Rotherham Safeguarding Adult Board

Safeguarding Adult Review

A 2016

Margaret

Overview Report

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1. Introduction and Background

1.1. Margaret was a 92-year-old who was a resident in a Nursing Care Home (NCH) from November 2012 until her death on 11th February 2015. Prior to her admission to the NCH on 8.12.2012, Margaret was a long-term resident at an Elderly Mentally Infirm Residential Care Home placement between 13.03.2007 and 01.11.2012. Margaret was discharged from NHS Mental health providers in July 2011. She was admitted to hospital on 13.09.2012 with significant pressure damage which resulted in amputation of her foot. Safeguarding concerns were raised with the Local Authority Adult Care Service. Margaret was reassessed as requiring a Nursing Care Home placement and transferred to the NCH in a funded nursing care (FNC) continuing health care placement (CHC)[1]. Margaret had significant health needs with hypothyroidism, depression, dementia, contracture of lower limbs and anaemia.

2. Circumstances Leading to the Review

2.1. In February 2015 Margaret was admitted by the GP to The NHS Foundation Trust Hospital due to concerns regarding her poor condition. It was believed she was at this point in a myxoedema coma[2], and was critically ill. Her temperature was unnaturally low (33.9°C) and she was slightly blue. Margaret died nine days after admission.

2.2. Margaret's death certificate stated:

- Myxoedema coma
- Hypothyroidism
- Alzheimer's dementia

2.3. Margaret's grandson raised a safeguarding alert related to his grandmother being admitted to hospital in a coma and having pneumonia. Concerns were that Margaret had been in an environment with windows left open. Subsequently the NHS Foundation Trust made a further referral due to concerns that Margaret was in a coma due to a thyroxine crisis and suggestions that she had not had her essential thyroxine medication for over 2 years and that this was more likely to be the cause of the poor physical condition that Margaret was in on admission.

2.4. The outcome of the ensuing Section 42Enquiry [3] was that neglect by omission in respect of the medication that was not received by Margaret, led to her death.

2.5. In July 2016, the Independent Chair of RSAB agreed that the criteria for a Safeguarding Adult Review was met.

3. Methodology

3.1. The Care Act 2014 states that a Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a

[1] National framework for NHS continuing healthcare and NHS funded nursing care
https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

[2] **Myxedema coma** is defined as severe hypothyroidism leading to decreased mental status, hypothermia, and other symptoms related to slowing of function in multiple organs. It is a medical emergency with a high mortality rate.

[3] An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.
http://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/

Safeguarding Adults Review (SAR) and these are included in Appendix 1

3.2. The Care Act 2014 Statutory Guidance states that the process for undertaking SAR should be determined locally according to the specific circumstances of individual cases.

3.3. This SAR was focused on one main issue related to how and why Mrs. B did not receive her medication and ultimately died as a result. The terms of reference and methodology were therefore based on a proportionate learning lessons model.

3.4. The SAR panel agreed to use a mixed methods approach based on systems methodology. Chronologies and a completed case file audit, using an agreed template, were requested from the agencies that had provided care to Mrs. B.

3.5. Members of the panel, practitioners and their line managers, report authors and safeguarding leads came together for a Practitioner Learning and Reflection Day (PLRD). Attendees at the PLRD had an opportunity to review the written material prior to and during the day. The PLRD also included group work whereby attendees identified areas where learning had occurred. In line with Care Act statutory guidance, the PLRD ensured full engagement from agencies who had provided care to Mrs. B and attempted to understand the systems that practitioners were working within to understand why practitioners practiced in the way that they did and how they made decisions.

4. The Reviewer

4.1. Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in Safeguarding roles in the NHS for a number of years. Karen is completely independent of RSAB and its partner agencies.

5. Process and Scope

5.1. Full Terms of Reference and Project plan were agreed on 11.11.2016 and are attached as Appendix 1. It was agreed that the scope of the review would take account of agency involvement from the time that Margaret became a resident at the NCH in November 2012 until the date of her death. This was later reviewed and amended to take the scoping period up to the date of admission to hospital on 2nd February 2015 as there were no concerns identified following that admission. Agencies were also asked to consider any relevant information prior to the scoping period.

5.2. Agencies who provided written reports and were involved in this review;

- The NHS Foundation Hospital Trust
- The Local Authority;
  - Adult Care Service
  - Strategic Commissioning
  - Adult Safeguarding Team
- The General Practitioner
- NHS Mental Health Provider (latterly provided information on request)

5.3. The NCH who provided care to Margaret has undergone significant changes since the time period under review. Shortly after the death of Margaret the previous management company deregistered the nursing beds, making it a residential care home. This then followed a change of management company and changes of registered manager. The current company and manager did not feel that they had the required knowledge of the circumstances of the time that Margaret was in the NCH to

be able to be involved in the review. This led to a significant gap in the information provided to the review from the systems perspective.

5.4. A registered manager from another care home, albeit that it was a care home without nursing beds, attended the PLRD to support the review in the understanding of the systems that care homes work within and this review benefited from that involvement.

5.5. Subsequently information was gathered by staff from the local authority from the records at the NCH to support the learning for this review. The lead reviewer had access to this information.

5.6. The community pharmacy who provided support to the NCH through most of the scope of the review changed in late 2014. The current pharmacy were contacted by the reviewer and were extremely helpful in providing information about their role within care home settings and were keen to understand any learning that may come out of the review. The previous contracted community pharmacy in the locality was also contacted. The pharmacy indicated that they no longer have responsibility for care homes and did not have staff that would have been involved but did give a national contact number. The national operations centre, however, indicated that the support offered to care homes was very much based on the contract/business arrangement with the care home at the time and could not comment or provide any further information. Further discussions with the Professional Standards Team at the National Operations Centre did reveal that they do have policies and procedures as well as newsletters that go to their community pharmacies that cover the issues that this review raises.

5.7. It came to light during the review that the funding and ultimate reviewing responsibility changed in January 2013 and therefore information was sought from the Mental Health NHS Foundation Trust.

6. Parallel Processes and Family Engagement

6.1. Margaret's grandson, was informed of the decision to commission a SAR. The RSAB manager met with him to give him more detail about the review. He indicated that the family would like the review to identify learning that means that no other adult in a care home goes without essential medication.

6.2. Margaret's grandson made some comments on the findings of the review to which the Chair of the Board and the Author responded during a visit.

7. Hypothyroidism

7.1. Margaret died as a result of very low levels of thyroxine in her blood thought to be from not taking her prescribed medication to maintain these levels. It is therefore important to understand the nature of the condition in order to inform the serious nature that the lack of thyroxine has on the body.

7.2. Hypothyroidism is the name given to the condition resulting from an under-active thyroid gland. This means that it is not producing enough thyroid hormone for the body's needs. There are a variety of causes of the disease and symptoms are varied but include;

- fatigue and tiredness
- increased awareness of the cold
- dry and coarse skin
- dry and thinning hair
- hoarse or croaky voice

- constipation
- muscle weakness, cramps and aches
- pins and needles in the fingers and hands (carpal tunnel syndrome)
- weight gain
- puffy face and bags under the eyes
- slow speech, movements and thoughts
- low mood or depression
- memory problems
- difficulty in concentration
- slow heart beat
- slightly raised blood pressure
- raised cholesterol

7.3. The treatment for this condition is thyroxine replacement. In the early stages blood levels of thyroxine are monitored until the correct dose is identified to maintain the right amount of thyroxine in the body. It is usual then for annual blood tests to be undertaken to ensure maintenance of healthy levels or incidental testing should any symptoms return.

7.4. Patients with hypothyroidism usually have their medication managed by the GP and would be referred to a specialist should management prove complex. People with hypothyroidism need to take replacement medication for life. A few missed doses of the medication are not likely to lead to serious medical concerns but prolonged failure to take the right level of medication may have serious consequences.

8. Medication management narrative

8.1. This section aims to provide the facts that were available to the review regarding what all agencies knew and understood about the management of medication for Margaret whilst she was in the NCH. It covers not only the specific medicine management issues but all aspects of other issues that impacted on the management of Margaret's medication.

8.2. Prior to admission to the NCH, the social worker undertook a care and support assessment to identify Margaret's needs and how these would need to be met. It was identified that Margaret had a known history of refusing medication and that this would require close monitoring to ensure that she was getting the required medication. The social worker devised the support plan based on Margaret's needs and shared this with the NCH; it advised seeking support from the GP and community mental health team if there were issues. In fact, there was no open referral to the Mental Health Team at this time.

8.3. Margaret was admitted to the NCH on 08.11.2012. When the social worker visited the home to review her placement on 06.12.12 it was noted that there were no care plans in pace for Margaret. This was thought by the PLRD attendees to be unusual. The Care Home Manager representative at the PLRD identified that it would be usual to spend a couple of weeks getting to know a new resident but that it would be best practice to have a care plan in place within 2 weeks of admission. There is no record that the system for flagging issues such as the lack of active care plans was triggered to the contracts compliance officer in the local authority.

8.4. A Deprivation of Liberty Safeguards (DoLs)[4] standard authorisation was not in place for Margaret on admission nor at any time during her placement and this is discussed further in the analysis.

8.5. Records from the NCH identified that the first entries in the care plans related to medication were made in December 2012 and this does not have a specific date but it is assumed that it follows the social work visit on 06.12.2012.

8.6. There were other care plans for Margaret with regard to communication, capacity and memory but these were written in December 2013. It is not clear, therefore, if these care plans were only completed at that time or if the original ones were not available to the reviewer.

8.7. The absence and delay in care plans was discussed at the PLRD and it was noted that issues such as this should to be raised with the contracts compliance team. It was highlighted that at the time, this NCH was being heavily monitored for non-compliance with its contractual requirements and that care plans were one of the noted issues. It is also of note that during the time that Margaret was resident, there were several actions required to improve notified by CQC once in relation to medicines management and on two occasions in relation to care plans. These issues are discussed in more detail in the analysis.

8.8. It had been identified that Margaret did not have the capacity to understand the need to take her medication and therefore medication was given in her best interests. The original care plan in December 2012 stated that Margaret was usually quite compliant with medication but that constant encouragement and reassurance was required to ensure this.

8.9. Throughout the latter part of 2013 and 2014 recording suggested that Margaret's compliance was variable from day to day. The care plan was not rewritten until 25.11.2014; this then stated that unfortunately Margaret was non-compliant with most of her medication and that her doctor was aware of this. There was a review of the care plan in December 2014 which identified no changes. There is no information within the care plan or any documentation as to the care that was actually required to ensure medication was given and what action was required if medication was refused or at what point the issue should be escalated to other agencies.

8.10. Throughout the period under review, the NCH had support on medicines management from a local community pharmacy. The pharmacy contract changed from one provider to another in late 2014. The role of the community pharmacist includes auditing and support with the Medication Administration Records (MAR) and supporting and advising on medicines management and storage. As indicated previously, it is not clear exactly what the contract with the first community pharmacy was. There is no evidence made available to this review that indicates that the pharmacy was aware of the issues. It was questioned at the PLRD as to the issue of there being a large amount of unused thyroxine medication if Margaret was refusing it. It was acknowledged however, that it would be issued and then the refusal may happen or that it was spit out by Margaret following administration, therefore there would not be any excess of medication. The role of the community pharmacy team is discussed more within the analysis.

8.11. From the MAR sheets that have been supplied to the reviewer, the coding for non-administration is not clear and does not comply with the usual coding for not taken/refused/unwell etc.

[4] **The Deprivation of Liberty Safeguards** (DoLs) are an amendment to the Mental Capacity Act 2005 that apply in England and Wales. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. Care homes or hospitals must ask a local authority if they can deprive a person of their liberty.

8.12. This then leads to questions about what other agencies knew of the medicines management issue. As noted above, the social worker and hospital staff were aware of the issue of compliance with medication and the social worker included this in the support plan that was given to the NCH. Care was reviewed by the social worker on 29.01.2014 and the NCH informed the social worker that Margaret was sometimes non-compliant with medication but that she generally would take it.

8.13. The agency with the most involvement and responsibility regarding medication and management of Margaret's hypothyroidism was the GP practice. At the PLRD the GP attending stated that there had been a longstanding issue with Margaret's compliance with medication. Despite this, her levels of thyroxine in the blood had not previously been of concern, thus indicating that even if she was not taking every dose, she was taking enough to maintain a healthy amount to sustain her body's requirements.

8.14. The first evidence to the GP practice that there was an ongoing issue with medication was in February 2013 when the GP was informed of this on a visit. The GP duly ordered a blood test to assess the level of thyroxine in the body. The advice at the time from the GP was to continue trying to give the medication and that he would endeavour to speak to Margaret's daughter and visit again in a week.

8.15. The GP spoke to Margaret's daughter on 19.02.2013 and discussed the ongoing issue of medication refusal and also that there needed to be a Do Not Attempt Resuscitation (DNAR) order in place signed by the GP. Margaret's daughter agreed that, in light of her dementia and other ongoing medical issues, it would not be in Margaret's best interests to attempt resuscitation.

8.16. On 22.02.2013 the GP visited again and, in an attempt to improve compliance with thyroxine medication, rationalised the number of medicines that were prescribed and asked that the staff continue to encourage the thyroxine medication and that blood tests had been requested.

8.17. On 07.03 2013, the GP telephoned the NCH to review the blood results but identified that the blood had not yet been taken. At this time the staff at the home informed the GP that there were no concerns and that Mrs was taking her thyroxine regularly. The GP added two medications to the regular prescription related to management of osteoporosis due to risk factors.

8.18. Shortly after this, on 14.03.2013, Margaret became unwell with a chest infection and within a few days was again refusing all medication. The NCH contacted the GP and asked if her medication could be put in her food. It is recorded in the GP notes that a senior GP advised that the medication could be mixed with custard. This conversation is not evident in the records from the NCH available to the reviewer (it is of note that all records may not have been available) and it is not known if this was carried out.

8.19. There were ongoing delays with the blood tests and it is not clear why this was. It was 11.04.13 before bloods were taken and this was done by the district nursing service. These results showed low levels of thyroxine. A discussion took place between the GP and NCH and it was felt that the low levels were due to poor compliance therefore the dose of Thyroxine medication was not increased at this point but it was changed to liquid form to try and assist with compliance. There was to be a further review of blood levels again in four weeks. It was a further six and a half weeks before the next blood test which again showed low levels of thyroxine and at this point, on 28.05.13, the dose of thyroxine was increased. The plan was to repeat blood test in four weeks presumably to check if the increased dose was having a therapeutic impact.

8.20. It is noted in the records that as Margaret was in a nursing bed that the blood tests should have been carried out by the nursing staff at the home. Although staff had accessed the training, there had been difficulties in being signed off as competent by external nursing mentors due to availability. The district nurses who had taken the bloods told the NCH that this should be done by the nurses in the care home and not referred to them. This issue is discussed further in the analysis.

8.21. In October 2013 Margaret again developed a chest infection which was treated by the GP. Thyroxine is not mentioned in records by the care home or GP on this occasion.

8.22. It was not until May 2014 (one year later) that the GP practice identified during a routine medication review, that further blood tests had not been undertaken, when they were done the results showed again that the results were abnormally low.

8.23. At this point the GP discussed with the care home whether ethically, medication could be given covertly. The GP identified that a best interests meeting should be undertaken and a date of 14.05.14 was noted. It is not clear who would be invited. When the GP visited the NCH on 14.05.14 staff informed the GP that Margaret was now compliant with medication and therefore they were happy to continue and a best interests meeting did not take place. Assessment of Margaret's capacity to understand the need for medication had indicated that medication needed to be given in Margaret's best interests. There was a history and difficulties with maintaining safe levels of thyroxine due to her mental capacity issues; it could therefore be argued that this may have been a missed opportunity to identify contingency planning in case of further issues with medication and is therefore discussed in the analysis.

8.24. On the 15.05.2014 there is a recording in the NCH Professional Visitors' record stating that the GP had carried out a medication review and had refused to write a letter to give medication covertly and to continue to offer medication daily. The GP that carried out the visit recorded that staff had reported Margaret to be taking her medication 'OK'. There is nothing in the GP records about the refusal to write a letter.

8.25. By June 2014, blood results showed some improvement but this was not sustained and by August levels were again very low. It was at this point that, on 06.08.2014, that the GP again contacted Margaret's daughter and they agreed that due to lack of capacity and the resulting harm if this was not taken, that the thyroxine medication should be given covertly.

8.26. The next day (07.08.2014) the GP sent a letter to the NCH providing clarity as to the agreement of covert medication. The letter stated that this should be undertaken in Margaret's best interests and highlighted the consequences of her not receiving this medication, which included coma as the most severe consequence. The letter also indicated the suggestion made by Margaret's daughter that Lucozade could be provided as it was felt by her daughter that Margaret is more likely to accept the medication with this. This episode and decision, whilst was necessary to ensure a way of giving the medication, did not follow NICE Guidance[5] for use of covert medication in Care Homes.

8.27. There is no indication within Margaret's record, that this letter was addressed by a review of the medication care plan and the reviewer can find no reference to this letter within the NCH records that are available albeit that the letter is in the bundle of records received from the NCH.

[5] Managing medicines in care homes, Social care guideline, Published: 14 March 2014, nice.org.uk/guidance/sc1

8.28. On 18.08.2014 a Healthcare Assistant from the GP practice visited Margaret to carry out a routine over 75 assessment. This was recorded as a long comprehensive consultation with no concerns reported. It is not clear if compliance with medication was part of this review.

8.29. On 30.09.2014 blood results were again showing very low levels of thyroxine and the GP called the care home who told the GP that Margaret had not been taking her medication for weeks; the GP encouraged the need for them to be taken. It not recorded in either GP records or the NCH records that the covert medication agreement was discussed. There is no record that blood tests were repeated after this time.

8.30. On 21.10.2014, a Fax was sent to the GP practice requesting a further prescription for thyroxine and a note was included stating that 'the patient continues to refuse to take it'; there is no recorded action or comment by the GP practice.

8.31. On 27.11.2014 an Advanced Nurse Practitioner from the GP Practice visited to review long term care plan. It is noted that no concerns were expressed by care staff. Margaret was given her Flu vaccination at this visit. The visit is not recorded in the NCH records available to the review.

8.32. A further visit was carried out by the GP on 08.12.2014 for a dressing to a wound on the leg and it was noted that Margaret was constipated. At this visit staff again indicated that Margaret was refusing her medication and the GP asked staff to encourage the thyroxine. At this visit the calcium medication and another osteoporosis medication was stopped. It is not clear if the calcium was stopped because it was an extra medication to be given in order to promote thyroxine being given, or if it was because of known interaction with thyroxine and calcium that are discussed in the analysis. There is no recorded discussion by the GP or the NCH as to whether medication was being given covertly and any discussion as to the outcome if Margaret continued to refuse or not be given her medication covertly.

8.33. Over December and January Margaret was visited by a GP on 2 occasions related to chest infections and being unwell. It is not clear if these were two separate infections or a continuation of the same one but by 01.02.2015 Margaret had deteriorated significantly and she was admitted to hospital. Margaret died on 11.02.2015.

9. Thematic analysis

9.1. The agency case audits, chronology and the discussions at the PLRD highlight several themes for further analysis. Focusing on the systems that practitioners were working in during the timeframe for this review leads to valuable learning.

Care Planning

9.2. The first area that arose for analysis and discussion was the issue of care planning. Within the initial support plan that arose from assessment of Margaret's needs carried out by the social worker, it was identified that Margaret could be non-compliant with medication. It was recorded that Margaret did not have the capacity to understand the need to take her medication and was therefore reliant on staff being aware of this and ensuring that medication was given. The support plan from the social worker had identified that staff at the NCH should liaise with the GP and the mental health team if necessary.

9.3. When the social worker returned to review the placement at the routine six-week point, it was noted that a care plan was not in place. Staff identified at each social work review (06.12.2012 & 29.01.2014) that, although there were some compliance issues, that in general Margaret was taking

her medication. This, in reality, was not an accurate picture as her blood results generally showed that her levels of thyroxine were low. The social worker is not a healthcare professional and therefore would not necessarily understand the significance of the issue even if an accurate picture had been given. It would not have been within the professional scope of the social worker to review medication records within the NCH. Advice given to social workers is that they should report the issue of lack of robust care plan to the contract compliance team.

9.4. In trying to understand why this inaccurate picture was given it may have been to do with the way that the care plan recording was written. There are seven out of the ten entries from December 2013 to September 2014 in the medication care plan that mention compliance. Each one states that compliance can be an issue but that this varies. Different nurses would administer medication, and therefore if sometimes she took her medication and sometimes she didn't, an individual view may be that she did generally take it. Nothing in the records or care plan appears to draw together the blood test results indicating very low levels of thyroxine, with a sense of urgency or escalation to identify a plan of care that would resolve the issue.

9.5. The first care plan around medication was not put in place until December 2012 and was not reviewed until November 2014. The documentation provided to the review indicates that the care plan regarding medication was inadequate. Good care planning requires regular review as needs change and should indicate how care should be given and provide contingency arrangements and points at which escalation is required if care needs are not able to be met. This did not happen and there is no recorded audit trail for how the issue was dealt with in the NCH. Evidence suggests an episodic approach rather than an overall review of the care plan to meet Margaret's needs.

> Learning Point 1: Robust care planning provides a point of reference and evidence that care needs are being met as well as contingency and escalation points where providing essential care is proving to be challenging (Recommendation 1a,1b &1d)

Communication and coordination related to medication.

9.6. Hypothyroidism is classified as a long-term condition[6] and therefore requires long term management and coordination especially where a person lacks capacity to understand their own condition. The communication and coordination related to Margaret's medication appears to have been very spasmodic and episodic. The GP practice were the service that were responsible for prescribing for and overseeing Margaret's long term condition and were aware that there was a history of difficulties with her complying with medication due to her dementia. The NCH were responsible for ensuring that Margaret received her prescribed medication. The community pharmacy were responsible for supporting the NCH with the management medication on a practical level. There were several areas where this communication and coordination were not robust that resulted from not having an effective care plan.

9.7. Section 8 identifies several breakdowns in the oversight of effective treatment.

- Blood tests were not completed on time and not chased by either practice staff or NCH staff.
- Nurses within the NCH were not able to take blood as their competence following training were not 'signed off'.
- Advice was based on 'at the time' view of the medication issue rather than an overview of the whole picture.

[6]Long-term conditions or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment. https://www.kingsfund.org.uk/

- Clarity was not given about medication priority e.g. that thyroxine must be the first drug offered.
- Calcium supplements for osteoporosis were prescribed at the same time of day as thyroxine for some of the period under review.
- There was no evidence that the urgency of the need to increase the levels of thyroxine in the blood was being addressed or coordinated.
- The MAR sheets were poorly completed and not reviewed and/or addressed by pharmacy or GP as part of the overall management and coordination.
- Visits for other reasons (e.g. chest infections) did not result in an opportunistic check of the medication issue that was known, and more medication for other conditions was often added as a result.

9.8. These issues resulted in little understanding of the scale of the issue and the impact that the long-term effect of poorly treated hypothyroidism was likely to be having on Margaret.

9.9. In an attempt to understand why this coordination did not happen, the discussions at the PLRD centred around how GP practices manage 'diary tasks' i.e. ensuring that there is a system in place to alert that routine and repeat blood tests are due and alerts that tests that have been requested have not been carried out.

9.10. The GP practice generally rely on patients to flag these issues e.g. a patient will be advised to book for a blood test and will then be asked to contact the practice for results. In this way, the patient becomes the alert system. Where the patient is resident in a NCH the GP practice relies on the home staff to undertake this on behalf of patients and may also inform the patient's family. In the case of Margaret, this was not robust or effective and it appears that issues were picked up coincidentally.

9.11. It is not clear how much the family were aware of the amount of times that medication was not being received by Margaret, that the covert medication agreement was not being applied and whether they were aware that this was extremely serious and could lead to her death.

9.12. The GP practice have indicated that they now have a system of manually adding tasks to a diary and that this is an administrative task that is an improvement, but is still not a very robust system.

9.13. The GP practice have also indicated that residential and nursing care homes are now aligned to GP practices and that weekly visits are undertaken by the same GP to all the residents within the home. This now means that there are better relationships between care home settings and GPs and that follow up is easier and more straightforward. Margaret did not benefit from this system as it was not in place at the time she was a resident in the NCH.

9.14. The PLRD discussion highlighted that there are still difficulties with how information is provided to the GP about care needs and how instructions from the GP are recorded. This led to agreement from the GP practice involved in this case, that written information needs to be provided to the GP about any issues and GPs need to provide written information in response about proposed treatments etc. to ensure robust communication.

9.15. The reviewer has also learnt, that whilst the community pharmacy now in place appears to offer very good support to the care home, due to the nature of the business arrangement and contract, it is reliant on care home staff alerting the pharmacy as to support that may be required. The role is not one of scrutiny, regulation or oversight. The current community pharmacist team member that the reviewer spoke to, indicated that they are often left out of the loop where conversations regarding medication are being held between homes and GPs and receive very little contact directly with GPs,

often being seen as just a dispensing service.

9.16. It could be argued that the GP may not know the pharmacy that the care home use, but when there are specific medication issues in the care of a patient, it is prudent to consider direct contact with the pharmacy for support with medicines management.

> Learning Point 2: Responsibility for managing long term conditions requires a robust multidisciplinary approach that includes good communication and coordination (Recommendation 2a,2b & 3).

Contract compliance and review of individual care needs

9.17. During the time that Margaret was being cared for at the NCH there were issues that the Local Authority contract compliance team were dealing with. Discussions at the PLRD and the author's research have led to areas for analysis and learning.

9.18. The NCH in question had been originally owned by a company that got into financial difficulty with its properties and was transferred to another company who also then went into administration in 2014 before being bought by the current owner. There had also been changes of registered manager; the review was informed that there was no registered manager in post in January 2014. Throughout the period under review, the NCH had been under scrutiny by CQC and the Local Authority contracts compliance team. The table below gives an overview of the continual fluctuation in CQC compliance and identifies issues with medicines management and care planning (records) as well as supporting staff with supervision and appraisal.

Date of inspection	Compliant ✓or X	Area of concern
January 2012	X (Minor concerns, 3 areas)	• Respecting dignity • Supporting staff • Records
April 2012	X	Medicines management
July 2012	✓ & X	Now compliant with medicines management but non-compliant with record keeping
Jan 2013	✓	
December 2013	X	Records
March 2014	✓	
June 2014	X	• Medicines management • Supporting staff • Assessing and monitoring service quality
September 2014	✓	

9.19. During this time, the LA Contact Compliance team were working hard with the NCH and there were improvement action plans in place. In April 2012, there had been a suspension of placements, and by September there had been some improvements in care planning but some care planning concerns remained that were identified on audit and brought to the attention of the then manager.

9.20. The concerns regarding medicines management were addressed by introducing a new electronic system of medicines management with the ability to produce reports of medication given and reduce medication errors. By October 2012 it was reported by commissioners in the local authority that the system was working well.

9.21. The default suspension notice was lifted on 17.10.2012 but there were again issues by August 2013 with a further default notice served in September 2013.

9.22. It is reported on the 10th September 2013 that the CCG carried out a series of health and well being checks as a result of being informed about the default notice. It has been clarified that these would have been to residents who were funded by Continuing Health Care and therefore the responsibility of the CCG. The s117 manager was not made aware of the default notice and therefore this information was not shared with the mental health provider trust, who are responsible for reviewing care of s117 funded residents (Margaret's funding arrangements had changed see below 9.31).

9.23. Given the scrutiny and the highlighted concerns with record keeping and medicines management it is of concern that Margaret died, in part, as a result of ineffective care planning and medicines management. The NCH as it was then, is no longer in existence therefore the review has only been able to look at possibilities as to why this situation occurred and only from the perspective of the other services involved. This leads to some assumptions made about the involvement of the NCH.

9.24. Information from the Local Authority Social Work Team Manager indicated that social workers are requested to complete an 'eyes and ears' document each time they assess or review someone in residential care and any concerns would be raised with CQC or safeguarding as appropriate. These documents are sent to the safeguarding Team in box and not always associated with a case record. There is no record of an eyes and ears document related to the reviews that the social worker carried out.

9.25. The GP practice shared at the PLRD that they were unaware of the issues of the above regulation compliance.

9.26. The social worker did not add any additional review of Margaret's care needs; records do not indicate that the social worker was aware of the regulation compliance issues.

9.27. The current community pharmacy was not involved in supporting the care home with their medicines management at this time.

9.28. It appears that the systems that are in place and that should have led to a review of Margaret's individual care needs failed.

9.29. The LA contracts compliance team indicated at the PRLD that they struggle to receive support regarding medicines management issues where care homes are non-compliant in this area.

9.30. It needs to be recognised that the care homes contract directly with the community pharmacy and that it is a business arrangement. It is not a regulatory or quality assurance relationship, albeit that serious safety concerns would be notified to safeguarding. This leads to a recognition in a gap regarding quality assurance and compliance around medicines management in care homes outside of the CQC regulatory visits.

Learning Point 3: Where Care Homes (residential or nursing) are facing compliance issues and are under scrutiny from CQC and the Local Authority, the needs of the individuals within the home may need to be reviewed by the multi-disciplinary team to ensure that their individual needs are being met and that they are being cared for safely despite the given issues (Recommendation 1a,1b,1c, 1d).

Learning Point 4: There is a benefit of having independent advice and support with a quality assurance oversight of medicines management, into care settings, by CCGs or other appropriate bodies, either as routine or when indicated as a need by the LA contract compliance team (Recommendation 5b)

9.31. There appears to be further issues that this case has raised regarding the overall responsibility for quality assurance and review of a person's individual needs outside of where there are contract compliance issues.

9.32. The original belief held by the professionals involved in this review was that Margaret's care had been funded under CHC funded nursing care. This led to questions about who held the responsibility for reviewing her needs and the placement and why this had only involved the local authority and that the CCG CHC team did not review the placement.

9.33. On further research by the CCG representative, it came to light that in fact the CHC funding for Margaret had been reviewed one month after it had been agreed. It became apparent that Margaret was entitled to on-going s117 aftercare provisions under the Mental Health Act (1983)[7]. This came about when a member of the finance team in the local authority, with responsibility for oversight of FNC payments, identified that Margaret was subject to s117. The FNC element transferred to s117 and the case was passed to the appropriate department within the PCT (became CCG in April 2013). S117 aftercare funding is a jointly held responsibility between the local authority and the CCG. The responsibility for the FNC element of s117 is commissioned by the CCG from the Older Peoples Mental Health Team in the Mental Health NHS provider. They were made aware of the need to review this plan and placement via a letter sent by the CCG s117 team in August 2013 and although this constituted an 8-month delay it would appear that this did not happen.

9.34. Following receipt of this information during the review, the author requested information from the Mental Health NHS Provider. It was identified that there was no knowledge of the s117 funding arrangements for the period of this review (although there is record of previous funding under those arrangements) within records held by the Provider. There were, therefore, no reviews of care arrangements and placement and indeed Margaret was not under the care of the Mental Health Provider during the scope of this review other than one episode when she was referred by her GP for specialist seating.

9.35. It does not appear that anyone involved in the care of Margaret had documented that her care needs were being met as part of her entitlement to s117 aftercare services due to her previous

[7] Section 117 of the 1983 Mental Health Act requires clinical commissioning groups (CCGs) and local authorities, in co-operation with voluntary agencies, to provide or arrange for the provision of after-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act who then cease to be detained.
After-care can encompass healthcare, social care and employment services, supported accommodation and services to meet the person's wider social, cultural and spiritual needs, if these services meet a need that arises directly from or is related to the patient's mental disorder, and help to reduce the risk of a deterioration in the patient's mental condition.
The duty to provide after-care services continues as long as the patient is in need of such services.
http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/01/Code_of_Practice.pdf

mental health section and admission. Social Care had knowledge of this s117 aftercare status as they had previously funded her care; the care home manger contacted the CHC team in January 2013 to enquire why funding had stopped. A phone call back to the home from the CHC team to the home provided information that FNC was via the 117 team and contact details given. There was, however, no care plan in place that received robust multi agency review of the need to continue s117 in line with the requirements of the MHA. When a patient is subject to s117 aftercare services they should remain open to mental health providers in order that the duties under the MHA can be discharged according to the Code of Practice.

9.36. This may therefore have been a further missed opportunity to have a robust plan and review of Margaret's care needs. This SAR recognises that s117 arrangements are related to mental disorder as opposed to the physical healthcare needs (hypothyroidism), but it is clear that it was dementia that was impacting on her mental capacity that in turn resulted in her refusing her essential medication. For this reason, the FNC element being under s117 arrangements was entirely appropriate.

> Learning Point 5: Clarity regarding funding arrangements is important in discerning who has the responsibility to oversee, manage and review that individual care needs are being met within a placement.
> Under terms of MHA, it is best practice to retain clients within mental health services whilst they are subject to s117 aftercare services in order that follow up and continuing care arrangements are reviewed in accordance with the Act (Recommendation 2c)

Mental Capacity, Best Interests and Covert Medication

9.37. It was apparent to those caring for Margaret and documented in the care plan that was developed by the NCH, that most of the decisions that were required in order to care for Margaret were made in her best interests as she did not have capacity to make safe choices about her care needs. She was able to indicate if she was hungry and what she wanted to eat and drink but more complex decisions caused difficulties. Margaret did not have the capacity to retain information regarding her decisions and choices. This was particularly so with medication to treat her hypothyroidism. She was assessed as not having the mental capacity to understand or retain information that medication was necessary to prevent serious medical consequences.

9.38. It is clear within all records that it was mainly Margaret's daughter who was her advocate and this was wholly appropriate under the terms of the Mental Capacity Act (2005)[8]. The GP discussed the concerns regarding medication and her daughter was present at the first two care and support assessments carried out by the social worker and indicated that her Mother sometimes refused medication.

9.39. One GP did indicate that the medication could be put in custard if necessary but this advice was not followed up with a letter. When there was a letter from the GP confirming that the GP had discussed the issue with Margaret's daughter, as he felt that it was in Margaret's best interests for her medication to be given covertly, this letter did not appear to result in this advice being applied robustly and the NCH medication care plan was not reviewed. Whilst it is ultimately a health professional in this case who made the best interests decision as it was based on medical need, it was good practice to consult with the person who was her advocate in line with the Mental Capacity

[8] Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/section/1

Act Code of Practice[9].

9.40. Notwithstanding the above, there is clear guidance from NICE[ibid] about the use of covert medication in care homes. The issue relates to whether it breaches someone's human rights to give medication covertly and therefore there are clear procedures that need to be followed to comply with the Mental Capacity Act, Human Rights Act (1998)[10] and Nice Guidance[ibid].

9.41. When it is thought that covert medication is a possibility, the assessment of capacity must be undertaken as a starting point; this was done. There is then a requirement to have a best interests meeting to include at least the prescriber (GP), pharmacist, care provider and advocate and in this case should have also included the social worker. The meeting should identify the necessity and purpose of the medication, advice from the pharmacist on how this should be given (e.g. some medication cannot be mixed with certain foodstuffs) how long the medication will need to be given covertly and when it will be reviewed. An agreed plan should then be drawn up that all are aware of and this should also include escalation and contingency arrangements if the plan is not ensuring that the medication is received or there is another challenge to continue to give the medication in this way. A review date should be set and the circumstances should be continually reviewed.

9.42. The reviewer discussed the support that care settings can get from the community pharmacy who are contracted to supply medicines into care homes. The NCH current contracted provider has clear policies and processes for covert medication. If a care provider setting wishes to give medication covertly then there is a form that must be completed. The pharmacist will be involved in the best interest meeting and will ensure that the medication is given in a way that does not affect the uptake and absorption in the body. The pharmacy will offer ongoing support around any issues with refusal of medication.

9.43. There is no evidence that the community pharmacies that were contracted with the NCH during the scope of this review were contacted about issues with Margaret's compliance with medication or involved in any covert medication plans by either the Care Home or the GP.

9.44. It can be seen therefore, that the decision to give medication covertly was made on sound reasoning and in Margaret's best interests but did not follow guidance and as a result there were several crucial elements missing. It also came to light during the review that the suggestion of mixing the medication with Lucozade would be contraindicated from a pharmaceutical perspective hence the importance of involving a pharmacist in the planning and review process.

9.45. When this was discussed at the PRLD it was identified that the GP practice was not aware of the NICE Guidance for Medication in Care Homes and the requirement for a multi-disciplinary plan.

9.46. There have been two court judgments that are relevant to the learning that this specific issue identifies. The first was in the Supreme Court in March 2014[11] that related to the three key questions that are the 'acid test' to identify is someone was being deprived of their liberty. They are:

[9] Office of the Public Guardian (2013) Mental Capacity Act Code of Practice
[10] Human Rights Act 1998 http://www.legislation.gov.uk/ukpga/1998/42/contents

[11] Cheshire West and Chester Council v P [2014] UKSC 19, [2014]

(1) The 'acid test' for deprivation of liberty is whether the person is under continuous supervision and control and is not free to leave. (2) The following are not relevant: (a) the person's compliance or lack of objection; (b) the relative normality of the placement (whatever the comparison made); and (c) the reason or purpose behind a particular placement. (3) Because of the extreme vulnerability of people like P, MIG and MEG, decision-makers should err on the side of caution in deciding what constitutes a deprivation of liberty.http://www.bailii.org/uk/cases/UKSC/2014/19.html

- Does the person lack the capacity to consent to their care/ treatment arrangements?
- Is the person subject to continuous supervision and control? *And*
- Is the person free to leave? – with the focus, the Law Society advises, being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave

9.47. It could be argued therefore that an application should have been made for an authorisation to deprive Margaret of her liberty lawfully. It is of note however, that prior to the Supreme Court judgement this element of DoLs was not well understood and took some time to embed in practice. It should have been considered later during her placement as the Supreme Court judgement implications received more clarity.

9.48. A more recent judgement by a District Judge in the Court of Protection[12] identified that the use of covert medication can constitute a deprivation of liberty in as much as it is an aspect of continuous supervision and control and therefore where a deprivation of liberty is not in place it should be applied for and where it is in place any intention to use covert medication must be undertaken via and amendments to the standard authorisation to the supervisory body (the Local authority).

9.49. It could be argued that the above judgement may be more relevant to medication that manages a person's mental health condition and behaviour rather than medication that is essential to manage a physical health condition. There is, however, still a need to identify that giving covert medication can be argued as a human rights issue and therefore robust application of legal policies and processes afford the best protection to those in receipt of covert medication and those who undertake the practice in that person's best interests.

9.50. It can be seen therefore, that in Margaret's case the law would support the giving of medication covertly but it could be argued that this was not done robustly and in fact there was no evidence that it was implemented effectively.

9.51. As NCH staff were not available to this review it is not possible to tell why the GP advice was either not challenged as it did not follow NICE Guidance that had been issued the previous March, or not being implemented for other reasons.

> Learning Point 6: In some cases, it is appropriate to give medication covertly. This must be done lawfully in line with existing legislation and more recent national guidance from various sources (Recommendation 2d & 5c)

10. Good Practice

10.1. It is important to note that many practitioners offer a good level of service to their clients/patients and follow policies and procedures that are provided to guide practice. Whilst recognising gaps in practice, SARs can also provide evidence of this as well as practice that goes over and above what is expected. Attendees at the PLRD were asked to identify these from their own and other agencies' involvement. It is important to highlight these as areas where learning can occur.

- When the NCH indicated difficulties with encouraging Margaret to take her medication, the GP reviewed her prescription and removed some items so that there were less to give.

[12] AG v BMBC & Anor [2016] EWCOP 37

- The Hospital NHS Foundation Trust, reviewed Margaret's needs using the Decision Support Tool that indicated the need for a nursing placement.
- Whilst Margaret was resident in the NCH there was no further pressure damage to skin that had been seen before
- On admission to hospital in February 2015, the care given was very good and there was good family involvement in decisions that were required.
- The safeguarding referral on admission was made in a timely manner
- Contract compliance monitored and reviewed the NCH
- The initial support plan identified the issue of compliance with medication
- The GP identified that covert medication required a best interest decision and had a discussion with Margaret's daughter to agree this.
- GP offered good support to the NCH and always visited on request

11. Conclusions and Learning

11.1. This review has focused on the issue of how it came to be that Margaret died as a result of myxoedema coma due to a prolonged period without having her essential medication to treat her hypothyroidism.

11.2. Margaret did not have capacity to understand the requirement to take the medication or to understand the serious consequences of not taking it. This was well recorded and understood by all those that worked to care for her.

11.3. Margaret had dementia which is a terminal illness and does create challenges for those caring for patients who do not have the capacity to understand the need for medication. The associated frailty and other medical conditions that Margaret suffered were likely to lead to her need for thyroxine to be carefully managed and monitored.

11.4. Despite the review focussing on one issue, the learning is multi-faceted. The learning lacks an understanding of the NCH perspective due to the changes which means that the reasons why the NCH undertook care of Margaret in the way that they did is not clearly understood but that does not mean that the learning for the future cannot be effective.

11.5. It is very clear that communication and coordination across the multi disciplinary team is crucial in order to resolve the complex challenges that caring for a person who lacks capacity can bring. Alongside robust care planning that has adequate review, in an environment that is safe and effective in its care of those people, all lead to positive outcomes.

11.6. It is precisely those challenges that the legislation, guidance, policies and procedures are aimed at resolving.

11.7. It is accepted in this case, that some of the most helpful guidance is more recent than when Margaret was resident in the NCH, but the legislation that underpins it had been in place for some time and should have afforded protection.

11.8. Communication and coordination within care home settings relies on good leadership and safe and effective care. It is known that there were issues within the care home leadership and management. Issues of contract compliance and CQC regulatory concerns were not known to those who were visiting and responsible for the prescribing (GP practice). There was a reliance on the NCH to chase and challenge regarding the necessary blood tests and the issue of covert medication. The GP practice assumed that the issue was resolved when they sent the letter in August 2014. It is not

known why this did not lead to Margaret getting her medication.

11.9. If the NCH had had good leadership and had been compliant with record keeping and management of medication consistently, the care plan and medication record would have provided the oversight and clarity that in fact, on the whole, Margaret did not receive her medication.

11.10. In order to safeguard Margaret's wellbeing, the GP practice needed to have known about the NICE Guidance and implemented a best interest meeting involving all those who were required to ensure that covert medication was given. The required review of the plan would have highlighted that the plan was not being implemented and any associated challenges.

11.11. More robust involvement of the community pharmacists may have been of benefit. The pharmacist could have provided advice on several aspects of the issues related to the prescribing and administration of the thyroxine and should have been involved in the covert medication planning.

11.12. The fact that there was no overall review of Margaret's care and placement, over and above the annual review by the social worker, given the difficulties and challenges that have been identified in this SAR, appear to be related in some respects to the funding responsibility issue. Mental Health NHS Provider records do not indicate that they knew of the continued requirement for review Margaret's care or placement and that they received information from the CCG that the FNC was changed to s117 aftercare and therefore the transfer of responsibility for review of care.

11.13. The S117 Manager in the CCG and others responsible for her care were not apparently aware of the CQC compliance issues. This appears to be related to the ongoing belief by those involved that Margaret's care and placement was being funded through CHC. Therefore, because she was not subject to that funding stream she was not subject to the health and well-being checks that were carried out by the CCG when CHC were notified of the default notice.

11.14. This review concludes that the systems that were in place did not afford the protection and care that they should either due to the systems not being known about, being poorly applied or failing. The above multi factorial issues appear to have been very crucial in the events that led to Margaret not having her essential medication and therefore lead to the recommendations below.

12. Recommendations

12.1. Where agencies have made their own recommendations in their review of Margaret's care, RSAB should seek assurance that action plans are underway and outcomes are impact assessed within those organisations.

12.2. The following recommendations are made as a result of the learning in this case and require that **RSAB seeks assurance from the appropriate partners that the following are addressed**:

1. Recommendations for the Local Authority:

That the Local Authority social care and contracts compliance team, in partnership with other agencies where appropriate, ensure:

a. Contract Compliance will be conducted through a targeted approach to contract compliance visits based on risk. For high risk settings contract compliance officers will identify that care plans and medication records within care homes are fit for

purpose and demonstrate they are in keeping with the needs of the individual (Learning Point 1 & 3).

b. Social Care reviews of residents in care homes involves health and care staff where appropriate (Learning Point 1 & 3).

c. Where clients are resident in settings that are non-compliant with CQC regulations and/or contracts, consideration should be given to review of care needs of residents dependent on the severity of the concern. This must include an audit trail that provides evidence that no resident has been missed. Consideration must be given to providing families with relevant information when appropriate. (Learning Point 3).

d. A review of the Local Authority Home Closure and Provider failure protocol to ensure that it remains fit for purpose in light of the above recommendations. (Learning Point 1&3)

2. Recommendations for the CCG:

a. management of long term conditions by GP's within residential and nursing homes are subject to robust processes of monitoring and review (Learning Point 2).

b. there are appropriate written communication tools in use between care homes and GP practices (Learning Point 2).

c. the system for notification of the changed funding arrangement for an individual is reviewed and audited to ensure that any failure to successfully transfer responsibilities is flagged. (Learning Point 5)

d. The CCG should provide support to GP practices across Rotherham to develop processes that take account of legislation, guidance and case law for when it is deemed clinically necessary to administer covert medication. Guidance should also include that Best Interest decisions are supported with agreed multi agency covert medication plans which are reviewed regularly (Learning Point 6).

3. Recommendation for CCG and Local Authority:

The CCG and Local Authority Contract compliance should gather information from relevant partners, including CQC, NHS Providers and local Care Home providers to establish whether there is evidence of uncertainty of roles and responsibilities in the provision of nursing care to nursing homes in the Borough. Dependent upon findings further recommendations should be made to address any issues found. (Learning Point 2)

4. Recommendations for NHS England.

NHS England in Yorkshire and Humberside should:

a. Publicise the safeguarding learning from this review amongst GP's in the region

b. Ensure the learning from this review is shared with the safeguarding lead nurses and GP's in the region

5. Recommendations for Rotherham Safeguarding Adults Board (RSAB).

a. Where agencies have made their own recommendations in their review of Margaret's care, RSAB should seek assurance that action plans are underway and outcomes are impact assessed within those organisations.

b. RSAB to write to NHS England to request the consideration of project funding to incentivise medicines management support to care homes. This would be consistent with work in other areas to provide oversight and scrutiny by medicines management staff especially where there are medicines management compliance issues flagged by LA CC teams and/or CQC (Learning Point 4).

c. That the DoLs subgroup of RSAB, consider the learning from this review and ensure that where medication compliance is an issue and covert medication is being considered, these cases should be included in the list of cases that require prioritisation. I.e. *Challenging behaviour requiring significant restrictions* should be prioritised for full assessment for DoLs authorisation. Scrutiny of the prioritisation of DoLs applications will ensure the priorities are compliant with ADASS guidance Learning Point 6).
https://www.adass.org.uk/media/5297/additional-dols-safeguards-final.pdf

d. Arrangements should be made to share the learning with the Local Pharmaceutical Committee and CQC.

e. The RSAB Making Safeguarding Personal sub group should share the learning from this review in the form of a briefing across all its member agencies. Assurance should be sought as to how this has been disseminated to professionals in those organisations followed by case audit to provide evidence of impact e.g. change of practice or policy/procedure etc.

f. Evidence and assurance should be provided to RSAB performance sub group on the completion and/or ongoing audits of the recommendations as appropriate.

g. Client stories to RSAB should be considered as a way of providing evidence that the system is effective.

Appendix One

Safeguarding Adults Review
Margaret
Terms of Reference and Scope

Introduction

A Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and RSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

Case Summary

Margaret had been residing in the Care Home from November 2012 until she was admitted to hospital on 2.02.2015. She had a diagnosis of dementia and had Hypothyroidism (under active Thyroid). On admission to hospital she was found to be Thyroxine crisis and died as a result 9 days later. She had not received her prescribed Thyroxine for 2 years

Decision to hold a Safeguarding Adults Review

The request for a safeguarding adults review was agreed by the Independent Chair of RSAB at the July 2016 Safeguarding Adults Board meeting.

Key Issues to be addressed

- How agencies understood oversight of medicines management within independent care homes

- How care homes receive support for people with dementia
- Policies and procedures that are in place to manage covert medication in respect of GP's and Care Homes
- How care homes are supported to manage medical conditions
- Which other key stakeholders e.g. GP/Pharmacist where involved in the prescribing and monitoring of medication to Margaret that led to the demise of Margaret.
- Whether the placement was appropriate or an alternative location/environment would have been more suitable.
- Safeguarding Investigation and process

Scope
The review should consider agency involvement from 08.11.2012 until the date of her death on 11.02.2015

Method of Review

The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

The SAR sub group agreed that as the main issue leading to the review was one of medicines management, a learning review related to this issue would be undertaken.

A chronology will be used alongside a Case file audit from each agency that identifies involvement and learning. A Practitioner Learning and Reflection Day would then be held to determine lessons identified for improvement.

Independent Reviewer and Chair

The named independent reviewer commissioned is **Karen Rees of 402k Consultancy Ltd.**

Organisations to be involved with the review:

- The NHS Foundation Hospital Trust
- The Local Authority;
    - Adult Care Service
    - Strategic Commissioning
    - Adult Safeguarding Team
- The General Practitioner
- NHS Mental Health Provider (latterly provided information on request)

Engagement with family

The RSAB Business Manager will meet with the family of Margaret before the PLRD as well as prior to publication of the final report.

Parallel proceedings

None

Timescales

Scoping Meeting	11/11/2016
Terms of Reference agreed	12/01/2017
Agency audits and chronologies due by latest	17/02/2017
Agency audits and chronologies circulated (following Quality Assurance Process by author)	22/02/2017
PRLD	01/03/2017
1st Draft of Overview Report Distributed	31/03/2017
Comments on V1 by	14/04/2017
Circulate V2	24/04/2017
Comments on V2 by	02/05/2017
V3 circulated	12/05/2017
V3 Overview report presented to RSAB	22/05/2017