Safeguarding Adults Review (SAR)

‘William’

LIVERPOOL SAFEGUARDING ADULTS BOARD

INDEPENDENT LEAD REVIEWER: DAVID MELLOR

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1.0 Introduction

1.1 The purpose of a Safeguarding Adults Review (SAR) is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The SAR can also provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases[1]

1.2 William (a pseudonym chosen by his family) died in Aintree University Hospital in January 2021. He was 81 years of age and had a diagnosis of Alzheimer's, arthritis and had a long-term catheter in situ due to incontinence. He had been admitted to Aintree University Hospital from Nursing Home A on 12th December 2020. The Hospital made two safeguarding referrals relating to the standard of care provided to William whilst a resident of the Nursing Home as when admitted to hospital he was found to have severe acute kidney injury, was malnourished and on examination of the catheter site it was found that the catheter tubing had eroded the head of his penis to his scrotum. The safeguarding referrals were received by Liverpool City Council (LCC) Adult Social Care but were not progressed until William's daughter enquired about the outcome of any safeguarding enquiry in May 2021. The Section 42 Safeguarding Enquiry which then took place found that the concerns that William's care was neglected whilst a resident in Nursing Home A were substantiated.

1.3 In November 2021 the Merseyside Safeguarding Adults Review Group on which representatives of the Knowsley, Liverpool, Sefton and Wirral Safeguarding Adults Boards are represented recommended that a SAR should be commissioned on the grounds that William had care and support needs, that suspected neglect may have been a factor which had contributed to his death and there was reasonable cause for concern about how the provider of the Nursing Home in which he resided until shortly before his death and partner agencies had worked together to safeguard him.

1.4 There was an initial delay in sourcing an independent reviewer and in progressing the SAR. David Mellor was appointed as lead reviewer for the SAR. He is a retired chief officer of police and has over ten years' experience of conducting statutory reviews. He has no connection to any agency in Liverpool. Membership of the SAR Panel which oversaw the review and the methodology by which the review was conducted is shown in Appendix A.

[1] Retrieved from https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

1.5 No inquest will be taking place.

1.6 Merseyside Police considered if neglect could be substantiated however in June 2025, they concluded a criminal investigation would not progress as a criminal threshold was not established.

1.7 Liverpool Safeguarding Adults Board wishes to express sincere condolences to the family and friends of William.

2.0 Terms of Reference

2.1 The primary time period on which the SAR has focussed is from 1st January 2020 until William's death on 10th January 2021.

2.2 The key lines of enquiry for the SAR are as follows:

a. How effective was William's discharge from hospital to the nursing home - initially on a short term basis?

b. How effective was the nursing home's assessment of William's needs?

c. How effective was the process by which the nursing home placement became permanent?

d. Were decisions about William taken within a Best Interests framework?

e. To what extent did the nursing home placement meet William's needs? In particular, how effective was the care provided to William in respect of hydration and nutrition, skin integrity and urinary catheter care.

f. How effective are single and multi-agency arrangements for long term urinary catheter care for people with care and support needs.

g. When safeguarding referrals were made in respect of William, were they handled in accordance with policy and procedure.

h. To what extent were the principles of the Care Act – empowerment, prevention, proportionality, protection, partnership and accountability – applied in respect of William?

i. To what extent were the principles of 'making safeguarding personal' applied to William?

j. Did the agencies in contact with William and his family work together, communicate and share information effectively?

k. Were there any specific considerations around equality and diversity issues in respect of William such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation?

l. Did the Covid-19 pandemic have any impact on William or the support offered or provided to William by agencies during the pandemic?

m. To what extent does this SAR provide a 'window into systems' for safeguarding adults from abuse and/or neglect? What does this review tell us about how safe local systems are?

n. Identify good practice.

2.3 When consulted on the key lines of enquiry, William's family asked that the SAR also addressed the following questions:

- To explore why the Nursing Home did not apply for a Deprivation of Liberty Safeguards authorisation.

- To understand why William's wife was not consulted in respect of decisions taken in the Best Interests of William, in particular the decision that William's placement in the Nursing Home should become permanent.

- To understand why care and nursing staff did not recognised that William was in pain and needed to be referred to his GP.

- To explore why William was not referred to the Speech and Language Therapy (SALT) service by the Nursing Home when this was necessary.

- When the safeguarding concerns raised on William's behalf by his family were enquired into and found to be unsubstantiated, they feel that the family should have been provided with advice about how to appeal against or otherwise challenge the 'unsubstantiated' finding.

- When a family raises safeguarding concerns in respect of a family member who is a resident in a care or nursing home, the local authority should gather information from all relevant agencies and not just the care or nursing home concerned.

- To explore why the safeguarding concerns raised following William's admission to Aintree University Hospital in December 2020 were overlooked.

3.0 Chronology of key events

3.1 William was a White British male who was born in 1939. He was born, lived and worked in the Liverpool area for his whole life. He had two brothers and four sisters. As a young man he was a promising footballer who had a trial with Everton Football Club. He and his wife were together for over 50 years. William was just old enough to complete National service and was later employed in the car manufacture and ship building industries. He was a very proficient darts player who won many trophies, and he enjoyed playing cards. Following his retirement he and his wife enjoyed cruises in the Mediterranean. (Details of children and grandchildren to be added). William's wife became his primary carer when he began to experience cognitive decline and struggle with his mobility.

3.2 He was assessed as having a mild cognitive impairment in December 2015 and from February 2016 he was supported by the Older People's Community Mental Health Team (CMHT) (provider Mersey Care NHS Foundation Trust) and was also referred to the post diagnostic dementia support group (PDSG).

3.3 William was admitted to Royal Liverpool University Hospital in February 2016 following what was documented to be a 'collapse?'. After he was discharged, William was supported by a home care package. Accompanied by his wife, William began attending the Everton in the Community (EITC) 'Pass on the Memories' programme at Goodison Park.

3.4 By September 2016 the Older People's CMHT were considering discharging William from their case load if his circumstances remained stable but decided to remain involved due to what was documented to be 'carer stress'. However, in February 2017 William was discharged from the CMHT and referred onto 'shared care' and the Care Navigator Service[2]. During 2017 William continued to engage with the PDSG and the Cognitive Stimulation Group (CSG).

[2] The Care Navigator service provides support and signposting for people with dementia and carers from diagnosis onwards.

3.5 William was admitted to Royal Liverpool University Hospital on 3rd January 2018 with likely gastroenteritis and mild acute kidney injury (AKI). He was noted to have reduced mobility and increased confusion. He was discharged on 12th January 2018 and it was documented that a home care package was in place. In April 2018 the Older People's CMHT followed up and encouraged CSG attendance but William's wife said they were not attending as both had been ill. She added that she was looking for respite.

3.6 William was again admitted to Royal Liverpool University Hospital on 11th April 2018 and treated for sepsis with a likely urinary cause. Increased confusion was again noted. He was discharged on 23rd April 2018 and his home care package restarted.

3.7 On 1st June 2018 William was again admitted to the Royal Liverpool University Hospital following a fall. He waited for an ambulance for four hours. (NWAS have advised the SAR Panel that the call was graded as a category 2 which covers incidents which are potentially serious conditions that may require rapid assessment, urgent on-scene clinical intervention/treatment and/or urgent transport). A urinary tract infection (UTI)[3] was diagnosed as was acute kidney injury (AKI)[4]. He was discharged on 4th June 2018 'ASAP at his wife's request'. It was documented that William and his family preferred to continue with intermittent self-catheterisation[5] rather than a permanent in-dwelling[6] catheter at that time.

[3] Urinary tract infections (UTIs) affect a person's urinary tract, including their bladder (cystitis), urethra (urethritis) or kidneys (kidney infection). UTIs may be treated with antibiotics, but they're not always needed. In older, frail people who have problems with memory, learning and concentration (such as dementia), and people with a urinary catheter, symptoms of a UTI may also include changes in behaviour, such as acting agitated or confused (delirium), incontinence that is worse than usual and new shivering or shaking (rigors).

[4] Acute kidney injury (AKI) is where a person's kidneys suddenly stop working properly. It can range from minor loss of kidney function to complete kidney failure. AKI normally happens as a complication of another serious illness. This type of kidney damage is usually seen in older people who are unwell with other conditions and the kidneys are also affected. It's essential that AKI is detected early and treated promptly. Without quick treatment, abnormal levels of salts and chemicals can build up in the body, which affects the ability of other organs to work properly. If the kidneys shut down completely, this may require temporary support from a dialysis machine, or lead to death.

[5] Self-catheterisation means that the person inserts a small, flexible plastic tube into the bladder via the penis. The urine flows out through this tube which is then removed. By emptying the bladder regularly in this way, they prevent a build up of stagnant urine and should feel more comfortable. They will also be keeping their kidneys and bladder healthy by preventing urinary infections.

[6] An indwelling urinary catheter is inserted in the same way as an intermittent catheter, but the catheter is left in place. The catheter is held in the bladder by a water-filled balloon, which prevents it falling out. These types of catheters are often known as Foley catheters. Urine is drained through a tube connected to a collection bag, which can either be strapped to the inside of your leg or attached to a stand on the floor. Indwelling catheters are sometimes fitted with a valve. The valve can be opened to allow urine to be drained into a toilet, and closed to allow the bladder to fill with urine until drainage is convenient. Most indwelling catheters need to be changed at least every 3 months.

3.8 On 9th November 2018 William's GP wrote a letter to assist William's daughter to obtain lasting power of attorney (LPA)[7] in respect of her father. The GP wrote that William currently had capacity to agree to this. LPA was registered with the Office of the Public Guardian (OPG) in December 2019.

3.9 On 14th February 2019 William was admitted to Royal Liverpool University Hospital reporting lower abdominal pain and was treated for a UTI. He was documented to be doubly incontinent and to have 'poor' mobility. He continued to be able to self-catheterise. He was discharged home on 22nd February 2019 where he was receiving four calls daily from his home care provider.

3.10 On 22nd May 2019 William was admitted to Royal Liverpool University Hospital after seeing his GP with signs of sepsis along with confusion and hallucinations secondary to a UTI. He was discharged home on the same day.

3.11 On 3rd August 2019 William was again admitted to Royal Liverpool University Hospital following what was documented as a 'collapse? Query secondary to UTI' and was discharged home the same day with a request that his GP to review his self-catheterisation technique as it was not felt to be clean. Following a telephone conversation with William's wife, the GP referred him to the District Nurses on 9th August 2019. The Hospital had suggested that a convene[8] catheter could be fitted but this was not felt to be ideal as William would pull at the leg bag and so he returned to using intermittent self-catheterisation.

3.12 On 30th August 2019 his GP made an urgent referral to the CMHT because of deteriorating dementia symptoms.

3.13 On 10th September 2019 William was admitted to Royal Liverpool University Hospital following a referral from his GP who had made a home visit following increasing confusion, hallucinations and UTIs which were unresponsive to antibiotics prescribed in the community. It appears that an in-dwelling catheter was fitted during William's admission. He was discharged on 17th September 2019 and was

[7] A lasting power of attorney (LPA) is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. This gives the person more control over what happens to them if they have an accident or an illness and cannot make their own decisions. There are two types of LPA – 'health and welfare' and 'property and financial affairs'.

[8] A convene catheter is an external urinary catheter that are worn like a condom. They collect urine as it drains out of the person's bladder and send it to a collection bag strapped to the person's leg.

followed up by the integrated community reablement and assessment (ICRAS)[9] team.

3.14 On 19th September 2019 William was seen for an Older People's CMHT medical review by a Consultant Old Age Psychiatrist (following the 30th August 2019 GP referral) who documented a deterioration in his dementia symptoms, in particular his concentration and memory were noted to be rapidly deteriorating. He was now doubly incontinent. He was to be prescribed Memantine[10] and to be seen regularly by the Older People's CMHT to monitor this.

3.15 On 25th September 2019 William attended Royal Liverpool University Hospital AED (accident and emergency department) presenting with retention of urine. The hospital noted that the District Nurses had changed his catheter bag the previous day after William had disconnected the catheter tubing and bag. He was re-catheterised and discharged home the same day.

3.16 On 1st November 2019 his GP visited William at home in respect of pain in the tip of William's penis apparently arising from him pulling on his catheter. The GP prescribed a local anaesthetic for the pain and antibiotics for a further UTI.

3.17 Between October 2019 and early January 2020 William was monitored by the Older People's CMHT. His wife initially reported a slight improvement after William commenced on Memantine – reduced irritability and swearing – but it was eventually concluded that the medication had made no difference and it appears that it was stopped. The CMHT noted that William continued to receive 4 home care calls per day although issues arose in respect of the carers emptying his catheter bag from time to time. At one point a care provider advised William's wife that they were 'not allowed' to change the catheter bag although this issue appeared to be resolved for a time. On one occasion carers declined to change the catheter bag when William had a UTI. The district nurses continued to monitor catheter care and advised William's wife to ensure that catheter care was included in William's care plan. William went into respite care (Nursing Home B) for a week to enable his wife to take a holiday during this period. His wife reported that he had returned home from respite with redness to his bottom and groin for which his GP had prescribed cream. William continued to suffer from recurrent UTIs. She also reported that William was

[9] The multidisciplinary ICRAS team work together to manage the care of people in the community requiring support of an urgent nature and who are at risk of imminent hospital admission and those transferring from a hospital environment and require additional support.

[10] Memantine is a medicine for dementia. It is used to treat memory loss which is one of the main symptoms of dementia. It is also used to treat the symptoms of Alzheimer's disease, dementia with Lewy bodies, mixed dementia and corticobasal degeneration.

bleeding from his penis – which she said was very sore. She was advised to monitor the latter issue and contact the GP if the bleeding continued.

3.18 On 7th December 2019 the district nurses changed William's catheter during a home visit.

3.19 On 2nd January 2020 the Older People's CMHT discharged William to the care navigators.

3.20 The following day (3rd January 2020) William's wife contacted the district nurses after William disconnected the night bag and leg bag from his catheter. She said she was struggling to re-attach the leg bag and the carer who attended that day was not trained to change catheter bags. A district nurse attended to assist William's wife. William's wife telephoned LCC Adult Social Care to request they contact Home Care provider 1 to ask them to 'support William with his catheter bag'. Home Care provider 1 advised that they did not assist with this and that it was Home Care provider 2 who provide this support. Home Care provider 2 advised that they had explained to William's wife that they supported with the catheter bag and a carer would be visiting William for this purpose later the same day. William's home care needs were being met by two separate home care providers at that time. On the same day William's wife rang the district nurses as she had been unable to attach the catheter bag properly.

3.21 On 6th January 2020 William's wife again telephoned Adult Social Care to say that a friend had recommended a domiciliary care provider who could provide all 4 calls per day 'and catheter care'. It was agreed that Home Care provider 2 would be asked to complete all 4 daily home care visits. If they were unable to do this a request to brokerage would be made.

3.22 On 10th January 2020 the district nurses visited William to check his pressure areas. A small area of moisture damage to his left buttock was noted which was noted to be healing well. Proshield cleanser and barrier cream were to be applied by the home carers. A Waterlow[11] risk assessment was completed which generated a score of 22 – indicating a 'very high risk' of developing a pressure ulcer. A Pressure Ulcer Care plan was created. Further visits were planned to review William's pressure areas. William was noted to require a catheter passport.

[11] The Waterlow assessment calculates the risk of pressure ulcers developing on an individual basis through a simple points-based system. A score of 10-14 indicates 'at-risk', a score of 15-19 indicates 'high risk' and a score of 20 and above indicates 'very high risk'.

3.23 During the morning of 14th January 2020 William was brought into Royal Liverpool University Hospital AED by ambulance after falling out of bed. He was complaining of left hip pain and a mild bruise was noted to his right elbow. His long-term catheter had not been draining since the previous night and his catheter bag was noted to be empty. He had recently been prescribed antibiotics for a urinary tract infection (UTI) from which he was noted to suffer recurrently. An X-ray disclosed no broken bones and William was referred to the falls team who provided advice to prevent further falls whilst being nursed in hospital. The falls team also recommended that William should be referred to the dementia nurse for advice and support and for volunteer support during his hospital admission.

3.24 It was noted that his urinary catheter was 'not in his penis' which was why the catheter was not draining. 'Some pus? from meatus' was documented which suggests there may have been an infection in the urethral meatus (the point from which urine leaves the penis). 'Poor genital hygiene' was noted as was some balanitis[12]. A 12G urinary catheter was inserted on a best interests basis as William was documented to be unable to consent. The insertion was described as uncomplicated and clear fluid was drained from William's bladder. After speaking to William's wife, who was documented to be 'not coping' - with her age (then 84 years) and back pain cited as factors – it was concluded that William's fall was due to agitation likely caused by urinary retention. It was documented that his catheter bag had been changed 4 days earlier and had subsequently fallen out.

3.25 William was admitted to Royal Liverpool University Hospital for review and it was documented that his care package would need to be increased (currently noted to be 4 visits daily). His pressure areas were noted to be intact although the signs of an 'old ulcer' were noted on William's bottom. On 15th January 2020 William was discharged home as he was considered to be likely to be near his baseline mobility level. He was able to mobilise for short distances using a wheeled zimmer frame. His wife reported managing well and was said to have no concerns about William returning home. She was documented to be changing home care providers. William was noted to remain at high risk of falls due to gait pattern, cognition and his dementia diagnosis. William's wife was provided with a leaflet for the 'Bring Me Sun Shine[13]' service 're shopping and cleaning'. Adult Social Care were notified of William's hospital admission which they documented to be following a fall considered secondary to urine retention due to a 'blocked' catheter.

[12] Balanitis is when the head of the penis is swollen and sore.

[13] 'Bring Me Sun Shine' help people who do not need personal or nursing care, but do need support, home help or companionship to enable them to stay comfortable, safe, happy and independent in their own home.

3.26 William's GP was also notified of his hospital admission and requested to note concerns that the family was struggling to cope on the current package of care and that an increase may need to be considered. The GP phoned William's wife on 17th January 2020 to discuss issues with insomnia. There is no indication that the district nurses were notified of the hospital admission.

3.27 On 24th January 2020 William's wife telephoned Adult Social Care to report that the morning carer had not arrived. This was followed up with the agency who apologised and advised another carer was on their way to support William.

3.28 On 27th January 2020 sacral redness was noted by the GP and a district nurse visit on 31st January 2020 resulted in a Datix[14] referral being made.

3.29 On 1st February 2020 the district nurses carried out a three-monthly review at which it was noted that William's existing moisture lesion was improving. The Waterlow score continued to indicate a 'very high risk' (24). In terms of his nutrition and hydration, it was noted that he needed encouragement and received a dietary supplement between meals.

3.30 On 3rd February 2020 Adult Social Care discussed direct payments with William's wife and a direct payment request was submitted (See Paragraph 3.33 for the outcome of the direct payment request).

3.31 On 6th February 2020 Adult Social Care generated a letter to William in error, which stated that they had repeatedly tried to contact him to conduct a needs assessment and that the matter would be closed if he did not contact Adult Social Care (It is unclear whether the letter was actually sent or not).

3.32 On 20th February 2020 William's wife telephoned Adult Social Care to say that she was unhappy as carers were repeatedly late or not attending for the morning call which affected William's departure for day care. She went on to raise concerns that the carers were 'not clear' on how to support William with his catheter, that she had received training from the hospital in catheter care and was having to show the carers how to support her husband with this.

3.33 On 6th March 2020 an LCC 'self-directed support officer' visited William's wife to discuss the start date for new home care providers funded from direct payments. However, after William's wife queried the £8 difference in hourly cost, the direct payment process did not go ahead and so the brokerage process re-commenced.

[14] Datix is a Risk Management Information System to collect and manage data on adverse events.

3.34 On the same date the district nurses visited and found William's moisture lesion to be improving. His wife advised the district nurses that the home carers were still not assisting with the catheter bag change. The district nurse experienced some difficulty in encouraging William to stand in order for the catheter bag to be changed. The district nurses planned to contact the home care provider and offer a joint visit if they were not fully competent in catheter care. The district nurses noted that William's home care plan had required home carers to empty and change his catheter bag and strapping when required and attach a night catheter bag on the evening call since 19th November 2019.

3.35 On 16th March 2020 William's wife contacted the care navigator to ask for names of care agencies which could complete catheter care as the current provider 'could not attend to his catheter'. She was advised to speak to William's social worker – which she said she had already done and that the social worker was awaiting a response from care providers.

3.36 On 20th March 2020 William's wife telephoned Adult Social Care to check on progress in securing a care package. During the call, she said that she was not coping as well as she had in the past due to her age and William's increasing needs. It was agreed that a review of William's care and support needs would take place although there is no record of such a review taking place prior to his admission to hospital and nursing home placement.

3.37 On 23rd March 2020 the first England lockdown commenced in response to the Covid-19 pandemic.

3.38 On 27th March 2020 William's wife spoke to the GP who noted a recent deterioration in William's dementia symptoms. His wife said that he 'used to have a dementia nurse' which appeared to prompt the GP to phone Mossley Hill (which was a hospital which provided dementia care) to request support for William's wife. The GP was advised that Mossley Hill did not provide the care package William's wife needed and to contact social services. The GP then contacted Adult Social Care.

3.39 Also on 27th March 2020 the district nurse visited William around 10.30am. He remained in bed and his wife said that no carer had arrived that morning. The district nurse rang the home care provider who initially claimed that William had received his breakfast visit, before concluding that he had not. When the home carer arrived the district nurse advised them that a missed or late breakfast call meant that William spent longer in bed increased his risk of pressure ulcers.

3.40 On 30th March 2020 Adult Social Care telephoned William's wife. A discussion took place about Home Care provider 3, a domiciliary care agency which had agreed

to deliver William's home care package. William's daughter had seen adverse online reviews for this agency and so William's wife decided not to accept the provider. The brokerage process was to continue.

3.41 On 8th April 2020 the district nurses visited to change William's catheter. He was 'very distressed' throughout the visit and the district nurses decided to rearrange the catheter change to enable a district nurse to whom William related well to change the catheter. The district nurse was concerned that if she attempted to remove the existing catheter on that day and William did not comply, a hospital admission may be needed.

3.42 The following day (9th April 2020) the district nurse returned to change William's catheter but he was documented to be 'uncooperative' and 'aggressive in his manner' and so the district nurse decided to postpone the catheter change until the following day when she would return with a colleague to assist with the procedure. The district nurse left a message with William's GP to consider prescribing a sedative and to advise that William needed to be reviewed by the mental health team given the difficulties his wife was experiencing in caring for him which was described as a 'constant battle'. The next day (10th April 2020) the district nurses were able to change William's catheter. He was noted to be calmer due to sedation (the GP had prescribed 5mg Diazepam[15] to be administered one hour prior to the District Nurse visit). The District Nurses documented a small wound opening up in William's meatus and Instillagel[16] was applied.

3.43 On 14th April 2020 William's wife chose to move forward with Home Care provider 4 as the new provider of her husband's homecare package. They provided care to William from 16th April 2020 until his hospital admission on 26th April 2020. Home Care provider 4 has provided a chronology of their contact with William during this period. They visited three times daily, at breakfast, evening meal and bedtime. They appeared to have had no difficulty in emptying William's catheter bag. On one occasion the carer noted that William 'was in pain and frustrated by his catheter'. He began presenting as agitated and abusive at times and on two evenings refused to go to bed and his daughter and son-in-law were called upon to assist on one of these occasions.

[15] Diazepam belongs to a group of medicines called benzodiazepines and is used to treat anxiety, muscle spasms and seizures or fits. It can also be taken to help a person relax before an operation or other medical or dental treatments. Diazepam is available on prescription only.

[16] Instillagel is a gel that is used to numb the parts of the body it is applied to (local anaesthetic). It is used when examining or putting an instrument into a body cavity, such as the mouth, bladder or vagina. It provides lubrication to ease this process.

3.44 On 16th April 2020 the District Nurses contacted the GP to request an assessment of William with a view to admission to an elderly mentally inform (EMI) unit as he was becoming increasingly agitated and uncooperative.

3.45 On 24th April 2020 the GP started William on lorazepam[17] 1mg at night when needed after his wife phoned to report agitation, insomnia and pushing carers away when trying to change his catheter bag.

3.46 During the late evening of 26th April 2020 William was conveyed to Royal Liverpool University Hospital AED where it was documented that his wife had reported that William had been increasingly confused which was associated with 'fevers'. He had a high temperature (39.2). The working diagnosis was that William had sepsis of unknown – but likely urinary – cause. He was admitted to a hospital ward and was given fluids and antibiotics intravenously.

3.47 The following day (27th April 2020) William presented as quite agitated which prevented a Covid swab being taken. His long term catheter was noted to be draining only a small amount. He was doubly incontinent and whilst receiving personal care a 'category 3 pressure ulcer?' was noted on his right buttock. The wound was cleaned and dressed, a 'trio' mattress (dynamic mattress?) ordered, a referral made for a tissue viability nurse and an entry made on the datix[18] system. The ward staff spoke to William's wife by telephone who said that whilst he was usually confused, he had been significantly more aggressive over the past two to three weeks, 'lashing out' and throwing meals at her. She went on to say that she didn't feel that she could cope if her husband's behaviour continued at this level. She added that he was in receipt of a package of care entailing three visits per day although the visits had been taking longer due to his level of aggression. She said that district nurses had been managing the sacral moisture lesion (it is presumed that William's wife was referring to the 'category 3 pressure ulcer?' noted by the hospital) but had also expressed concern about his aggressive behaviours and had contacted his GP about this. William's wife said that his mobility was usually poor due to osteoarthritis but had been particularly poor during the two days prior to hospital admission.

3.48 Later the same day ward staff again spoke to William's wife by telephone and advised her that he was clinically stable and that the apparent deterioration in his health may reflect a general decline or an 'acute delirium on chronic cognitive problems'. The hospital's plan was to medically optimise William and to liaise with

[17] Lorazepam belongs to a group of medicines called benzodiazepines. It's used to treat anxiety and sleeping problems that are related to anxiety.
[18] Datix is a Risk Management Information System to collect and manage data on adverse events.

therapy and community teams in respect of his discharge destination and healthcare needs. It was stated that William would need an EMI bed and there was also a reference to NHS continuing healthcare (CHC)[19]. William's wife was documented to be happy with this plan and agreed to a DNACPR being put in place.

3.49 On 28th April 2020 William was seen by the Tissue Viability Nurse who noted a small lesion on his left inner buttock and other skin breaks on his bottom which were felt to be related to moisture. They advised the ward staff to regularly apply barrier cream and reposition every two hours. The Tissue Viability Nurse was advised by ward staff that William was experiencing soreness to the penile area. The Tissue Viability Nurse noted that there was a catheter in situ and that the penile area looked slightly red to the base of the head of the penile area. There was no visible skin break. A Deprivation of Liberty Safeguarding (DoLS) referral was processed the same day.

3.50 On 28th April 2020 the Hospital issued a Section 2 Notification[20] and assigned William a hospital social worker to support his discharge from hospital. A neighbourhood social worker was also allocated to him. A Nursing Needs Assessment was completed to inform his pathway out of hospital and was sent to bed brokerage.

3.51 On 1st May 2020 William was assessed by a medical student in the hospital as lacking the capacity to make complex decisions about his future care and that a discussion between family and medical staff concluded that it was in William's Best Interests to go into 24-hour Nursing care. A social care assessor also spoke to William's wife who discussed her difficulty in caring for her husband over the past six months during which his needs had been increasing. She said she found his attempts to take his catheter out 'quite distressing' and that he had been aggressive towards her in recent months. William's wife was advised that he would be able to move to a 'care home' for an initial 28-day period. She responded by saying that she didn't want him to be placed in 'the respite placement' (presumed to be Nursing Home B) as she had not been satisfied with their care.

3.52 By 8th May 2020 William had completed his course of antibiotics for UTI and was medically optimised for discharge and was awaiting a nursing home placement, in respect of which a search was ongoing.

3.53 On 15th May 2020 Nursing Home A accepted William subject to a negative Covid swab prior to discharge. William's wife was documented to be happy with this

[19] Some people with long-term complex health needs qualify for free social care arranged and funded solely by the NHS. This is known as NHS continuing healthcare (CHC).
[20] Section 2 (of the Community Care (Delayed Discharges) Act 2003) requires an NHS body to notify social services of a patient's likely need for community care services after discharge.

plan. The Hospital Physiotherapist recommended that William was nursed in bed as the physiotherapist had experienced difficulty in encouraging William to engage, and, as a result had not seen him sit up or transfer safely and went on to note that William appeared to be content in bed.

3.54 The following day (16th May 2020) William's wife raised concerns about her husband's lack of mobilising whilst in hospital, adding that at home, she would not ask him to get up but would tell him. His wife was advised that after being nursed in bed William's ankles had a reduced range of movement and that stretching them caused him to shout out in pain which prevented him from tolerating mobilising. If in future William showed interest in sitting out of bed and mobilising the Nursing Home would be able to support and arrange community therapy referral although it was currently not possible to make that referral from hospital, as community physiotherapists were not going into care homes because of Covid-19 restrictions.

3.55 On 18th May 2020 William was discharged from Royal Liverpool University Hospital to Nursing Home A. The discharge summary stated that a previous category 2 pressure ulcer to his buttock had cleared up and that a dressing was no longer being applied, that he should be nursed in bed at the present time as he had not engaged with the hospital physiotherapist and should be referred to community physiotherapy when it was possible to do so, that his long term catheter was changed during his hospital admission on 12th May 2020 and was therefore due for change again on 12th August 2020 (a Healthcare pack was provided by a commercial provider of supplies to people living with medical conditions as was William's catheter passport) and that hospital staff had needed to prompt William at mealtimes. A negative Covid-19 swab had been completed.

3.56 Nursing Home A is a residential care home providing personal care and nursing care for older and younger people. The most recent inspection by the regulator the Care Quality Commission (CQC) grading was 'inadequate' with multiple breaches of regulations.

3.57 In their contribution to this SAR the Nursing Home has advised that at the time William's temporary placement began on 18th May 2020 an Admission Assessment was completed along with a number of risk assessments which have been shared with the SAR Panel. The Nursing Home has advised that William's mobility care plan indicated that he could bear weight and was able to walk with a zimmer frame. The Nursing Home also advised that a full body map was completed which disclosed bruising to William's right elbow cleft, right wrist and right abdomen and a scratch to his right shin. William's family have advised the independent reviewer that they requested records relating to his day to day care for his entire placement at Nursing Home A but have received this information only for the period from 1st August until

12th December 2020. When requested to provide additional information to the SAR, the provider of Nursing Home A also shared records of his day to day care from only August to December 2020. The provider stated that some records had been lost in a fire.

3.58 Also on 18th May 2020 Adult Social Care documented that William was 'placed in a reablement bed' following the aforementioned Nursing Needs Assessment. The following day (19th May 2020) Adult Social Care documented the reablement plan which appeared to envisage that following the 28-day placement in Nursing Home A, William would return home.

3.59 Adult Social Care's service provision notes on the Liquid Logic information system note that William's placement at Nursing Home A became permanent on 16th June 2020. (No further details)

3.60 On 20th June 2020 the Nursing Home completed a body map in respect of William which indicated that his right wrist was red and swollen, which remained the case the following day. There is no reference in the Nursing Home A chronology to cause, investigation, hospital admission or whether they considered a safeguarding referral. (If the Provider of Nursing Home A is given an opportunity to read and comment on the SAR report, they may be able to clarify this, and other points raised in the SAR report).

3.61 The following day (21st June 2020) William's daughter rang 111 for advice as she was concerned about her father's wrist which appeared swollen and injured. She added that she had been asked by the Nursing Home whether she would like her father to have an x-ray and hospital visit. Adult Social Care have documented that the 111 call operator spoke with the Nursing Home who appeared unaware how William had injured his wrist and unaware of the processes they should follow when this kind of incident occurs. At the time William's daughter rang 111, no clinician was available due to increased service demand and so the details were sent to the Out of Hours GP*. 111 raised a safeguarding concern to Adult Social Care given William's daughter's concerns about the Nursing Home care in relation to her father's wrist injury. Later the same day William was taken to Royal Liverpool University Hospital by his daughter. The hospital noted that William was complaining of pain to right hand which was swollen with no range of movement. The injury was x-rayed and found to be a soft tissue injury, a splint was applied and RICE (rest and protect the injured or sore area) given together with pain relief advice and William was returned to the Nursing Home. There is no indication that William's GP practice was notified of this hospital attendance. At this point he was still registered with GP Practice 1.

3.62 On 22nd June 2020 Adult Social Care, having received the safeguarding concern from NWAS (provider of 111 service), telephoned William's daughter. She reiterated her concern that Nursing Home staff did not appear to know how to respond to her father's injury, did not respond to him being in pain and did not escalate the injury. The onus was placed on her to contact 111 and obtain medical support and she went on to express concern in respect of how the Nursing Home would ensure her father has appropriate support when she does not visit. She also felt that the Nursing Home minimised the concern about her father's injury when contacted by 111. William's daughter was also concerned about how the Nursing Home would care for her father after she had reported her concern about their care of him.

3.63 The following day Adult Social Care commenced a Section 42 Safeguarding Enquiry and established that William's daughter's desired outcomes were better communication between the family and Nursing Home staff, the family to be offered 'alternative options of support if the daughter was unable to support' (this outcome is not fully understood. It is intended to ask the family about this when the findings from the SAR are shared with them), possible future training for staff in relation to handling incidents/procedures and family to be reassured and confident in Nursing Home's processes/ procedures should this happen again.

3.64 On 26th June 2020 the manager of the Nursing Home advised Adult Social Care that William's wrist injury had been reported to the nurse monitoring during the afternoon when William's family attended and took him to hospital for an X-ray. The manager added that there was no fracture and that William had reported no swelling or redness since. It was noted when William first arrived at the Nursing Home he was 'immobile' and had only recently begun to mobilise using a Zimmer frame. The manager stated that the swelling on his wrist may have been aggravated from Zimmer frame use as, until recently, he had not been using his hands and wrists as much. The manager added that William had been taking off the provided wrist splint. William's GP records contain no reference to this Section 42 Safeguarding Enquiry. He was still registered with GP practice 1 at this point.

3.65 The Nursing Home manager was asked to provide an investigation report to support the Safeguarding Enquiry which was received by Adult Social Care three days later. The two-page document contained limited additional detail. Care/Nursing staff were to monitor William's wrist for redness and swelling. It was noted that the Nursing Home used the Abbey Pain Scale'[21] to support identification of pain in residents.

[21] The Abbey Pain Scale is an instrument designed to assist in the assessment of pain in residents who are unable to clearly articulate their needs and focusses on

3.66 William transferred to GP practice 2 on 6th July 2020. His new GP practice received his electronic records on the same date and his paper records on 24th September 2020. William's family have advised the independent reviewer that they found out about William's change of GP inadvertently on 3rd August 2020 when they asked if he had received antibiotics for a UTI (Paragraph 3.75) and were told that the Nursing Home was waiting on GP practice 2.

3.67 From 4th July 2020 Covid-19 restrictions in England began to be lifted although relatives continued to be unable to enter care/nursing homes to visit family members.

3.68 On 9th July 2020 William commenced Cefalexin[22] 500mg 3 times daily for 5 days for a UTI. (William's GP has no record of this. The first contact from the Nursing Home to the GP regarding a UTI was on 30th July 2020). (The information relating to the commencement of the Cefalexin is taken from the Nursing Home A chronology. The provider of Nursing Home A may be able to clarify if they read the SAR report).

3.69 On 14th July 2020 the Nursing Home updated William's mobility care plan to state that he now required a hoist and sling as he was unable to weight bear. Contributing factors included prior knee surgery and arthritis.

3.70 On 23rd July 2020 Adult Social Care completed the Section 42 Safeguarding Enquiry which concluded that the family's allegations were unsubstantiated and that the Nursing Home had followed all correct policies and procedures with no evidence to suggest that the injury was caused via neglect and that the Nursing Home's documentation evidenced that medical attention had been sought and the incident had been monitored by nursing staff appropriately. The Safeguarding Enquiry found that the injury to William's wrist had been documented on the morning of the family attending which was supported by nursing notes which stated that there was no obvious injury (as supported by hospital documentation) and to continue monitoring. The family had visited shortly after initial pain was identified and following advice from NHS 111 the family had transported William to hospital where an X-ray found no injury found and no probable cause had been identified.

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measuring the effectiveness of pain-relieving interventions.

[22] Cefalexin is an antibiotic. It belongs to a group of antibiotics called cephalosporins.
It's used to treat bacterial infections, such as pneumonia and other chest infections, skin infections and urinary tract infections (UTIs).

3.71 It is unclear whether the Safeguarding Enquiry was discussed with the then NHS Clinical Commissioning Group – now Integrated Care Board (ICB) as commissioners. The LCC Quality Assurance team or CQC. It is also unclear when the outcome was shared with William's family).

3.72 Subsequently CQC inspected Nursing Home A. The CQC found that the Nursing Home remained 'inadequate' overall. The inspection findings were consistent with learning identified in William's Review.

3.73 The CQC noted that the Nursing Home provider had completed an action plan following the last (September 2019) inspection to show what they would do and by when to improve. The CQC found that not enough improvement had been made and that the provider was still in breach of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) and identified new breaches of Regulation 11 (Need for consent), Regulation 13 (Safeguarding service users from abuse) and Regulation 14 (Meeting nutritional and hydration needs), meaning that the service had further deteriorated. The service was therefore in 'special measures'. The CQC stated that they took account of the exceptional circumstances arising as a result of the Covid-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

3.74 The CQC planned to meet with the provider following the publication of their inspection report to discuss how they will make changes to ensure they improve their rating to at least good. The CQC also planned to work with the local authority to monitor progress and would return to re-inspect within 6 months to check for significant improvements. Should the provider not have made enough improvement within this timeframe, and there was still a rating of inadequate for any key question or overall rating, the CQC planned to take action in line with their enforcement procedures, which meant that they would begin the process of preventing the provider from operating the service – which would usually lead to cancellation, or varying the conditions, of registration. For adult social care services, the maximum time for being in special measures would usually be no more than 12 months.

3.75 On 3rd August 2020 Nursing Home A documented that the Bladder and Bowel service contacted them to discuss a plan relating to William trial without catheter (TWOC) which was apparently due to take place on 12th August 2020. The Bladder and Bowel service were apparently to recontact Nursing Home A on 13th August 2020 to check how the trial had progressed (The Bladder and Bowel has no record of this contact with Nursing Home A - see paragraph 3.81)

3.76 On 5th August 2020 William was commenced on Cefalexin for 5 days for a UTI by GP practice 2.

3.77 On 12th August 2020 a self-suspension was put in place in respect of Nursing Home A which was lifted on 24th March 2021. During the self-suspension no new placements in Nursing Home A were made either by the Local Authority or Health although self-funded placements could proceed. Any self-funded placements would be advised of the self-suspension.

3.78 On 13th August 2020 William's catheter was changed. The next planned catheter change was therefore due to take place on 13th November 2020. (The catheter change took place 1 day late (3 months) or 9 days late (12 weeks). Nursing Home A have not yet provided any further information about the catheter change and the condition of William's penis at this time. However, in the 'continence notes' Nursing Home A has shared with the family, it is documented that staff had been advised to 'clean the genitals' as there was 'discharge coming out'. There is no indication that the planned TWOC trial did take place. (William's family has informed the SAR that the catheter equipment provider has advised them that Nursing Home A did not order a catheter for William from them for the catheter change which should have taken place on 12th August 2020 but did not take place until the following day. The family therefore conclude that the catheter fitted on 13th August 2020 had not been prescribed to William and must have been taken from a stock of catheters held by Nursing Home A).

3.79 On 22nd August 2020 the Nursing Home documented that Ensure (oral nutritional supplement) and Lorazepam were discontinued by William's GP. (GP practice records state that during a consultation with Nursing Home staff and GP practice 2 on 7th August 2020 the comment was made that 'unnecessary medications stopped'. Ensure was not explicitly mentioned but this is seldom prescribed in Nursing Homes due to the expectation of dietary support from the Home. Lorazepam was never stopped but was kept in the 'acute' section of his medications which means it needed to be requested each time as opposed to re-ordered by simply ticking a box.

3.80 On 27th August 2020 the Nursing Home updated William's Nutrition care plan and Choking risk assessment. The Choking risk assessment disclosed a high risk of choking which should have led to contact with a Speech and Language Therapist, clear guidelines included in his care plan, all staff to be made aware of action to be taken in case of a choking incident and any intervention that may be required. The Nutrition care plan was updated to indicate that the assistance of one carer was needed with eating, but it is unclear whether the Nursing Home implemented any other actions. The Nurse/Senior Carer documented that William was 'currently tolerating well with no issues'.

3.81 Also on 27th August 2020 an audit of William's care plan found that the planned TWOC on 12th August 2020 had not taken place, and an urgent message was left with the Bladder and Bowel service to check whether the TWOC trial was still required. The following day the Bladder and Bowel service responded to Nursing Home A, stating that they had no record of advising a TWOC trial and that it didn't sound a viable idea as William had a long-term catheter in place.

3.82 On 30th August 2020 the Nursing Home documented 3 bruises to William's right forearm. No further information provided.

3.83 On 1st September 2020 Nursing Home staff noticed that William's penis appeared swollen when they completed personal care and a 'very smelly' discharge was 'oozing'. The nurse on duty 'checked him over' and the GP was to be called. There is no indication that William's GP was contacted.

3.84 On 11th September 2020 the CQC published the Nursing Home A inspection report.

3.85 On 7th and 24th September 2020 GP practice 2 held (proactive as opposed to reactive) video conference multi-disciplinary reviews of William. The first review involved the GP and Nursing Home staff. The second also involved the Community Matron.[23]

3.86 On 9th September 2020 the Community Matron Service received a referral from the Nursing Home advising that William's GP had prescribed antibiotics for a UTI. The Community Matron advised the Nursing Home Registered Nurse of the correct way to obtain a urine sample and monitoring for symptoms of a UTI, specifically not to take a catheter sample.

3.87 On 21st September 2020 the Nursing Home A Daily Progress Notes state that William was very unsettled all night, that staff noticed 'pain in lower abdomen' and that his catheter was not draining. His catheter was flushed twice and drained a very minimal amount of 'milky' urine. The catheter bag was changed but the catheter blocked intermittently. The Notes requested staff to observe and re-catheterise if required. At 11am on the same date the Nursing Home removed William's catheter 'as advised' and he appears to have been tried without a catheter until 10pm that

[23] Community Matrons support patients who have complex long term conditions and currently have a very high intensity use of health care. Community Matrons provide advanced specialist nursing care, and support patient to remain at home longer and to have more choice about their health care. A Community Matron is attached to every nursing/care home.

day when he was re-catheterised, having not passed urine since his catheter was removed at 11am.

3.88 On 7th October 2020 the Nursing Home documented a bruise to William's right forearm. No further details.

3.89 On 10th October 2020 a Nutrition assessment of William conducted by the Nursing Home noted weight loss of 4kg (nearly 9 lbs) indicating a MUST (malnutrition universal screening tool)[24] score of 1 which indicates a 'medium' risk on the MUST scale of 0 – 'low' (routine clinical care), 1 'medium' (observe) and 2 'high' (treat). The recommended management guidelines for 'medium' risk are to document dietary intake for 3 days. If adequate there is little concern and repeat screening monthly for care home residents is necessitated. If dietary inadequate there is a clinical concern and it is necessary to follow local policy, set goals, improve and increase overall nutritional intake and monitor and review the care plan regularly. For all categories of risk, it is necessary to treat the underlying condition and provide help and advice on food choices, eating and drinking, when necessary, record the malnutrition risk category and record the need for special diets and follow local policy.

3.90 Also on 10th October 2020 care staff attending to William's personal care noted his 'groin area' to appear red and tender to touch. He was given a 'gentle wash' around his groin and barrier cream applied.

3.91 On 14th October 2020 a three-tier system of Covid-19 restrictions began in England.

3.92 Whilst providing personal care to William on 15th October 2020, Nursing Home staff noticed redness and a discharge from his penis. The nurse was informed but no further action appears to have been taken.

3.93 During the evening of 17th October 2020 William began to punch and kick out at Nursing Home staff providing personal care.

3.94 On 19th October 2020 William complained of pain in his penis to Nursing Home staff.

[24] 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

3.95 On 20th October 2020 the Nursing Home carried out a further Nutrition assessment of William which disclosed a further weight loss of 2kg, and which continued to indicate a MUST score of 1 ('medium' risk).

3.96 On 22nd October 2020 the Nursing Home carried out a Nutritional care plan review in respect of William following which a senior carer noted 'All meals eaten, good appetite, weight remains stable'. Nursing Home A's SAR chronology notes that the senior carer's note was inconsistent with William's obvious weight loss.

3.97 On 31st October 2020 the second England Covid-19 lockdown began.

3.98 On 1st November 2020 William was noted to have experienced a further weight loss of 2KG which indicated a MUST score of 1. Nursing Home A's SAR chronology notes that the MUST score should have been 2 ('high' risk).

3.99 On 4th November 2020 William's family emailed the Nursing Home manager to ask when he was last tested for a UTI as he had appeared 'out of sorts' and 'quite teary' when they made a 'window visit' to him the previous day. When the family received no reply to their email, they sent a further email to the Nursing Home manager on 10th November 2020.

3.100 Shortly before 6am on 10th November 2020 William was noted to be holding his stomach and saying that he was in pain. The nurse in charge was informed.

3.101 On 11th November 2020 LCC Contracts Monitoring completed a remote monitoring exercise in respect of the Nursing Home following which an action plan was put in place in respect of processes and procedures relating to mandatory training, DoLS and Mental Capacity records.

3.102 On 12th November 2020 the Nursing Home A Registered Nurse made a referral to District Nurses marked as 'emergency (very urgent)' requesting that William be re-catheterised. The District Nurses service advised that on checking the notes from the 24th September 2020 MDT (Paragraph 3.85) that the catheter was last changed on 21st September 2020 and so the catheter change was not due until 14th December 2020. William was also discussed in the District Nurse Safety Huddle held on the same date. The Community Matron was present who planned to discuss William with the Nursing Home manager as he was a 'Nursing' resident and staff had been unable to access catheterisation training due to Covid-19 restrictions. William was discharged from the District Nurse caseload as he was a 'Nursing' resident. The Nursing Home Registered Nurse was contacted and informed accordingly and advised that if support was required at William's next catheter change on 14th December 2020, then they should contact the District Nursing Service. It would

appear that the Nursing Home Registered Nurse was unaware of the unscheduled catheter change which had taken place on 21st September 2020 (Paragraph 3.87).

3.103 On 16th November 2020 Nursing Home staff noted that William's catheter was not draining, and the registered nurse gave him a 'bladder wash'[25] following which his catheter was documented to be draining well.

3.104 On 17th November 2020 William was commenced on Cefalexin 500mg for 5 days for a UTI. On the same date the GP documented the completion of a DNACPR form after a discussion between Nursing Home staff and William's wife during which the latter was said to have declined hospital admission for her husband at that time. (Completing the DNACPR was an outstanding action from the 24th September 2020 MDT) Also on 17th November 2020 William's family have advised the SAR that they made a 'window visit' and that they observed that William was unwell and, in their experience, needed intravenous antibiotics and therefore he needed to be seen by a paramedic and admitted to hospital if necessary (The family dispute the suggestion that they declined hospital attendance on behalf of William).

3.105 On 18th November 2020 the Nursing Home contacted the Out of Hours GP due to William's 'poor presentation' and were advised to allow the prescribed antibiotics to work. Nursing Home A have provided no further details of William's 'poor presentation'. The NWAS chronology (NHS 111) states high temperature of 39 degrees although this later fell to 37.6.

3.106 On 20th November 2020 Adult Social Care records show that a referral was made to the Commissioning Support Unit for a NHS continuing healthcare (CHC) decision support tool as William had been in a 'CCG-funded' nursing bed which was initially funded from specific Covid-19 related funding which was coming to an end, hence the CHC referral to identify a more appropriate funding pathway. This was not progressed due to William's subsequent hospital admission.

3.107 William's family have advised the SAR that on 24th and 27th November 2020 they made 'window visits' and observed that he remained unwell in bed.

3.108 On 28th November 2020 a review of William's Nutritional care plan took place, and the Nursing Home senior carer noted 'All meals eaten, good appetite, weight remains stable'. The Nursing Home A chronology observes that the senior carer did not acknowledge or respond to William's obvious weight loss missing another opportunity to take appropriate action.

[25] A catheter flush and bladder washout are essentially the same procedure and help to remove any debris that may be in the bladder, which can lead to blocking the catheter, preventing it from draining.. The procedure is carried out using a bladder syringe and 0.9% Sodium Chloride (salty water) flushed through the catheter.

3.109 William's family have advised the SAR that on 1st December 2020 they made a 'window visit' and noticed that although he was no longer in bed, they felt he was clearly unwell and was visibly losing weight each time they saw him. They state that they were told that William was no longer able to feed himself and was being helped to eat mashed food. They state that they asked to speak to the registered nurse on duty but were advised that he was busy with other residents and so they requested that a message was passed to the nurse that William may need antibiotics or to see a GP or a paramedic to be assessed.

3.110 William's family have advised the SAR that they emailed the Nursing Home on 2nd December 2020 to express their concerns about William's deteriorating health.

3.111 On 3rd December 2020 William commenced on Cefalexin 500mg for 5 days for a UTI. The Out of Hours GP prescribed this medication. The following day the Nursing Home contacted GP practice 2 to request long term antibiotics due to recurrent UTIs as each UTI affects him very badly and the family are very concerned.

3.112 The family have advised the SAR that they made a 'window visit' to William on Saturday 5th December 2020 and observed a nurse who was visiting from a different Nursing Home A Provider establishment struggling to encourage William to swallow an antibiotic – which they described as 'quite a large pill' – and asked the nurse if liquid antibiotics could be prescribed as an alternative. The family state that the nurse advised that them that liquid antibiotics would be requested via the OOH doctor service but the family state that they are not confident that this request was actually actioned. They noted that William's mouth appeared very dry, that he coughed after each drink he was being given to assist him to swallow the tablet and kept spitting the tablet out.

3.113 On 7th December 2020 William was commenced on an additional Cefalexin 250mg to be taken twice daily.

3.114 The family have advised the SAR that they made a 'window visit' to William on 8th December 2020 when he appeared 'so ill' slumped in his chair, holding his head, unable to make eye contact with his family and sucking his fingers 'as if it was a drink'.

3.115 On 9th December 2020 a planned MDT review was completed in respect of William by a member of the GP practice team (not a GP) at which the request for long term antibiotics was discussed with a task generated to arrange a phone call with the GP to discuss this. As a result, the GP practice arranged an administrative

consultation (no-one else present) for Monday 14th December 2020 when relevant tests including bloods and scans were arranged. However, this administrative consultation took place following William's hospital admission of which the GP practice was unaware at that time as the admission had taken place over the preceding weekend.

3.116 On Saturday 12th December 2020 the Nursing Home called NHS 111 in order to speak to the Out of Hours GP in respect of William whose health was documented to have deteriorated, and he was not eating or drinking. During the afternoon an Out of Hours GP visited William in the Nursing Home and noted right iliac fossa[26] pain causing William to shout out in pain during the examination. Given William's low blood pressure, weak pulse, marked abdominal tenderness – which was said to be new – and the fact that his clear urine and absence of fever did not suggest a further UTI, it was decided that William should be admitted to hospital. Later in the day William was conveyed to Aintree University Hospital AED by ambulance where he was documented to have left sided abdominal pain, decreased diet and fluid and increased lethargy. The Hospital had been advised by the Nursing Home that William had not been drinking for one day but concluded that he had probably not been drinking for a much longer time given the severity of his AKI (Acute Kidney Injury) and increased sodium. He was admitted to the Medical Assessment Unit then transferred to a ward.

3.117 Early the following morning (Sunday 13th December 2020) nursing staff requested a review of William's catheter site by medical staff as his penis was severely eroded out of the penis head to the scrotum (documented as 'eroded inferior aspect of meatus'), apparently by the catheter tubing and which appeared painful. There was a discharge which was swabbed and Instillagel was prescribed for pain. The Hospital discussed the erosion of William's penis with the Nursing Home who advised that his catheter had been inserted on 21st September 2020 by a staff nurse at which time there was no report of any concern and no concerns documented since. (Nursing Home documentation entries dated 15th and 19th October 2020 contradict this) A safeguarding referral was completed and a Datix record created. Medical photographs were also taken. Hospital staff spoke with William's wife who said that she was shocked by her husband's appearance the previous day as he had lost a lot of weight and she noted that he wasn't dressed in his own clothes. She said that she was worried that he had not been properly looked after and didn't want him to be discharged back to the Nursing Home. William's wife was consulted on, and agreed to, a DNACPR.

[26] Right iliac fossa (RIF) pain is one of the most common presentations to acute general surgical services. Causes include appendicitis, other gastrointestinal, urological, gynecological, vascular and musculoskeletal pathologies.

3.118 On Monday 14th December 2020 Aintree University Hospital sent a Section 2[27] notification to LCC which referred to William's severe dehydration and trauma to his penis. The family have shared two Section 2 notifications with the SAR. The first one was completed at 6.10am on Sunday 13th December 2020 and answers both the questions 'Have they been harmed?' and 'Safeguarding?' 'Yes'. Under 'Explanation of safeguarding type' the Section 2 notification states 'William has been admitted to hospital with severe acute kidney injury and dehydration. On examination of the catheter site with a medical consultant we found that William's catheter tubing had eroded the head of his penis to his scrotum. When contacting the Nursing Home, they said that the catheter had been inserted on 21st September by a member of their own staff. The Nursing Home members of staff stated that there was no paperwork for the inserted catheter or for previously inserted catheters.

3.119 The second Section 2 notification was completed at 9.40am on Sunday 13th December 2020 and again answered the 'harm' and 'safeguarding' questions in the affirmative. Under 'Explanation of Safeguarding Type' the Section 2 notification states 'Patient has been admitted severely hydrated and with catheter that has been in place since September and has now causes significant trauma. Wife was shocked and distressed at her husband's appearance following his admittance to hospital'.

3.120 A safeguarding referral was sent separately on the same date (Monday 14th December 2020). On the same date William was seen by SALT who documented moderate dysphagia[28] impacted by cognitive impairment and advised a modified diet and fluids to reduce the risk of aspiration[29]. He required full assistance and supervision, his chest was to be monitored closely and any concerns should lead to consideration of 'nil by mouth'. On the same date Adult Social Care received the Section 2 from Aintree University Hospital and entered the details onto William's case notes. The information contained in the Section 2 constituted a safeguarding concern but was not recorded as such.

3.121 Also on 14th December 2020 the Aintree University Hospital Safeguarding Team contacted Careline – which manages all Adult Social Care enquiries online or by telephone - however the safeguarding referral submitted by the hospital 'went missing' and so no Safeguarding Enquiry was generated.

3.122 On 15th December 2020 an urgent DoLS application for a standard authorisation from Aintree University Hospital was processed by Adult Social Care.

[27] Section 2 (of the Community Care (Delayed Discharges) Act 2003) requires an NHS body to notify social services of a patient's likely need for community care services after discharge.
[28] Dysphagia is the medical term for swallowing difficulties.
[29] Aspiration is when food or drink enters the lungs rather than the stomach.

On the same day Adult Social Care noted the receipt of 'two safeguarding Section 2 forms. No safeguarding concern had yet been generated on the Adult Social Care system.

3.123 On 17th December 2020 Aintree University Hospital sent a further Section 2 to Adult Social Care in which the safeguarding concerns were mentioned.

3.124 On 18th December 2020 William's daughter raised a complaint about her father's care with Nursing Home A which she shared with the CQC who then sent it to the LCC QA manager and expressed concern that William's daughter's complaint fell within the existing Regulation 14 breach which was subject to a warning notice from the CQC. The daughter's complaint raised concerns relating to the care and support provided to William in respect of drinking, possible UTI requiring treatment, and deterioration in his presentation. There is no record that Nursing Home A referred this matter as a safeguarding concern to LCC. The daughter's complaint makes no mention of the trauma to William's penis and mention of catheter care is limited.

3.125 A Section 42 Safeguarding enquiry commenced, and Nursing Home A provided a 4 page investigation report to support the enquiry. The outcome was there was no evidence of intentional abuse or neglect at the Nursing Home although William's daughter's concerns were noted to be partially substantiated. (It is not entirely clear which aspects of the concern were substantiated.)

3.126 By 21st December 2020 it was noted that William was nearing the end of his life and discharging William to a hospice received consideration. An end-of-life care plan was started. An NHS CHC fast track assessment to support discharge into a 'more suitable nursing home' was commenced.

3.127 William appeared to test positive for Covid-19 which delayed his discharge to the hospice and prevented his family spending time with him although video calls were facilitated. His discharge was provisionally planned for 14th January 2021, but he died in Aintree University Hospital on 10th January 2021. A death certificate was completed by a doctor on the ward which stated that cause of death was advanced Alzheimer's dementia.

3.128 On 13th May 2021 William's daughter telephoned Adult Social Care to seek an update on the Safeguarding Enquiry raised regarding her father's care at Nursing Home A. It was established this concern had not been recorded and progressed. A Section 42 Safeguarding Enquiry was initiated and concluded on 28th June 2021. Neglect was substantiated and the following recommendations were made:

1. Catheter passport to be completed accurately and kept with the patient notes at all times. Intervals between catheter changes to be recorded at 12 weekly intervals and a day of the week to be allocated to leg bag changes.
2. 24-hour records to be dated and timed. Documentation recorded consistently with a full description of the care provided and any changes and/or signs and symptoms to be documented clearly with all appropriate actions recorded.
3. A full set of clinical observations to be recorded where the condition of the patient has led to a concern. Ongoing monitoring of clinical observations as specified within the care home policy or on clinical judgement.
4. Professional visit log to be updated and maintained for all external health care professional communication including telephone calls, visit and emails.
5. A robust care plan implemented for patients with indwelling catheters, details to include risks associated with long term catheter use, close monitoring of a urinary catheter system, attachment and changes to leg and night bags, securement of catheter tubing, moving and handling of patients with long term catheters and a robust personal hygiene/catheter care regime.
6. Fluid balance charts to be completed over a 24-hour period, totals to be closely monitored and any concerns to be escalated to senior staff and/or the GP in a timely manner.
7. MAR charts to be completed accurately and consistently ensuring close monitoring of balances are recorded accurately.
8. Antibiotic Care plans to be updated when treatment has changed and/or been included.

3.129 On 29th June 2021 Nursing Home A was advised of the outcome of the Safeguarding Enquiry was substantiated and the recommendations outlined above. The letter also advised that a referral for a Safeguarding Adults Review would be made. It is unclear from the records whether the Nursing Home responded to this letter, whether they accepted the recommendations and made changes to their policy and practice as a result of the findings. To this end it is not clear if transferrable risks have been managed.

4.0 Family contribution to the SAR

4.1 The independent reviewer has met with William's wife and daughter at the home William and his wife shared for 50 years. William's daughter has also shared copies of all the records she has accessed relating to the care of her father and all the correspondence relating to her complaints with the independent reviewer. However, the independent reviewer has relied upon the chronologies, reports and additional information shared with the SAR by the agencies involved to complete this SAR report. On those rare occasions when the independent reviewer has made use of the records shared with him by the family, this is clearly stated in the report.

Care prior to April 2020 hospital admission

4.2 William's family said that he suffered with water infections regularly. They added that a 'week or two' before his April 2020 hospital admission William, wouldn't let the District Nurse change his catheter. She obtained some diazepam from the family's GP practice and his wife gave it William 30 mins before the District Nurse arrived to change the catheter. The family observed that William never liked the catheter.

4.3 His family said that William couldn't understand why non-family carers began coming into the family home and sometimes became frustrated and shut the blinds.

4.4 Prior to the onset of the Covid 19 pandemic William went to Everton in the Community on Monday and Tuesday afternoons and attended the Brookside Day Centre on Wednesdays and Thursdays. This support came to an end at the onset of the pandemic. William and his wife weren't able to go out and he couldn't understand why family members were no longer allowed to visit him in-person. William's wife began to struggle to care for him and he began refusing to go upstairs to bed.

Nursing Home A

4.5 William's family are firmly of the opinion that Nursing Home A provided inadequate care to William, although they didn't realise this during the early months of his placement there. The family dearly wish that William had never been placed there.

4.6 Reflecting on the care William received whilst a resident in Nursing Home A, his family felt that there was a deep-rooted culture of not wanting to hear or listen to family concerns.

4.7 The family also feel that the CQC inspection which took place whilst William was a resident had made a difference – including improved record keeping and better care plans - but they also attributed some negative consequences to the CQC Inspection including the departure of the registered manager and the senior carer who had been looking after William and whom the family trusted.

4.8 William's daughter said that the family were not informed that the registered manager had left and that she (the daughter) continued to email the manager for several weeks after she left, and her emails went unanswered. When she later asked the Nursing Home why the family hadn't been informed that the manager had left, she said that she was told that the family 'didn't need to be told.'

4.9 William's wife said that she phoned Nursing Home A every day - or every other day - and was always told that William was 'fine'. The family felt that no-one was picking up on William's declining health and the fact that he was no longer eating.

4.10 William's daughter said that when her father looked to be in pain the response of Nursing Home staff was to ask him if he was in pain, but she felt that because of his cognitive decline, he couldn't understand the question. William's family state that he was never prescribed paracetamol during his 7-month placement despite the fact that he was 'riddled' with arthritis and suffered with knee pain – both knees having been replaced.

4.11 When he was admitted into Aintree University Hospital in December 2020 – William did not have his spectacles, false teeth, and wasn't wearing his own clothes. The family said that he was always dressed in other residents clothes despite the family sewing labels in.

4.12 The family state that at the time of his Aintree University Hospital admission in December 2020 William was suffering from re-feeding syndrome[30] which they said was irreversible because he had gone so long with so little hydration/nutrition for an older person.

4.13 His family said that William quietly got on with life and was not a complainer.

Best Interest Decisions

[30] Refeeding is potentially a fatal condition defined by severe electrolyte and fluid shifts as a result of a rapid reintroduction of nutrition after a period of inadequate nutritional intake.

4.14 William's wife was happy for him to remain in Nursing Home A after the initial 28 days but advised the independent reviewer that she didn't know she had a choice for him to go somewhere else.

4.15 The family have subsequently obtained a number of Best Interests decision records completed in Nursing Home A and they say that they have been falsely completed in so far as they say that William's wife 'agreed' with the decision and say she was not actually consulted.

Catheter care

4.16 The family state that they have found the information about the erosion of William's penis and the photographs particularly hard to bear. They believe that the problem with catheter care started at the time of the urgent change in September 2020 or perhaps as early as August when they understand the staff were discussing trialling William without a catheter. The family say that they believe that Nursing Home A staff were awaiting catheter training.

4.17 The family feel that William should have been admitted to hospital from Nursing Home A much earlier than he was and, in their view, no later than 16th November 2020. The family noticed William rubbing his groin but were only able to see him through a window twice a week at that time as a result of Covid-19 restrictions. When they asked Nursing Home A staff about this William's family say that they were repeatedly told that he had a UTI.

Hydration and nutrition

4.18 His family state that William weighed 52 kilos when he left hospital in May 2020 and transferred to Nursing Home A. He was recorded as weighing 62 kilos in November 2020, but the family don't accept the accuracy of this figure as they believe he may have been weighed in his clothes. The family state that Aintree University Hospital didn't weigh William in December 2020 as he was too ill. William's family say that in Nursing Home A he had a beaker of water, but he couldn't have reached it and his carers didn't have time to support him to drink.

Covid impact on visiting

4.19 The family said that their visits to William were restricted to viewing and attempting to communicate with him 'through the window' visiting primarily or 'through the fire door' when William was in the Nursing Home A lounge. They added that during the summer months care staff wheeled him out into the garden to see them. The care staff also opened William's window, and they were able to play Al

Jolson music to him. They said that William couldn't understand why his family couldn't go into Nursing Home A to see him. The family say whilst they were 'window visiting' in the later months of his placement they could see that he was deteriorating but were not aware that he wasn't eating.

Safeguarding referrals

4.20 *June 2020 wrist injury:*
The family state that they went to see William on Father's Day when he was complaining of pain in his wrist. The family say they could see that his wrist was swollen and looked like a bed rail had dropped across his hand. The family said that care staff couldn't explain it and no incident report had been completed. They said that Nursing Home A planned to send William to hospital in a taxi unaccompanied and so the daughter took her father to hospital after speaking to NHS 111.
The family say that they felt that raising a safeguarding concern 'wouldn't go down well' with Nursing Home A and that they were worried that raising the concern could adversely affect the care William received in Nursing Home A.

4.21 *Complaint to the CQC*
William's daughter complained to the CQC the morning after he was hospitalised in December 2020 because he was dehydrated and had been harmed.
The safeguarding was filed unsubstantiated. The family told the CQC they didn't agree based on the '4 sheets of paper' submitted by Nursing Home A. The family also felt that the safeguarding process could have been better explained to them and felt like they were kept in the dark. They said that the process of making a complaint and raising a safeguarding concern 'shouldn't be this hard' when there are legitimate questions to ask.

4.22 *Aintree University Hospital safeguarding concerns*
The family said that they were very concerned that the safeguarding referrals made by Aintree University Hospital had been lost.

GP practice

4.23 William's GP practice changed after his placement in Nursing Home A commenced but the family weren't consulted over the change. The family said that Nursing Home A said they had spoken to William's wife about the change in GP but the family say they only found out about the change in July or August 2020. The family spoke highly of their previous GP at GP Practice 1 who knew William and his wife well.

General reflections

4.24 As a family they said that they had 'no idea' about how the care system worked prior to William's placement in Nursing Home A. They strongly felt that William didn't go into Nursing Home A to die and that his deterioration whilst resident there was not a natural deterioration. The family say that Nursing Home A told them that there was nothing wrong with William but the family suspect that they didn't want to admit that their care was poor. The family state that William didn't eat or drink for 26 days prior to his December 2020 admission to hospital. The family advised the independent reviewer that William's wife can't talk about what happened to her husband in Nursing Home A without crying.

Raising concerns following William's death

4.25 The family state that they have found it difficult to obtain complete records relating to William's placement from Nursing Home A. Initially they were provided with records from 26th November 2020 until his hospitalisation the following month. The family say that they went back to Nursing Home A for the rest of William's records and were given an additional 300 pages, but this didn't cover the whole period William was resident. They say that Nursing Home A still haven't given the family all the information they have requested. William's daughter felt that she had faced 'so many closed doors'.

4.26 Independent Reviewer, David Mellor met with William's family once the SAR Report was concluded to advise them of the findings and recommendations for change arising from the SAR.

5.0 Analysis, findings and recommendations

How effective was William's discharge from hospital to the nursing home - initially on a short term basis?

5.1 By the second day of his admission to Royal Liverpool University Hospital (27th April 2020) it had been concluded that William would need to be discharged to an elderly medically infirm bed (EMI) (Paragraph 3.48). A Nursing Needs Assessment was completed on 4th May 2020 which recommended a general nursing placement on the grounds that William had experienced a general decline over the past six months, which had worsened over the last 3-6 weeks according to his wife – who was consulted as part of the assessment. The assessor went on to state that William's needs had been difficult to manage with the package of home care provided and that his wife and family were in agreement with a general nursing placement. William was said to need 24 hour care as he needed pressure area care, continence care, administration of medication, management of his nutritional status, management of his behaviour and deteriorating cognition. The assessor concluded by stating that without these interventions, William would be placed at potential risk.

5.2 William was assessed as lacking capacity to make complex decisions about his future care and that a discussion between family and medical staff concluded that it was in William's Best Interests to go into 24-hour nursing care (Paragraph 3.51). The SAR noted that the capacity assessment was conducted by a medical student who provided valuable support to hospitals during this period of very high demand arising from the onset of the Covid-19 pandemic. It appears that the discharge into 24-hour nursing care was to be for an initial 28-day period (Paragraphs 3.51).

5.3 Nursing Home A accepted William subject to a negative Covid swab and William's wife was documented to be happy with this plan. The only documented preference expressed by William's wife was that he should not be discharged to the care home in which he had spent time on respite as she had not been satisfied with the care he received there (Paragraphs 3.17 and 3.51). The placement was initially funded 'by the NHS until the end of the current Coronavirus emergency period'. Once the emergency period came to an end it was intended to complete a 'full review' to decide whether William was eligible to receive funding. The process of assessing William's eligibility for NHS continuing healthcare (CHC) funding although this process was ongoing at the time his placement at Nursing Home A ended with

his admission to Aintree University Hospital on 12th December 2020 (Paragraph 3.106).

5.4 Given that William's placement was entirely funded from the emergency Covid-19 budget, the SAR Panel queried the extent to which the effectiveness of the placement was monitored by the commissioners of that placement – as would normally be the case for a CHC funded placement for example. The SAR Panel has been advised by the NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) that a safe and well check was completed two days after William's placement began and that a telephone care review took place on 5th November 2020. The outcome of the initial safe and well check was that there were no immediate concerns in relation to meeting William's needs and the outcome of the subsequent telephone care review was that William's condition had remained settled since his placement began and that there had been no change in his presenting needs since a 14–21-day reassessment had been completed on 5th June 2020. The SAR Panel also noted that the Enhanced Health in Care Homes (EHiCH) model was in place which provided real time monitoring of care home residents health via multi-disciplinary reviews. The NHS Framework for Enhanced Care in Care Homes (EHiCH) was issued in March 2020 and states that people living in care homes should expect the same level of support as if they were living in their own home. The Framework goes on to describe the EHiCH model which moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. The Framework notes that such care can only be achieved through a whole-system, collaborative approach (1). Multi-disciplinary reviews took place in respect of William on a virtual basis twice in September 2020 (Paragraph 3.85) but there then appeared to be quite a lengthy gap until the next review which began on 9th December 2020 (Paragraph 3.115). Unfortunately this gap coincided with the period when William's health and the care he was receiving from Nursing Home A began to deteriorate. The SAR has been advised that multi-disciplinary reviews of residents in nursing homes take place on a weekly basis and that identification of the individuals to be discussed at the weekly meeting will be agreed in advance and could be based upon use of validated tools, clinical judgement and feedback from care home staff. It is not known why there was a gap in William being discussed in the weekly multi-disciplinary meetings given the deterioration in his health during this period (24th September to 9th December 2020).

5.5 The Named GP for Safeguarding at NHS Cheshire and Merseyside has contributed to this SAR and has proposed a standardised agenda for all CQC registered Liverpool care and nursing homes EHiCH multi-disciplinary meetings to include 999 calls, emergency admissions, falls, new admissions and readmissions to the home and safeguarding concerns including - but not limited to - failure to attend

appointments (weekly agenda) and changes in MUST scores, number of patients with a catheter, number of patients with a catheter passport, number of catheter UTIs, number of patients with categories 1/2/3/4 pressure ulcers (monthly agenda). It is therefore recommended that Liverpool Safeguarding Adults Board requests NHS Cheshire and Merseyside to introduce a standardised agenda for EHiCH multi-disciplinary meeting to discuss patients who are residents in care or nursing homes and advises the Safeguarding Adults Board of the outcome of this piece of work

Recommendation 1

That Liverpool Safeguarding Adults Board requests NHS Cheshire and Merseyside to introduce a standardised agenda for Enhanced Health in Care Homes multi-disciplinary meetings which discuss patients who are residents in care or nursing homes and advises the Safeguarding Adults Board of the outcome of this piece of work.

How effective was the nursing home's assessment of William's needs?

5.6 As previously stated a Nursing Needs Assessment had been carried out early in William's admission to Royal Liverpool University Hospital. This Assessment appears to have been instrumental in determining that William required 24 hour nursing care in an EMI bed.

5.7 The provider of Nursing Home A state that William's admission was successful, necessary risk assessments were carried out and a comprehensive body map completed. The author of the Nursing Home A report submitted to this SAR states that the initial care plans appear comprehensive, identify William's needs and describe how these are to be met.

5.8 Nursing Home A's provider subsequently shared the Admission Assessment completed for William with the SAR. It consists of a comprehensive template requiring completion of sections on medical history, capacity, communication, comprehension, hearing/vision, memory/cognition, temperament/mood/behaviour, co-operation/concordance, skin, mobility, transfer and repositioning, breathing, nutrition/hydration/eating/drinking, current weight, dental health, elimination/continence care, personal care, medication care, symptom control/end of life, sleep pattern and stability of condition. This Admission Assessment was fully completed – with the exception of dental health – by the then Nursing Home manager on the day of William's arrival. The information gathered appeared to be a sound foundation for the development of care plans and risk assessments. Nursing Home A's provider also shared the dependency assessment, choking risk assessment, nutritional screening assessment, mobility plan and the continence

assessment. The overall care plan has not been shared with the SAR. It is noted that the continence assessment makes no mention of William's catheter and in answer to the question 'does the patient have any other bladder problems (i.e. difficulties passing urine and/or pain?' the 'no' response was circled. The continence assessment states than, on completion, the next step is for a continence care plan to be formulated. No recognisable continence care plan has been shared with this SAR by Nursing Home A's provider although two records headed 'Section 5 – continence' have been provided. These contain a series of entries relating to continence and catheter care which contain 15 dated entries for the duration of William's placement. The entries are brief and not particularly informative. Following William's death, his family were provided with what appears to be a continence care plan by Nursing Home A's provider. The continence plan is very brief and states that 'he has a catheter in place as he is prone to urine infections' and goes onto specify the type of catheter and provides the contact details of the continence equipment providers. The continence plan goes onto state that the expected outcomes are for William to be 'treated in a dignified manner' and for staff to monitor for any changes in William's continence needs'.

How effective was the process by which the nursing home placement became permanent?

5.9 Amongst the records subsequently shared with the SAR by the provider of Nursing Home A is a mental capacity assessment conducted by a registered nurse on 19th June 2020 which concluded that William lacked capacity to consent to residing in Nursing Home A. There is also a record of a Best Interest meeting following the capacity assessment in which the same registered nurse documented that they believed that William should reside at Nursing Home A because of his progressive illness (Alzheimer's) and that he had no real insight into potential risks. The registered nurse completed this Best Interest meeting record on the same date as the capacity assessment (19th June 2020) but it was not countersigned by a second professional (clinical lead) until 27th August 2020 – over two months later. The record states that William's wife agreed with the decision. William's family have advised the SAR that they were never involved in best interest meetings and decisions including the decision that William's placement in Nursing Home A should become permanent. On the basis of the information shared with this SAR it is not possible to reach a firm conclusion about the involvement of William's family in the decision to make his placement permanent. It would be helpful if the professional completing the Best Interest meeting record was required to document the time, date and method by which the nursing/care home communicated with the family. It is noted that Nursing Home A should have consulted William's daughter as part of the Best Interest process as she had had LPA since December 2019. On the

Admissions Assessment William's daughter's contact details are noted but not the fact that she had LPA.

5.10 The SAR has been advised by the LCC Quality Assurance Team Manager that pre-pandemic, she was confident that nursing and care homes were well equipped to fulfil their responsibilities in respect of Best Interest framework decision-making and documentation but felt that since the pandemic standards in this area had diminished. The Quality Assurance Team provide an induction to new management teams in care and nursing homes which addresses the Best Interest process, but the Team Manager felt that there had been such an influx of new management and staff into care and nursing homes that she could not be confident that they were using LCC recommended policies and procedures. The Manager felt that Best Interest decision making, and documentation could usefully be a priority for future Focussed Visits to care and nursing homes by the Quality Assurance Team. It is therefore recommended that Liverpool Safeguarding Adults Board requests that the Liverpool Quality Assurance Team include Best Interest meeting record keeping in their Focussed Visits to Care and Nursing Homes – with a particular emphasis on the recording of family involvement in Best Interest decisions – and that the Quality Assurance Team provide a report on the outcome of the visits to the Safeguarding Adults Board.

Recommendation 2

That Liverpool Safeguarding Adults Board requests that Liverpool City Council Quality Assurance Team include Best Interest meeting record keeping in their Focussed Visits to Care and Nursing Homes – with a particular emphasis on the recording of family involvement in Best Interest decisions – and that the Quality Assurance Team provide a report on the outcome of the visits to the Safeguarding Adults Board.

5.11 As previously stated Nursing Home A should have consulted William's daughter as part of the Best Interest process as she had had LPA since December 2019. Unfortunately, the fact that William's daughter had LPA was not documented on the Nursing Home A Admissions Assessment. It is recommended that Local Authority and Integrated Care Board commissioners of Care/Nursing Home placements should support Care/Nursing Homes to identify training programmes in respect of the Mental Capacity Act and specifically in respect of Lasting Power of Attorney and that the Liverpool City Council Quality Assurance Team will ensure such training is in place and will audit processes in respect of Lasting Power of Attorney. It would also be of value for the wider system – including visiting professionals and review activities conducted by the CHC and Adult Social Care for example – to support the

recording of Lasting Power of Attorney details and ensuring that individuals with LPA are involved in Best Interest decisions.

Recommendation 3

That Liverpool Safeguarding Adults Board requests
(a) Local Authority and Integrated Care Board commissioners of Care/Nursing Home placements to support Care/Nursing Homes to identify training programmes in respect of the Mental Capacity Act and specifically in respect of Lasting Power of Attorney and
(b) the Liverpool City Council Quality Assurance Team to ensure such training is in place and to audit processes in respect of Lasting Power of Attorney.

Recommendation 4

That Liverpool Safeguarding Adults Board obtains assurance that professionals from agencies which are part of the wider system – including visiting professionals and review activities conducted by the CHC and Adult Social Care for example – support the recording of Lasting Power of Attorney details and ensuring that individuals with LPA are involved in Best Interest decisions.

5.12 It is also noted that prior to the decision to make William's placement permanent following his discharge from Royal Liverpool University Hospital there should have been a Care Act assessment under the 'discharge to assess' policy but there is no indication that this took place.

Were decisions about William taken within a Best Interests framework?

5.13 The decision to discharge William from Royal Liverpool University Hospital to Nursing Home A was taken within a Best Interests framework (Paragraph 3.51).

5.14 There were a number of Best Interests decisions documented during William's placement in Nursing Home A. Records of Best Interests decisions in respect of Covid-19 testing, the decision to make William's placement permanent, care and treatment, medication and the taking of photographs have been shared with the SAR. All state that William's wife was consulted and agreed with the relevant decision. It is noted that the mental capacity assessments in respect of care and treatment and medication were not completed until 24th July 2020 – two months after William's placement began and one month after his placement was made permanent.

5.15 William's family have advised the SAR that all Best Interests decision records completed during his placement in Nursing Home A have been falsely completed in so far as they say that William's wife 'agreed' with the particular decision and say she was not actually consulted.

5.16 The CQC inspection of Nursing Home A conducted on 23rd July 2020 (Paragraph 3.72) found that people were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. There were no assurances that people made their own decisions about their care and treatment.

To what extent did the nursing home placement meet William's needs? In particular, how effective was the care provided to William in respect of hydration and nutrition, skin integrity and urinary catheter care.

5.17 The catheter care provided to William whilst a resident of Nursing Home A is considered later in this report (Paragraphs 5.16 to 5.43).

5.18 Nursing Home A did not respond effectively to William's weight loss. After noting a weight loss of 4kg on 10th October 2020 a MUST assessment disclosed a 'medium' risk (Paragraph 3.89) which should have resulted in the documenting of his dietary intake for 3 days and if dietary intake was found to be inadequate, this should have been treated as a clinical concern and goals should have been set and overall nutritional intake improved and increased and the care plan regularly monitored and reviewed. Nursing Home A certainly monitored William's dietary intake as a further nutrition assessment took place 10 days later when a further weight loss of 2kg was noted (Paragraph 3.95), followed by another weight loss of 2kg 10 days after that (Paragraph 3.98). However, when William's nutritional care plan was twice reviewed by a senior carer, they documented 'all meals eaten, good appetite, weight remains stable' on both occasions. In reaching this conclusion William's continuing weight loss appeared to have been overlooked by the senior carer. Nursing Home A also state that when the MUST assessment was repeated on 1st November 2020 the score should have been '2' ('high' risk) rather than the '1' ('medium' risk) documented (Paragraph 3.98). However, some confusion may have arisen over the method used to weigh William – i.e. whether weight was to be recorded when clothed or unclothed or was to be estimated as his weight on discharge from Royal Liverpool University Hospital in May 2020 was 52.5kg and was then documented to have increased to 70.2kg by 5th September 2020 before falling to 64kg by 20th October 2020.

5.19 When William was admitted to Aintree University Hospital from Nursing Home A on 12th December 2020 the Hospital had been advised by the Nursing Home that William had not been drinking for one day but the hospital concluded that he had probably not been drinking for a much longer time given the severity of his AKI (Acute Kidney Injury) and increased sodium (Paragraph 3.116). This raises questions about the care provided to William in Nursing Home A and the record keeping in Nursing Home A. When a person with care and support needs is transferred from one setting to another, it is vital that the setting from which the person is being transferred shares full and accurate information with the setting to which the person is being transferred.

5.20 Nursing Home A appear to have mistakenly assumed that the Lorazepam which had been prescribed to William by his first GP practice to address agitation and insomnia had been discontinued (Paragraph 3.79) when in fact Lorazepam was kept in the 'acute' section of his medications which means it needed to be requested each time as opposed to re-ordered by simply ticking a box.

5.21 When William's family began expressing increasing concerns about William's presentation from mid-November 2020 onwards, they don't feel that the Nursing Home took their concerns seriously enough.

5.22 Amongst the records the Nursing Home A provider subsequently shared with the SAR was an audit of William's care plan completed by a 'named nurse' between 7th and 9th December 2020 which found numerous important deficiencies including the need to re-write the nutrition section of the care plan to reflect his recent weight loss and his need for much more assistance with eating and drinking, the need to re-write the mobility section to reflect William's immobility and requirement to be hoisted, the need to review the moving and handling risk assessment and the need to review the continence section to refer to recurrent UTIs and long term catheter care. The audit of William's care plan also found that the daily progress notes contained some 'basic entries' and the named nurse who completed the audit observed that risk assessments were not always reviewed and that monthly observations had not been completed since September 2020.

5.23 The CQC inspected Nursing Home A during William's placement there and found that the Nursing Home remained 'inadequate' overall and that the two domains inspected on that occasion – 'safe' and 'well-led' - were also assessed as 'inadequate' (Paragraph 3.72). Of relevance to this SAR, the CQC found that:

- Care records were not maintained so that people's care, support and treatment could be accurately documented and monitored.

- Risk assessments were not always in place or adequate to minimise risks to people.
- The service did not always identify and report accidents and incidents appropriately and refer incidents to safeguarding for investigation when necessary.
- Assurance and auditing processes did not assess, monitor and drive improvement in the quality and safety of the service being provided. Governance systems were ineffective and did not mitigate risk to the health and welfare of people living at the service.

5.24 Overall the care provided to William reflected the findings of the July 2020 CQC inspection. In particular the management of his nutrition and hydration appeared to deteriorate over time. Catheter care by Nursing Home A will be addressed in the next section of the SAR report.

5.25 Following the adverse July 2020 CQC inspection a self-suspension was put in place in respect of Nursing Home A which prevented new placements – other than self-funders - taking place between 12th August 2020 and 24th March 2021 (Paragraph 3.77). The SAR has been advised that the families of existing residents such as William should have been advised of the suspension although the means of notifying families was through the regular formal meetings between Nursing Home A and the families of residents. However, these meetings did not take place during the pandemic and so it is assumed that the families of existing residents of Nursing Home A were not made aware of the suspension. The SAR has been advised that there was no formal policy relating to the notification of families of existing residents of care and nursing homes that new admissions have been suspended. A new (May 2023) Quality Assurance Suspension Protocol has been shared with the SAR which states that 'the Local Authority will agree with the provider the actions to be taken to inform service users, carers and next of kin as to the circumstances that have led to the suspension. The service users, carers and next of kin will also need to know about the arrangements, if any, for providing the service during the period of suspension'.

How effective are single and multi-agency arrangements for long term urinary catheter care for people with care and support needs.

5.26 When William's catheter site was examined by nursing staff at Aintree University Hospital following his admission from the Nursing Home on 12th December 2020, they noted that his penis was severely eroded out of the penis head to the scrotum (documented as 'eroded inferior aspect of meatus'), apparently by the catheter tubing and which appeared painful. There was also a discharge from the penis (Paragraph 3.117).

5.27 A Consultant Urologist has viewed the images taken of William's penis at the time of his admission to Aintree University Hospital and read this SAR report. The Consultant's opinion is that the images clearly show a condition which is known as urethral erosion which is sometimes seen in men with long term catheters. He went on to advise that the cause of the erosion is best described as a type of pressure ulcer of the urethra, due to the long-term presence of the catheter against the wall of the urethra, adding that it always happens on the underside (ventral surface) of the penis because this is where the tissues are thinnest. The Consultant stated that no particular medical condition or clinical diagnosis had caused it. The Consultant advised that the risk of urethral erosion happening can be greatly reduced by careful attention to catheter care including the use of a catheter G-strap which holds the body of the catheter on the thigh, and leg bags that are not under any tension. He added that a confused or agitated patient who regularly pulled at their catheter may increase their risk of catheter related urethral erosion. In summary, the Consultant stated that William's urethral erosion was not caused by a particular medical condition (except for the reason for which the catheter was needed) and that poor catheter care was the usual cause.

5.28 A British Association of Urological Surgeons (BAUS) and Nurses (BAUN) consensus document on the management of the complications of long-term indwelling catheters published in April 2021 stated that catheter erosion through the tissues of the penis commonly occurred where the method of securing the catheter was inappropriate and caused undue tension or pressure. It can also happen in patients who are seated for prolonged periods, those with impaired perineal sensation or patients with impaired cognition or arousal (2).

5.29 Turning to William's known history of catheter care, he managed intermittent self-catheterisation from at least June 2018 when he and his family advised the Royal Liverpool University Hospital that he preferred to continue with intermittent self-catheterisation rather than a permanent in-dwelling catheter at that time (Paragraph 3.7). William's family have advised the SAR that he managed intermittent self-catheterisation well although they observed that there had been a recurring problem of his bladder not fully emptying – which they believed to be the cause of frequent urinary tract infections.

5.30 Royal Liverpool University Hospital expressed concern that William's self-catheterisation technique was not 'clean' on 3rd August 2019 and asked his GP to review it. The GP referred William to the District Nurses and after a convene catheter was considered and rejected because William 'would pull at the leg bag', he briefly returned to self-catheterisation (Paragraph 3.11).

5.31 It appears that William was fitted with an in-dwelling catheter during his September 2019 admission to Royal Liverpool University Hospital (Paragraph 3.13) although there appear to have been some initial difficulties with the retention of urine which was noted by Royal Liverpool University Hospital on 25th September 2019, when he was re-catheterised (Paragraph 3.15). The change to an in-dwelling catheter took place at the same time as a rapid deterioration in William's dementia symptoms (Paragraph 3.14) which may have made self-catheterisation more challenging for William to manage.

5.32 During the period in which William was managing intermittent self-catheterisation, the SAR is aware of six UTIs in April 2018 (Paragraph 3.6), June 2018 (Paragraph 3.7), February 2019 (Paragraph 3.9), May 2019 (Paragraph 3.10), August 2019 (Paragraph 3.11) and September 2019 (Paragraph 3.13). All six UTIs resulted in admissions to Royal Liverpool University Hospital. There is no indication that the specialist opinion of a Urology Nurse was obtained although it is accepted that the August and September 2019 admissions led to William moving from intermittent to an in-dwelling catheter.

5.33 NHS guidance on GP treatment for UTIs 'that keep coming back after treatment' or if a person has two UTIs in 6 months states that the GP may prescribe a different antibiotic or prescribe a low-dose antibiotic to take for up to 6 months or refer the person to a specialist for further tests and treatments (3).

5.34 From September 2019 until his admission to Royal Liverpool University Hospital on 26th April 2020 William had an in-dwelling catheter which was changed every twelve weeks by the District Nurses and his day-to-day catheter care was managed intermittently and somewhat reluctantly by home care providers. The home care providers emptied William's day catheter urine bags at regular intervals during the day and attached the larger night catheter bag to a stand at the side of William's bed whilst he slept. William's wife was concerned that one of the two home care providers were not 'catheter trained' and so she had to show them what to do (Paragraph 3.32). She was also unhappy that one of the carers frequently forgot to close the 'tap' at the bottom of the catheter bag which allows the urine to be emptied into the toilet. Not closing the tap meant that urine spilled onto the floor once the bag was re-attached to William and his bladder began to empty. Home Care provider 4 assumed responsibility for home care during the ten-day period prior to William's admission to Royal Liverpool University Hospital on 26th April 2020 and appear to have had no difficulty in emptying William's catheter bag, although on one occasion their carer noted that William 'was in pain and frustrated by his catheter' (Paragraph 3.43). Two days prior to the Royal Liverpool University Hospital admission, his GP started William on lorazepam for agitation, insomnia and pushing carers away when trying to change his catheter bag (Paragraph 3.45).

5.35 During this period of in-dwelling catheter care in the community there were three further UTIs in November 2019 (Paragraph 3.16), January 2020 (Paragraph 3.23) and the 26th April 2020 UTI which precipitated the admission to Royal Liverpool University Hospital from which he was discharged to Nursing Home A. The first of the three UTIs did not necessitate hospital attendance. Overall, the change from intermittent self-catheterisation to in-dwelling catheterisation appeared to reduce the frequency of UTIs and the need for hospital attendance for UTIs during this period.

5.36 William's wife reported that William was bleeding from his penis – which she said was very sore following his period of respite care in Nursing Home B in October 2019 (Paragraph 3.17) although this appears to resolve itself. He was re-catheterised during the January 2020 admission to Royal Liverpool University Hospital after the catheter was found to be no longer in his penis and so had not been draining his bladder. 'Some pus? from the urethral meatus was documented alongside 'poor genital hygiene' as was swelling and soreness to the head of the penis. He had been taken into the hospital after falling out of bed and hurting his hip and elbow. However, this fall appears not to have been the cause of the removal of the catheter from his penis as it was documented that the catheter had not been draining since the previous night (Paragraph 3.24). William had previously been prescribed a local anaesthetic by his GP for pain in the tip of penis arising from pulling his catheter out (Paragraph 3.16).

5.37 When he was next re-catheterised in April 2020 the District Nurses initially struggled to change the catheter as William was documented to be 'distressed', 'uncooperative' and 'aggressive' and the District Nurses were only able to change his catheter on the third home visit after the GP prescribed Diazepam in order to sedate him. On the date on which they managed to change William's catheter (10th April 2020) the District Nurses documented a small wound opening up in William's meatus and Instillagel was applied.

5.38 William's admission to Royal Liverpool University Hospital began on 26th April 2020 and ended on 18th May 2020 when he was discharged to Nursing Home A. During William's admission it was documented that his long-term catheter was draining only a small amount (Paragraph 3.47), and he was re-catheterised whilst in hospital on 12th May 2020 (Paragraph 3.55). Also, during his admission, the Tissue Viability Nurse was advised by ward staff that William was experiencing soreness to the penile area. The Tissue Viability Nurse noted that there was a catheter in situ and that the penile area looked slightly red to the base of the head of the penile area but there was no visible skin break (Paragraph 3.49). It is not known whether there was any further action taken in respect of the soreness of the penile area.

Also, during the admission, a social care assessor spoke to William's wife who said she found his attempts to take his catheter out 'quite distressing' (Paragraph 3.51). It seems that William's attempts to remove the in-dwelling catheter from his penis may have become a persistent problem. It is not known if this continued into his Nursing Home A placement and whether this removal and re-insertion was a factor in the subsequent erosion of his penis.

5.39 William was a resident of Nursing Home A from 18th May 2020 until his admission to Aintree University Hospital on 12th December 2020. He wasn't mobilising at the time his placement began and although he managed to mobilise again for a time, he was later unable to weight bear and began to be nursed in bed, or in a chair at the side of his bed and used a wheelchair. As previously stated, the risk of catheter hypospadias is likely to increase in people who are seated for prolonged periods, confined to a wheelchair and in people with impaired cognition.

5.40 During his almost seven months placement in Nursing Home A William had five further UTIs on 9th July 2020 (Paragraph 3.68), 5th August 2020 (Paragraph 3.76), 9th September 2020 (Paragraph 3.86), 17th November 2020 (Paragraph 3.104) and 3rd December 2020 (3.111). All of these UTIs were treated by either William's GP or the Out of Hours GP – although his GP has no record of the 9th July 2020 UTI. The final UTI led to a MDT review by William's GP which resulted in relevant tests including bloods and scans being arranged, although William had been admitted to Aintree University Hospital over the weekend which preceded this MDT.

5.41 The BAUS/BAUN paper states that catheter-associated UTI (CAUTI) is one of the leading causes of secondary care-acquired sepsis and admission to hospital. The paper goes on to observe that studies suggest that as many as 70% of all CAUTIs are preventable with current evidence-based strategies, including the investigation of recurrent CAUTIs (e.g. ultrasonography[31] and cystoscopy[32]). The paper observes that in most cases CAUTI will require antibiotic therapy. When UTI treatment is required, the paper advises that consideration should be given to removing or changing the catheter if it has been in place for more than 7 days and that ideally catheter change should be performed during the antibiotic course (4).

5.42 In the IMR Nursing Home A submitted to this SAR, they noted that William acquired a lot of UTI's which could be the result of having acute urinary retention. They add that this could have been reviewed, and consideration given to a

[31] A procedure that uses high-energy sound waves to look at tissues and organs inside the body.
[32] A cystoscopy is a procedure to look inside the bladder using a thin camera called a cystoscope.

Suprapubic[33] catheter to reduce the amount of UTI's and lower the risk. Also Nursing Home A note that William was prescribed 5 courses of Cefalaxin which could have led to a bacterial tolerance of the antibiotic and given how close some of these courses were to each other it is questionable whether the treatment worked in the first place. They felt that consideration should have been given to an additional second line antibiotic.

5.43 As previously stated (Paragraph 5.33) NHS guidance on GP treatment for UTIs 'that keep coming back after treatment' includes the option of referring the person to a specialist for further tests and treatment. Given the recurring problems of UTIs in the community and subsequently in the Nursing Home and the lack of success of antibiotic treatment, the case for making a specialist urology referral appears to have been quite strong.

5.44 When William was admitted to Aintree University Hospital on 12th December 2020 the hospital had been advised by Nursing Home A that William had not been drinking for one day but concluded that he had probably not been drinking for a much longer time given the severity of his AKI (Acute Kidney Injury) and increased sodium (Paragraph 3.116). UTIs are usually caused by bacteria from faeces entering the urinary tract. Things that increase the risk of bacteria getting into the bladder include not drinking enough fluids (6)

5.45 Turning to the catheter care William received whilst a resident of Nursing Home A, a plan to trial William without a catheter appeared to be under consideration in August 2020. Nursing Home A documented that this had been suggested by the Bladder and Bowel service (Paragraph 3.75), although the latter service later advised Nursing Home A that they had no record of advising this as it did not sound a viable idea (Paragraph 3.81). Nursing Home A appears to have tried William without a catheter for a 12-hour period on 21st September 2020 (Paragraph 3.87) before re-catheterising him after he did not pass urine during the period in which he had been without a catheter.

5.46 Whilst NICE (The National Institute for Health and Care Excellence) recommends that 'catheterisation should be used only after considering alternative methods of management, the person's clinical need for catheterisation should be reviewed regularly and the urinary catheter removed as soon as possible. The need for catheterisation, as well as details about insertion, changes and care should be

[33] A suprapubic catheter is a hollow flexible tube that is used to drain urine from the bladder. It is inserted into the bladder through a cut in the tummy, a few inches below the navel (tummy button). This is done under a local anaesthetic or a light general anaesthetic.

documented'. It is difficult to understand why William was trialled without a catheter, unless it was to check whether he was able to pass urine without assistance.

5.47 The unscheduled re-catheterisation which took place on 21st September 2020 does not appear to have been adequately recorded by Nursing Home A because on 12th November 2020 the Nursing Home Registered Nurse made an urgent referral to District Nurses requesting their support in re-catheterising William. The District Nurses advised Nursing Home A that William had been catheterised on 21st September 2020 and so his next catheter change was not due until 14th December 2020 (Paragraph 3.102). The information documented in relation to this contact appeared to indicate that Nursing Home A staff lacked confidence in relation to catheter care and that they had been unable to access catheterisation training due to Covid-19 restrictions. The SAR has been advised District Nurses would have considered providing support to Nursing Home A in respect of William's catheter care if Nursing Home A had more fully shared any concerns they may have had in relation to William's catheter care at that time.

5.48 It is noted that William's catheter was flushed twice on 21st September 2020 (Paragraph 3.87) because the catheter was not draining and was intermittently blocked.

5.49 On 16th November 2020 Nursing Home staff noted that William's catheter was not draining (Paragraph 3.103). He had been holding his stomach and saying he was in pain six days earlier (Paragraph 3.100). The registered nurse gave William a bladder wash on 16th November 2020 following which the catheter was documented to be draining well.

5.50 Turning to the trauma to William's penis which must have happened during his placement at Nursing Home A, the first documented reference to a problem occurred when his catheter was first changed in Nursing Home A on 13th August 2020 (Paragraph 3.78). In the Nursing Home A 'continence notes' it was documented that staff had been advised to 'clean the genitals' as there was 'discharge coming out'. On 1st September 2020 Nursing Home staff noticed that William's penis appeared swollen when they completed personal care and a 'very smelly' discharge was 'oozing'. The nurse on duty 'checked him over' and the GP was to be called. There is no indication that William's GP was contacted (Paragraph 3.83). On 10th October 2020 care staff attending to William's personal care noted his 'groin area' to appear red and tender to touch. He was given a 'gentle wash' around his groin and barrier cream applied (Paragraph 3.90). Whilst providing personal care to William on 15th October 2020, Nursing Home staff noticed redness and a discharge from his penis. The nurse was informed but no further action appears to have been taken (Paragraph 3.92). On 19th October 2020 William complained of pain in his penis to

Nursing Home staff (Paragraph 3.94). It seems that some indications of the gradual erosion of William's penis head, in particular the pain he reported and the unpleasant discharges, were observed and documented by care staff but that no follow up investigation was undertaken.

5.51 Having seen the photographs of the trauma to William's penis which were taken on the day after he was admitted to Aintree University Hospital from Nursing Home A, the lack of documentation of the development of the wound, the lack of documentation of the pain and discomfort William must have felt, the apparent absence of care and the ineffectual efforts to escalate the limited concerns which care staff documented is incomprehensible. The documents subsequently shared with the SAR by the Nursing Home A provider do not shed any further light on matters other than the independent reviewer's observation that what appears to have been the continence care plan did not appear to be a 'plan' in that it consisted of two pages of chronological entries relating to continence and catheter care which are brief and not informative (Paragraph 5.7). The audit of William's care plan reached similar conclusions about the usefulness of the continence section of his care plan (Paragraph 5.20).

5.52 From the District Nurse records of William's in-dwelling catheter care in the community, it is clear that William found catheter care an unpleasant aspect of his daily care and as his mental health deteriorated, catheter care, particularly the re-catheterisation could cause him to become agitated. Assuming he continued to find catheter care unpleasant after he moved into Nursing Home A, it seems likely that carers may have struggled to provide catheter care at times. If so, this was not documented by Nursing Home A staff.

5.53 As well as having no recognisable plan to manage William's catheter care, the Nursing Home did not appear to appreciate the impact of other aspects of William's care, particularly hydration, on his catheter care nor to appreciate that unsatisfactory catheter care, urinary retention and confusion arising from UTIs are factors which may increase the risk of falls (Paragraph 3.24) and may lead to behaviours which challenge.

5.54 The family state that William's catheter passport went with him to Royal Liverpool University Hospital on 26th April 2020 and when William was discharged from the Royal Liverpool University Hospital to Nursing Home A on 18th May 2020 his catheter passport accompanied him (Paragraph 3.55). It appears that Nursing Home A did not keep William's catheter passport fully updated and in particular omitted the catheter change which took place on 21st September 2020. The BAUS/BAUN report recommends the use of a catheter passport to ensure catheterised people receive the optimum standard of care by improving communication between hospital,

community and the person. The passport should be issued to people after insertion of a urinary catheter (7). It is therefore recommended that the Local Authority quality assurance process for Nursing/Care Homes should include a check that catheter passport is in place for all residents with an in-dwelling catheter.

5.55 The safeguarding concerns raised by Aintree University Hospital following William's admission from Nursing Home A in December 2020 were later substantiated and the safeguarding enquiry made the following catheter related recommendations:

- Catheter passport to be completed accurately and kept with the patient notes at all times. Intervals between catheter changes to be recorded at 12 weekly intervals and a day of the week to be allocated to leg bag changes.

- A robust care plan to be implemented for patients with indwelling catheters, details to include risks associated with long term catheter use, close monitoring of a urinary catheter system, attachment and changes to leg and night bags, securement of catheter tubing, moving and handling of patients with long term catheters and a robust personal hygiene/catheter care regime.

- A full set of clinical observations to be recorded where the condition of the patient has led to a concern. Ongoing monitoring of clinical observations as specified within the care home policy or on clinical judgement.

5.56 A series of recommendations are made in respect of catheter care and urinary tract infections by this SAR. Firstly, it is recommended:

Recommendation 5

Given the frequency with which William's UTI's recurred, that Liverpool Safeguarding Adults Board request NHS Cheshire and Merseyside Integrated Care Board to ensure that the care of recurring UTIs by Primary Care is in accordance with local policies in relation to the management of recurrent UTT's and catheter associated UTIs.

Recommendation 6

That Liverpool Safeguarding Adults Board requests that Liverpool Adult Social Care (commissioners of domiciliary care) and NHS Cheshire and Merseyside Integrated Care Board Liverpool Place (commissioners of NHS Continuing HealthCare) confirm that commissioned providers have the necessary training required to support the person as outlined within their support plan specifically relating to catheter care.

Recommendation 7

That Liverpool Safeguarding Adults Board requests Liverpool Adult Social Care and NHS Cheshire and Merseyside ICB Liverpool Place to review commissioning arrangement for Liverpool Care/Nursing Homes to ensure the provision of continence and catheter care training, training compliance and catheter care quality assurance audits are in place. Specifically that
(a) NHS Cheshire and Merseyside ICB Liverpool Place ensure the provision of training for continence care for the Liverpool Care/Nursing Home sector,
(b) Liverpool City Council Quality Assurance Team to include the take up of continence care training in their audit programme,
(c) NHS Cheshire and Merseyside ICB Liverpool Place, via its commissioning arrangements, ensures the provision of training in catheter care to nurses employed in Liverpool Nursing Homes, and
(d) NHS Cheshire and Merseyside ICB Liverpool Place, via its commissioning arrangements, ensure the inclusion of catheter care plans in Liverpool Nursing homes quality assurance audits.

(The ICB have observed that as they work with the Local Authority in relation to the transformation agenda, the commissioning of providers to deliver and support care within the care home sector may change in the future therefore Recommendation 7 should be high level rather than mentioning specific providers).

Recommendation 8

That Liverpool Safeguarding Adults Board requests Liverpool City Council to enhance their Quality Assurance process for Nursing/Care Homes to include checks of catheter care plans and to check that an up-to-date catheter passport is in place for all residents needing catheter care. In order to implement this recommendation adequately, the Liverpool City Council Quality Assurance Team would need to be able to call upon clinical expertise. This would need discussions to take place between Liverpool City Council and NHS Cheshire and Merseyside Integrated Care Board.

5.57 The CQC were invited to contribute to the SAR but did not submit a report or attend any SAR Panel meetings which was disappointing. However, at a late stage of the review the Safeguarding Adults Board manager and the independent reviewer met with the CQC to discuss the review. The CQC confirmed that they had recently inspected Nursing Home A and found it to be inadequate in respect of each of the domains assessed – safe, effective, caring, responsive and well-led – and inadequate overall. Since the CQC inspection of Nursing Home A which took place whilst William

was a resident in July 2020, the standards of care provided by Nursing Home A appear to have further deteriorated.

5.58 The most recent CQC inspection of Nursing Home A found that:

- Identified risks to people were not always considered or planned for.
- Medicines were not always managed appropriately.
- Staff supporting people were not familiar with individuals' needs and there was a lack of guidance and support available to these staff.
- Cleanliness and infection prevention and control procedures were not effective, with many areas of the service requiring cleaning.
- There was a lack of management of staff and no effective oversight of staff recruitment and information relating to agency workers.
- Detailed information about people's eating and drinking needs and preferences was not always available which resulted in staff supporting people who were not aware of people's dietary needs and preferences.
- Newly recruited staff and agency staff were not aware of people's needs and wishes. People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.
- Information available to staff was limited and failed to give sufficient guidance on how to engage with people. This was reflected in staff carrying out task-based work and not involving people in making choices or decisions.
- People's care and support was not planned in a person-centred way which promoted their choice, control or preferences.
- Staff supporting people did not have access at all times to effective, person-centred care plans.
- Records were not always fit for purpose and put people at serious risk of not receiving the care, treatment and support they needed.
- Audits and checks in place had failed to identify areas of improvements needed identified during this inspection.
- Staff were not always clear about their roles and the support people needed.
- No systems were in place to ensure that people were supported by staff who had information and guidance to meet the needs of people.

(Concerns were expressed by the SAR Panel that the specific information contained in Paragraph 5.58 could enable the reader to identify Nursing Home A. The Safeguarding Adults Board may therefore wish the information to be further edited in the published SAR report).

5.59 The most recent CQC inspection report does not specifically refer to catheter care but, taken together, the recent concerns raised by the CQC suggest that the circumstances in which poor catheter care appears to have led to the erosion of William's penis continue to exist despite the efforts of the CQC as regulator and local commissioners to work with the provider of Nursing Home A to improve standards of care. Additionally, the information shared with this SAR by Nursing Home A contains little detail on the learning that the provider of Nursing Home A has derived from reflecting on the care provided to William or improvements made in order to try and prevent any repetition.

5.60 The CQC advised the SAR that they work closely with the Local Authority and meet with them every 4-6 weeks. The CQC also explained their enforcement powers that the process they follow which may lead to the cancellation of a care or nursing home provider's registration.

5.61 However, the poor care provided to William is consistent with broad strategic trends in Liverpool. During 2022/2023, a decline in the quality of provision within the Liverpool care home market has significantly impacted on the availability of general and dementia nursing care home placements in the city with a number of care homes being closed to new admissions due to quality concerns and/or as a result of regulatory interventions from the CQC (8). Poor CQC ratings are more prevalent amongst care homes that offer nursing care, with less than half of those homes rated 'good' or better. Liverpool City Council's Adult Services and Health Directorate's Market Sustainability Plan 2022/2024 recognises that overall quality in the market must improve, whilst acknowledging challenges such as attracting and retaining nursing staff in care home settings given the competition from six local hospitals and large community NHS provider typically offering higher pay and significantly better terms and conditions of employment than care homes in the city are able to offer and the commissioning activities of neighbouring local authorities – specifically in respect of nursing beds – which significantly outweigh placements obtained by Liverpool CC outside of its own borders.

5.62 The learning from this SAR which could help to reverse the decline in the quality of provision is that statutory safeguarding enquiries should have a stronger influence on the quality assurance efforts of the Local Authority and NHS commissioning. (See Paragraph 5.72).

5.63 Returning to the role of the CQC as regulator, it is recommended that Liverpool Safeguarding Adults Board share this SAR report with the CQC and draw the attention of the CQC in particular to the poor continence/catheter care which resulted in the erosion of William's penis, the limited record keeping and complete absence of any escalation by the Nursing Home in respect of this issue, the poor

care in relation to nutrition and hydration and lack of responsiveness to legitimate concerns raised by William's family. The CQC should also be requested to advise the Safeguarding Adults Board how the learning from this SAR will influence their role as regulator of the care and nursing home sector.

Recommendation 9

That Liverpool Safeguarding Adults Board share this SAR report with the Care Quality Commission and draw their attention in particular to the poor continence/catheter care which resulted in the erosion of William's penis, the limited record keeping and complete absence of any escalation by the Nursing Home in respect of this issue, the poor care in relation to nutrition and hydration, the absence of safeguarding referrals and the lack of responsiveness to legitimate concerns raised by William's family. The CQC should also be requested to advise the Safeguarding Adults Board how they propose to support the implementation of recommendations in this SAR report which are relevant to the CQC as regulator. The CQC should also be requested to advise the Safeguarding Adults Board how the learning from this SAR will influence their role as regulator of the care and nursing home sector.

5.64 No referral to Merseyside Police was considered by Liverpool Adult Social Care when they conducted the Section 42 Safeguarding Enquiry into the harm to William which occurred during his placement in Nursing Home A. As part of the Government's response to the public inquiry conducted by Sir Robert Francis QC into events at Mid-Staffordshire NHS Foundation Trust, offences contrary to Sections 20 and 21 of the Criminal Justice and Courts Act 2015 were created. The Section 20 offence is referred to as 'the care worker offence'. It is an offence for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that other individual. The Section 21 offence is referred to as 'the care provider offence'. It is an offence for an individual who has the care of another individual by virtue of being part of a care provider's arrangements to ill-treat or wilfully neglect that other individual, or if the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, or if the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected.

5.65 After receiving the opinion of the Consultant Urologist that William's urethral erosion was not caused by a particular medical condition, but that poor catheter care was the usual cause (Paragraph 5.27), it was decided to make a referral to

Merseyside Police in respect of offences contrary to Sections 20 and 21 of the Criminal Justice Act 2015. Outcome stated at (Paragraph 1.6).

When safeguarding referrals were made in respect of William, were they handled in accordance with policy and procedure.

5.66 The first safeguarding referral made in respect of William arising from his placement in Nursing Home A was made by NWAS on 21st June 2020 (Paragraph 3.61) given William's daughter's concerns about the Nursing Home's care in relation to her father's wrist injury (Paragraphs 3.60 to 3.70). When later contacted by Adult Social Care, William's daughter expressed concern that Nursing Home staff did not appear to know how to respond to her father's injury, did not respond to him being in pain and did not escalate the injury. She felt that responsibility was placed on her to contact 111 and take her father to hospital.

5.67 Adult Social Care completed a Section 42 Enquiry which concluded that the family's allegations were unsubstantiated and that the Nursing Home had followed all correct policies and procedures with no evidence to suggest that the injury was caused via neglect and that the Nursing Home's documentation evidenced that medical attention had been sought and the incident had been monitored by nursing staff appropriately.

5.68 A Section 42 Safeguarding Enquiry was initiated after William's daughter made a complaint to Nursing Home A about her father's care which was shared with the CQC. The CQC shared the complaint with the LCC QA manager which led to the Section 42 Enquiry being initiated. William's daughter's complaint related to hydration, UTI treatment and the Nursing Home's response to William's deteriorating health. The complaint did not apparently refer to the trauma to William's penis but information about this had been included in the Section 2 notifications sent by Aintree University Hospital to Adult Social Care and one would have thought that reasonably diligent enquiries would have uncovered these concerns and incorporated them into the ongoing Safeguarding Enquiry.

5.69 The outcome of the Safeguarding Enquiry was that there was no evidence of intentional abuse or neglect at the Nursing Home although William's daughter's concerns were noted to be partially substantiated. It is not entirely clear which aspects of the concern were substantiated (Paragraph 3.125).

5.70 It is of concern that Nursing Home A made no safeguarding referral in respect of the trauma to William's penis once they were asked about this by Aintree University Hospital or following the complaint made by William's daughter.

5.71 Aintree University Hospital also made two safeguarding referrals following William's admission from Nursing Home A on 12th December 2020. These safeguarding referrals appear to relate to the trauma to William's penis and his dehydration/acute kidney injury. These safeguarding referrals 'went missing' (Paragraph 3.121) and were overlooked until William's daughter enquired about them five months later (Paragraph 3.128).

5.72 The Careline manager has contributed to this SAR and the outcome of the internal investigation into the missing safeguarding referrals has also been shared with the SAR. The two safeguarding referrals submitted by Aintree University Hospital in respect of William were received by Careline but were lost in between the referrals being uploaded by the customer service advisors and screening by a social worker. Thus, the two safeguarding referrals were never screened by a social worker. The SAR has been advised that at that time there was no monitoring mechanism to notice when safeguarding referrals had not progressed to social workers for screening. This represented a serious system weakness. It is therefore not possible to say whether the loss of safeguarding referrals related to this case only or was a more widespread problem. The SAR has been advised that there is no evidence to suggest that any more safeguarding concerns were lost during this period.

5.73 The SAR has been advised that the weakness in the system – where it was possible for customer service advisors to 'lose' safeguarding referrals as a result of human error – has now been rectified to an extent. As part of a wider transformation programme, safeguarding referrals which are submitted online automatically pass into a 'safeguarding work tray' and therefore cannot be lost to the system. However, the risk of loss of safeguarding referrals by human error remains for safeguarding referrals made by telephone to customer service advisors. The SAR has been advised that the practice of making safeguarding referrals by telephone is being discouraged although professionals who need to report an urgent safeguarding concern and believe that an individual is at serious risk of harm and will require a response within 48 hours are advised to ring Careline. The SAR has been advised that the advice to professionals in relation to reporting urgent safeguarding concerns is currently being updated. Other measures to further reduce the risk of safeguarding referrals being lost would be to introduce a system of notifying the referrer of the outcome within 48 hours. If a referrer is not notified of an outcome within 48 hours, the referrer could follow up on their original referral – which would then flag up the potential loss of a telephone safeguarding referral.

5.74 The internal investigation into the loss of the two Aintree University Hospital safeguarding referrals also focussed on the opportunities which the Section 2 notifications provided for safeguarding concerns to be picked up. These notifications

were screened by a customer service advisor but not shared with and the Careline Adults Social Work team.

5.75 The Safeguarding Adults Board is asked to note the changes which have taken place which will reduce the possibility of safeguarding referrals being lost by Careline. However, the risk that safeguarding referrals could be lost remains for those made by telephone and so it is recommended that the Safeguarding Board request a report from Liverpool Careline setting out the steps taken or planned to reduce the risk of the loss of safeguarding referrals submitted by telephone.

Recommendation 10

That Liverpool Safeguarding Adults Board note the changes implemented to reduce the possibility of safeguarding referrals being lost by Careline. However, the risk that safeguarding referrals could be lost remains for those made by telephone and so it is recommended that the Safeguarding Board request a report from Liverpool Adult Social Care setting out the steps taken or planned to reduce the risk of the loss of safeguarding referrals submitted by telephone.

5.76 The SAR has been advised that Nursing Home A were made aware of the outcome of the Section 42 Safeguarding Enquiry completed in June 2021 (Paragraph 3.129) but that it is unclear from the records whether the Nursing Home responded to this letter, whether they accepted the recommendations and made changes to their policy and practice as a result of the findings. To this end it is not clear if transferrable risks have been managed. As stated in Paragraph 5.59 the learning from this SAR which could help to reverse the decline in the quality of provision in the Liverpool Care Home Market is that statutory safeguarding enquiries should have a stronger influence on the quality assurance efforts of the Local Authority and NHS commissioning. It is therefore recommended that Liverpool Safeguarding Adults Board request a report from Liverpool's Adults Services and Health Directorate which sets out the process by which learning from substantiated or partly substantiated Section 42 Safeguarding Enquiries is shared with the Liverpool Quality Assurance team so that an improvement plan can be agreed with the relevant provider and so that the learning informs the Quality Assurance team's Focussed Visits.

To what extent were the principles of the Care Act – empowerment, prevention, proportionality, protection, partnership and accountability – applied in respect of William?

5.77 The Care Act principles of empowerment and could be discerned in the support provided to William and his wife as his primary carer to enable him to live at home for as long as possible. It was recognised that these arrangements were beginning

to break down by the District Nurses and the decision to transfer William from Royal Liverpool University Hospital to Nursing Home A in May 2020 was proportionate. There were examples of positive approaches to partnership working such as the District Nurses offer of making a joint home visit with the home care providers to support the latter service with catheter care.

5.78 William was not protected from neglect whilst a resident in Nursing Home A who also missed the opportunity to work in partnership with William's family subject to the limitations arising from the pandemic restrictions.

To what extent were the principles of 'making safeguarding personal' applied to William?

5.79 Making Safeguarding Personal enables safeguarding to be done with, not to, people – 'no decision about me, without me'. It is an approach which aims to develop a person-centred and outcome focused approach to safeguarding work. The adult concerned must always be at the centre of adult safeguarding enquiries, and their wishes and views sought at the earliest opportunity.

5.80 This approach appeared to be present when Adult Social Care initiated a Section 42 Safeguarding Enquiry on 23rd June 2020 (Paragraphs 3.61 – 3.65) in that they established William's daughter's desired outcomes from the Safeguarding Enquiry.

5.81 The Making Safeguarding Personal approach was less in evidence when Adult Social Care commenced a Section 42 Safeguarding Enquiry following William's daughter's complaint about her father's care in Nursing Home A (Paragraphs 3.124 – 3.125). Given that William lacked the capacity to articulate his concerns for himself, this placed greater emphasis on information gathering from all relevant sources to clarify what had happened. As previously stated information gathering was far from comprehensive.

Did the agencies in contact with William and his family work together, communicate and share information effectively?

5.82 There was generally effective partnership working when William was being supported in the community. The District Nurses could have considered escalating concerns about William's homecare providers inability and/or unwillingness to provide catheter care to Adult Social Care as the commissioners of the home care. At a very challenging time there was very effective partnership working between Royal Liverpool University Hospital and the CCG to secure William's placement in Nursing Home A. There was some effective partnership working through the multi-

disciplinary meetings to consider William's health needs whilst a resident in Nursing Home A, although there was a long gap in considering William's case at multi-disciplinary meetings after September 2020 covering the period in which William's care really deteriorated. As previously discussed, there was a system failure when the two safeguarding referrals sent to careline by Aintree University Hospital were lost.

5.83 William's family have advised the SAR that they were unaware that his placement in Nursing Home A, or rather the decision that the placement would become permanent, would result in a change of GP practice. There does not appear to be any system for notifying family members of this change of GP practice. As stated, William's daughter had LPA for 'health and welfare' so there ought to be a system by which the GP practice or the care/nursing home notify her. Perhaps the manner in which the Nursing Home A placement became permanent by default was a factor in the family not being notified of change of GP.

Recommendation 11

That Liverpool Safeguarding Adults Board requests Liverpool Adult Social Care to update the 'care home brochure' to ensure that information and advice for family members of people about to be placed in a care or nursing home to contain the advice that the placement will necessitate registration with the GP practice linked to the care or nursing home – unless that GP practice happens to also be the person's existing GP practice.

Were there any specific considerations around equality and diversity issues in respect of William such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation?

5.84 A high proportion of people living in Liverpool suffer from poor health. On average, men born in Liverpool can expect to live to 76.1 years while women born in Liverpool can expect to live to 79.9 years, both significantly below the England average and the 2nd lowest out of 8 core cities after Manchester. This poor health results in more people needing help from the Council to meet their social care needs at an earlier point in their life. The average age of a person commencing a domiciliary care package is just 77 years old and a person moving permanently into a care home just 78 years old. In William's case he needed a domiciliary care package from the age of 77 but did not need residential nursing care until the age of 81 (9).

Did the Covid-19 pandemic have any impact on William or the support offered or provided to William by agencies during the pandemic?

5.85 The Covid-19 pandemic represented an unprecedented challenge which had a profound impact on all areas of the health economy including primary care, acute and specialist care and residential care. This was the context in which William's health deteriorated in the weeks prior to his admission to Royal Liverpool University Hospital on 26th April 2020 and was discharged to, and cared for in, Nursing Home A.

5.86 William's family feel that the impact of the first Covid-19 lockdown on his health and wellbeing in the weeks prior to his admission to the Royal Liverpool University Hospital should not be understated. The respite enjoyed by William and his wife stopped and his family were unable to visit him, other than to greet him through the window of his home. His family say that William was unable to understand why these changes in his normal routine had taken place.

5.87 It is worthy of note that families of residents of residential and nursing homes represent an informal but important form of surveillance of standards within residential and nursing homes which has been seriously disrupted by visitor restrictions arising from the management of the Covid-19 pandemic. One wonders whether this has received sufficient weighting in the assessment of risks to residents in residential and nursing homes about which there are concerns.

5.88 Government guidance on care home visiting (10) stated that every care home resident should have an identified essential care giver who would be allowed to visit the home to offer companionship or help with care needs even during periods of isolation or outbreak.

5.89 Staff lacked catheterisation training due to Covid-19 restrictions (Paragraph 3.102)

To what extent does this SAR provide a 'window into systems' for safeguarding adults from abuse and/or neglect? What does this review tell us about how safe local systems are?

5.90 The key system issues this SAR has highlighted are as follows:

- The system for recording and assessing safeguarding referrals by Careline.
- The system for notifying providers of care and nursing homes of the outcomes of Section 42 Safeguarding Enquiries and requesting the provider to address any areas in need of improvement.

- Systems for ensuring that the learning from Section 42 Safeguarding Enquiries informs Quality Assurance work with care and nursing homes.

Identify good practice

5.91 There was much solid professional practice by professionals supporting William and his wife in the community and during William's hospital admissions.

5.92 The audit of William's care plan carried out by a 'named nurse' between 7th and 9th December 2020 found numerous important deficiencies which led to a number of recommendations for improvement (Paragraph 5.22).

Additional terms of reference question
Responding to indications of 'carer stress'

5.93 There were indications of increasing 'carer stress' for William's wife over the months prior to the April 2020 hospital admission which led to his placement Nursing Home A. On 14th January 2020 Royal Liverpool University Hospital documented that William's wife was 'not coping' - with her age (then 84 years) and back pain cited as factors. (Paragraph 3.24). However, during the same admission, William's wife was reported to be 'managing well' and was said to have no concerns about William returning home. (Paragraph 3.25). But the GP was requested to note concerns that the family was struggling to cope on the current package of care (Paragraph 3.26).

5.94 During a call to Adult Social Care on 20th March 2020 William's wife said that she was not coping as well as she had in the past due to her age and William's increasing needs (Paragraph 3.36). During William's admission to Royal Liverpool University Hospital from 26th April 2020 onwards, William's wife said that she didn't feel that she could cope if her husband's behaviour continued at the level experienced recently (Paragraph 3.47).

5.95 The Care Act 2014 substantially replaced and consolidated existing legislation for carers and those they support. The Act introduced parity of esteem between carers and service users, strengthened carer's rights to an assessment of need and placed a new duty on local authorities to fund support for carers 'eligible needs'.

5.96 Adult Social Care arranged for the completion of a carers supported self-assessment with William's wife in January 2017 which demonstrated her eligibility for social care support from the Local Authority on the grounds that her physical or mental health was deteriorating or was at risk of doing so and that there were specific areas of her life she was unable to manage without support as a result of her caring role, namely

- Managing and maintain daily routines without feeling stressed or anxious.
- Maintaining own health and wellbeing attending appointments etc.
- Having time to herself to pursue her own leisure and social needs.

5.97 William's wife was assisted by a worker from Liverpool Carers Centre to develop a carers support plan and was provided with Carers Vouchers to fund a sitting service for 5 hours per week although she often appeared to be reluctant to avail herself of this service as she was reluctant for William to be with someone he didn't know. She also received a direct payment to enable her to employ a cleaner.

5.98 Her carers assessment was reviewed in June 2018, and this identified a new need relating to crushed vertebrae in her back which caused her to struggle to complete housework - particularly cleaning the floors - and care for William. She said that she would like to be able to afford to increase the hours of her cleaner from every fortnight to weekly, but it is unclear if it was possible to action this. However, William's access to day care twice each week allowed his wife more time to do the shopping and take a break.

5.99 William's wife appeared to have been offered and accepted a carers review in October 2019. This took place in January 2020, and she was provided with information in respect of Liverpool Carers Centre, an application for a Carers Emergency Card and a referral to the Alzheimer's Society Side by Side service.[34]

5.100 Following the onset of the pandemic Mytime[35] telephoned William's wife in later April 2020 just after he had been admitted to hospital and Liverpool Carers Centre texted her in November 2020 to ask her to contact them if she was feeling isolated or required further support. In December 2020 Mytime donated seasonal food to William's wife. Around that time her case was closed as she no longer had direct caring responsibilities.

5.101 Overall, William's wife received valuable support as a carer which appears to have been generally responsive to her changing needs as a carer. The onset of the pandemic appears to have been a very challenging time for William and his wife. Although their home care package continued, William's day care ceased as did the respite this provided for his wife. The network of local family support she and William relied upon was also disrupted with no in-person support allowed.

Nursing and Care Home provider engagement with the SAR process

[34] Side by Side helped people with dementia to keep doing the things they enjoy with the support of a volunteer.
[35] Mytime connects carers who could benefit from a break from their demanding roles with businesses and organisations offering complimentary leisure, cultural and educational activities.

5.102 Each agency which had had relevant contact with William and his family were requested to complete a chronology of contact and a second report in which they were asked to reflect on the key lines of enquiry adopted by the SAR Panel. The chronology and report submitted to the SAR by the provider of Nursing Home A and nine other residential care homes was unsatisfactory in that the chronology was brief and incomplete and the report was superficial. A further report was requested from the provider in which they were asked a number of key questions formulated by the SAR Panel. The response provided was again unsatisfactory and was even described by the provider as 'vague' and containing 'limited information'. The provider sent 453 pages of records in support of this second submission which was disorganised and contained some repetition. However, the records contained some documents which were of relevance to the SAR. Having said that the provider did not appear to have read the records they shared with the SAR as the records contained information which undermined one of the answers to the questions formulated by the SAR Panel. In mitigation, the provider stated that they had had a fire in their 'archive stores' which destroyed 'a lot of information and records'.

5.103 The unsatisfactory reports submitted to the SAR by the provider has prevented the SAR Panel from fully exploring all the key lines of enquiry. In particular, the provider has been completely unable to assist the SAR Panel to understand how William sustained the trauma to his penis and why this wasn't documented when he received personal care or when his catheter bag was changed and if noticed – as it must have been – why it wasn't documented and escalated.

5.104 It is not known whether the unsatisfactory contribution to this SAR by this particular provider is an issue limited to this particular provider or is a wider problem. In the independent reviewer's experience providers of care and nursing homes have frequently struggled to fully engage with SARs. It is therefore recommended that Liverpool Safeguarding Adults engages constructively with local providers of care and nursing homes to advise them of the requirements of the Care Act and the expectations of the Safeguarding Adults Board in respect of their contribution to SARs, offering support and guidance where appropriate. The Safeguarding Adults Board may also consider requesting commissioners of placements in care and nursing homes to include Care Act requirements/Safeguarding Adults Board expectations relating to SAR engagement in their contracts with providers.

Recommendation 12

That Liverpool Safeguarding Adults to work with local providers of care and nursing homes to co-produce shared expectations in relation to the requirements of the Care

Act and the expectations of the Safeguarding Adults Board in respect of their contribution to SARs, offering support and guidance where appropriate. The Safeguarding Adults Board may also consider requesting commissioners of placements in care and nursing homes to include Care Act requirements/Safeguarding Adults Board expectations relating to SAR engagement in their contracts with providers.

Family questions:

To explore why the Nursing Home did not apply for a Deprivation of Liberty Safeguards authorisation.

5.105 There is no record of Nursing Home A applying for a Deprivation of Liberty Safeguards (DoLS)[36] authorisation. The Nursing Home A provider has advised the SAR that they do not have access to any records relating to DoLS but that there is reference in an internal investigation report which states that a DoLS application was submitted on 1st October 2020. However, amongst the records subsequently shared with the SAR by the provider is an audit of William's care plan completed between 7th and 9th December 2020 (shortly before his placement at Nursing Home A ended) which states that the professional completing the audit could find no evidence on file that a DoLS authorisation had been applied for.

To understand why William's wife was not consulted in respect of decisions taken in the Best Interests of William, in particular the decision that William's placement in the Nursing Home should become permanent.

5.106 This question is addressed in Paragraphs 5.13 to 5.16.

To understand why care and nursing staff did not recognised that William was in pain and needed to be referred to his GP.

5.107 This question is addressed in Paragraphs 5.26 to 5.56

To explore why William was not referred to the Speech and Language Therapy (SALT) service by the Nursing Home when this was necessary.

5.108 William was seen by a SALT shortly after admission to Aintree University Hospital and identified a risk of aspiration (paragraph 3.114). He was also seen by SALT shortly after his admission to Aintree University Hospital from Nursing Home A

[36] The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

(Paragraph 3.120). At that point SALT documented moderate dysphagia impacted by cognitive impairment and advised a modified diet and fluids to reduce the risk of aspiration. He required full assistance and supervision, his chest was to be monitored closely and any concerns should lead to consideration of 'nil by mouth'. There is no indication that Nursing Home A considered a referral to SALT which was an omission given William's risk of aspiration.

When the safeguarding concerns raised on William's behalf by his family were enquired into and found to be unsubstantiated, they feel that the family should have been provided with advice about how to appeal against or otherwise challenge the 'unsubstantiated' finding.

5.109 The SAR has found that the Section 42 Safeguarding Enquiry conducted by Adult Social Care in December 2020 was not conducted thoroughly.

When a family raises safeguarding concerns in respect of a family member who is a resident in a care or nursing home, the local authority should gather information from all relevant agencies and not just the care or nursing home concerned.

5.110 This question is addressed in Paragraphs 5.66 and 5.67.

To explore why the safeguarding concerns raised following William's admission to Aintree University Hospital in December 2020 were overlooked.

5.111 This question is addressed in Paragraphs 5.69 to 5.73.

6.0 List of recommendations

Recommendation 1

That Liverpool Safeguarding Adults Board requests NHS Cheshire and Merseyside to introduce a standardised agenda for Enhanced Health in Care Homes multi-disciplinary meetings which discuss patients who are residents in care or nursing homes and advises the Safeguarding Adults Board of the outcome of this piece of work.

Recommendation 2

That Liverpool Safeguarding Adults Board requests that Liverpool City Council Quality Assurance Team include Best Interest meeting record keeping in their Focussed Visits to Care and Nursing Homes – with a particular emphasis on the recording of family involvement in Best Interest decisions – and that the Quality Assurance Team provide a report on the outcome of the visits to the Safeguarding Adults Board.

Recommendation 3

That Liverpool Safeguarding Adults Board requests
(a) Local Authority and Integrated Care Board commissioners of Care/Nursing Home placements to support Care/Nursing Homes to identify training programmes in respect of the Mental Capacity Act and specifically in respect of Lasting Power of Attorney and
(b) the Liverpool City Council Quality Assurance Team to ensure such training is in place and to audit processes in respect of Lasting Power of Attorney.

Recommendation 4

That Liverpool Safeguarding Adults Board obtains assurance that professionals from agencies which are part of the wider system – including visiting professionals and review activities conducted by the CHC and Adult Social Care for example – support the recording of Lasting Power of Attorney details and ensuring that individuals with LPA are involved in Best Interest decisions.

Recommendation 5

Given the frequency with which William's UTI's recurred, that Liverpool Safeguarding Adults Board request NHS Cheshire and Merseyside Integrated Care Board to ensure that the care of recurring UTIs by Primary Care is in accordance with local

policies in relation to the management of recurrent UTT's and catheter associated UTIs.

Recommendation 6

That Liverpool Safeguarding Adults Board requests that Liverpool Adult Social Care (commissioners of domiciliary care) and NHS Cheshire and Merseyside Integrated Care Board Liverpool Place (commissioners of NHS Continuing HealthCare) confirm that commissioned providers have the necessary training required to support the person as outlined within their support plan specifically relating to catheter care.

Recommendation 7

That Liverpool Safeguarding Adults Board requests Liverpool Adult Social Care and NHS Cheshire and Merseyside ICB Liverpool Place to review commissioning arrangement for Liverpool Care/Nursing Homes to ensure the provision of continence and catheter care training, training compliance and catheter care quality assurance audits are in place. Specifically that
(a) NHS Cheshire and Merseyside ICB Liverpool Place ensure the provision of training for continence care for the Liverpool Care/Nursing Home sector,
(b) Liverpool City Council Quality Assurance Team to include the take up of continence care training in their audit programme,
(c) NHS Cheshire and Merseyside ICB Liverpool Place, via its commissioning arrangements, ensures the provision of training in catheter care to nurses employed in Liverpool Nursing Homes, and
(d) NHS Cheshire and Merseyside ICB Liverpool Place, via its commissioning arrangements, ensure the inclusion of catheter care plans in Liverpool Nursing homes quality assurance audits.

Recommendation 8

That Liverpool Safeguarding Adults Board requests Liverpool City Council to enhance their Quality Assurance process for Nursing/Care Homes to include checks of catheter care plans and to check that an up to date catheter passport is in place for all residents needing catheter care. In order to implement this recommendation adequately, the Liverpool City Council Quality Assurance Team would need to be able to call upon clinical expertise. This would need discussions to take place between Liverpool City Council and NHS Cheshire and Merseyside Integrated Care Board.

Recommendation 9

That Liverpool Safeguarding Adults Board share this SAR report with the Care Quality Commission and draw their attention in particular to the poor continence/catheter care which resulted in the erosion of William's penis, the limited record keeping and complete absence of any escalation by the Nursing Home in respect of this issue, the poor care in relation to nutrition and hydration, the absence of safeguarding referrals and the lack of responsiveness to legitimate concerns raised by William's family. The CQC should also be requested to advise the Safeguarding Adults Board how they propose to support the implementation of recommendations in this SAR report which are relevant to the CQC as regulator. The CQC should also be requested to advise the Safeguarding Adults Board how the learning from this SAR will influence their role as regulator of the care and nursing home sector.

Recommendation 10

That Liverpool Safeguarding Adults Board note the changes implemented to reduce the possibility of safeguarding referrals being lost by Careline. However, the risk that safeguarding referrals could be lost remains for those made by telephone and so it is recommended that the Safeguarding Board request a report from Liverpool Adult Social Care setting out the steps taken or planned to reduce the risk of the loss of safeguarding referrals submitted by telephone.

Recommendation 11

That Liverpool Safeguarding Adults Board requests Liverpool Adult Social Care to update the 'care home brochure' to ensure that information and advice for family members of people about to be placed in a care or nursing home to contain the advice that the placement will necessitate registration with the GP practice linked to the care or nursing home – unless that GP practice happens to also be the person's existing GP practice.

Recommendation 12

That Liverpool Safeguarding Adults to work with local providers of care and nursing homes to co-produce shared expectations in relation to the requirements of the Care Act and the expectations of the Safeguarding Adults Board in respect of their contribution to SARs, offering support and guidance where appropriate. The Safeguarding Adults Board may also consider requesting commissioners of placements in care and nursing homes to include Care Act requirements/Safeguarding Adults Board expectations relating to SAR engagement in their contracts with providers.

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Appendix A

Process by which the SAR completed and membership of the SAR Panel

It was decided to adopt a broadly systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Membership of the SAR Panel:

David Mellor, Independent SAR Panel Chair and Independent Reviewer
Liverpool City Council
Liverpool University Hospitals NHS Foundation Trust
Cheshire & Merseyside NHS - Integrated Care Board - Liverpool Place
North West Ambulance Service NHS Foundation Trust
Merseyside Police
Mersey Care NHS Foundation Trust
Liverpool Safeguarding Adults Board

Chronologies which described and analysed relevant contacts with William and his family and reports which addressed the SAR terms of reference questions were completed by the following agencies:

- Home Care providers
- Liverpool City Council Adult Social Care
- Liverpool University Hospitals NHS Foundation Trust
- The provider of Nursing Home A
- Mersey Care NHS Foundation Trust
- North West Ambulance Service
- Primary Care

The chronologies were analysed by the SAR Panel and learning themes identified. The chronology and report submitted by the provider of Nursing Home A was not considered to have provided sufficient information about the care provided to William or to have fully addressed the SAR terms of reference questions and so they were requested to revise and resubmit their report.

Additionally, the lead reviewer had separate conversations with the CQC and the Liverpool Head of Careline. A Urology Consultant also read and commented on sections of the SAR report relating to catheter care.

William's wife and daughter contributed to the SAR and also shared copies of documents they accessed from the agencies involved in William's care.

The independent reviewer developed a draft report which reflected the chronologies, reports, conversations with professionals and the views of William's family. The report was further developed into a final version and was presented and agreed by Liverpool Safeguarding Adults Board.