Briefing Paper For Coroner	
Adult Social Care Response to HM Coroner Regulation 28 Report	
Date	10 September 2015
Contact officer(s)	[redacted] Strategic Manager Hospital, Independence and Safeguarding Services [redacted] [redacted]

1. Purpose

To provide an adult social care response to the questions raised by HM Coroner in the Regulation 28 report to prevent future deaths in relation to Mrs Janine Eugenie Pierette Kaiser (deceased).

2. Background

Mrs Kaiser became resident at New Park Nursing Home in December 2013. She was placed and funded by Staffordshire County Council who retained assessment and care management responsibility for her under the Ordinary Residence Rules.

Stoke on Trent City Council was involved in undertaking adult safeguarding investigations on two occasions (23 June 2014 and 24 July 2014). The investigations were undertaken in line with the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Interagency Adult Protection Procedures which were in place from 2010 to the implementation of the Care Act in 2015. In both cases an assessment of mental capacity was undertaken by the investigating worker and Mrs Kaiser was deemed to lack the mental capacity to agree to the investigation process and the decision was therefore taken to proceed in her best interests.

The first investigation was commenced in June 2014 in response to allegations from Mrs Kaiser that she was not receiving appropriate care and support. It concluded that the allegations were unsubstantiated. The daughter was involved in the investigation and agreed with the conclusions reached. She voiced no concerns about the care her mother was receiving.

The second investigation was initiated in July 2014 following a visit to Mrs Kaiser by the Tissue Viability Nursing (TVN) Service and the allocated social worker from the Staffordshire and Stoke on Trent Partnership Trust (SSOTP). The concerns were that she had a urinary tract infection (UTI) and was dehydrated, that she was being nursed on an inappropriate pressure relieving mattress and despite a deterioration in her pressure sores the home had not

referred Mrs Kaiser back to the TVN service. The TVN Service and Social Worker had visited at 1.30pm but turn charts had been completed up to 3.00pm which was also cause for concern. As a result they had arranged for Mrs Kaiser to be moved from the home to Sycamore Ward, Bradwell Hospital.

The safeguarding investigation was undertaken by a Senior Social Worker in conjunction with a Continuing Healthcare Safeguarding Nurse. Visits were undertaken to the nursing home and Bradwell Hospital, records were reviewed and key staff were interviewed.

Staff interviewed included:

- The Manager and Senior Staff Nurse at New Park House
- Tissue Viability Nurse (SSOTP)
- Deputy Ward Manager at Sycamore ward Bradwell Hospital
- Doctor at Bradwell Hospital
- Allocated worker from Staffordshire Social Care (SSOTP)

Records checked included:

- Documentation at the home - Care plans, professional visit records, pain assessment records, medication administration charts, general care records, behaviour monitoring charts, toileting/pad change charts, repositioning charts and fluid intake charts.
- Documentation at the hospital – risk assessments and care plans, pain assessment tool, dehydration assessment tool and risk assessment score, malnutrition risk assessment tool, pressure damage assessment score and body map.
- Documents provided by the allocated worker – copies of records taken by the TVN service from the home (which were then cross referenced with those at the home)

The investigation found:

- No issues in relation to the documentation and care planning at New Park. No evidence was found to corroborate the allegation that documentation had been falsified
- No concerns in relation to the allegation that there was a lack of general nursing care
- No issues in relation to there being a lack of involvement of TVN service in the management of the pressure sore
- No evidence of a UTI or that Mrs Kaiser was dehydrated (confirmed by the hospital)
- That fluid intake was recorded as good at both the nursing home and the hospital
- No concerns raised by the GP
- Evidence that Mrs Kaiser consistently declined repositioning and that her behaviours in regards to this were difficult to manage

The allegations were unsubstantiated but recommendations were made to the

home about their recording and how this could be improved.

Mrs Kaiser returned to New Park House in September/October 2014 (date unknown but return confirmed by the investigating worker with the home on 3 October 2014) following a full assessment of need undertaken at Bradwell. She died on 21 October 2014 but Stoke on Trent Social Care were not advised.

No further concerns were raised with Stoke on Trent City Council following Mrs Kaiser's return to the home.

3. Coroners Concerns

1. **The deceased had in place a management plan for dealing with her pressure sores. The plan was not adequately followed; turns were missed leaving long periods when the deceased remained unturned. Records were not appropriately kept when the deceased declined intervention. Records had been falsified and turns recorded when they had not been done. It was not possible to identify which member of staff had completed the forms. Nursing staff were not available to take calls from the Tissue Viability Nurses.**

   The investigation undertaken following concerns raised in July 2014 showed no evidence that the management plan for dealing with her pressure sores was not adequately followed. There was evidence in the records that the home had made regular contact with the TVN service for advice and support. Mrs Kaiser had been referred to and assessed by the TVN service three times in June and July 2014 and had been discharged with clear management plans in place. These plans were shown to have been followed.

   Some turns had been missed but Mrs Kaiser was known to regularly refuse to comply with the turn regime in place. It was acknowledged that such refusals were not always documented and the home took this away as a recommendation from the investigation for further work with the staff.

   There was no evidence found to support the claim that documentation had been falsified.

   Whilst there were occasions where the nursing staff at the home were unable to take the calls from TVN service (due to medication rounds etc) there was evidence that calls had been returned.

2. **Records were difficult to interpret and did not accurately record times at which fluid and food had been offered to the deceased. The amounts taken by the deceased were not adequately recorded**

   There was no evidence found to support this in the investigation

undertaken in July 2014.

3. **Staff appeared inadequately trained in record keeping**

   There were recommendations made to the home about improvements that could be made to record keeping.

4. **There was poor continuity of staff**

   This did not form part of either of the investigations undertaken so I am unable to comment on this element.

5. **Twice daily pressure mattress checks were fully completed indicating an appropriately functioning mattress. However when a mattress check was made by Tissue Viability Nurses the mattress was not alternating and the fault alarm on the mattress had been turned off. The attention of the staff was drawn to this but it was not subsequently recorded in the deceased's records. The staff were inadequately trained in pressure mattress management. They apparently checked that the mattress had a power source but did not check that the mattress was functioning correctly.**

   These concerns appear to have arisen following Mrs Kaiser's return to New Park House from her stay in Bradwell Hospital. These were never raised with Stoke on Trent Social Care so no investigation was undertaken and I can therefore make no comment.

6. **The referral to Tissue Viability Nurses should have been made sooner.**

   When the investigation was undertaken in July 2014 it was evident that advice and support had been sought from the TVN service with referrals and assessments taking place three times in June and July.

7. **The deceased had lost a considerable amount of weight but there was no referral to a dietician (although the GP had been consulted regarding her weight loss and had prescribed supplements). The importance of the supplements was not fully appreciated by all of the staff. The deceased's weight was maintained during a hospital stay but deteriorated on her return to New Park Nursing Home.**

   The issue of weight did not form part of the investigation undertaken in July 2014. As stated earlier the City Council was not notified of any concerns following Mrs Kaiser's return from Bradwell Hospital.

8. **The deceased was incontinent and had required cleaning before**

the Tissue Viability Nurses were able to examine her.

This issue was not raised with the City Council so did not form part of the investigation.

9. **Single agency staff investigating Adult Protection Referrals had closed their investigation and recorded the allegations as unsubstantiated without obtaining full details of concerns raised by other professionals**.

The investigation undertaken in July 2014 was not carried out by a single agency. The investigating Senior Social Worker was supported in the process by a Senior Safeguarding Nurse from the Stoke on Trent Clinical Commissioning Group (CCG) as is usual practice in cases such as this where nursing practices are being investigated. They reviewed documentation and care records and undertook interviews with clinical and nursing staff, including TVN service and the allocated social worker involved with Mrs Kaiser's care. There is evidence in the investigation report and the Stoke on Trent Social Care record (CareFirst) to support this. Before the investigation was concluded, as strategic safeguarding lead for Stoke on Trent City Council, I reviewed the information and was assured that every area of the investigation had been appropriately covered. I was in agreement with the outcome being recorded as unsubstantiated.

4. Conclusion / Next Steps

As described the City Council was involved in two adult protection investigations for Mrs Kaiser. Issues identified following her return to New Park House from Bradwell Hospital were not raised with the City Council, which is of concern given the seriousness of the allegations. Under the agreed multi-agency adult protection procedures it would be expected that any such concerns would result in an adult protection referral to adult social care so that a further investigation could be carried out. The apparent failure of their staff to follow procedures has been raised with the safeguarding lead for SSOTP.

As strategic lead for safeguarding I would not routinely be involved in individual cases however I stayed closely involved because of concerns raised about the actions of the TVN staff when Mrs Kaiser was removed from the home and placed at Bradwell Hospital on 24 July 2014. Concerns included:

- The home were not spoken to about the concerns and there was no consultation with them before Mrs Kaiser was moved out of the home.
- Photographs were taken and documentation was removed from the home without consent which was potentially in breach of data protection legislation.
- Mrs Kaiser was deemed to lack mental capacity to consent to the adult protection process but no mental capacity assessment / best interests decision was undertaken before she was moved. Nor was her daughter

consulted. As might be expected Mrs Kaiser was reported as being very distressed by the move.

- As I understand it the TVN service has no protocol for direct admissions to hospital and their actions were considered by myself, the Safeguarding Lead Nurse from the Stoke on Trent CCG and the Management at the home to be disproportionate. This view was supported by the outcomes of the subsequent investigation which did not corroborate the allegations made about poor care.
- There is no record that Mrs Kaiser was dehydrated or suffering from a UTI on admission to Bradwell Hospital.

The concerns about the SSOTP TVN staff actions were raised by myself with the Safeguarding Lead Nurse for the Stoke on Trent CCG who in turn raised them with the provider trust. The Home also made a formal complaint to SSOTP.

The learning from the investigation has been shared with the home and recommendations have been made to improve recording. New Park House was subject to a large scale adult protection investigation over 3 years ago. The management team worked closely with the local authority at that time to make the necessary improvements and raise care standards and they continue to work in partnership with us. The home was open and transparent throughout the investigations ensuring that their staff were available for interview and all their documentary evidence was available for inspection. The City Council continues to make placements into the home, as does the CCG and Staffordshire County Council.