West Sussex Safeguarding Adults Board

Safeguarding Adults Review in respect of Beverley

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1. Independent Chair foreword

1.1. The West Sussex Safeguarding Adults Board (SAB, or the Board) has published a Safeguarding Adults Review (SAR, or Review) in relation to Beverley. The Board and the Independent Reviewer wish to express their sincere condolences to the family and friends of Beverley.

1.2. We also thank Beverley's family and friends for their significant and highly valued contribution to this Review. Beverley's family have requested that her name be used to ensure that Beverley's voice is heard, and the report provides a personalised legacy to her. They have also contributed a foreword to the report encouraging practitioners to "reflect and strive to remember that within their individual roles, the most important person of a multi-disciplinary team, is the person themselves." The families' voice and involvement has been central to this Review supporting a making safeguarding personal (MSP) approach.

1.3. Beverley was a 67-year-old lady and a much-loved Mother, Grandmother, Great Grandmother, Sister, Aunty, and friend. She was described by her daughter as a very proud and independent person, and the "matriarch" of a very large family. Beverley was well thought of by family, friends, and her local community. She also had a special relationship with all her grandchildren and great grandchildren and loved her large and extended family.

1.4. Beverley died in Worthing Hospital in March 2022. Before her admission to hospital, she had lived in Elmcroft Care Home from 2020 and prior to this she had lived independently in her bungalow. Beverley had a number of health-related issues which had compromised her mobility for some time. Following Beverley's death, a safeguarding enquiry concluded that improvements could have been made to the support and coordination of care for Beverley, and that she was not always part of the decision-making about her own care. Due to this, a referral was made to our Board in August 2022, for consideration of a SAR.

1.5. The SAR subgroup acknowledged the areas of improvement identified and agreed that the criteria for a SAR was met. They appointed Independent Reviewer Anna Berry to lead this Review.

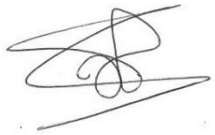
1.6. The purpose of a SAR is to identify how lessons can be learned, and services improved for those who use them, and for their families and carers. This Review looked at the circumstances prior to Beverley's death and the actions of agencies. Recommendations made will enable lessons to be learned and contribute to service development and improvement.

1.7. The Review made recommendations in relation to multi-agency working, workforce skills and knowledge, and person-centred care. Although agencies have not waited for the outcome of this SAR to consider their own learning, we will ensure that they are fully engaged in taking forward, together, the Review recommendations.

1.8. The Board will monitor progress on the implementation of recommendations to reduce risks and ensure the development of systems and procedures to improve practice.

1.9. The Board will also ensure that learning from this Review is widely shared and that the outcomes of the learning will lead to improved services in West Sussex.

Annie Callanan



Independent Chair

Family foreword

1.10. "We are extremely grateful for this review being done but also find it very sad that it took our Mother's, Grandmother's, Great Grandmother's, Sister's, Auntie's and friend's death for her voice to be heard.

1.11. We hope lessons have been learnt and that the necessary changes will be implemented and that all involved will go away from this and really reflect and strive to remember that within their individual roles, the most important person of a multi-disciplinary team, is the person themselves. Their voice and their family's voice should always be at the forefront of their care.

1.12. Nothing will bring Bev back and she should never have had to go through what she did, but we feel that her voice is being heard now, and lessons have been learnt so that hopefully no one else has to go through what she did. This will be the legacy that Bev left."

2. Introduction

2.1. The Care Act 2014, Section 44, requires that Safeguarding Adults Boards must arrange a SAR when certain criteria are met. These are:

- When an adult has died and the SAB knows or suspects that there may be abuse or neglect, or has not died but may have experienced serious abuse or neglect, and;
- There is a concern that partner agencies could have worked more effectively to protect the adult.

2.2. SARs are required to reflect the six safeguarding adults' principles, as defined in the Care Act 2014. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

2.3. The aims of the SAR are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends.

2.4. There are clear Review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the Review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

2.5. The Review process to meet these aims and objectives has followed a clear path. The methodology chosen for this Review is a Learning Together approach. This included a case group to agree terms of reference and a focus on themes, patterns, and factors together with family discussions. The Independent Reviewer has conducted research by analysing the information provided and by interviewing representatives of agencies; culminating in a planned SAR outcome panel meeting and presentation to the West Sussex Safeguarding Adults Board.

3. Overview of the case and circumstances leading to the Review

3.1. Beverley was a 67-year-old lady who died in Worthing Hospital in March 2022. She had lived in Elmcroft Care Home from 2020 to the time of her death. Prior to that time, she lived independently in a bungalow.

3.2. Beverley had a number of health problems and was restricted to her bed due to her reduced mobility contributed to by her weight, lymphoedema and leg wound.

3.3. The services involved in her care in the last two years of her life were her GP, the vascular team, the lymphedema team, the Tissue Viability Nursing Team (TVN), a social worker from the community team (regarding placement) and the staff in the care home who were responsible for carrying out the care prescribed by the specialist teams.

3.4. A post-mortem examination was not conducted and there was no requirement for an inquest. Her death certificate records cause of death as:

- 1a. Multi-organ failure
- 1b. Acute kidney injury
- 1c. Obstructive uropathy
- 1d. Fibroid uterus
- 2. Venous thromboembolic disease, Atrial fibrillation, morbid obesity, Type 2 diabetes, Leg ulcers and Covid-19

3.5. A referral was made by West Sussex County Council on 3 August 2022 for consideration of the SAR criteria.

3.6. The SAR subgroup acknowledged that there were areas of improvement identified for the planning and coordination of multi-agency care. The initial safeguarding enquiry also found that Beverley was not always part of the decision-making regarding her own care.

4. Key themes identified for this Review

- Person-centred care and decision-making
- Multi-disciplinary team working
- Wound care, and wound care planning and training
- Pathways during the COVID-19 pandemic
- Similar themes and learning from existing Reviews

4.1. These themes are reflected in the following terms of reference:

- Health oversight and multi-disciplinary coordination
- Person-centred planning, including voice, capacity and decision-making, and listening to family
- Placement suitability - staff skills and knowledge
- COVID-19

5. About Beverley

5.1. Beverley moved to Elmcroft Care home in 2020 after a period of hospitalisation and she lived there for two years until her death. Prior to that she had lived independently for a number of years in a bungalow close to friends and family.

5.2. Beverley's friends and family have contributed significantly to the Review by providing insight in her personality, her life before Elmcroft, and the impact of moving into the care home. Her daughter, Nicola, has spoken at length with the reviewer to support the learning.

5.3. Beverley had a number of health-related issues which had compromised her mobility for some time. She had previously been hospitalised with cellulitis, had lymphedema, Atrial Fibrillation (AF) and frequently suffered from dizziness. She had lived in her bungalow for approximately 11 years prior to moving into Elmcroft.

5.4. Nicola describes Beverley as a very proud and independent person, and she identified her role as the "matriarch" of a very large family.

5.5. In view of the challenges she experienced with her health, she researched these issues to ensure that she could make informed decisions; it was very important to her to remain in control of plans about her health. She was described as a very proactive person who was always very clean, well dressed and liked to have nice hair and makeup. She was particularly vigilant about her skincare routine, and she would encourage her family to follow her example.

5.6. Beverley had lots of friends and on birthdays, special occasions, or Christmas, her bungalow was described as "looking like a florist" which was testament to how well she was thought of by family, friends, and her local community. She had a special relationship with all her grandchildren and great grandchildren, always offering words of wisdom and never judging. She was one of seven children herself and loved her large and extended family.

5.7. Beverley was described by one close friend as a "fighter" who has survived many difficult challenges in life. In other accounts she is described as kind and caring and there are many examples provided of where she had helped and supported people.

5.8. Despite the limitations caused by her health problems, she was a lady with many interests. She particularly enjoyed doing crosswords and reading and the local library would deliver bags of books for her regularly. She enjoyed music and was a big fan of Tom Jones, Rod Stewart, and Gary Barlow.

5.9. She was very loved by her grandchildren and always kept up-to-date with the latest music trends and films so that she could discuss this with them. Her grandchildren and great grandchildren would regularly video call their Nanna, which Beverley loved.

5.10. In 2020 Beverley had a period of hospitalisation and it was upon discharge at this time that she moved in Elmcroft Care Home as she could no longer live independently in her bungalow and all other options of home care had been exhausted.

5.11. Nicola reports that despite the initial period of adjustment and acceptance that she needed to live at Elmcroft, Beverley was happy there. She had made her room feel like her own with her much loved Beryl Cook pictures on the wall, matching curtains, and lampshade. She had made a good friendship with another resident, and they would often spend time together and would be referred to fondly as "Thelma and Louise". This provides some insight into Beverley's sense of humour and personality.

5.12. Sadly, the period of time that Beverley lived within Elmcroft was a challenging one with the restrictions that COVID-19 imposed on people; this particularly impacted on people living within care homes. This was described as an incredibly difficult time for Beverley, as family could only visit/see her through the window or through telephone calls.

5.13. In terms of Beverley's daily experiences, her family were desperately worried about her as her general demeanour and appearance changed. She was described as a "shadow" of herself and would frequently call her daughter and describe her pain levels as excruciating (relating to her leg wound). She was frightened as she could not see her own leg and she did not feel that she was being listened to. This was expressed multiple times by Nicola and other family members.

5.14. To note, Beverley had worked with care home settings at times during her life. She was very passionate and vocal on social media about quality of care and did have a good grasp of some of the complexities of health care provision and the need to keep the person at the centre of their care. Some examples of her interest in this area were shared by her family.

5.15. Her family felt that the "sparkle" had gone out of Beverley, and they provided photographs of her prior to, and during, her time at Elmcroft to demonstrate the difference in her general appearance.

5.16. There was an occasion in November 2021 when a placement meeting took place in the home to try and address some of the challenges that she was experiencing. This had been arranged by the social worker from the Community Team related to her placement. Beverley tried to articulate that she was particularly worried about her leg; she felt that she was not being listened to and described how she wanted to remain in control of decisions about her care. It is reported by Nicola that the care home manager at that time told her to go and live somewhere else if she wasn't happy. This distressed Beverley greatly as she was in fact quite happy with the home, but unhappy with some of the elements of her care that she didn't agree with, or where she didn't feel listened to. This could have been an opportunity to address the issues raised.

5.17. The last few months of her life were incredibly difficult for Beverley, and Nicola describes how desperate she felt to hear her mum crying on the phone about her leg. On later visits the family reported her leg wound to "look and smell terrible", but the more she tried to advocate for her and speak to services, the more she felt she was pushed away. There were multiple phone calls and emails where she tried to express and escalate the concerns that Beverley (and she) had.

5.18. In the days leading to her death, she told her daughter that "no one is listening to me". She described her pain at that time as immense and she believed she was going to die if she didn't get help.

6. Engagement with family

6.1. Engagement with family members and listening to their perspectives and experiences is essential to develop learning when undertaking a SAR. A focus on their understanding about how their family member was supported on a daily basis, and their experience of services and whether they found these to be helpful, provides a more personal insight into how agencies managed events.

6.2. The statutory guidance requires early discussions with the individual (where possible), family, and friends to agree how they wish to be involved. It further requires that families should be invited to, and understand how to, be involved, with their expectations managed appropriately and sensitively[1].

6.3. Beverley's family and friends contributed significantly to the Review, providing multiple examples, anecdotes, photographs, and information. This provided a whole life context to the information that was available. Their contribution provided a rich and meaningful understanding of Beverley's personality, life experiences and quality of life at different times.

6.4. In particular Beverley's daughter Nicola, provided significant insight into her Mum's life and her last experiences which have helped to identify the learning for future practice.

6.5. The family strongly believe that there is meaningful learning that can be gained from reviewing Beverley's case. This learning includes person-centred care, quality of care, multidisciplinary coordination and delivery of care, family engagement and communication. They hope that agencies will use this learning to improve practice.

6.6. It is the wishes of the family that this Review is not anonymised and therefore Beverley's name is used throughout this Review.

7. Key findings

7.1. For reference, background, and context it is helpful to consider the relevant statutory process and their conclusions.

7.2. In Beverley's case there was not a post-mortem examination or an inquest. The death certificate states cause of death to be:

- 1a. Multi-organ failure
- 1b. Acute kidney injury
- 1c. Obstructive uropathy
- 1d. Fibroid uterus

[1] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.165)

- 2. Venous thromboembolic disease, Atrial fibrillation, morbid obesity, Type 2 diabetes, Leg ulcers and Covid-19

7.3. There are no other parallel statutory processes in relation to Beverley.

7.4. In respect of Elmcroft it is relevant to note that seriousness of the safeguarding concern raised in respect of Beverley contributed to work being carried out under the "Provider Concerns Framework" to consider risk to others within the home. Multiple areas were identified where improvements were required and this was subsequently supported by the findings of a CQC inspection in March 2022.

7.5. It is helpful to note the finding of the CQC Inspection of Elmcroft Care Home.

7.6. The Care Quality Commission (CQC) is England's independent health and social care regulator. Its goal is to make sure that health and social care services offer individuals safe, effective, compassionate, and high-quality care, and it continually encourages providers to improve their services. The fundamental standards of CQC are built on the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

7.7. The CQC conducts frequent inspections at care homes, which include discussions with employees, evaluating care, and examining documents. The goal is to gain a thorough understanding of the level of services delivered. The CQC bases its decision on two critical frameworks: the Key Lines of Enquiry (KLOEs) and the Quality Standards.

7.8. The KLOE are:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

7.9. Following a review of their findings, the CQC will assign a grade to the care provider based on its key line of enquiries. Elmcroft was inspected on 31 March 2022 and the overall rating was found to "require improvement". The areas that were found to require improvement were within the "safe" and "well led" domains. The other areas were found to be "good" with many examples of good practice in other aspects of care.

7.10. The CQC inspection found that "people did not always receive care in line with their assessed needs and plans of care. People did not consistently receive safe wound care as guidance from health professionals was not always followed to ensure risks to people's health and safety were mitigated […] Systems to monitor the quality and safety of the service were not robust enough to identify shortfalls in people's care, communication or records relied upon to demonstrate the care people had received"

7.11. These areas identified did resonate with some of the circumstances of this Review in terms of clinical oversight and adherence to wound care management plans, albeit this Review will consider findings in the context of the wider system.

7.12. Key missed opportunities:

7.13. Within the information provided for this Review there is evidence of over 50 episodes of contact between Elmcroft, the TVN team, the vascular team, the lymphedema team, and the GP. The episodes varied to include new referrals to the TVN service, clinical assessments, treatment for leg infections, vascular appointments, emails between teams, phone calls, wound care management plans being shared, and photographs emailed. There was no point where a meeting was held between these teams and involving Beverley.

7.14. Each and every one of these contacts related to the care of Beverley's leg with multiple examples of times when different people had different perspectives on the status of the leg wound.

7.15. There was never an occasion where it was documented that Beverley was thought to lack capacity, yet none of these episodes demonstrate a sense of Beverley's perspective or voice. The SAR panel and family members agree that Beverley did not lack capacity and the reviewer has not found any evidence to the contrary.

7.16. To note, during the latter stage of this Review, the TVN team report that they raised concerns with the care home manager at that time about Beverley's ability to understand treatment plans and to consider a mental capacity assessment. This is not reflected in care home records and there is no evidence that this view was more widely discussed, documented, or shared, nor is there any evidence of this being followed up by the TVN team. The Review has not found any evidence that Beverley was lacking capacity.

7.17. The only occasion where some professionals came together in this timeframe was for a placement review in November 2021. Beverley expressed concern about the management of her leg on this occasion; this could have provided an opportunity to hold a full multi-disciplinary team (MDT) meeting with Beverley at the centre.

7.18. Summary of findings:

- Inconsistent application of the multi-disciplinary care plan - silo working
- Person-centred care planning was not evident in terms of Beverley feeling listened to and involved in her care decisions
- The care plan and care delivery was not always reflective of the specialist recommendations
- Insufficient attention to the view of the family
- A "separation" of the care home and the wider MDT (this is a previous SAR finding)
- Limited evidence of coordinated clinical oversight

- Clinical leadership and oversight could have been strengthened to ensure that staff had the skills and knowledge to carry out wound care

8. Overarching learning

8.1. The Review has identified learning following consideration of the following areas of practice that were identified during the Review process, highlighted within the agency reports, and discussed at the practitioner event.

8.2. Areas of learning:

- Health oversight, coordination and MDT working (including wound care)
- Person-centred planning, voice and listening to family
- Placement suitability - staff skills and knowledge
- COVID-19

9. Analysis of findings

9.1. **Health oversight, coordination and MDT working (including wound care)**

9.1.1. Beverley's needs required different speciality teams to contribute to an overarching plan of care. This included her daily care provider (Elmcroft), her GP, the Tissue Viability Team, the vascular team, the lymphedema team, and the social worker (in respect of her placement).

9.1.2. Beverley's daily care was being delivered by a blended team of nurses and care support workers. The clinical oversight and responsibility for delivery of her care plan was held by the Nursing and Midwifery Council (NMC) registered nurses within the home (hereon referred to as registered nurses).

9.1.3. This was within the context of a pandemic, with limited face-to-face contact from different agencies, and professionals who were restricted by visiting limitations, particularly if the care home was in Covid outbreak measures. Additionally, the care home, like many others, experienced some challenges such as staffing.

9.1.4. To note, Elmcroft is a residential care home providing accommodation and nursing care. In terms of nursing care, at this time there was only one registered nurse on duty within the home. The registered nurse is responsible for the oversight of clinical and care needs of 30 residents residing on the "nursing floor" and the team leader is responsible for the remaining residents.

9.1.5. Beverley resided on the "nursing floor" and received (registered) nursing input with respect to the care of her leg and wider daily care from healthcare support staff.

9.1.6. It can be noted that Beverley's physical health and wellbeing appeared to be deteriorating over the period of time the Review is capturing. Additionally, she became withdrawn, which is at odds with the multiple descriptions of Beverley provided by her family and friends. Some evidence is found in her care plan and in the description provided by the care home that she did not like to widely socialise and did not like to participate in activities. Beverley was also in pain and her leg wound was documented to be deteriorating. This is all evidenced in the number of contacts between services, and in the reports that her family provide.

9.1.7. The question of the leg wound created multiple discussions through the course of the Review, with some professionals feeling the status of the wound remained the same and others saying it had deteriorated, and this is supported by the family. There is also the effect of lymphoedema on the leg wound healing process and this will be considered later. Generally, the evidence obtained from the chronology, family reports, re-referrals to the TVN team, photographs and verbal accounts support the view that the leg wound had worsened over the timeframe of this review. If we listen to how Beverley reported it herself, we know she was in increased pain and becoming very distressed by the status of her leg.

9.1.8. The care home and the GP both reflect that the family visited regularly and there were lots of conversations with them at different times, however the multi-agency communication as a whole could have been strengthened to ensure that Beverley and Nicola were fully informed of all aspects of care both in the care home and with the clinical management plan. There appears to have been a difficulty with the components of the MDT, and how they worked together with Beverley and interacted with Nicola.

9.1.9. Having considered the chronology and through panel discussions, there is some frustration evident across the MDT that despite assessments (virtual and physical), emails and conversations, adherence to the required/prescribed care was not always as evident as it could have been. This was formally raised as a safeguarding concern by the TVN team later in the timeframe but not before. It was also raised by the family on behalf of Beverley multiple times. To note, the safeguarding enquiry found that the wound care plan was not adequately reflective of the required dressing regime or recommendations given by the lymphoedema and TVN team. For example, there was evidence on occasions where the incorrect dressings had been used, dressing changes had been delayed, and new assessments and treatment plans were not always reflected and amended in her care plan.

9.1.10. Reflected in the information are multiple conversations and emails between Elmcroft, the TVN team, the lymphedema team, the GP, and the family. It is not entirely clear who was coordinating the care plan and its mechanism of delivery. Beverley and her family certainly found it difficult to navigate the communication consistently across these teams, leading to a sense of disempowerment from Beverley's perspective, and a sense of frustration from her daughter.

9.1.11. The delivery model for the TVN team at that time did not lend itself to a "coordinating role". This is because they did not hold a caseload and described themselves as an "advisory" service, thus each new contact/referral was a new episode of care and did not provide continuous oversight. The GP was reliant on the steer from the speciality clinical teams, and Elmcroft were trying to deliver the prescribed care with compromised skills and knowledge to do so (this will be discussed later in the review). The care home acknowledged this and requested training for the dressings that were required. To note, the TVN team do not have any responsibility to provide training. It is however evidenced that the Lymphoedema team did provide some advice to the care home in terms of accessing training.

9.1.12. In terms of a coordinating or lead role, this does not need to be prescriptive and could have been established within a robust MDT meeting. Generally, a lead professional role would be someone who is integral to the majority of the care provision and less often a speciality clinical team. This would have been valuable for Beverley (and Nicola) as they would have had a lead professional and a point of contact to clarify issues and raise concerns or anxieties.

9.1.13. Collaboration between health and social care services and private providers is required to explore methods of preventing deterioration of individuals in care homes for people with complex needs. This could support staff to identify deterioration early and improve effective communication so that people are cared for in the right place at the right time. Within West Sussex there are now "care home Matrons" who work with care homes to support residents with needs such as Beverley's. This is a development that Beverley would have welcomed as she had in fact discussed the benefits of the role of the Matron with Nicola during her time in Elmcroft.

9.1.14. Often there may be a main carer/key worker who understands the person's needs, but robust processes should be in place to ensure if, and when, that key worker is absent, all staff are able to provide person-centred support for health and social care needs. The Review explored the clinical oversight within the home and concluded that the responsibility for coordinating delivery of the care plan sits with the registered nursing staff on duty. However, during that period of time there was only ever one registered nurse on each shift, and sometimes this was an agency nurse, therefore, the daily oversight and consistency of how care was being delivered could have been strengthened.

9.1.15. This was raised by the TVN team as a safeguarding concern the day before Beverley's death. This included concerns that she wasn't receiving the wound care that she required, the recommended plan wasn't being followed, and they also raised several other issues such as poor adherence to Aseptic Not Touch Technique (ANTT), poor documentation, and concerns that the staff were not skilled to carry out wound care. It was also highlighted that the Elmcroft care plan did not always reflect the wound care requirements. The care home considered this finding and highlight that there were frequent changes to the requirements which may have been a factor in maintaining and delivering the care plan.

9.1.16. In contrast, Elmcroft identified that the oversight from the TVN team was limited; there is evidence that Elmcroft, and other services did not fully understand the TVN delivery model and thus their expectations of consistent and regular reviews was not provided. There was a misconception of the role that the TVN team could take at that time. In their contribution to the safeguarding enquiry, Elmcroft identified that they had considered raising a safeguarding concern on the basis that the TVN team were not providing the service that they felt Beverley needed.

9.1.17. These are two directly opposing views of each other's services in terms of care oversight and delivery and yet there is no evidence that they came together to have a meaningful discussion to overcome these perceptions. Of note, the reflective views of this case explored during this Review have still not fully aligned the views of these two services in respect of this case (TVN team and Elmcroft) despite the conclusions of the Review supporting the findings of the initial safeguarding enquiry.

9.1.18. Additionally, during January and February 2022, Nicola raised significant concerns about her Mum. This is evidenced in a high number of messages, calls and emails between Beverley and Nicola, and also between Nicola, the care home, the TVN team and the lymphoedema team. During mid-February 2022 Nicola liaised directly with the care home manager and requested for a safeguarding referral to be raised. The reasons for this include general deterioration, Beverley reporting that she was not being listened to, high levels of pain, lack of confidence in wound management (there had been an instance of a six-day gap between dressing changes), concerns about TVN oversight and Beverley's own reports of how ill she felt, with symptoms of increased fatigue, vomiting and poor urine output. Despite assurance from the care home which was contained in an email to Nicola, this referral was never made.

9.1.19. It can be noted that Beverley's voice and views did not come through in the safeguarding concern raised by the TVN team, and some of the language in the referral relating to Beverley was not reflective of a person-centred approach; this will be discussed later.

9.1.20. There was a high amount of evident communication, emails and discussions between the vascular team, the lymphedema team and the TVN team. Separately there was contact between Beverley and the GP, and Beverley's daughter and the TVN team. The team at Elmcroft were also trying to navigate their way through these multiple communications to understand the coherent plan that was required.

9.1.21. Although the leg wound is not documented as the cause of death, it formed a large part of her care and focus of this Review. She was in pain, distressed, and her family were trying to advocate for her and understand what the plan was to address the deteriorating situation.

9.1.22. In summary, an impression from reading the available information and discussions with professionals and family is that Beverley was receiving assessments, oversight, and care plans from specialist teams, namely vascular, lymphedema and TVN. When specialist services were contacted, they provided clear advice and these plans were documented, shared and were clinically sound. However, less obvious is the care delivery mechanism, for example how all these assessments, reviews and care plans came together and joined up with Elmcroft, who would actually be delivering them. And most importantly how they were communicated with Beverley and her family, so they understood exactly how her care was being managed and delivered. There was no one assuming the role as the lead coordinator of care. This is not a new finding in West Sussex.

9.1.23. Multi-disciplinary planning should have been seen as essential. It would have facilitated the exchange of information, for example with respect to strategies for communication and care planning.

9.1.24. It is important to note that the wider MDT consists of specialist clinical professionals who have a clear understanding of their areas of expertise. Although there was a registered nurse on each shift with the expectation that they maintain clinical oversight, largely the staff at Elmcroft are care support staff and whilst they are experienced in the role they do, they may not always have the relevant training, skills, and knowledge to deliver or understand parts of a complex wound care plan. To note, within Elmcroft it would always be a registered nurse who would carry out any wound care/dressing changes, however, as a large part of Beverley's daily care was carried out by care support staff, the opportunity to identify any deterioration relating to the wound or generally, may have been more limited than it could have been.

9.1.25. Each individual component within the wider MDT has their own service specification and responsibilities, however there is always strength in coming together for the benefit of the service user. This opportunity allows for any difficulties or challenges in care delivery to be understood and a joint solution reached with the person at the centre.

9.1.26. Therefore, the opportunity for the care staff team to thoroughly understand the whole management plan and for the leadership team at Elmcroft to ensure their staff are appropriately trained and experienced was not evident. This is not a new finding for West Sussex.

9.1.27. It does not appear that any of the professionals raised a safeguarding concern about Beverley until shortly before her death. Already highlighted, in retrospect Elmcroft reflected that they had considered raising a safeguarding concern due to the perceived lack of visibility of the TVN team (we have explored the misconception about the TVN model of working). However, throughout this time, Beverley and her daughter were regularly raising concerns about the wound care that was being provided. They raised concerns to the home, the GP, the TVN team, the lymphoedema team and also to the social worker at the placement review meeting in November 2021. This did not have an impact on care delivery or multidisciplinary approaches.

9.1.28. The safeguarding enquiry found that:

- the Elmcroft care plan was not reflective of the required care and treatment
- the overarching care plan did not include a pain assessment
- Elmcroft staff did not have the skills required for the prescribed care
- the level of contact and consistency from the TVN team was limited due to their delivery model
- agency involvement did not reflect Beverley's voice and views
- agency involvement did not listen to Beverley's daughter
- agencies worked within their own remit and did not coordinate care together with Beverley at the centre

9.1.29. Therefore, the only occasion that a service formally raised concerns was in the week leading to her death. However, there is evidence of multiple concerns about how care was being delivered and different perspectives from each service. It should be noted that the concerns frequently raised by Beverley and Nicola were much earlier in the timeframe.

9.1.30. The chronology and panel discussions align with Nicola's reports about the challenges Beverley encountered related to the care of her leg wounds, communication and coordination issues, and the deterioration of Beverley's health and overall wellbeing. It is important to recognise that the family feel that she suffered unnecessarily in the months leading up to her death and this is somewhat supported by the safeguarding enquiry.

9.1.31. It is not the remit of this Review to monitor the clinical effectiveness of the pathways for wound care, however it is the conclusion of this Review that the pathways didn't work effectively for Beverley. This was in part due to a failure to communicate meaningfully, to ensure that plans were understood and being delivered, and additionally there was a lack of understanding of new models of working (due to the Covid-19 pandemic) between the various agencies and with Beverley and her family.

9.1.32. In terms of how clinical plans were communicated, there was sometimes the expectation that the care home would be the conduit to sharing other agency information with Beverley. This would require "translation" of specialist clinical information into a care delivery plan and also for Beverley's benefit. Elmcroft were not always integral to the planning of care despite the fact that they would be delivering it, and this may be a contributory factor to the lack of robustness in following prescribed care. There was a disconnect between the wider MDT and the team at Elmcroft. This is not a new finding in West Sussex.

9.1.33. Within this Review, the multi-disciplinary care plan refers not only to the plan in place within the care home but also the wider clinical specialty plan. An MDT meeting refers to a formally arranged and minuted meeting to review all aspects of care both within the home and all the clinical input. An MDT did not take place during Beverley's time within the care home and there is no evidence that it was considered either. Discussions with panel members suggest that MDT meetings for care home residents (generally and not only Elmcroft) are not common practice.

9.1.34. In summary, there was not an easy solution for the care of Beverley's leg, and it required several specialist teams to input into a plan which needed to be continually translated for Beverley, and into a care plan that Elmcroft felt confident to deliver. If MDT meetings had taken place, the overall multi-disciplinary care plan, understanding of the status of the leg wound, and the impact on Beverley's overall health, communication and awareness of any delivery barriers would have been much improved.

9.2. Person-centred planning

9.2.1. A striking point in the information and reflections provided for this Review is the extent to which each and every service identified that Beverley was vocal about her care and had capacity. However, her voice was not integral to her care planning and delivery.

9.2.2. In contrast her voice was often seen negatively, for example the safeguarding referral says; "patient dictates care" which suggests that she shouldn't have a choice. Another insight is that she was asked not to contact professionals herself with the rationale that these communications should be done via professionals. With reference to this finding, Nicola comments that her mother "did not go into a care home to lose her purpose and voice".

9.2.3. The Review has identified occasions where this is demonstrated. There was a mattress offered to Beverley that may had aided care delivery that Beverley declined. Another example is where Beverley requested manuka honey dressings for her leg wound (previously used) which were not within the recommended clinical treatment options.

9.2.4. Beverley was known to have full capacity; this was never in question. However, the extent to which these occasions were explored with Beverley to understand her perspective and rationale, and to ascertain the extent to which she had all the information about the consequences of her decisions, is not evident. There are examples where one would expect a robust record of Beverley's views.

9.2.5. Beverley has always coordinated her own healthcare, contacting the GP and other services that were involved. However, when she moved into Elmcroft there was an expectation that she would cease to do this. Beverley reported to her family that she had been asked by Elmcroft to stop directly contacting services with particular reference to the GP and TVN team. The GP understood that Elmcroft had asked Beverley to go through staff to contact the GP, and in contrast Elmcroft report that the GP practice requested that Beverley goes through the care home for any GP calls.

9.2.6. In contrast to the above point, Elmcroft do not accept that they asked Beverley to go through their staff, and in contrast report that the GP practice made this request. It can be seen here that even with the benefit of hindsight and for the purpose of this Review, there is confusion and lack of clarity on this point. This provides some insight into the amount of "multi-way" conversations that were taking place, with Beverley not at the centre.

9.2.7. It is known that she had expressed several times that she didn't feel listened to, and one can only imagine how disempowered the above finding may have made her feel. It is understood that the rationale for this was to prevent confusion and aid communication; paradoxically it did neither but could have promoted a multiagency approach or identification of a lead contact person as discussed in the previous section.

9.2.8. The GP described Beverley as "eloquent" and care home staff described Beverley as "forthright". She did carry out some of her own observations in line with medication requirements, and she also administered some of her own medications. It is interesting to consider the contrast between this and the lack of her voice and views when it was related to her leg wound.

9.2.9. As time went on and Beverley felt that she was not listened to, or fully understand the care plan that was in place for her leg wound, she frequently contacted her daughter to express that she was in pain. She did not feel confident that her leg wound was being managed properly and she was in significant pain. This is a direct reflection of how Beverley viewed her experience.

9.2.10. It is noted that Beverley's daughter tried to advocate for her Mum on a number of occasions to little avail. Often services would not discuss the situation with her because she did not hold Lasting Power of Attorney (LPA) over health matters. This should have been overcome by speaking to Beverley who they knew to have full capacity, and who had in fact given permission for services to communicate with her daughter. Or indeed to explore why someone with full capacity did not feel listened to and needed a family member to represent them. Therefore, the key learning point here is the centrality of relationship-based work, in the first instance with Beverley and then informed by the understanding from those who knew her best such as her daughter.

9.2.11. There is evidence of good engagement from the Lymphoedema team with Beverley, Nicola, and other services. Records and conversations reflect episodes of care from December 2021 to February 2022 where a visit and assessment took place; the team spoke at length with Beverley to go through the reasons why her leg was not healing, and to agree the treatment plan (which was compression wraps). There is also evidence of communication with the care home manager which included suggestions and options for accessing training for care home staff. The treatment plan letter was then emailed to the care home manager, the GP and the TVN team.

9.2.12. Lymphoedema was a significant factor in Beverley's care, treatment, and leg wound healing and thus translation and understanding of their assessments was crucial to the care plan. It is helpful to look at a definition of this condition. Lymphoedema is a long-term (chronic) condition that causes swelling in the body's tissues. It can affect any part of the body, but usually develops in the arms or legs. It develops when the lymphatic system does not work properly. The lymphatic system is a network of channels and glands throughout the body that helps fight infection and remove excess fluid[2]. Therefore a patient with lymphoedema will experience delayed wound healing due to fluid retention within damaged body tissues and specific wound care strategies are required including compression techniques.

9.2.13. To note, the lymphoedema team did recognise that Beverley had given consent for them to discuss care with Nicola and this is reflected in conversations that took place between the lymphoedema team and Nicola throughout February 2022.

9.2.14. Throughout the chronology and the other documentation made available to the Review, one captures glimpses of how Beverley perceived the last two years of her life where she felt disempowered, not listened to, frustrated and unhappy.

9.2.15. The information provided demonstrates that Beverley felt out of control of the decisions about her health. She was significantly anxious about the care of her leg (which she could not actually see due to mobility) and she was suffering significant pain. It should not have been difficult for services to place Beverley at the centre of her care and work together and with her to provide consistent and coordinated care.

9.2.16. The family describe feeling excluded from care planning when they were trying to advocate for Beverley. They do not feel that her wishes and feelings were evident, and they identify communication difficulties between Beverley, family, GP, specialist services and the care home.

9.2.17. The relationship between Nicola and some agencies (TVN team and Care Home) became particularly problematic with the daughter feeling that she may have been perceived as obstructive when asking for clarity on clinical decisions. Nicola feels that it did not make a difference how many times Beverley expressed her concerns or how many times she (Nicola) phoned and complained to the care home and the TVN team, they simply were not heard.

[2] Lymphoedema - NHS (www.nhs.uk)

9.2.18. It is acknowledged above that Beverley's daughter did not have LPA for health matters, however this could have been easily overcome. It should be noted that family members are powerful advocates for their loved one and understand their needs better than anyone, so supporting them through good information and shared goals helps them to advocate effectively for their family member. If there was a barrier to communication this should and could have been addressed by getting all the agencies together to understand how it could be overcome.

9.2.19. It was a finding of the safeguarding enquiry that Beverley wanted her daughter to be part of her planning. Nicola also provided evidence to the Review that her mother had indeed provided consent for information to be shared with her, but despite this there were several occasions when there was a refusal or a failure to share information or include Nicola in planning and decisions.

9.2.20. Analysis of this theme acknowledges that there was an absence of Beverley's voice in her overall care planning and a barrier in working with her and her family that impacted on robust planning and coordination. An opportunity to work together to overcome these issues was not facilitated. The panel agreed that there was sufficient reason for a multi-disciplinary meeting to have been triggered for Beverley which may have facilitated a robust plan to be developed, communicated, and implemented, keeping Beverley at the very centre of it.

9.3. Placement suitability: staff skills and knowledge

9.3.1. West Sussex County Council carried out a needs assessment in 2020 at the point that Beverley required additional care and support. This is when she moved into Elmcroft. It could also have triggered a Continuing Health Care (CHC) checklist but, in this case, didn't. This is not a criticism, simply an observation and will be described below.

9.3.2. NHS continuing healthcare funding is provided if you are considered to have a 'primary health need' for health care and as such Beverley may then have been entitled to NHS fully funded CHC if a primary health need had been identified.

9.3.3. For clarity, the assessment relies on the distinction between social care and health care. Social care is funded by individuals or social services, while health care should be funded by the NHS. Individuals may be awarded NHS funding when they are considered to have an 'overall need' for health care.

9.3.4. Having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall day-to-day care needs to be taken in their totality. In Beverley's case she was in receipt of "Social Care funding" and there was a placement review conducted within the time frame of this Review.

9.3.5. As noted earlier, Elmcroft is a residential care home providing accommodation and nursing care. In terms of nursing care, at this time there was only one registered nurse on duty per shift for up to 30 residents (on the nursing floor), and a team leader who took responsibility for the remaining residents. There was also an additional team leader who worked across the care home.

9.3.6. It is important to consider the context of the care provision. In particular, the differences between a care home and a nursing home. Both nursing homes and residential care homes provide care and support 24 hours a day, however the main difference is that a care home provides personal care and support for people who need help with daily tasks, such as washing, dressing, or eating, but do not need nursing care. Beverley needed both and this was provided within the offer at Elmcroft, however the Review finds that there was limited registered nurse staffing ratios and a reliance of agency staff at that time. This is not unique to Elmcroft.

9.3.7. Already identified is the insufficient clinical oversight for Beverley's care provision. It is noted that appropriate advice was sought from external health providers regarding wound care management. However, Beverley did not always receive wound care in line with her assessed need, there was an occasion where there was a delay in wound dressing change and the opportunity to identify overall deterioration was therefore more limited than it could have been. This was a finding of the safeguarding enquiry and the subsequent CQC inspection. With reference to care package commissioning, the panel concluded that even with CHC eligibility, her placement offer may not have been fundamentally different as it did in fact provide nursing care.

9.3.8. The Review found that there was only one occasion where a safeguarding concern was raised, and this was in March 2022 at the time of Beverley's death. This was raised by the TVN team with concerns about the care delivery at Elmcroft.

9.3.9. Although subsequently found to require improvement, there were no known concerns about Elmcroft at this time and therefore the home was not under the radar of the Local Authority. The framework that this level of activity would come under is the "Operational Framework for Managing Provider Concerns", which was utilised shortly after Beverley's death.

9.3.10. The wider MDT continued with expectations that their agreed plans should be followed, in this case the TVN, vascular and lymphedema teams, and the GP, but when it became apparent that there were inconsistencies, miscommunications and challenges in delivering the right care to Beverley, the root case was not fully explored, and thus no sustainable changes happened. This was explored earlier in terms of the absence of an MDT approach and the lack of Beverley's own views and feelings.

9.3.11. In terms of the care that Beverley needed, it would have been sensible to have considered what knowledge and skills those supporting her would need, and bespoke consideration for each residents' needs should indicate the level of training and qualifications of the staff involved.

9.3.12. With reference to "compression wraps", this is evidenced in several discussions about the provision of training, with consideration of where Elmcroft could access it. Elmcroft understood that training was restricted due to COVID-19. The TVN team clarified that is it not their responsibility or that of their organisation to provide training to care homes, or seek assurance that staff are appropriately trained. This can also be applied to the Lymphoedema team but there is evidence that they did have a discussion with the care home manager about accessing leg ulcer courses and the availability of specific "compression" training via the companies that provide the products. This Review demonstrates a misconception about the accessibility of specific types of training, who is responsible for providing it, and where it can be accessed.

9.3.13. The family have indicated that in the course of several discussions with Elmcroft staff, there was a misconception that compression wrap training should be provided by the TVN team. It is clarified above that this is not the case. The Lymphoedema team did however provide helpful advice about access to training, although there is no evidence that this advice was followed, albeit this was shortly before the time of Beverley's death.

9.3.14. Regarding the above point, it is useful to consider the timeline. Compression wraps were agreed as the most appropriate form of treatment in December 2021. There was some delay in the wraps being delivered (a manufacturers delay) and thus the Lymphoedema team planned to next visit when they had been delivered. This treatment plan letter was shared with the TVN team, the care home, and the GP. In the meantime, the TVN team had been contacted to visit Beverley although this visit was delayed. It was throughout January and February 2022 that Nicola became significantly concerned about the leg wound and about Beverley's overall wellbeing.

9.3.15. It was recognised that communication needed to be strengthened to ensure that all health care plans were being delivered in the right way and any issues communicated back to the MDT. Therefore, this should have led to detailed consideration of whether staff were appropriately trained to deal with Beverley's leg wound, and how they might have been supported to coordinate care in Elmcroft in a more robust way. Lack of scrutiny in these areas led to inconsistency in care delivery.

9.3.16. In summary, although there was a registered nurse on duty per shift at Elmcroft, there were sometimes agency staff and care support staff and whilst they are experienced in the role they do, they may not always have the relevant training, skills, and knowledge to deliver or understand indicators and signs of deterioration of wounds. The opportunity to explore the required skills, knowledge, and training to deliver the required care was missed in the absence of a multi-disciplinary approach.

9.4. Covid-19

9.4.1. Consideration has been given to the impact of the Covid-19 pandemic in terms of delivery of care. This is because the care delivery models of crucial teams changed during this time thus impacting on continuous oversight of leg wound care.

9.4.2. In particular was the TVN delivery model whereas they did not have a "case load", they did not deliver any sort of training on wound care, and thus each episode of care was a new contact/referral. This did not allow for consistency or continuity and impacted on the ability to build a meaningful relationship with their patient.

9.4.3. The Review finds that other agencies/services did not fully understand what the new delivery model consisted of and therefore their expectations were compromised.

9.4.4. There is no evidence that Beverley's care was significantly compromised directly because of this as despite the lack of continuity, the TVN team did respond to each individual referral and fundamentally the clinical assessment and plans were sound. It was the delivery and oversight of the plan that was compromised and due to the absence of MDT processes, it was not collectively understood that there was a problem with the communication, translation, and delivery of the clinical wound care requirements.

9.4.5. Therefore, whilst recognising that there was a general misconception about the delivery model of the TVN team, there is no direct evidence that Covid-19 was a causal or contributory factor to the way services worked together in this case. However, it did expose some systemic issues in terms of how services work together generally.

10. Improvements made

10.1. There are three recommendations to be made in this Review against key areas of practice. However, it is encouraging to see the areas of improvement where learning has already been taken forward and implemented. These developments are all relevant to Beverley's circumstances and ongoing assurance of effectiveness should be sought on a continual basic.

10.2. Progress to note is as follows:

- Sussex Community NHS Foundation Trust have implemented a new model of "Care Home Matrons" to support care homes and residents with more complex needs. With respect to Elmcroft, there are now weekly clinical meetings that commenced in November 2022.

- Sussex Community NHS Foundation Trust have reviewed their service delivery model and now keep each new referral open for an eight-week period; this is included on the advice forms that are provided to referees.

- West Sussex SAB have implemented a Multi-Agency Risk Model but recognise that cases that would not meet this criteria should be strengthened, and work has commenced to consider multi-agency approaches.

- Elmcroft have strengthened their registered nursing staffing ratio during the day shift.

- Elmcroft nursing staff are now accessing compression bandaging training with an external company that specialises in compression bandaging and garments.

- Elmcroft have now embedded mandatory training in wound management which is delivered to all nurses (including the agency nurses).

- Elmcroft have now implemented training in pressure ulcers (including prevention) for all care staff, including how to escalate concerns.

- Elmcroft have implemented a new model of working to strengthen oversight of wound care management that includes a nominated/allocated wound care nurse each week. This provides a consistent point of contact for other agencies.

- The Shaw Healthcare Limited (national provider of Elmcroft) Regional Operations Manager is a clinical leadership role with regular contact arrangements with the community matron to strengthen oversight.

11. Summary

11.1. It is evident that the right services were in place to provide the correct expertise for Beverley's needs, however the extent to how these services worked together with Beverley at the centre is less evident. The fact that a person with full capacity did not know what was happening with her leg wound demonstrates this.

11.2. There was an assumption that the care home as her daily care provider had the skills, knowledge, and expertise to carry out care. It should be noted that with reference to the compression treatment, Elmcroft had identified that specialist training was required for their registered nurses. This was not raised formally by agencies until the week of her death, but it was raised by Beverley and her daughter.

11.3. There are acknowledged gaps in training and knowledge related to some types of wound care treatments within Elmcroft. It is important that assurance and oversight of this is robust to evidence effectiveness of care delivery. This is not unique to Elmcroft and should be applied as a routine method of assurance.

12. Conclusion

12.1. This SAR Overview Report is the West Sussex Safeguarding Adults Board's response to the death of Beverley, to share learning that will improve the way agencies work individually and together.

12.2. The move into a care home was a difficult time for Beverley who had always maintained control and independence over her health matters. During the time that she lived within Elmcroft her voice was lost.

12.3. In terms of the management of her leg wound there was a lack of robust, effective, and coordinated multi-agency work to manage her deteriorating leg wound. This was the source of a great deal of distress and pain. There was no occasion in this case that all those who knew Beverley were convened with her to share information and plan care. If applied, the findings above would have promoted the principles of person-centred care which should underpin good practice care delivery.

12.4. Prior to Beverley requiring care within a care home setting, she was an independent lady with a good quality of life. Although her family recognise that Beverley needed a period of adjustment to come to terms with living in a care home, they note that she could have been happy if she had been listened to and heard, and if her wound care had been managed differently.

12.5. It is not possible without hindsight bias to comment on whether there could have been a different outcome, however Beverley may have experienced an improved quality of life if the following areas had been strengthened:

- Listening and hearing her voice and daily lived experience.
- Ensuring that she was integral to her own care planning.
- Considering the support of her family as a strength and harnessing that to improve outcomes.
- A strong multi-disciplinary approach with Beverley at the centre of it and an identified lead professional.
- Consistent clinical oversight of care plans.
- Confidence in the skills and knowledge of the daily care provider to deliver care in accordance with specialist clinical plans.

12.6. The Review has considered the degree to which this case highlights systemic issues in how the multi-disciplinary team work with daily care providers to ensure quality oversight. The conclusion reached is that this case reflects wider challenges regarding system working and the knowledge and experience of staff responsible for meeting people's needs. This is not a new finding.

12.7. The case also raises the question of who we mean when we refer to a "multi-disciplinary team"; the daily care provider must be central to that and not separate to it. This is not a new finding.

12.8. It is hopeful that the outcomes from this Review will recognise thematic areas of learning from previous Reviews. The findings and recommendations should be monitored for compliance, implementation, and assurance by the West Sussex SAB.

13. Recommendations

13.1. It is noted that progress has been made in some areas of findings by Elmcroft, who have been making improvement in response to the CQC findings. However, the recommendations made in this Review should be applied as learning for the system where deeper and continual assurance is required.

13.2. Arising from the analysis in this Review the following recommendations are made to the West Sussex SAB. These are repeated recommendations:

13.2.1. **Multi-agency working:** the West Sussex SAB are asked to consider its approaches to multi-agency working to include practice guidance for the workforce and:

- Assurance of collaboration and inclusion of the wider/independent care sector
- Assurance of its effectiveness
- Escalation processes both single agency and multi-agency

13.2.2. **Workforce skills and knowledge:** the West Sussex SAB are asked to seek assurance from commissioners and providers on arrangements for ensuring that staff have the necessary knowledge, experience, and skills for meeting the health needs of residents placed in care homes who require specialist care. This should include consideration of bespoke individual training packages.

13.2.3. With reference to the finding of this Review, this should include consistent application of tools for:

- Wound care
- Pain management

13.2.4. **Person-centred care:** The West Sussex SAB are asked to seek reassurance that person-centred care is accurately understood, and that understanding is embedded in practice across partner agencies.