OSAB
Oxfordshire Safeguarding Adults Board

Safeguarding Adults Review – Rhonda

Introduction

Rhonda had been relatively well most of her life but had been declining in the short months leading up to her admission to Hospital and her eventual death a month later.

There were a number of concerns relating to her care whilst at Banbury Heights raised by her sister, which were subject to a Section 42 enquiry. As an adult with a learning disability, Rhonda's death was also subject to a review under the Learning Disability Deaths Review (LeDeR) process.

The Safeguarding Adults Review (SAR) subgroup of the Board agreed to conduct a discretionary review of what happened during Rhonda's care. This review brings together the findings of the Section 42 enquiry conducted by Oxfordshire County Council and the LeDeR review process carried out by the Clinical Commissioning Group.

The LeDeR report and this SAR report will be shared with the Care Quality Commission (CQC).

Review Methodology

The SAR group commissioned a SAR into the care of Rhonda. Adopting a proportionate response, the Board agreed to bring together the two learning reviews already conducted as well as incorporating comments and questions from Rhonda's sister, Rhonda's Sister.

The Author is the Manager of the Safeguarding Adults Board and has no line management responsibility for any person or service involved in this review.

Rhonda's Background

Rhonda was born partially sighted and with a mild learning disability after her mother contracted German measles during pregnancy. Although partially sighted, Rhonda had learnt to read and write. Rhonda's Sister explained that Rhonda could express her needs eloquently and was described as a bubbly, lovely lady who loved ballroom dancing.

She attended mainstream school with her sisters thanks to her parents' insistence. Rhonda's Sister said that she and her other sister had to protect Rhonda from harsh remarks from other children. She learnt to read and write, albeit slowly, and she didn't manage to do any exams.

She left school at 16 and got a job as a laundry assistant, and then went to work at M&S. She met her husband aged 21. He was a soldier in the Scots Guards. They had two children, a girl and a boy. Rhonda's husband became abusive and they divorced when the children were 6 and 7. Rhonda moved back to Banbury to be near her family as her husband got custody of the children. She did maintain contact with them although they were aware that their mum had learning needs.

Later in life, she moved into sheltered housing flat with support from her family. She then met a gentleman who although 20 years older than her was a lovely caring gentleman. She would visit him most days but return to her flat at night.

About 7 years ago she started becoming forgetful and she was eventually diagnosed with dementia in 2017. She also developed arthritis in her hips which caused her a lot of pain.

Rhonda moved into her partner's house in March 2020 temporarily after discussion between him, his daughter and her sister (and care provider) to ensure that during lockdown she received more companionship and meals. This worked well but tragically her boyfriend, who was in his 80s and had multiple health issues, succumbed to COVID in early April and died in the Horton Hospital. Rhonda really struggled with this, especially as there wasn't a funeral.

After discussions with his daughter, it was agreed that Rhonda and her partner's daughter would both benefit from the company they could offer each other at this sad time and Rhonda also still required help. Rhonda's family paid for Rhonda's living expenses while she was with the partner's daughter.

By prior arrangement and after setting up care visits at her flat, Rhonda returned home on the 6th June 2020. Her health was declining both mentally and physically, prompting the move back into her own flat with four visits a day arranged by social care and agreed by her Doctor

Within 48 hours Rhonda was found wandering in the communal hallway by other tenants, and she was then taken into hospital that night by the paramedics, where she was found to have a UTI. From there she was transferred two days later into a Hospital Hub Bed at Banbury Heights Care Home, under the joint care of Banbury Heights Care Home and the Hospital Hub Unit. At no point was Rhonda's Sister advised another MRI had been carried out while Rhonda was in Hospital and the decline that it has shown, this was revealed at a meeting held much later. As Rhonda's legal guardian and POA [should this be LPA?], this should have been shared with Rhonda's Sister at the time of the event, which would have helped her understand why the mental health decline was so obvious.

While at Banbury Heights there were a number of issues, which are explored further in this report. These included a lack of clarity about responsibilities for a patient in a hub bed, an overshadowing of perceived behaviours, failure to maintain regular recording and a lack of action in response to concerns raised by Rhonda's sister, Rhonda's Sister.

Rhonda's Sister did say that when Rhonda was admitted to Hospital the day before she died she was yellow 'from top to toe' and that in spite of everyone's efforts she died in pain. This is her last memory of her sister and she wants to try and stop this happening to anyone else.

Medical & Health Conditions

As well as being born partially sighted and with a mild learning disability, Rhonda had a number of medical and health conditions. This included Dementia, dyspepsia, osteoarthritis and hypercholesterolaemia.

Rhonda's usual medications were Paracetamol, Simvastatin, Gaviscon, Naproxen, Codeine and Amitriptyline, treating her pain, her cholesterol and her reflux.

At the time of her death, Rhonda was receiving Oramorph, Ondansetron & Coamoxiclav (by IV) as well as IV fluids.

Chronology of events

This is an abridged version of the full chronology assembled for the reviews, focussing on the events mentioned within this report. This is reflective of the records on the electronic recording systems of organisations involved in Rhonda's care, it is not an analysis of the actions taken.

Date	Source	Notes
14 July 2014	GP notes	Diagnosed with osteoarthritis of the ankle and foot.
24 May 2017	GP notes	Diagnosed with Dementia in Alzheimers disease.
23 April 2019	GP notes	Diagnosed with osteoarthritis of the hip.
February 2020	GP notes	Referred back to the memory clinic, due to concerns re deteriorating memory and increased care needs, but this was then postponed due to Covid.
17 February 2020	SAR scoping	Sister asks ASC for support as RN is due to have a hip replacement and would require specialist aftercare.
March 2020	GP notes	Seen in GP surgery with sister, to arrange Power of Attorney and was felt to be able to understand the relevant issues and to have capacity to make this decision.
03 March 2020	SAR scoping	Care assessment agreed following assessment by ASC north team – 4 x daily visits to start in June.
April 2020	SAR scoping	Partner dies in hospital from Covid – RN stays living with 'step' daughter.
08 June 2020	SAR scoping	RN moves back to supported living with care package in place.
09 June 2020	SAR scoping	RN found wandering in the corridors– delirious – taken to Horton hospital.

Date	Source	Notes
10 June 2020	Care Provider notes	Tested negative for Covid-19.
10 June 2020	OUH - SJR	Admitted to Horton Hospital with significant confusion, caused by a UTI. A course of nitrofurantoin was given. Naproxen, amitriptyline, and omeprazole were stopped due to low serum sodium. Codeine was stopped due to confusion. The bloods rapidly corrected and the patient was discharged to a hub bed for further rehab/respite. An MRI was carried out. Results were not shared with Rhonda's Sister.
11 June 2020	SAR scoping	Discharged to hub bed at Banbury Heights.
12 June 2020	SAR scoping	Visited by Social Worker. Daily visits by physio commence.
12 June 2020	OUH S42	During the pandemic, the Multi-Disciplinary Team (MDT) meetings were held in Banbury Heights but due to the nursing home provider restrictions, NHS staff were not allowed to review patients in person. The OUH Hospital Hub Bed therapy staff were permitted to continue their input with patients as they were designated to the Care Home and would not be providing care in any other facility. Additional reviews on an ad hoc basis were discussions via telephone/email. MDT's also occurred on 16th, 23rd, 24th June and 1st July.
15 June 2020	OUH information	Physio assessment in Banbury Heights. These also happened on 16th, 17th, 18th, 19th and 22nd, 26th June.
16 June 2020	SAR scoping	MDT - Sister asks about pain relief as she feels RN is in pain – told all meds stopped because they would interfere with antibiotics. Sister challenges as antibiotics have finished.
17 June 2020	OUH - SJR	The Discharge Liaison Sister (Nurse Prescriber) was informed that the patient was experiencing pain in their knees whilst mobilising with the therapy team. Naproxen was restarted and a community prescription was raised by the Discharge Liaison nurse (DLN) on and was sent to the community pharmacy to be processed and sent to Banbury Heights. The DLN recommended bloods to be taken again after one week to check Rhonda's sodium levels as it was an issue whilst in hospital and the team wanted to be sure that the patient was on the most effective medication for pain.
23 June 2020	OUH information	Therapy Assistant note: Observed Rhonda mobilising with carer to the shower. TA later popped back to Rhonda, Rhonda in a low mood and very tearful.

Date	Source	Notes
		TA spoke with Rhonda about completing a kitchen assessment and explained what she has do. Rhonda states she doesn't feel confident to make herself a cup of tea as she feels nervous because of her visual impairment.
23 June 2020	SAR scoping	SW conversation with sister who was relatively happy with the care.
23 June 2020	OUH information	MDT at Banbury Heights. Reason for Discussion: Discharge Planning. Joint visit with visual team and L and D team. Has settled into Banbury heights there recommendation is to remain at Banbury heights. Social worker to complete assessment and ask managers if she can stay at Banbury Heights.
24 June 2020	OCC Reporting form	Care Act Assessment completed.
24 June 2020	OUH S42	RN was reviewed at the weekly MDT meetings held on Tuesdays. In line with COVID- 19 restrictions this was not face to face unless a problem was highlighted by the Banbury Heights nursing. If this was the case then the nursing staff would telephone the OUH Hospital Hub Bed team to escalate concerns about a patient in order to review care and treatment. Daily monitoring of RN's condition and notification of any changes was the responsibility of the Banbury Heights team. Present: Home Manager Banbury Heights, Lead Nurse Banbury Heights, OUH Discharge Liaison Sister, OUH Physiotherapist, OUH Therapy Assistant, OCC Care Coordinator and OCC Social Worker.
24 June 2020	OUH information	Physio mobility review. Observed Rhonda mobilising with the carer from her room to the lounge. Rhonda mobilising well.
25 June 2020	OUH - SJR	An email from Banbury Heights was forwarded to the OUH DLN by the OCC Care Coordinator stating that the patient was complaining of stomach pain. The DLN recommended that they commence administration of Gaviscon (QDS) prior to meals and Nocte from the homely pack (this is a pack of simple over the counter medications stored at the nursing home which can be used as an immediate action). A prescription for regular Gaviscon was also raised by the DLN for on-going management; she encouraged the Banbury Heights staff to offer it regularly. The DLN also asked the Lead Nurse at Banbury Heights to obtain a blood sample from the patient so that she could review the sodium levels and discuss with the medical team regarding restarting the Proton Pump Inhibitor (PPI). The DLN explained that the risk of prescribing the PPI without checking sodium levels is that it would interact with the normal

Date	Source	Notes
		functioning of the patient's renal system and may lead to renal failure.
26 June 2020	OUH information	Physio assessment. Rhonda asleep on arrival, Rhonda woke by voice. Rhonda a little down but well in herself. Rhonda gave consent to a mobility review.
29 June 2020	SAR scoping	Sister: *I asked for a nurse to come into her room to see Rhonda as I was VERY worried about her condition. This was witnessed by her ex-housing flat Warden, Sue Bacon, who was allowed to come in with me I spoke to one nurse in the corridor and she said to me that 'they' tend to get upset when family visit! That day, for the first time, Rhonda pleaded with me to take her home, crying inconsolably.*
29 June 2020	OUH information	Therapy Assistant note: Rhonda has a friend visiting. Rhonda mobilised from her room to the lounge with her friend. TA helped Rhonda sit at the table ready for lunch.
01 July 2020	OUH information	MDT at Banbury Heights. Reason for Discussion: Discharge Planning. MCA completed. Best Interest decision completed. SW asking OCC managers if she can stay in Banbury heights due to L & D. Rhonda's Sister expressed concerns to SW about this.
03 July 2020	OUH information	Therapy Assistant note: Rhonda seen with RGN present, Rhonda has been vomiting. RGN informed me Rhonda is very constipated and hasn't been eating/drinking very well. Rhonda very emotional today. no therapy input today.
03 July 2020	OUH S42	Sister emailed care coordinator expressing concerns re stomach pain is forwarded to OUH inbox that is not monitored out of hours.
03 July 2020	Banbury Heights S42	Lactulose given as constipated.
03 July 2020	SAR scoping	Sister: *when I visited Rhonda she had virtually stopped eating, and I had to hand feed her just a little bit of mashed potato as she was feeling so ill. She was so upset she was shouting "my tummy is burning". I asked the nurse on duty that Rhonda be seen by a doctor as something was clearly wrong. Nurse rang the hospital team again, she apparently was told by a Doctor, "No, it is reflux, she can have Gaviscon and paracetamol only". Apparently the Gaviscon had been introduced the week prior. I said "nurse, feel her. She is so cold and clammy".*
03 July 2020	OUH S42	Rhonda informed the OUH Therapy Assistant that she felt very constipated and did not feel like eating or drinking, she was very emotional so no therapy took place. The Nurse caring for RN at Banbury Heights was present during this intervention. The DLS was not informed of this episode.
03 July 2020	Banbury Heights S42	As Rhonda is in a hub bed any request for the involvement of a doctor would come from the 'hub team' as there is no doctor

Date	Source	Notes
		assigned to these beds and OOH will not visit. The staff therefore deny having agreed to this practice as it is not normal practice.
04 July 2020	SAR scoping	Sister: *"late morning, I called around to the Care Home, without an appointment, as I was so terribly worried about Rhonda. A nurse came to the door, I explained who I was and that I was worried about Rhonda after my upsetting visit the previous day and could I ask "how is she today?". The nurse took the TV magazine I had brought with me for R from me, said "she is fine" and closed the door! I spoke to R on the phone later that day and she was crying, saying repeatedly "my tummy hurts so much". How can that be interpreted as "she is fine" by a trained nurse?"*
06 July 2020	OUH S42	RN complained of indigestion and feeling nauseous. Gaviscon was given with good effect and the DLS was contacted to review her acid reflux medication. The DLS was in the process of speaking to the Medical team following receipt of the email from OCC Care Coordinator. The DLS discussed with the Medical Registrar in EAU, informing him of RN's background, current medication and the medication that was discontinued on her admission to the Horton Hospital in June. In view of RN's recent low sodium level, the OUH Medical Registrar suggested starting Famotidine 20mg once daily at night as a safer alternative to Omeprazole as it does not pose the same risk to kidney function. The DLS raised a prescription for this and took it to Banbury Heights on 06/07/20 at 16:15. On arrival at Banbury Heights, the DLS was made aware of an emergency with RN. RN appeared pale and drowsy, clinically no change in her observations but she had a distended abdomen and it was tender. She requested to use the toilet, where she had her bowels opened and black tarry stools were seen. The DLS recommended the Banbury Heights staff contact 999 and request an ambulance, this was called and she was transported to EAU at 17:00.
06 July 2020	Care Provider notes	On the day of her hospital admission, she had complained of feeling unwell with indigestion at approximately 11am. Gaviscon was administered with good effect and the discharge coordinator contacted for a review of acid reflux medication. At this time all her clinical observations were normal for her. For the rest of the day she appeared ok and was interacting with staff and other residents. She was eating and drinking throughout the day. At approximately 16.31 on contact with staff she appeared drowsy and pale, clinically there was no change in her observations, she had abdominal discomfort and on examination it was distended and tender, she requested to go to the bathroom and she opened her bowels, black stools were seen. 999 was called and emergency assistance summoned, she was transferred to the hospital at approx 17.00.

Date	Source	Notes
		Before she left the home she was seen eating and was able to converse clearly with her daughter. At the point of leaving the home there were no other concerns.
06 July 2020	OUH information	Record of Discussion - (DNACPR) Discussion between Doctor and Sister - explained severity of illness has had a large bleed, giving blood and fluids and are planning on looking into stomach to find out what has caused this. Discussed that in the event of deterioration CPR may be unlikely to work and if output was possible then quality of life may decline from the current baseline. Rhonda's Sister reports currently Rhonda requires lots of assistance, doesn't feel that Rhonda has a good quality of life currently. Rhonda's Sister is in full agreement that CPR would not be in her best interests. Agreed with Dr Ward that DNACPR would be put in place
06 July 2020	OUH - SJR	The patient complained of indigestion and feeling nauseous. Gaviscon was given with good effect and the DLN was contacted to review the acid reflux medication. The DLN informed Banbury Heights she was in the process of speaking to the Medical team about an alternative PPI. The DLN discussed with the Medical SpR in EAU, informing him of the patient's history, active medication and discontinued medication from previous admission. In view of the recent low sodium level, the Med SpR suggested starting Famotidine 20mg once daily at night as a safer alternative to Omeprazole as it does not pose the same risk to kidney function. The DLN raised a prescription for this and took it to Banbury Heights on 06/07/20 at 16:15. On arrival at Banbury Heights, the DLN was made aware of an emergency with the patient. The nurse was allowed to review the patient and noted a distended abdomen. The DLN Sister recommended the Banbury Heights staff contact 999 and request an ambulance and the patient was transported to EAU HH at 17:00
07 July 2020	OUH information	Patient had been admitted to EAU from ED. Patients sister was not with her on arrival but arrived later and stayed with her until sometime before midnight, on agreement with ward co-ordinator. She was stable on admission. Asking for water, sips given with assistance after checked with Medics who said she can have sips until 04:00. Reviewed by medics and to have a further 2 units of blood. 3rd unit commenced at 00:00; clinical observations checked but patient was very agitated, reaching out with her hands, trying to say words but they were not making sense and she was cool to the touch, clammy and the bed sheets were soaked from sweat. Co-ordinator called to review and doctor called.

Date	Source	Notes
		She was given IV paracetamol and was able to take oramorph; she was able to say 'help me' and voice that her tummy was hurting. After the oramorph she settled and became less agitated. We are able to change her pad as it was wet; no bowel motion, changed her sheets and changed her into a hospital gown. 4th unit of blood commenced and doctor asked for family/NOK Rhonda's Sister to be called at approx 01:05. Bloods were taken and sent to the lab along with a VBG. Rhonda's Sister arrived at approx 01.35 and has been spoken to by medics and is aware prognoses is not good for her sister. Patient is not responding to voice, her breathing has become more laboured. Rhonda's Sister remains sitting with patient. 07/07/2020 at 05:31 attended Rhonda as she was shouting out in pain, administered morphine. Medical registrar also present. Rhonda was clearly approaching end of life and after confirmation from medical registrar observation machine was turned off and Rhonda passed away. Rhonda's Sister stayed with her sister until the end and a little longer after she had passed.

Safeguarding Concerns

Rhonda's Sister has raised serious concerns that resulted in a Section 42 inquiry. Rhonda's Sister raised a safeguarding referral on the 7th of July (the day of her sister's death). A supporting statement was received on 23rd July 2020. The concerns raised within the report essentially allege that the care, treatment and concerns of Rhonda Nicol and her sister Rhonda's Sister failed to be addressed or met adequately during her time at Banbury Heights, hospital hub bed and as a result in the week leading up to her death she suffered significant avoidable and unnecessary pain and distress as a result.

The concerns raised in her report included the following:

A. Concern that there may have been poor communication between the multidisciplinary team prior to and during Rhonda's stay at Banbury Heights. The MDT for Rhonda comprising of social care professionals, nurses/staff at Banbury Heights and the Short Stay Hub Team (SSHB) team providing clinical cover.
B. That Sister fully understood and accepted that pain killers and anti-inflammatories would be removed during the two week period following transfer from hospital to Banbury Heights, to allow full and effective completion of the two week course of anti-biotics to treat a UTI (Sister reports completed one week after transfer to Banbury Heights). However Sister alleges that she also conveyed continually and repeatedly to MDT professionals thereafter at Banbury Heights that her sister Rhonda should resume pain-killers as it had caused no contra-indications in the past and

asked for this to be re-instated and the covering practitioner informed, but her requests ignored/not actioned.

C. That her sister Rhonda was in excruciating pain for days prior to her death, despite both she and Rhonda highlighting concern, therefore not listened to or treated appropriately.
D. On admission from Banbury Heights to Hospital on the 6 th of July it is reported that Sister spoke with admitting consultant. Sister states that the admitting consultant had deep concerns about the lack of continuity of care prior to Rhonda being admitted to the Horton. Sister stated that 'the dr told me, and he was happy for me to relay his thoughts' , that he and two other senior colleagues, a gastric consultant and an anaesthetist, had also expressed deep concern during the handover of shift after Rhonda had died that she had clearly not been listened to in her last few days.
E. That Sister visited Banbury Heights care home three times the week before Rhonda passed away and was concerned about her deteriorating health. Sister reports that she asked the care home to speak with the hospital hub team to request that Rhonda be seen by a doctor and was told on each occasion was told that the care home would do this but (she alleges) didn't.
F. Sister alleges that in the Saturday before Rhonda was taken into hospital she knocked on the door at Banbury Heights and was informed that 'everything was calm, Rhonda was fine and the door was shut in her face.. Rhonda was admitted to Hospital on the Monday.
G. It is alleged by Sister that Rhonda relayed to her before her death that she was told that she was told by care home staff that she had been pressing the call bell too much, resulting in her reluctance to use it and not calling out when needed:

It is expected that with follow-up of the recommendations, there will be, as Rhonda's Sister hopes, less incidences where users of the service, or relatives who are disappointed with the care received. More robust systems in place will enable the likelihood of this happening again to lessen.

Additional comments from Rhonda's Sister

"I have said throughout this enquiry that Covid 19 should not have made any difference to the care Rhonda received but this excuse has been used many times by the care home and indeed the hospital hub unit. If a doctor from the Horton Hub Unit was not allowed to visit the home during Covid 19 and lockdown, alternative measures should have been put in place to ensure that Rhonda was seen by the appointed home doctor. If that had happened, she would not have been made to endure weeks of agonising pain. This was something I queried several times when I was told by Duty Nurses they would have to ring and ask the Hub Unit doctor, when I queried her state of health and meds....or lack of them. Each time I was told, "no, she is under the care of The Horton Hub Unit", so cannot be seen by our visiting Dr.....how ridiculous!

Omitted from BHCH reporting is the fact that I was telephoned by the Duty Nurse when the paramedics had been called and asked to talk to Rhonda on the phone to try to calm her while the paramedics were in the room. I also spoke to one of the paramedics who advised me Rhonda was not at all well and advised me of the procedure to follow to hopefully be able to be with Rhonda at the hospital on arrival. I spoke with Rhonda, promised and reassured her I would be with her at the hospital and managed to calm her quite a bit. At this stage she still understood what I was saying to her. By the time I did see Rhonda just an hour or so later, she

had been admitted, crashed, and had been moved to the ITU. From that point, Rhonda was aware I think that I was with her but could not converse really. The Duty Nurse who rang me at BHCH to alert me to the fact the paramedics were there, said to me "we did not want to call an ambulance any sooner as I remembered how distressed and disorientated Rhonda was the last time when she arrived by ambulance". On hindsight, I believe this statement was made to me because at last they realised just how ill Rhonda was..... panic had set in.

Rhonda was not eating or drinking normally, or conversing normally during the last few days -they are lying. When I went to get her some lunch (to try to get her to eat in her room) on the Friday prior to her death, she refused it, bar a couple of spoonful's. The carers serving the food said "she has hardly eaten anything for days". I managed to get her to eat just a couple of spoons of mashed potato. The reporting to your enquiry on her health and welfare by the home is incorrect. The Carers also said she was staying in bed much of the time and not wanting to go into the day room. I think this version of events fits more with the GRADE 3 bed sore found on Rhonda's buttock by The Horton Hospital when she was admitted on 6th July. My visits to BHCH should and could have been verified by them as, due to Covid restrictions, strict appointments for visits had to be made by the secretary....THEY SHOULD HAVE RECORDS ACCORDINGLY!!

To this day I can remember and could easily identify the Duty Nurse that opened and closed the door to me on that Saturday, two days prior to Rhonda's death and the work rota should identify exactly who was on duty that day, late morning. When I handed the nurse the tv times magazine I had taken for Rhonda, "I said please make sure you give it to her, she loves looking at the pictures and reading bits, tell her her sister dropped it off and give her my love". ... When I rang Rhonda on her mobile phone that afternoon, I asked her if she was happy to see her magazine. She said she had not received it. I told her it was in a big white envelope....."oh, I can see something on a chair over by the door"..... How difficult would it have been to take it to Rhonda, put it in her hand and say her sister had brought it for her and give her my love!!? This, especially as Rhonda's mobility, being so much worse, would have made it difficult for her to get to the other side of the room to pick it up.

Responding to the Safeguarding Concern

Below are extracts from the Section 42 investigation conducted by Oxfordshire County Council's Adult Safeguarding Team. As with the chronology, this is not an analysis of the Section 42 itself but a record of what was concluded within the investigation.

A) Concern that there may have been poor communication between the multidisciplinary team prior to and during Rhonda's stay at Banbury Heights. The MDT for Rhonda comprising of social care professionals, nurses/staff at Banbury Heights and the Short Stay Hub Team (SSHB) team providing clinical cover - **This allegation was partially upheld**

Although there were regular MDT meetings, weekly on a Tuesday either in Banbury Heights or via M.S Teams, the focus was about Rhonda's social circumstances and health history leading to admission to the care home. Other areas covered were Rhonda's immediate needs I.E. continence

and mobility and ongoing discussions about her remaining at Banbury Heights in her best interests.

Outside of the meetings there is evidence of communication between the home and the discharge liaison nurse. The Hub team were providing the oversight for Rhonda's clinical care but would be reliant on the care home staff consulting with them as needed for non-urgent care.

The information provided indicates that communication took place. Details of ongoing daily concerns do not appear to have been discussed and this would have ensured a regularly changing plan was in place.

B) That Rhonda's Sister fully understood and accepted that pain killers and anti-inflammatories would be removed during the two week period following transfer from hospital to Banbury Heights, to allow full and effective completion of the two week course of anti-biotics to treat a UTI (Rhonda's Sister reports completed one week after transfer to Banbury Heights). However Rhonda's Sister alleges that she also conveyed continually and repeatedly to MDT professionals thereafter at Banbury Heights that her sister Rhonda should resume pain-killers as it had caused no contra-indications in the past and asked for this to be re-instated and the covering practitioner informed, but her requests ignored/not actioned. - **This allegation was partially upheld**

The information available would indicate that this issue was discussed between professionals but that there was on-going concern by Rhonda's Sister that Rhonda did not have sufficient pain relief.

The sister's email sent to the OCC involved team/worker on the 3rd of July citing 'deep concerns' was acknowledged. Unfortunately, the email was 'forwarded to an individual worker's email address within the Hub team and therefore not accessed until 6th July. This is a learning point for organisations that team emails should be used whenever possible.

The Omeprazole was never re-introduced, although it was considered. The nurse practitioner spoke to a medical practitioner on 6th July with background information including outcome of the recent sodium result which was low. The medical practitioner prescribed Famotidine instead. 'This was considered a safer alternative to Omeprazole as it does not pose the same risk to kidney function'. On her delivery of this medication to Rhonda, the nurse practitioner became aware of how acutely unwell Rhonda had become and an ambulance was called and resulted in her return to hospital.

C) That her sister Rhonda was in excruciating pain for days prior to her death, despite both Rhonda's Sister and Rhonda highlighting concern, therefore not listened to or treated appropriately. - **This allegation was upheld**

Following receipt of the email on the 25th of June from Rhonda's Sister, this was actioned with a request to obtain a blood sample to review sodium levels with a view to reinstating Omeprazole.

Rhonda's clinical presentation was changing, and observations appear to have been done without a baseline or clinical tool for any comparisons which would have picked up Rhonda's decline earlier, this could have been evidence by using a separate pain chart. There is evidence in daily notes of complaints of pain, followed up by administering pain relief.

The care plan on admission identified that Rhonda suffered from Osteoarthritis and was awaiting a hip operation, which could impact on her pain and mobility, physiotherapy assessment on 16th June indicates that Rhonda complained of pain in her hip, it is reported that her pain improved later on the 16th June and 17th June. Evidence therefore suggests that Rhonda was able to provide staff with information about where the source of the pain was. However, as her pain increased it may have been more difficult for her to express the exact location of pain.

D) On admission from Banbury Heights to Hospital on the 6th of July it is reported that Rhonda's Sister spoke with admitting consultant. Rhonda's Sister states that the admitting consultant had deep concerns about the lack of continuity of care prior to Rhonda being admitted to the Horton. Rhonda's Sister stated that *'the dr told me, and he was happy for me to relay his thoughts'* , that he and two other senior colleagues, a gastric consultant and an anaesthetist, had also expressed deep concern during the handover of shift after Rhonda had died that she had clearly not been listened to in her last few days - **This allegation was not upheld.**

There is no information received that confirms this statement within the record. However, there was the acknowledgement that Rhonda may have had difficulty expressing her discomfort and that the sister's concerns would need to be looked in to.

E) That Rhonda's Sister visited Banbury Heights care home three times the week before Rhonda passed away and was concerned about her deteriorating health. Rhonda's Sister reports that she asked the care home to speak with the hospital hub team to request that Rhonda be seen by a doctor and was told on each occasion that the care home would do this but (she alleges) didn't. & **F)** Rhonda's Sister alleges that in the week before Rhonda was taken into hospital (Saturday) she knocked on the door at Banbury Heights and was informed that 'everything was calm, Rhonda was fine and closed the door' - **This allegation was partially upheld.**

The frequency of the visits the week prior to Rhonda's death is not clear. Banbury Heights has provided evidence of a letter addressed to Rhonda's Sister explaining the Covid restrictions this was dated the 3.7.20. There is documentary evidence that two booked visits took place on the 29th of June and the 3rd of July.

The sister's reported unannounced visit on Saturday the 4th July where 'magazines were taken and the door to the building closed', the care home has no evidence to confirm this (i.e. no CCTV, or record within care notes).

In terms of the request for medical consultation, information confirms that the sister's concern raised on the booked visit on the 3rd July was not forwarded on to the hub team that day. Evidence indicates that the clinically changing need could have been identified in a timelier way.

G) - It is alleged by Rhonda's Sister that Rhonda relayed to her before her death that she was told by care home staff that she had been pressing the call bell too much, resulting in her reluctance to use it and not calling out when needed - **This allegation was not upheld.**

The call bell log was reviewed and confirmed frequent use by Rhonda. Daily recording notes in the home indicates that she was 'ok' when staff arrived in response to the call bell. Records indicate that Rhonda was a sociable, tactile person, responding well to reassurance of staff, which would appear from the daily records to have been given on a regular basis as they often recorded this on the daily notes.

There were fewer calls the day prior to her admission to hospital which could have been an indicator that Rhonda was becoming increasingly unwell. The Council's Adult Safeguarding Team were therefore unable to confirm that Rhonda was told she was pressing the call bell too frequently.

Findings
There are four key areas that need addressing.

There was a clear **failure to monitor and identify a deteriorating patient**. There were no pain charts, observations were irregular, there was no use of recognised warning tool and no evidence of use of the bowel charts.

The **overshadowing of perceived behaviour and known minor illnesses** potentially contributed to a failure to identify a deteriorating patient.

Patients in hub beds should receive the same level of nursing care and monitoring as in a hospital bed (e.g. daily observations which were in Rhonda's care plan). Nursing staff caring for patients in hub beds have a duty of care to ensure their patients are safe and that appropriate tools and guidance is used at all times (eg Restore2, pain charts, bowels charts).

Nursing home need to change practice for patients in hub beds to ensure there is regular monitoring of patients to ensure timely management of issues and prompt identification of a deteriorating patient. The health system to organise a series of learning sessions on the use of Restore2 tool.

There was a **lack of clarity between teams about who was responsible** for what and how to escalate concerns. Staff need clearer documented information about who is following up on which issues and that explicit processes are in place for sharing concerns, whether or not they are deemed valid or not.

Oxford University Hospitals (OUH) should develop guidance for care homes and the MDT re responsibilities for patients in hub beds. Clarity to be sought from commissioners regarding expectations of care and clinical oversight of patients in hub beds.

Rhonda's Sister did not feel her **concerns were being heard and valued** and **did not know how to escalate** these when nursing home staff did not value them. Family members & carers have invaluable knowledge of an individual and not considering these is short-sighted of organisations and potentially could lead to important information or opportunities being missed.

All organisations involved need to ensure that staff are listening to and valuing a family member's concerns. OUH need to develop a leaflet for individuals and their families about how to escalate concerns when the person is in a hub bed. The Vulnerable Adults Mortality Steering group should consider if this is needed for other settings.

Conclusion
Rhonda's final days were spent in unnecessary pain due to the issues outlined in this report. While professionals can never know the severity of that suffering, this must be taken as an opportunity for organisations to learn the lessons highlighted in this report to bring about positive change, ensuring all reasonable steps are taken to prevent this happening again to another person.

Learning & Action Plan
The action plan table below brings together the learning, the associated recommendations and the actions required to meet the recommendations.

The organisations have been proactive in addressing the concerns, sharing the learning and taking remedial action while the production of this report has been underway. The table outlines what has been done to date.

A learning point that was actioned prior to the production of this report concerned the medical provision for care homes. The provision of primary care cover for the hub beds in Banbury Heights has been commissioned with a new contract in place with the local GP practice. This learning led to commissioners checking the medical provision for all care homes and been assured that the Banbury Heights hub beds was the only gap identified, which has now been resolved.

As a SAR, the action plan will be monitored by the Performance, Information & Quality Assurance (PIQA) group of the Safeguarding Adults Board. This will ensure multi-agency challenge and scrutiny of the progress against the plan as well as offering quality assurance that the actions taken have actually resolved the issues identified throughout the report.

OSAB
Oxfordshire Safeguarding Adults Board

Learning & Action Plan

Identified Issue	Learning	Recommendation	Actions	Timescales
Lack of pain charts, use of recognised warning tool etc may have led to a missed opportunity to identify a deteriorating patient	Patients should be monitored according to their individualised care plan nursing staff should use professional judgement in assessing health needs	Nursing home's should: • ensure there is regular monitoring of patients **as per care plan** to ensure timely management of issues and prompt identification of a deteriorating patient • ensure that appropriate tools and guidance is used at all times (eg Restore2, pain charts, bowels charts) • ensure that nursing and care staff have up to date training to be able to spot a deteriorating patient	Commissioning of care homes/ nursing homes should check that facilities have: • Individualised care plans that include whether a patient should be routinely monitored • Are using appropriate tools (eg Restore2, pain charts, bowels charts) • That nursing staff have up to date training in how to spot a deteriorating patient	Completed in Nursing Home involved To be developed at system level
Overshadowing of perceived behaviour and known minor illnesses potentially contributed to a failure to identify a deteriorating patient	Staff must be aware that known physical or behavioural conditions can mask a serious underlying condition	• All individuals should have personalised care plans • Staff should be trained in caring for individuals with Learning disabilities • Staff should consider the interplay between existing known health and emotional conditions and new emerging risks	As above	

Identified Issue	Learning	Recommendation	Actions	Timescales
Lack of clarity between teams about who was responsible for what and how to escalate concerns	Staff need clearer documented information about who is following up on which issues •Staff need explicit processes for sharing of concerns, whether or not they are deemed valid or not	There must be clarity for staff, patients and family members about who is responsible for which areas of care and how and who to escalate concerns to.	• OUH to develop guidance for care homes and the MDT re responsibilities for patients in hub beds • Clarity to be sought from commissioners regarding expectations of care and clinical oversight of patients in hub beds.	In process Completed
R's sister did not feel her concerns were being heard and valued and did not know how to escalate these when nursing home staff did not value them.	Family members/ carers have invaluable knowledge of an individual and not considering these can lead to missed opportunities	• Settings must develop a personalised care plan for every individual in their care • Settings must work in partnership with family members	• OUH to develop leaflet for individuals and their families re how to escalate concerns when in a hub bed • To be monitored as part of contract meetings and CQC inspections	Ongoing