South Ayrshire Health and Social Care Partnership

REPORT

Meeting of **Held on**	**South Ayrshire Chief Officers Group** **7th April 2021**
Agenda Item	**9**
Title	**Significant Case Review - MJ**
Summary: The purpose of this report is to allow chief officers to consider the significant case review report in relation to MJ.	
Presented by	**Chief Social Work Officer**
Action required: It is recommended that the Chief Officers Group consider the content of this report and the issues identified therein. Chief Officers should note the legal advice offered at 6.3	

Implications checklist – check box if applicable and include detail in report									
Financial	☐	HR	☐	Legal	☐	Equalities	☐	Sustainability	☐
Policy	☐	ICT	☐						

SOUTH AYRSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP
CHIEF OFFICERS GROUP
7th April 2021
Report by Chief Social Work Officer

Significant Case Review - MJ

1. PURPOSE OF REPORT

1.1 The purpose of this report is to allow chief officers to consider the significant case review report in relation to MJ.

2. RECOMMENDATION

2.1 It is recommended that the Chief Officers Group consider the content of this report and the issues identified therein. Chief Officers should note the legal advice offered at 6.3

3. BACKGROUND INFORMATION

3.1 On admission to hospital, numerous wounds (7 in number) were noted on the patient's body which prompted an Adult Protection referral to the HSCP. However, the Adult Protection referral was not progressed because MJ passed away the following day.

An Adverse Events Review Group considered the circumstances of MJ`s death and this led to a referral to the Adult Protection Committee requesting an Initial Case Review "to establish how a patient who was known to district nursing and home care services was admitted to hospital with Grade 4 pressure sores. "

The referral was considered by the Adult Protection Committee in December 2019. An Initial Case Review (ICR) meeting was held on 14th January 2020, which agreed to recommend to the Chief Officers' Group (COG) that an independently chaired Significant Case Review (SCR) be convened. The COG supported the recommendation and an Independent Chair was appointed.

Chief Officers accepted the independent chair's SCR report on 10th March and asked for the action plan to be brought forward at today's meeting for scrutiny and assurance.

4. REPORT

4.1 This report introduces David Crawford, independent chair, to talk Chief Officers through his activity, report and findings in relation to MJ.

5 STRATEGIC CONTEXT

5.1 This report aligns with the strategic objective in relation to grow well, live well and age well.

6 RESOURCE IMPLICATIONS

6.1 Financial Implications

6.1.1 None

6.2 Human Resource Implications

6.2.1 None

6.3 Legal Implications

6.3.1 Legal services in South Ayrshire Council and NHS Ayrshire and Arran have received a copy of the Significant Case Review report and legal opinion requested.

South Ayrshire Council legal services advise that if a claim is made, this is not likely to be large given that the sores were not established to be directly related to the cause of death. They would advise, however, that Insurance is put on notice.

At the time of writing no legal view had been forthcoming from NHS Ayrshire and Arran colleagues.

7 CONSULTATION AND PARTNERSHIP WORKING

7.1 The SCR action plan will require input across a range of services. Dependent on the outcome of today's meeting further communications activity is planned.

8. Risk Assessment

8.1 The report contains within it a range of areas requiring remedial attention across the system. Without adequate addressing of these issues' risks will remain in relation to patient safety and associated reputational risks to NHS Ayrshire and Arran, South Ayrshire Council and South Ayrshire Health and Social Care Partnership.

9. EQUALITIES IMPLICATIONS

9.1 The issues contained within the report will disproportionality affected our older population, a protected characteristic within the Equality Act (2010).

10. SUSTAINABILITY IMPLICATIONS

10.1 None

REPORT AUTHOR AND PERSON TO CONTACT

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BACKGROUND PAPERS

Attached SCR Report

31st March 2021

SECTION 1 – INTRODUCTION

1.1. BACKGROUND

MJ (D.O.B. 2.4.1930) was 89 years old when she was admitted to University Hospital Ayr on the 19th July 2019. She was admitted because of respiratory arrest and she passed away in the early hours of the following day.

At the time of her admission it was identified that she had severe pressure ulcers (bedsores). Her family advised that they were told by the medical staff in the hospital that the pressure sores were “the worst they had ever seen”. A letter sent from the hospital to MJ`s GP after her death states that she had “overwhelming sepsis”. The death certificate records the cause of death as “gastrointestinal bleed and atrial fibrillation”. The family were advised that the concerns were such that there was consideration of referral to the Procurator Fiscal however, the records state that “as wounds not directly related to cause of death no requirement for further discussion with Procurator Fiscal”.

MJ`s condition on admission to hospital triggered the NHS Adverse Events process. An Adverse Event is defined as “an event that causes, or has the potential to cause, unexpected or unwanted effects involving the safety of patients “

On admission to hospital, numerous wounds (7 in number) were noted on the patient's body by the Staff Nurse on shift, and the staff had made an Adult Protection referral. However, the Adult Protection referral was not progressed because MJ passed away the following day. An Adverse Events Review Group considered the circumstances of MJ`s death and this led to a referral to the Adult Protection Committee requesting an Initial Case Review "to establish how a patient who was known to district nursing and home care services was admitted to hospital with Grade 4 pressure sores. "

The referral was considered by the Adult Protection Committee in December 2019. An Initial Case Review (ICR) meeting was held on 14th January 2020, which agreed to recommend to the Chief Officers' Group (COG) that an independently chaired Significant Case Review (SCR) be convened. The COG supported the recommendation and an Independent Chair was appointed.

1.2. THE REVIEW PROCESS

A Significant Case Review group was established and the full membership of the group is attached at Appendix 1

The review process follows the guidelines set out in the national guidance (Interim National Guidance for Adult Protection Committees for Conducting a Significant Case Review.) The review group met for the first time on 20th February 2020, considered the Terms of Reference and agreed an initial plan of work. Contact was made with MJ`s family and an initial meeting was held with a member of the family on 13th March 2020.

The impact of the Covid pandemic and related lockdown meant that is was not possible to continue with the review at that time. The reasons for this were explained to the family and the review was therefore suspended by decision of the COG until August

2020. From the point where the review recommenced, all work, including all contact with the family, was undertaken remotely either by phone or via video-conference.

1.3. INFORMATION GATHERING

The review gathered all relevant documentation from all of the agencies involved. We had access to the records from social work, from district nursing and from the integrated care team and the daily care logs kept by the care provider. We had access to the relevant GP records and the hospital records relating to the admission on 19th July 2019. We looked at the contract which is the basis of the relationship between the Health and Social Care Partnership and Care Providers. We had access to the details of the complaint made by the family to the Care Inspectorate and their response.

We interviewed the Registered Manager and a Director of the home care provider, Active Care. We also interviewed 2 of the home carers directly involved in providing care to MJ. Both of these individuals have now left the employment of Active Care. This made the process of arranging the interviews more complicated and significantly slowed the process. However when we did get to speak to them both carers provided invaluable insights in relation to their direct experience of providing care to MJ and we are extremely grateful to them for their cooperation.

In the period from her discharge from hospital in May 2019 until her death, MJ received support from the EICT Team, which is a multidisciplinary team which provides intensive support and rehabilitation on discharge from hospital. We were able to speak with two of the nurses who had direct contact with MJ and with their line managers. MJ also received support from the district nursing team. The nurse who dealt directly

with MJ was on maternity leave and not available for interview but we were able to talk with the Team Leader who was familiar with the background to the case.

As a part of the work of the review, an independent review of the nursing practice was commissioned from staff in another Health Board with specialist knowledge of the management of pressure sores. The report focused particularly on the assessment, treatment and management of pressure sores/tissue viability. The full report is attached at Appendix 2 and the review group had the opportunity to discuss the report with one of the authors.

1.4. A NOTE ON PRESSURE SORES

Pressure sores, also known as bedsores or pressure ulcers, are sore or broken (ulcerated) areas of skin caused by irritation and continuous pressure on part of the body.

There is a standard grading system for these wounds (Source -- The Scottish adaptation of the European Pressure Ulcer Advisory Panel Pressure Ulcer Classification Tool) which reflects their severity.

Grade 1 -- intact skin with redness usually over a bony prominence

Grade 2 -- shallow open ulcer

Grade 3 -- full thickness skin loss

Grade 4 -- full thickness tissue loss. Extensive destruction with exposed bone, tendon or muscle

Ungradable - full thickness skin/ tissue loss where the depth of the ulcer is obscured by dead skin.

On admission to hospital MJ was identified as having sores of differing severity including Grade 4 sores (visible bone) and ungradable sores.

SECTION 2 - HEALTH AND SOCIAL CARE PROVISION TO MJ

2.1. RELEVANT CARE TEAMS

MJ lived on her own following the death of her husband. She had family nearby including her sons and her granddaughter. She first received a care at home service in March 2017. This was provided by Active Care who are a home care provider registered with the Care Inspectorate and who were commissioned by South Ayrshire Health and Social Care Partnership to provide home care services to people assessed by the partnership as needing such services. The last published inspection for Active Care was in November 2019 and the service was rated as “good“ for the quality of care and support and for the quality of staffing.

On her discharge from hospital in May 2019 MJ was referred to the Enhanced Intermediate Care Team (The Enhanced Intermediate Care Team is referred to in some of the records as the ICT Team).

This is a multidisciplinary team which facilitates hospital discharge and supports rehabilitation on a short term and intensive basis. There are a total of 19 staff with backgrounds in nursing, physiotherapy and occupational therapy and there are a range of grades from Band 4 to Band 6.

The team covers all of the South Ayrshire area and over time, the staffing numbers in the team have been declining. Three Advanced Nurse Practitioners have left the team and not been replaced and the linked GP post is unfilled.

The district nursing team, which worked with MJ, provides a service to three GP practices. At the time that MJ was receiving a service from them, there were 12.6 WTE

staff in post against a complement of 20.4. The difference results from unfilled vacancies, sickness absence and maternity leave.

We were told that the staff group, which previously provided a service to one GP practice, now provides a service to three practices with the same staff complement. The team comprises a mixture of Band 3, Band 5 and Band 6 staff. Band 6 would be the traditional grade for a fully trained district nurse but the team has a significant number of Band 5 staff including newly qualified staff nurses.

MJ had input from the district nursing team on 18th and 20 June 2019 and was again referred to the district nursing team by the GP on 4th July 2019 to provide nursing input in relation to the management of pressure sores.

2.2. OVERVIEW OF EVENTS AND CARE RECORDS

From the available records and from talking to those involved it would seem that there were no issues of significance in relation to the service provided by Active Care in the period from 2017 to April 2019. MJ and her family were satisfied with the service and there are no records of complaints or other indicators of dissatisfaction. Although there was an element of personal care in the care plan MJ is described as being very independent and wanted to do her own care whenever possible. MJ was admitted to hospital on 12th April 2019 following a fall. She sustained a fractured pelvis and was in hospital until 16th May 2019. Prior to her discharge the view was that her mobility was improving and that she should have physiotherapy follow up once she was home. Her family did work to ready the house for her discharge.

On discharge, the home care package was restarted at the same level of 3 visits per day; 7 days per week, with one of the visits intended to include the provision of

personal care. The discharge was viewed as a restarting of previous service and a new community care assessment was not done prior to discharge.

The records show that the care package re-commenced on 17th May and that on that day MJ declined assistance with personal care. This was the beginning of a pattern of MJ regularly declining assistance with her personal care, which continued right up until her re–admission to hospital on 19th July 2019.

From the 17th of May until the 7th of June records indicate that MJ declined personal care on 17 occasions (including 6 consecutive days between 27th May and 1st June) and only accepted assistance with her personal care on 4 occasions.

MJ was visited by a nurse from the ICT team on 7th June and the record of that visit is shown below:

Visited by Nurse

Evidence of vomiting bug. GP has commenced on anti-emetics.

No analgesia for two days as it was causing a rash. GP changed to oramorph.

Patient in bed and evidence of loose stools - bed covers and nightdress soiled.

Examined groin area - extremely excoriated and weeping with evidence of fungal infection. Patient states these are very painful.

Nurse washed and cleansed groin and underneath breasts. Gave patients a body wash as carer's had documented that patient was refusing same for some time. Nightgown changed. Cleaner arrived and was changing her bed linen.

Care company supervisor informed of state of patients skin and asked if staff could be vigilant of same. Social Worker also informed of patients non-compliance with carer's regarding personal care. Nurse contacted GP surgery to provide cream of excoriation.

The ICT contacted social work to identify concern regarding personal care to highlight MJ has been declining personal care, excoriated skin below breasts and by groin, which is bleeding. Allocated worker confirmed with Active Care requirement for carer's to prompt with personal care and application of prescribed anti-fungal cream. ICT to visit over the weekend.

From the records, it seems clear that this visit and the contact with the care provider brought about some change. In the following days, the records show MJ accepting assistance with her personal care and the care staff applying the creams as requested. The nursing record for the 9th of June says "evidence that cream was being applied". This improvement appears to have been sustained until the 21st of June when the previous pattern of MJ declining assistance with personal care begins to re-emerge. Between 22nd June and the 3rd of July, records indicated that MJ declined assistance with her personal care on 8 occasions.

On 3rd July, there was a further visit from a nurse from the EICT Team and the record is shown below:

Visited by Nurse, ICT

Breast excoriation had cleared up. Groin slightly red, evidence of cream being applied. Patient lying in a soiled bed and refused to have this cleaned up. Also refused to be freshened up. Obs checked. Social worked informed that patient has declined treatment form nurse.

Last visit from ICT. Discharged to the care of District Nurse and social work as patient non-compliant with therapy. Discharge letter sent to GP on 19/07/19 stating:

"Patient lies in bed for most of the day, refusing to engage with ICT. Refusing personal care at times from carer's. Has commode at bedside. Transfers with zimmer. Can

mobilise short distances with same but refuses. Social Worker aware of the above will go out to assess patient. Has community alert" Discharged from ICT on 03/07/19 however, letter completed on 19/07/19

The decision to terminate the involvement of the ICT team was made on 3rd July but because of holidays, the letter confirming this to the GP was not completed until the 19th of July. Social work were notified by phone on 19th July (the day of MJ's readmission to hospital) and the issue of MJ's non-compliance with the care plan was again highlighted.

On 4th July, the records show that in addition to the carers who were visiting three times per day MJ was visited by the supervisor from Active Care and her GP.
The record of the GP for this date is as follows:

I received a home visit from a carer due to some blood in either clothing or commode. It was unclear from the history exactly where the blood was from. I was unable to fully assess MJ and as a consequence requested and assessment from the District Nursing Team on my return to the surgery. I had no further contact after 4.7.19

On 5th July 2019, the district nurse team visited and the record shows the following:

DN visit to check sacrum carers request, continue barrier cream

The district nurse team visited for the final time on the 8th of July and the record is as follows:

DN visit to review sacral area, area almost healed advised to continue barrier cream. Discharged advised carer's to call DN team if needed

From 9th July until her admission to hospital on 19th July, the care of MJ was provided solely by the carers from Active Care. During this period, the records show that MJ declined assistance with personal care on a further 5 occasions.

The records for Active Care for 17th July indicate the following:

MJ tired. Assisted body wash, fresh nightie on. Bed sheet and pillowcases dirty/filthy. I've asked twice to change them but MJ refused, offered second time and she got very angry. Office informed. SOH contacted. Toast and tea for breakfast. Flask with tea, glass with water, jug with milk. Commode emptied. Rubbish out. All well on leaving

From the records it appears that a homecare service was provided for the final time on 18th July. MJ was admitted to hospital on 19th July and died the following day.

2.3. COMMENTARY

Over the period of their involvement, MJ had contact with 2 nurses from the ICT team as well as a physiotherapist and an occupational therapist. The view of this team was that MJ was happy to be home from hospital after discharge in May 2019 and her initial engagement was good. However, over the weeks MJ`s cooperation with them declined. She refused continuing physio and OT support and was increasingly reluctant to engage with the nurses. She declined the nurse's offers of assistance with personal care and declined their offer to check her pressure sores. They found MJ reluctant to get out of bed and, although the original purpose of the service was to assist MJ to return to the level of functioning that she had prior to her hospital

admission, by 3rd July a multi- disciplinary decision was made within the team that MJ should be discharged from their service as she was" non- compliant with therapy".

2.4. DISTRICT NURSING TEAM

At the point where MJ was discharged from the district nursing service, they were not aware that the EICT Team had already discharged MJ from their caseload. From the 8th of July until her return to hospital on 19th July, the only service in contact with MJ was the home care service provided by Active Care.

The Active Care record for 18th July are shown below:

MJ tired. Assisted body wash, fresh nightie on. Bed sheet and pillowcases dirty/filthy. I have asked twice to change them but MJ refused, offered second time and she got very angry. Office informed. SOH contacted. Toast and tea for breakfast. Flask with tea, glass with water, jug with milk. Commode emptied. Rubbish out. All well on leaving. MJ feeling better. Commode emptied and cleaned. Soup for dinner. Fresh tea made. Bread and butter pudding for after. Flask refilled. Had a chat. MJ ok. Still not 100% Commode emptied and cleaned. Cup of tea, rice pudding and melon left. Water prompted. Curtains shut. Had a chat.

MJ ok this morning. Didn't sleep to good. Declined personal care, told me that her cleaner will do it later. When she moves into her new bedroom. Commode emptied. Blinds open. Toast and marmalade for breakfast x 2. Cup of tea and flask of tea. All well on leaving.

MJ fine. Half fish-pie and half potato mash, tea. Dishes done. Commode emptied and cleaned. Had a chat, all well.

MJ fine. Boiled egg sandwiches, tea. Fresh flask of tea. Dishes done. Commode emptied and cleaned. Chat all is well.

From our discussions with the Active Care carers, they felt that MJ was becoming increasingly frail. She found it difficult to get out of bed and difficult to stand. She may have been in pain from her previous hip fracture. She was extremely tired and they felt that she declined personal care because she was simply too tired to accept it. Even when she did accept their assistance, the "body wash" they were able to do was extremely superficial. MJ would not allow them to see or touch most of her body. They would wash her hands and face and sometimes her legs. They advised us that they were not aware that the bedsores were developing and did not see the vulnerable areas of her body even when providing a body wash.

SECTION 3

3.1. SPECIALIST REPORT FROM NHS GREATER GLASGOW AND CLYDE

As a part of the review, a report analysing the nature and quality of the nursing service was commissioned from Greater Glasgow and Clyde Health Board. The report is attached at appendix 2. The key conclusions of the report include the following;

- There are clear omissions in recording of information and identification of the assessors, designation, timeline and signatures
- Patient information and identifiable information was not evident
- No treatment plans across the disciplines,(EICT and DN services)
- There is no evidence of care plans or the use of equipment to relieve pressure areas

- There is lack of evidence of appropriate use of tools/frameworks to assess the patient's needs
- There was a lack of recording of name or signature of assessor, no patient identifiable information, use of abbreviations, no date, time of assessment, or treatment plan completion
- There was no pressure ulcer risk assessment in place, where it was recorded that there was a pressure area risk
- No preventative action to reduce further ulcer damage documented. This would have included equipment consideration.
- No accurate charting of wound so unable to say if change to pressure area for ongoing treatment planning
- Wound recorded as very small breaks to both buttocks, aetiology not described
- No documentation regarding the areas being pressure ulcers, moisture lesions or trauma
- Not recorded in pressure ulcer record
- Documented that patient was spending long periods in bed, no evidence prompted of pressure ulcer risk/prevention or equipment use
- AWPARAC was updated however did not reflect presentation and risk, as it was assessed as lower than clinical presentation
- No pressure ulcer chart and no pressure ulcer prevention care plan
- Patient discharged from DN caseload despite ongoing tissue viability issues

SECTION 4

ANALYSIS AND CONCLUSIONS

4.1. MJ was discharged from hospital with a care package including both health and social care services, which was intended to keep her safe and well at home and to assist her to return to her previous level of functioning. When she was re admitted to

hospital she had severe pressure sores. It is clear from the severity of the sores that the care package had failed to ensure her safety and wellbeing.

Before outlining the key issues in this case, it should be made clear that the matters outlined below arise from the operation of the care system, which was there to support MJ, and not from the failings of any individual or group of staff. We found the staff we spoke to caring and committed. They were honest and forthright in expressing their views and without their direct evidence we would not have as full a view of the events and circumstances. They spoke of MJ with genuine affection. A nurse described spending an hour trying to "cajole" her into accepting help with her personal care which she declined despite the fact that her clothing and bedding were soiled. When the nursing teams had withdrawn the home carers were there three times a day, every day, trying to do their best for a client who was unwilling, and increasingly unable, to accept their assistance.

We would identify four key issues, which contributed significantly to the failure of the community care package to safeguard MJ and to promote and sustain her wellbeing.

4.2. The nature and quality of the nursing service.

The report provided by NHS Greater Glasgow and Clyde is critical of the standards and practice of both the EICT team and the district nursing team. The EICT team was the core team supporting MJ after her discharge. The district nurse team involvement arose specifically from concerns about pressure sores.

Both teams accept the conclusions of the report as fair and accept that the standards asserted in the report are those, which should have guided the care, which MJ received. Staff acknowledged that there was a significant deficit in the recording of the

care provided to MJ and while they believed that some elements of the care was better than the records suggest they accepted that the poor quality of the record keeping meant that they could not provide evidence in support of this view. We were told that a process of audit and improvement had been put in place to respond to each of the issues raised in the report.

4.3 . The decision to withdraw the nursing service

The EICT withdrew their support from MJ on the basis that MJ was not cooperating with the rehab services. The district nurse team withdrew on the basis that their task had been completed i.e. the sores were healing. As stated earlier the district nursing team did not know that the EICT Team had withdrawn. It is now accepted that the decision to close the case should not have been made and that the lack of communication between the teams in this case was reflective of a wider issue of the lack of integration and coordination between different elements of the nursing services. At that time the teams operated with separate, paper-based recording systems so decisions made by one team were not visible to the other team.

4.4 . The lack of knowledge and experience of the staff providing the home care service

The home care staff who cared for MJ were not sufficiently experienced or trained for the tasks they were expected to undertake. The impact of this inexperience was exacerbated by the decisions of the EICT team to withdraw which left them with the sole responsibility for her care.

The role of home care staff in the management of pressure sores is limited. As in this case, they can apply ointments as prescribed and there would be a reasonable expectation that in assisting someone with their personal care they would be vigilant to signs of pressure areas developing or deteriorating, particularly if there was a history

of sores developing. In such circumstances, they should seek immediate support of the GP or nursing services.

In this case the carers told us that they did not recall receiving training in relation to the identification or management of bed sores and they said that at the time they were caring for MJ they had never actually seen a bed sore. They did not understand the significance, or the impact, of MJ spending more and more time in bed and they did not receive the support or guidance that they needed in order to deal with a client whose capacity to cooperate with the provision of personal care was deteriorating. For all their inexperience they did properly identify that the care plan for MJ did not properly reflect her deteriorating health.

4.5 . The failure to address non-compliance with the care plan

From the day of her discharge from hospital there were issues relating to MJ`s reluctance to accept personal care. There is no question that she had the mental capacity to make decisions about her own care. She was entitled to be independent and to guard her privacy and dignity. However, her continued refusal to accept assistance with personal care, whether offered by nursing staff or by home care staff, cannot be viewed as fully informed decision on her part. There is no evidence that she was assisted to understand that by declining assistance with her personal care she was endangering her general health. The care staff could not monitor the vulnerable areas of skin and by declining assistance even when the bedding was soiled by faeces she was putting herself at risk of infection. At no point did anyone take a step back and say, “this just isn’t working”. Had this happened there could have been a concerted effort to influence MJ`s decisions by enlisting the support of her family and the various professionals involved in her care. It has already been shown that the intervention by an experienced nurse from the ICT Team on 7th June resulted

in a period of increased cooperation with the home carers. It is clear from the records that the home carers alerted their managers to their concerns about MJ declining assistance with personal care and that the supervisor from Active Care visited in response to this.

The contract, which defines Active Care's responsibilities states

(i) Work closely with other agencies and support services involved with and working on behalf of Service Users, adopting an enablement/rehabilitative approach where this is identified in the individual Support Plan;

(ii) Provide services as part of a planned programme of care designed for the Service User;

(iii) Work to achieve the outcomes as specified for the Service User in their individual Support Plan;

(iv) Consider the safety of the Service User

It is not clear that Active Care properly complied with this obligation. The records show the nursing service highlighting concerns to social work and social work immediately contacting Active Care. There is no record of Active Care ever contacting social work to express concerns or to convey to them that a key element of the care plan was not being implemented.

SECTION 5. RECOMMENDATIONS

The review group would make the following recommendations:

1. The Health and Social Care Partnership should take the measures necessary to ensure that there is proper adherence to national clinical standards across all of its community nursing services. In order to achieve this recommendation, the partnership

will require to review the resources available to community nursing teams in order to ensure that the staffing arrangements are sufficient to meet the standards.

2. The Health and Social Care Partnership should take the measures necessary to ensure the proper coordination of community nursing services, including measures to improve communication and the sharing of information.

3. Home care providers should ensure that, at a minimum, the induction training for home care staff should include input on the recognition, and provide clarity on the limited role of home carers, in the management of pressure sores.

4. The Health and Social Care Partnership should develop a protocol to guide staff where there is significant non-compliance with a care plan. The protocol should include guidance on risk, on case review, on escalation, and on “capacity” issues.

5. The Health and Social Care Partnership needs to be able to satisfy itself that provider organisations are fully compliant with the terms of the contract for home care provision. In order to do this the HSCP needs to have sufficient resource dedicated to contract compliance activity to be able to provide assurance that the externally purchased home care services, which constitute 70% of the total home care provision, are consistently operating to the required standards.

6. The family made a complaint to the Care Inspectorate in 2019 regarding the service provided by Active Care. The specific concerns were

1. MJ did not experience care and support in accordance with her care plan.

2. The care service did not adequately communicate with the appropriate individuals regarding a deterioration in MJ's health and skin integrity.
3. The care service did not maintain adequate records regarding a deterioration in MJ's health and skin integrity.

The Care Inspectorate did not uphold any of the complaints. We would recommend that this review is sent to the Care Inspectorate in order that they might review their findings.

SECTION 6 – APPENDICES

Appendix 1– List of Review Panel Members

Appendix 2 – Greater Glasgow & Clyde Report

APPENDIX 1 – **List of Review Panel Members**

LIST OF REVIEW PANEL MEMBERS

NAME	DESIGNATION
David Crawford	Independent Chair – Significant Case Review
Mark Taylor	Adult Support & Protection Lead Officer
Karen Briggs	Legal & Licensing Manager, South Ayrshire Council
Billy McClean	Head of Service, Community Health and Care Services
Rosemary Robertson	Associate Director of Nursing NHS Ayrshire and Arran
D.C.I. Amanda McHarg	Police Scotland
D.C.I. Kenny Armstrong	Police Scotland

APPENDIX 2 – Greater Glasgow & Clyde Report

Review of case records on behalf of NHSA&A undertaken by NHSGGC 31/08/20

ISSUE IDENTIFIED	WHAT SHOULD HAVE HAPPENED	SUPPORTING EVIDENCE

ICES comprehensive assessment: • no patient identifiable information recorded on document • no name, designation or signature of assessor • frequent use abbreviations • no date and time of assessment (assuming completed at first visit on 17/5) • section for treatment plan/recommendations blank • comprehensive assessment information does not appear to include pressure ulcer risk assessment • comprehensive assessment information identifies "very red and fragile right heel, at risk of breaking down" No evidence of preventative action taken to reduce risk of further pressure ulcer damage	All documentation should adhere to NMC code, section, 10 Keep clear and accurate records relevant to your practice Pressure risk assessment should be done on admission to community caseload in line with National standards Pressure ulcer prevention care plan should have been completed and reviewed in line with changing clinical assessment	NMC The Code 2015 Health Improvement Scotland National Prevention and Management of Pressure ulcer Standards, September 2016
ICT input: 23/5/19 assessment identified patient spending long periods in bed, no evidence that this prompted a reassessment of pressure ulcer risk or evidence that pressure ulcer prevention discussion took place including consideration of equipment to reduce pressure risk	Pressure risk assessment should be reviewed when clinical condition changes Pressure ulcer prevention care plan should have been completed and reviewed in line with changing clinical assessment	Health Improvement Scotland National Prevention and Management of Pressure ulcer Standards, September 2016

07/06/19 (ICT Team) visit recorded however unable to determine why as previous entry (06/06/19) stated visit would be the following week. At this visit patient only eating small amounts (previously recorded 2 stone weight loss), was experiencing loose stools and reported to be lying on faeces soiled bedding. Excoriated and weeping areas on groins and below breasts, evidence of fungal infection. This was the first time that it was documented that patient was "non-compliant" with personal care. Evidence in patient record of communication with care at home supervisor and allocated social worker	Patients altered bowel habits should have triggered a reassessment including; • continence assessment • medication assessment • pressure ulcer risk assessment Poor appetite should have triggered; • nutritional assessment (MUST) Excoriated and weeping areas should have triggered; • wound assessment chart The nurse should have recorded what actions were taken to encourage patient to allow personal care to be carried out.	NMC The Code 2015 Health Improvement Scotland National Prevention and Management of Pressure ulcer Standards, September 2016 Health Improvement Scotland, Food , Fluid and Nutritional Care Standards, 2014 Health Improvement Scotland, Scottish Wound Assessment and Action guide, 2010
09/06/19 (ICT) breast excoriation remained extensive and weeping. No evidence that other issues relating to loose stools or non-compliance with personal care were discussed.	• pressure ulcer risk assessment should have been completed • wound assessment and chart should have been completed	Health Improvement Scotland National Prevention and Management of Pressure ulcer Standards, September 2016 Health Improvement Scotland, Scottish Wound Assessment and Action guide, 2010

13/06/19 (ICT) a visual check of breasts and groins were recorded. Recorded that patient states “heels and sacrum intact”	Pressure areas should have been checked, if patient not consenting to pressure area checks this should be recorded within the record and any actions undertaken to increase concordance. Wound assessment chart should be in place for excoriation	Health Improvement Scotland National Prevention and Management of Pressure ulcer Standards, September 2016 Health Improvement Scotland, Scottish Wound Assessment and Action guide, 2010
17/6/19 (DN) referral made to District Nurse service, first visit carried out on 18/06/19 Risk Assessment ; Evidence that NHSA&A Adapted Waterlow Pressure Area Risk assessment chart (AWPARAC) was completed at first visit however: • risk assessment did not accurately reflect clinical presentation and as a result the risk assessment outcome was lower than it should have been • pressure ulcer record did not accurately record grade using (Scottish Adapted European Pressure Ulcer Advisory Panel Pressure Ulcer Grading Tool 2014). The pressure ulcer was graded as 1 / 2 • no evidence of wound assessment chart • no evidence of pressure ulcer prevention care plan Pressure ulcer prevention discussion documented in visit record, specific mention made to pressure relieving mattress which patient advised she had purchased and was awaiting delivery. There	Holistic nursing assessment should have been completed including: • continence assessment • medication assessment • accurately completed pressure ulcer risk assessment • nutritional assessment (MUST) • accurately completed wound assessment	NMC The code 2015 Health Improvement Scotland National Prevention and Management of Pressure ulcer Standards, September 2016 Health Improvement Scotland, Scottish Wound Assessment and Action guide, 2010 Health Improvement Scotland, Food , Fluid and Nutritional Care Standards, 2014

was no anticipated date for delivery recorded. Documentation provided to review team does not appear to include a nursing assessment document, only AWPARAC, Care plan and evaluation sheet. This may have been completed but we are unable to determine if a continence assessment and nutritional assessment were completed in full. Review team would like to note that there does not appear to be any sharing of information with ICT team who still had patient as an open case		

03/07/19 (ICT) Visit record notes that patient is lying in soiled bed, refusing change of bedding. Appetite remains poor, evidence noted that personal care has been refused by patient. When contacting allocated social worker the nurse noted that they were on leave until 15/07/19. Plan noted to discuss with social worker regarding refusing of personal care however unclear if this was on the return of the allocated social worker or with a duty social worker No evidence of assessment of nutrition, continence, pressure ulcer risk assessment or pressure area. Patient appears to have been discharged the following day, unclear if this was communicated to the patient.	Holistic nursing assessment should have been completed including: • continence assessment • accurately completed pressure ulcer risk assessment • nutritional assessment (MUST) • accurately completed wound assessment The care record should have evidence that the nurse explained the risks to skin integrity by not having regular personal care and associated risk factors included poor appetite, reduced mobility, faecal incontinence. Social work should have been informed by the nurse and the care at home service of the non-compliance with personal care and the outcome of the discussion should be recorded in the patient record	NMC The Code 2015 Scotland National Prevention and Management of Pressure ulcer Standards, September 2016 Health Improvement Scotland, Scottish Wound Assessment and Action guide, 2010 Health Improvement Scotland, Food , Fluid and Nutritional Care Standards, 2014 Adult Support and Protection Scotland Act 2007

05/07/19 (DN) Appears to have been a planned visit for pressure area check. Evidence that NHSA&A Adapted Waterlow Pressure Area Risk assessment chart (AWPARAC) was updated at this visit however: • risk assessment did not accurately reflect clinical presentation and as a result the risk assessment outcome was lower than it should have been • no evidence of wound assessment chart • no evidence of pressure ulcer prevention care plan Pressure ulcer prevention discussion documented in visit record, specific mention made to hospital bed and the patient advised she had purchased her own. No remedial action appears to have been taken around the temporary use of a pressure relieving surface until own equipment was delivered. Documentation provided to review team does not appear to include a nursing assessment document, only AWPARAC, Care plan and evaluation sheet. This may have been completed but we are unable to determine if a continence assessment and nutritional assessment were completed in full. Documented that patient had superficial break in nursing record however pressure ulcer record records it as a pressure ulcer grade 2 – superficial break doesn't accurately describe aetiology of wound Unclear if shared records available re ICT social work referral re non-compliance with personal care. No evidence that DN service communicated with Social Worker or Care at Home service despite finding patient again on soiled bedding.	Holistic nursing assessment should have been completed including: • continence assessment • medication assessment • accurately completed pressure ulcer risk assessment • nutritional assessment (MUST) • accurately completed wound assessment An escalation of concern around personal care should have been made to the care at home service and the allocated social worker. The nurse should have recorded what actions were taken to encourage patient to allow personal care to be carried out.	NMC The Code 2015 Scotland National Prevention and Management of Pressure ulcer Standards, September 2016 Health Improvement Scotland, Scottish Wound Assessment and Action guide, 2010 Health Improvement Scotland, Food , Fluid and Nutritional Care Standards, 2014 Adult Support and Protection Scotland Act 2007

08/07/19 (DN) Follow up visit for wound care. Patient was feacally soiled on nurse's arrival and required assistance into bathroom and with personal care. Assisted back into bed with soiled bedsheet as patient refused to allow nurse to change. Unable to determine if initial wound had changed due to no accurate wound assessment chart or even measurement within the care record. Additional wounds recorded as very small breaks to both buttocks, no documentation available to determine whether these are pressure ulcers, moisture lesions, trauma etc. Unable to determine how many breaks. Not recorded in pressure ulcer record. The NHSA&A Adapted Waterlow Pressure Area Risk assessment chart (AWPARAC) was updated at this visit however; • risk assessment did not accurately reflect clinical presentation and as a result the risk assessment outcome was lower than it should have been (it had been reduced to low risk despite ongoing high risk factors) • no evidence of wound assessment chart • no evidence of pressure ulcer prevention care plan Patient discharged from DN caseload despite ongoing tissue viability issues. Care of wounds delegated to care at home service despite evidence that patient was non-compliant with care at home service input and wounds had increased in number over a period of 3 days. It would appear from the DN care record that the patient was never reviewed by a District Nurse, all care was provide by staff nurses. DN evaluation sheet does not consistently have printed name or designation of assessor. Time not always recorded.	Holistic nursing assessment should have been completed including: • continence assessment • medication assessment • accurately completed pressure ulcer risk assessment • nutritional assessment (MUST) • accurately completed wound assessment An escalation of concern around personal care should have been made to the care at home service and the allocated social worker. The nurse should have recorded what actions were taken to encourage patient to allow personal care to be carried out. Patient should not have bed discharged to care at home service for wound care All documentation should adhere to NMC code, section, 10 Keep clear and accurate records relevant to your practice	NMC The Code 2015 Scotland National Prevention and Management of Pressure ulcer Standards, September 2016 Health Improvement Scotland, Scottish Wound Assessment and Action guide, 2010 Health Improvement Scotland, Food , Fluid and Nutritional Care Standards, 2014 Adult Support and Protection Scotland Act 2007