updated personally by the lead social worker but were disappointed not to have had their concerns investigated. The lack of investigation into their concerns prevented the family from feeling satisfied with the enquiry and prevented the initiation of improvements to service which could have been fed back to them. However, it is clear that the family were spoken to regularly through the investigation by the lead social worker, with the interactions appropriately recorded, and that a good relationship had developed between them;
- The meeting did not have all required information it should have expected to receive and this was not further requested. The opinion of the Report Author is that the conference focused on the next steps required, rather than the investigation findings;
- The conference found the investigation to be substantiated on the information available, which was appropriate because Mr Z had been admitted to the L&D with stroke symptoms and the home failed to recognise this and actions were set to escalate concerns for the home and to feed back to, and support, Mr Z's family.
- However, this review has established that some areas were inconclusive and not adequately investigated; firstly the involvement of the Community Nurses and understanding of action taken to manage Mr Z's pressure ulcers as a result of their records never having been reviewed, a report not having been submitted, and follow up action not requested by their clinical manager, the lead social worker or conference chair in line with the safeguarding policy. Secondly, there was no report provided by the police in support of their decision not to instigate a criminal investigation or to become involved with the investigation.

Appendix 3: Single Agency Recommendations

Luton and Dunstable Hospital

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
When patients cases are referred to the MDT meeting for review that this is expedited in an appropriate manner and timeframe	Adult Safeguarding Lead to feedback findings from this investigation to all Medical teams through Clinical Governance forums and all safeguarding training sessions.	Adult Safeguarding Lead Nurse	September 2016	All medical teams when referring patients to the MDT do so within a timely manner and then relay the outcomes to patients and family members as appropriate
When advice is sought from Specialist teams that recommended actions are implemented in an appropriate timeframe	Adult Safeguarding Lead to feedback findings from this investigation to all Medical teams through Clinical Governance forums and all safeguarding training sessions.	Adult Safeguarding Lead Nurse	September 2016	All Medical and Nursing teams when requesting specialist advice then implement suggested actions in a timely manner.
The L & D should review their discharge letters.				

Central Bedfordshire Council Leighton Buzzard Older Person's Team

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
1x safeguarding audits per year	To be carried out by a senior manager of a safeguarding case	Integrated operations manager	Implemented with immediate effect	To ensure safeguarding procedures are followed
1x shadowing per year	Shadow safeguarding meeting	Integrated operations manager	Implemented with immediate effect	To provide feedback to team managers on chairing to upskill and provide learning.
Training on chairing safeguarding meetings.	Specific to Central Bedfordshire Council procedures	Safeguarding manager	Implement within 6 months	Up skill managers to undertaking safeguarding meetings
Develop a risk matrix	to determine complexity of safeguarding cases	Safeguarding manager	Implement within 6 months	Complex multi agency safeguarding meetings to be

				chaired by senior managers and /Joint chair with team manager in order to upskill managers
Multi disciplinary training	on multi agency safeguarding policy	Safeguarding manager	within 6 months	Greater understanding of statutory requirements roles and responsibilities within the safeguarding context

Central Bedfordshire Council Hospital Social Work Team

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
Page 5 from ward Therapist to be made available before referral to step down unit	Guidance to HT information shared with hospital	Team manager	Immediately	Better information for step down unit

SEPT Community Health Services

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
Record keeping needs to improve to ensure correct information of patients care requirements, procedures undertaken and patients views are recorded	<p>Training/ workshops specifically for record keeping are being rolled out across our SEPT nursing teams in Bedfordshire.</p> <p>Peer review audits are being undertaken by all senior staff (Nursing Sister, Team Leader and Locality Managers) on a monthly basis to ensure that standards of record keeping are maintained. The themes and findings from the peer audits are reported into a monthly peer review meeting.</p> <p>Weekly caseload assurance to confirm that patients on the caseload have up to date care plans and</p>	All community nursing staff	On-going	Increased detail and personalisation of clinical records

	risk assessments in place. Audit on outcome to take place			
Improve communication between community health services and acute trust when patient transfers with wounds	<p>1. Transfer paperwork to be sent when admission is known.</p> <p>2. Follow up patient and ensure that information is discussed regarding any pre-existing/ relevant wound care when leaving and transferring to and from services.</p> <p>Assess equipment requirements when transferring patient back into the community setting.</p> <p>To consider need for MDT meeting in advance of discharging a patient back into the community particularly when complex or family have raised concerns.</p> <p>Complete an audit to measure effectiveness of action</p>	All clinical staff community and acute	On-going	
DISCHARGE ALERT forms to be completed by SEPT staff and discussed with partner organisations via agreed processes. Subsequent learning should be shared across both organisations	SEPT staff have all been advised to complete a datix for all poor discharges and to complete a poor discharge form for escalating to our SEPT discharge planning team	SEPT Community Nursing Staff	On-going	

Greenacre Care Home

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
Consider whether the current assessment form provides sufficient detail	Analyse current form and produce new form if needed	Home Manager Greenacre	Completed	Assessment form that clearly identifies all the needs of anyone entering Greenacres
Home Manager to ensure that they are aware of the needs of new customers into the	Home Manager to read assessment prior to admittance	Home Manager Greenacre	Ongoing	Assessment form thoroughly completed and Home Manager

service	so they can provide specific guidance to staff team			able to speak knowledgeably about a new client as soon as they enter the service
Care staff to understand the needs of family members and provide empathy care	All staff to receive customer care training	Home Manager Greenacre	Ongoing	Care staff to listen to family members and respond appropriately to their requests to be empathetic to the needs of the family
Team leaders to spend more time working on the floor with the care staff	Team leaders to provide leadership and guidance to care staff and to respond to the specific care needs of customers	Home Manager Greenacre	Ongoing	For team leaders to be able to identify when a customer is not receiving the care they require and direct staff to ensure that care is delivered appropriately
Develop a culture of collaboration	Ensure that family and others are consulted and listened to	Home Manager and all staff	Ongoing	That a more collaborative/ participative culture is developed

Central Bedfordshire Council OT Service

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
Review of OT documentation on SUSD	<ul style="list-style-type: none"> Speak with therapy staff to relay requirement and expectations within documentation Secure process for handover of information between therapists 	Katherine Quail	31 st March 2016	Improved evidence of information and actions to support decision making with therapy services
Review current MDT recording protocol	Liaise with Ops manger of SUSD to ensure MDT meetings are recorded and where information is held	Katherine Quail	31 st March 2016	Ensure evidence of MDT input to clients on SUSD and evidence of single multi agency concerns and action plan for clients is met.
Review reporting pathway of general concerns with SOVA team	Liaise with SOVA lead to review reporting pathway to ensure that concerns raised through management team are reviewed by SOVA team to ensure actions are completed to address	Katherine Quail	31 st March 2016	Ensure all staff are aware and confident in reporting concerns. Concerns will be reviewed and monitored

	concerns			independently of SUSD.
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Bedfordshire Clinical Commissioning Group

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
There needs to be a clearer, more transparent, process in determining whether a patient can be discharged to their own home or to a care setting, and that this is communicated to all agencies	Sharing the decision making with other professionals and also with the patient and their family			Improved care and patient transfer from hospital to care setting or their own home and greater patient satisfaction
There needs to be timely notification to the GP surgery of where a patient is being discharged to and all the arrangements that have been made.	Clear sections on discharge papers that reflect this			Improved awareness by the GP surgery of where there patient is discharged to so that care can be unaffected
There needs to be timely re registering of patients by nursing homes and care homes with a local GP surgery once they are admitted for care.	The nursing home or care home should contact their local area surgery to register the patient with a local GP			Improved access to medical/GP care
There needs to be education to staff in nursing home and care home settings of the recognition of a stroke and its key signs / indicators	The FAST rule to be taught			Improved recognition and management of suspected stroke cases
The CCG should assure itself that effective MDT meetings are in place for patients with complex care needs.				