Trafford Strategic Safeguarding Board

SAFEGUARDING ADULT REVIEW

OVERVIEW REPORT CONCERNING

Mrs Green

Final report 8 August 2018

Independent Chair: David Hunter

Independent Author: Ged McManus

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1 Introduction

1.1 This Safeguarding Adult Review, hereinafter referred to as the Review, is about Mrs Green[1], a 95 year old lady who had been resident in Shawe House nursing home since 2010. She had a diagnosis of non-specified dementia with Parkinson's and did not have capacity to take decisions or consent to her care. She was largely unable to communicate effectively and most of her needs had to be anticipated by carers.

1.2 Mrs Green was married for many years and had two children, a son and a daughter. She had been widowed for twenty five years. She was described by her family to professionals as a social person who enjoyed attending; church, yoga and dancing prior to her diagnosis of dementia. Following the death of her husband she adjusted to her circumstances well and continued to socialise despite her loss. She had previously worked as a dinner lady in a local school.

1.3 Mrs Green's daughter became concerned about her mother's welfare living alone and as a result Mrs Green moved into sheltered accommodation near to her daughter. As her symptoms of dementia increased she moved into a care home but due to disease progression the care home found that they could no longer manage her needs. As a result, she moved into Shawe House nursing home in September 2010.

1.4 Mrs Green was described by staff at the home as 'wandersome'. She would often walk around the home and did not go to bed at night, preferring instead to sleep in a recliner chair in a lounge. Her family said that she had not gone to bed for many years.

1.5 In February 2016, Mrs Green suffered an ischaemic stroke[2]. This left her with weakness on her right side meaning that she was unable to support herself. She continued to live at Shawe House nursing home and was visited almost daily by her family.

1.6 From March 2016, professionals began to express concerns about the breakdown of Mrs Green's skin on her heels and later on her buttocks or sacrum. She continued to live in Shawe House nursing home, she was visited and treated by a number of professionals and recommendations for her care were made to Shawe House. She passed away on 3 February 2017. The cause of her death was recorded as 'Chest infection, infected sacral ulcer.' Parkinson's dementia contributed to her death. An inquest held on 24 February 2017, determined Mrs Green died from natural causes.

[1] Mrs Green is a pseudonym which is used to protect the identity of the subject of the review

[2] Ischaemic strokes are the most common type of stroke. They occur when a blood clot blocks the flow of blood and oxygen to the brain. These blood clots typically form in areas where the arteries have been narrowed or blocked over time by fatty deposits known as plaques.

2 Establishing the Safeguarding Adult Review

2.1 Decision to Hold a Safeguarding Adult Review

Section 44 Care Act 2014 Safeguarding Adults Reviews says:

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

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

(b) Condition 1 or 2 is met

(2) Condition 1 is met if-

(a)the adult has died, and

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

2.1.1 On 12 April 2017, the Chair of Trafford Strategic Safeguarding Board determined that the circumstances of Mrs Green's death met the criteria for a safeguarding adult review.

2.1.2 On 22 June 2017 David Hunter was appointed as the chair for the Review and was supported by Ged McManus who wrote the report. Neither has worked for any of the agencies contributing to the review and they were judged by the Chair of Trafford Strategic Safeguarding Board to have the experience necessary to conduct an independent and thorough enquiry. The first meeting of the Safeguarding Adult Review panel took place on 15 December 2017.

2.2 Panel members

Name	Position	Agency
Morgan Adams	Support officer	Trafford Metropolitan Borough Council
Karen Ahmed	Director of all age commissioning	Trafford Metropolitan Borough Council
Mark Albiston	Strategic lead Adult Social Care	Central neighbourhood Trafford Metropolitan Borough Council [Adult Social care]
Nikki Brown	Named nurse for Safeguarding families	Pennine Care NHS Foundation trust
Jacquie Coulton	Designated nurse Safeguarding Adults	Trafford Clinical Commissioning Group

Anne Marie Jones	Chief Executive	Age UK Trafford
Sally Kass	Clinical lead continuing health care	Trafford Clinical Commissioning Group
Andy Latham	Chief officer	Health Watch Trafford
Sarah Owen	Named nurse Adult safeguarding	Manchester University NHS Foundation Trust
Zyla Graham	Detective Inspector	Greater Manchester Police
Alison Troisi	Detective Sergeant	Greater Manchester Police
Debbie Ward	Head of nursing - safeguarding	Manchester University NHS Foundation Trust
Sophie Triantaffilou	Board manager	Trafford Strategic Safeguarding Board
Ged McManus	Author	Independent
David Hunter	Chair	Independent

2.3 Agencies contributing information to the review

Trafford Metropolitan Borough Council Adult Social Care

General Practitioner

Trafford Clinical Commissioning Group Continuing Health Care

Pennine Care NHS Foundation Trust [Tissue Viability Nurses]

Manchester University NHS Foundation Trust

Greater Manchester Police

3 Terms of Reference

3.1 General

3.1.1 The safeguarding adult review needs to determine whether any learning can be gained from the way the agencies worked together prior to Mrs Green's death and how effective such working was.

3.2 Specific Terms

1. Which professionals, including clinicians, had contact with Mrs Green?

    a. The time and date of the contact
    b. The nature of the contact

2. What indicators of abuse or neglect, did the professional[s] identify?

3. Were there any opportunities missed to raise a safeguarding alert and hold a strategy meeting?

4. Were any concerns raised about the quality of care provided in nursing home 1.

5. What did agencies do about any concerns raised?

6. Did the Nursing Home, Local Authority and the CCG provide the CQC with accurate and timely information around the quality and safety of the care provision within the home to enable the regulator to fulfil their primary function?

7. What support was offered to the nursing home from primary care and community services?

8. How did NHS commissioners, Adult Social Care and Care Quality Commission act to monitor the quality of care provided and support improvement? Have any changes been sustained?

9. How were the views of nursing home residents and their relatives taken into account by

    a. The nursing home.
    b. NHS commissioners, Adult Social Care and Care Quality Commission.
    c. The multi-agency quality management process

10. How effective were the multi-agencies in affecting and change within this provider, were any changes sustained by the home?

3.3 Time Period under Review

From 1 January 2015 to date of Mrs Green's death in hospital on 3 February 2017

4 Notable events

Set out in the following table are brief details of the notable events identified by the review panel. They are listed without commentary. The analysis of the events appears in Section 5.

Date	Event
27/5/15	The manager of Shawe House requested an urgent and standard authorisation for Deprivation of Liberty Safeguards [DoLS] regarding Mrs Green. This followed an examination by a consultant psychiatrist which concluded that Mrs Green was experiencing dementia and lacked mental capacity.

10/6/15	A Best Interests Assessor carried out an assessment which concluded that Mrs Green should be deprived of her liberty in her best interests. During the assessment her son raised a concern that it was absolutely necessary for the right staffing levels to be in place to care for Mrs Green. The BIA placed the following condition on the DoLS. 'The managing authority must formally request a care management review from Adult Social Care as the last identified review was in 2013'.
7/12/15	A reviewing officer from Adult Social Care visited Mrs Green to conduct a review of her placement in Shawe House. Mrs Green's needs appeared to be being met. The needs were documented as • Assistance with personal care and hygiene • Full assistance to eat and drink. Soft diet • Regular monitoring of skin and assistance to change position due to high risk of breakdown. Skin currently intact but has recurring red sore area on sacrum. Had small skin break on sacrum 17/6/15 and 7/8/15. • Continence care due to being doubly incontinent • Full assistance with all tasks as unable to express needs • Medication to be administered Mrs Green was unable to take part in the review. Her son raised a concern regarding the cleanliness of his mother's fingernails and reiterated the importance of staffing levels to meet her care needs. There was evidence that she had lost weight and it was agreed with the Nursing Home manager that Mrs Green would commence on Complan for two weeks and if there was further weight loss a referral to a dietician would be made. The outcome of the review was that the placement was to continue with a further review in twelve months.
23/2/16	Mrs Green suffered an ischaemic stroke[3] and was admitted to hospital.
24/2/16	Following assessment in hospital Mrs Green returned to Shawe House nursing home. The stroke caused a significant loss of function and weakness on Mrs Green's right side. It was necessary to use a full body hoist with two staff members in order to move her.
25/2/16	Mrs Green was seen by a GP and a "Do Not Attempt Cardio Pulmonary Resuscitation" decision was recorded.
7/3/16	Mrs Green was seen by a nurse practitioner [GP] who attended to cellulitis[4] in her arm. The nurse practitioner noted the start of skin breakdown on her heels and supplied appropriate dressings.

21/3/16	Mrs Green seen by a GP regarding a urinary tract infection. Antibiotics were prescribed.
21/3/16	Mrs Green's daughter contacted Adult Social Care requesting a review of the services provided to her mother as her care needs had increased since the last review.
13/4/16	Mrs Green was seen by a locum GP. The skin on her heels continued to breakdown despite dressings being used and a referral to a Tissue Viability Nurse [TVN] was made. Small breaks in the skin on Mrs Green's buttocks were also noted. The referral was rejected by the Single Point of Access service as District Nurses do not visit Nursing Homes.
15/4/16	A social worker visited Mrs Green and identified that her care needs had increased. Her daughter was given advice to request that a Continuing Heath Care checklist be completed.
18/4/16	A social worker carried out a mental capacity assessment in relation to the decision for an assessment of Continuing Health Care. Mrs Green lacked capacity to make this decision.
22/4/16	Mrs Green had an assessment by a podiatrist due to pressure sores developing on her heels. She was seen regularly by a podiatrist until January 2017 and the condition of her heels improved significantly.
27/5/16	Mrs Green was seen by a GP who noted that she had a pressure sore on her buttock. A second referral to a Tissue Viability Nurse was made.
8/6/16	A Tissue Viability Nurse spoke to staff at Shaw House. It was explained that Mrs Green was nursed in a chair 24 hours a day. The TVN highlighted the risks of this and recommended a discussion with family to highlight the risks.
13/6/16	Staff at Shawe House spoke to Mrs Green's daughter regarding Mrs Green being nursed in a bed rather than a chair. Her daughter requested one to one care if her mother was in bed as she had not gone to bed for many years.
13/6/16	Mrs Green's daughter contacted a social worker to report her mother's declining medical situation. She raised concerns regarding the bed rest recommended by the TVN saying that Mrs Green may become agitated and tended to cough when in bed. Mrs Green's daughter further said that she

[4] Cellulitis is a bacterial infection of the skin and tissues beneath the skin. Staphylococcus and Streptococcus are the types of bacteria that are usually responsible for cellulitis, although many types of bacteria can cause the condition.

	felt her mother needed one to one support if on bedrest.
14/6/16	A Tissue Viability Nurse visited Mrs Green whose skin appeared to be intact and nursing home staff reported that her condition had improved since the GP referral. The TVN assessed that Mrs Green was at high risk of pressure ulceration due to low body weight, prominent bone structure and an inability to reposition as she spent all day [24 hours a day] in the same chair. This had been agreed between Mrs Green's family and the nursing home. The TVN spoke to Mrs Green's son and outlined her concerns. He agreed to try bed rest periods when the family could be present.
17/6/16	Between this date and 26/6/16, Mrs Green was facilitated to have bed rest during family visits.
22/6/16	Mrs Green sustained an injury to her right hand whilst being moved in a wheelchair. Her daughter telephoned a social worker to report the incident.
24/6/16	A Safeguarding Adult referral dated 22/6/16 and completed by Shawe House staff was received by Adult Social Care reporting the injury to Mrs Green's hand sustained on 22/6/16. This was recorded as a safeguarding enquiry[5] under Section 42 of the Care Act 2014 and allocated to the manager of Shawe House for investigation.
26/6/16	Following a choking episode during a family visit Mrs Green was returned to being nursed in a chair 24 hours a day.
28/6/16	The manager of Shawe House requested an urgent and standard authorisation for Deprivation of Liberty Safeguards [DoLS] regarding Mrs Green.
5/7/16	A Multi-Disciplinary Team meeting including Mrs Green's son took place to review her care needs. It was found that she was eligible for Continuing Health Care [CHC] funding.
21/7/16	Adult Social Care received the investigation report from the manager of Shawe House regarding the injury that Mrs Green sustained to her hand on 22/6/16. The outcome was that staff confirmed that they had witnessed the incident. Actions had been taken to remind junior staff of techniques required when transferring Mrs Green and supervisory staff had been reminded of their responsibilities. The safeguarding concern was substantiated. Shawe House were asked for an updated risk assessment and manual handling plan but there is no evidence that this was received.

[5] An enquiry is any action that is taken [or instigated] by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

29/7/16	Mrs Green's daughter spoke to a social worker on the telephone and raised concerns about the care her mother was receiving in relation to access to medical treatment and the organisation of the home. Mrs Green's daughter said that she wished to move her mother and the social worker sent her a list of suitable homes.
8/8/16	Mrs Green's case was closed to Adult Social Care as the Clinical Commissioning Group Continuing Health Care team would now oversee her placement. Mrs Green's daughter as informed.
7/9/16	Mrs Green was seen by a GP. She was noted to have a tachycardia[6] and was generally lethargic.
19/10/16	A Continuing Health Care funding review took place. This highlighted that Mrs Green was not having bedrest as had been advised by TVN's. Mrs Green was observed sat in a recliner chair leaning towards her right hand side. She had poor head and neck control and her daughter supported her mother's forehead to control the raising of her head. There was no clinical reason for Mrs Green to remain in a chair twenty four hours a day.
9/11/16	Mrs Green's daughter spoke to the CCG clinical lead for Continuing Health Care. She did not wish her mother to use a bed as she did not believe her mother would sleep. She did not accept that her mother was at risk of falling out of the chair and felt that the use of a hoist was undignified. It was clarified that the family did not hold a Power of Attorney for health and welfare. Mrs Green's daughter was advised that based on a clinical assessment it was inappropriate for her mother to remain in a chair twenty four hours a day. It was thought that a 'best interests' decision may have to be made using an Independent Mental Capacity Assessor to represent Mrs Green.
11/11/16	The CCG clinical lead attended for the meeting as arranged and met the nursing home manager. Mrs Green's family did not attend as they had now reluctantly accepted the rationale for bedrest.
15/11/16	A Best Interests Assessor carried out an assessment; Mrs Green was also seen by a consultant psychiatrist who concluded that she had a mental health condition and it was unlikely her condition would be impacted as a result of being deprived of her liberty.
25/11/16	Mrs Green was seen by a GP who noted further areas of skin breakdown on the buttocks. A 'best interests' decision was made to nurse Mrs Green in bed with meals to be given in a recliner chair in the bedroom. Her family agreed to this.

[6] Tachycardia, also called tachyarrhythmia, is a heart rate that exceeds the normal resting rate. In general, a resting heart rate over 100 beats per minute is accepted as tachycardia in adults.

28/11/16	The CCG clinical lead for Continuing Health Care reviewed Mrs Green's sleeping arrangements with the manager at Shawe House. Mrs Green was now going to bed at night and being nursed on an alternating airflow mattress.
20/12/16	Shawe House made a referral to TVN team due to a deterioration of the wound to Mrs Green's right buttock.
21/12/16	TVN contacted Shawe House by telephone and spoke to the duty nurse. Advice was given regarding managing Mrs Green's condition.
22/12/16	TVN contacted Shawe House by telephone and spoke to the duty nurse. Advice was given regarding managing Mrs Green's condition.
23/12/16	TVN contacted Shawe House by telephone and spoke to the duty nurse. Advice was given regarding managing Mrs Green's condition. TVN was assured by duty nurse of the care being given and advice on managing Mrs Green's condition was reiterated.
28/12/16	TVN contacted Shawe House by telephone. Duty nurse was concerned that Mrs Green's wound may be infected and was awaiting a GP visit.
29/12/16	TVN visited Mrs Green. On examination she had an unstageable pressure ulcer, there were no signs of infection but given her double incontinence there was a high risk of infection. The TVN noted that Mrs Green's seating cushion and pump were visibly dirty with urine present and taps in the bedroom were faulty hindering hand washing. Detailed advice to rectify the faults and manage Mrs Green's condition was given.
29/12/16	Following the visit to Shaw House to see Mrs Green the TVN made a Safeguarding Adult referral.
6/1/17	TVN contacted Shawe House by telephone. Duty nurse stated Mrs Green's pressure ulcer was showing signs of improvement, the pressure cushion had been renewed and there were currently no additional concerns.
11/1/17	Adult Social Care screened the Safeguarding Adult referral of 29 December 2016 and recorded it as a Safeguarding enquiry under Section 42 of the Care Act 2014. It was allocated to a community social work team. The Care Quality Commission and in house commissioning team were notified. The senior practitioner of the community social work team sent the information to the Clinical Commissioning Group and TVN team asking how they wished to proceed as the concerns were health related.
11/1/17	TVN contacted Shawe House by telephone. In addition to previous advice the TVN advised that an adhesive secondary dressing should be applied.

16/1/17	Shawe House staff contacted TVN reporting that Mrs Green's wound appeared to have deteriorated.
17/1/17	TVN visited Mrs Green. Her pressure ulcer had increased in size. It was assessed as an unstageable pressure ulcer that was malodourous. It was noted that the air flow cushion had been changed but needed to be cleaned. It was also noted that the faulty taps had been fixed.
18/1/17	Mrs Green seen by a GP following a concern being raised the previous day by a TVN about a potentially infected pressure sore. Mrs Green was prescribed anti-biotics and the GP assessed her as otherwise well. The TVN thought that Mrs Green should be in hospital, but her daughter wished her to stay at Shawe House.
18/1/17	TVN spoke to staff at Shaw House regarding Mrs Green whilst visiting other patients. Advice was given that Mrs Green should be nursed in bed 24/7. Staff stated that her daughter would object to this. Shawe House staff were advised to arrange a best interests meeting to include the family, GP and TVN.
23/1/17	Mrs Green was seen by a TVN. The pressure ulcer had increased in size and was showing signs of infection. She was being nursed in bed for most of the time and was sitting out of bed for thirty minute meal times. Previous advice was reiterated.
27/1/17	Mrs Green was seen by a GP and noted to have grade 4 pressure sores on her buttocks. She was to be regularly assessed by the TVN and continued on antibiotics. Her daughter said that she wanted her mother to stay at Shawe House.
31/1/17	Mrs Green was seen by a GP and an end of life care plan developed. Blood tests showed significant infection and deranged renal function. The GP spoke with her family and it was agreed that she should stay at Shawe House.
1/2/17	TVN visited Mrs Green. The Nursing home staff had failed to apply the antimicrobial dressing as prescribed and the outer secondary dressing had not been applied. The wound was significantly deteriorated and malodourous. Staff said that the dressing had not been changed correctly as a bank nurse had been on duty.
1/2/17	Following the visit to Mrs Green the TVN made a Safeguarding Adult referral.
2/2/17	The safeguarding referral was received by Adult Social Care and recorded as a Safeguarding enquiry under Section 42 of the Care Act 2014. It was

	allocated to the same community social work team that held the previous Section 42 enquiry originating from the TVN visit to Mrs Green of 29/12/16.
3/2/17	The senior practitioner of the community social work team linked the two Section 42 enquiries. Communication took place with health colleagues and a professionals' meeting was to be organised.
3/2/17	Mrs Green passed away.
	The safeguarding concerns in the referral of 29/12/16 were substantiated. The outcome of the referral of 1/2/17 was inconclusive.

5 Analysis of notable events

5.1 Which professionals, including clinicians, had contact with Mrs Green?

a. The time and date of the contact
b. The nature of the contact

5.1.1 Mrs Green lived at Shawe House nursing home for seven years and was seen by many professionals in that time. The main professional contacts occurring during the timeframe of the review are detailed in section 4 of the report.

5.1.2 **General Practitioner**
Mrs Green's GP visited her at the nursing home as required. On 25 February 2016, a GP recorded a Do Not attempt Cardio Pulmonary Resuscitation" decision, this was soon after her return from hospital having suffered a stroke. During March and April 2016, Mrs Green was seen by a GP and nurse practitioner and treated for cellulitis and a urinary tract infection. On 7 March 2016, a nurse practitioner noted that the skin on Mrs Green's heels had started to break down. Despite treatment this continued and when seen by a locum GP on 13 April 2016, a referral to a podiatrist and Tissue Viability Nurse team was made.

5.1.3 Mrs Green was seen by a podiatrist on 22 April 2016 and regularly thereafter. The condition of her heels slowly improved over time and this element of her care was managed effectively.

5.1.4 The referral to the Tissue Viability Nurse team of 13 April 2016, was sent incorrectly to the district nurse team rather than the Tissue Viability Team and rejected as district nurses are not commissioned to visit care homes. On 27 May 2016, a GP examined Mrs Green and saw that she had developed a pressure sore on her buttock. A second referral was made to the Tissue Viability Nurse team.

5.1.5 Mrs Green continued to be seen for routine matters by her GP practice, she was prescribed antibiotics on a number of occasions. On 25 November 2016 a GP noted that

there were further areas of skin breakdown on Mrs Green's buttocks. As her medical condition deteriorated throughout December 2016 and early 2017, the GP continued to visit and prescribe antibiotics as required. On 31 January 2017, the GP recorded an end of life care plan as Mrs Green had a significant blood infection and deranged renal function. It was agreed with her family that Mrs Green should stay at Shaw House and not be admitted to hospital.

5.1.6 **Tissue Viability Nurses**

The first involvement of TVN's during the timeframe of the review was when a TVN telephoned Shawe House on 8 June 2016, to discuss Mrs Green's case after a referral had been received from her GP. The TVN immediately recognised the increased risk to Mrs Green of developing pressure sores because she was being nursed in a chair twenty four hours a day and asked Shawe House staff to discuss this with her family.

5.1.7 On 14 June 2016, a TVN visited and examined Mrs Green and saw that her skin appeared to be intact. Shawe House staff reported an improvement in her condition since the GP referral. The TVN spoke to her son and highlighted the high risk of her developing pressure sores because of her physical condition and because she was unable to reposition herself in the chair where she was nursed twenty four hours a day. Following this discussion Mrs Green's family agreed to try bedrest during the day time when they could visit. This was discontinued following a choking episode on 26 June 2016.

5.1.8 The next TVN involvement with Mrs Green was on 21 December 2016, following a referral from Shawe House. A TVN telephoned the nursing home and gave advice on managing Mrs Green's condition. This was followed up by further calls on 22 and 23 December 2017. It was emphasised during these calls that if her condition deteriorated then the TVN or GP should be contacted. On 28 December 2016 during a telephone call to the home a TVN was informed by a duty nurse that Mrs Green may have an infected pressure ulcer.

5.1.9 On 29 December 2016, a TVN visited and examined Mrs Green who was found to have an unstageable pressure ulcer [Full thickness tissue loss in which the actual depth of the ulcer is completely obscured by slough or eschar]. No infection was found to be present but the TVN was concerned by a number of aspects of Mrs Green's care. The seating cushion was dirty and contained urine and taps in the bedroom were faulty so that handwashing was difficult. The TVN left a detailed plan for staff to follow. After considering the issues raised during the visit the TVN submitted a safeguarding referral to Adult Social Care.

5.1.10 On 6 January 2017, a TVN contacted Shawe House to discuss Mrs Green and was told that the pressure ulcer showed signs of improvement and that the pressure cushion had been replaced. On 11 January 2017, in a further telephone call advice was given to apply an adhesive secondary dressing.

5.1.11 On 16 January 2017, Shawe House contacted the TVN team and said that Mrs Green's pressure ulcer appeared to have deteriorated. This resulted in a TVN visiting on 17 and 18 January 2017. The pressure sore was by now malodourous. The TVN advised that Mrs Green should be nursed in bed twenty four hours a day. It was thought that her daughter may object to this and the TVN suggested that a best interests meeting including her

family and GP should be arranged. Mrs Green was also seen by a GP who prescribed anti-biotics to treat the infected pressure sore.

5.1.12 On 23 January 2017, a TVN again visited Mrs Green. The pressure sore had increased in size and was still showing signs of infection. Mrs Green was by now being nursed in bed and only sitting out of bed for mealtimes. Previous advice regarding her care was reiterated.

5.1.13 On 1 February 2017, a TVN visited Mrs Green and saw that the pressure ulcer was significantly deteriorated and malodorous. [A GP had noted a grade 4 pressure ulcer on 27.1.17]. Nursing home staff had failed to apply the antimicrobial dressing as prescribed and the outer secondary dressing had not been applied. The TVN was told that this was because a bank nurse had been on duty overnight. Following this visit a further safeguarding referral was made by the TVN.

5.1.14 **CCG Continuing Health Care Team**

On 5 July 2016, a multi-disciplinary team was convened in order to assess Mrs Green's care needs and whether she qualified for continuing health care funding. It was noted that due to her current level of cognitive impairment, she was unable to contribute or meaningfully participate. Her son was however present and contributed to the meeting.

5.1.15 The review recorded that Mrs Green slept in a chair in the lounge and that this was long standing practice by her for the past twelve years, originally arising from anxiety. It was noted that regular pressure relief [by bed rest] had been recommended by the TVN. Her son said that this only happened if either he or his sister were present for the period of bed rest to offer reassurance. Mrs Green frequently experienced episodes of coughing within and outside mealtimes. This impacted on the length of time it took her to eat a meal which could be up to ninety minutes and had been exacerbated by the stroke in February 2016 which left her mouth weak and caused excessive salivation. It was assessed that Mrs Green was totally reliant on the skill, familiarity and knowledge of others to monitor and interpret presenting signs, symptoms and needs.

5.1.16 On 19 October 2016, a review of the continuing healthcare decision took place. This highlighted that Mrs Green was not having bedrest as had been recommended. As a result, Shawe House was asked to review her sleeping arrangements and provide bed rest. Her daughter disputed the recommendation and wished for her mother to continue to sleep in a chair. Following discussions with CCG staff she wrote to complain and threaten legal action if anything untoward happened to her mother. It was established that whilst there was a power of attorney in place for financial matters there was no POA in place regarding health and welfare.

5.1.17 Mrs Green's family did not attend the planned meeting of 11 November 2016. They had previously communicated with the nursing home manager that they reluctantly accepted the rationale for Mrs Green being nursed in bed.

5.1.18 Following the meeting of 11 November 2016, Mrs Green was put to bed at night. It was noted that she was sleeping in bed and appeared a little more alert during the daytime.

On 25 November 2016, following a GP visit a best interests decision was made to nurse Mrs Green in bed.

5.1.19 **Adult Social Care**

On 21 March 2016, Mrs Green's daughter contacted ASC as she considered that her mother's needs had increased since her last assessment and that Shawe House was not meeting them. This prompted a visit to Mrs Green by a social worker and her daughter was advised to request a continuing health care checklist. There was evidence to suggest that Mrs Green's needs were above what could be supported by the existing care package however there is no evidence of consideration of how Mrs Green's needs would be met whilst exploring the funding element of her care. An assessment of her mental capacity should have taken place with a Best Interests meeting to evidence decision making within the legal framework. There is no written evidence that this was considered. The visit appears to have focussed on the funding element of her care and did not take a holistic view. This visit was a missed opportunity to explore the issues in relation to Mrs Green's care which were being raised by her family. The social worker involved was a newly qualified social worker on the AYSE programme[7], whilst it could be suggested that an escalation to management could have taken place at this point the supervisor of a social worker on AYSE should take a proactive role in monitoring the work completed. There is no evidence that this happened in relation to this visit.

5.1.20 On 13 June 2016 Mrs Green's daughter contacted the allocated social worker. She was concerned that a TVN had recommended bedrest and felt that her mother needed one to one care if that was the case. There is no record of any action being taken or information being shared after this contact. This was a missed opportunity to look further into the concerns raised by Mrs Green's family.

5.1.21 On 22 June 2016, Mrs Green's daughter contacted the allocated social worker and reported that her mother had sustained a cut to her hand. She also told the social worker that she was concerned about the level of care being provided to her mother. No action was taken as a result of this telephone call. The incident in which Mrs Green was injured was reported as a safeguarding referral by the clinical lead at Shawe House on 24 June 2016.

5.1.22 On 29 July 2016, Mrs Green's daughter contacted the allocated social worker regarding the quality of care at Shawe House, access to medical treatment and the organisation of the home. The social worker sent a list of other homes. Nothing further was done to explore the concerns raised. Information could have been shared with the ASC commissioning team or a safeguarding alert made. This was a missed opportunity.

5.2 **What indicators of abuse or neglect, did the professional[s] identify?**

[7] The ASYE is a twelve month, employer led programme of support and assessment against the Knowledge and Skills Statement for social workers in adult services. Participation in the ASYE supports newly qualified social workers (NQSWs) to consolidate their degree learning

5.2.1 In December 2015, a reviewing officer from Adult Social Care visited Mrs Green to conduct a review of her placement in Shawe House. Her needs appeared to be being met. Mrs Green's son raised a concern about the cleanliness of her fingernails although acknowledging that she may not wish to have them cleaned. Her son also said that his mother's care needs being met was dependent on the staffing levels of the home.

5.2.2 On 23 February 2016, Mrs Green suffered a stroke. Following assessment in hospital she returned to Shawe House on 24 February 2016. The stroke left her with significant weakness on her right side, a weak mouth which lead to excessive drooling and limited control of her head and neck. Mrs Green was observed by professionals to be sat in her chair in a foetal position and was unable to reposition herself. This was a significant point in time when a review of her care plan should have led to changes in the way that her care needs were met. Instead she continued to be nursed in the same way as prior to the stroke. The family's view that she should be nursed in a chair twenty four hours a day was given precedence over the clinical need to manage the risk of Mrs Green developing pressure sores in a different way than had been done prior to the stroke.

5.2.3 The Department of Health and Social Care document 'Safeguarding Adults Protocol – Pressure Ulcers and the interface with a Safeguarding Enquiry' [January 2018] contains the following information which appears to be highly relevant to Mrs Green's case.

5.2.4 'Skin damage has a number of causes, pressure ulcers are caused by sustained pressure, including pressure associated with shear, where the person's individual tissue tolerance and susceptibility to pressure has been overcome. External shear forces occur due to movement of the skin surface relative to a supporting surface, such as when an individual slides down the bed when in a semi-recumbent sitting position. This results in distortion of the soft tissue layers, including the blood vessels. Shear commonly occurs at the sacrum and heels. Internal shear forces can occur within the soft tissue layers due to both compression and shear forces'.

5.2.5 'Shear is an applied force that tends to cause an opposite but parallel sliding motion of the planes of an object. Such motions cause tissues and blood vessels to move in such a way that blood flow may be interrupted, placing the patient at risk of pressure ulcers. **An example of a shearing force is seen when a patient slumps in a chair, the skin around the buttocks is stretched by the movement and interferes with circulation.** (Medical Dictionary 2015)'.

5.2.6 On 7 March 2016, only two weeks after Mrs Green suffered a stroke, a nurse practitioner noted the beginning of skin breakdown on Mrs Green's heels. Whilst this was treated medically it was an early warning sign which was not recognised.

5.2.7 On 27 May 2016, a GP examined Mrs Green and noted a pressure sore on her buttock. This resulted in the first involvement of a Tissue Viability Nurse on 8 June 2016. During a telephone call the TVN immediately recognised the risk to Mrs Green of being in a chair twenty four hours a day and made a recommendation that she should have bed rest.

Whilst the Department of Health and Social Care document quoted was not published until January 2018, the risks of shear caused by being slumped in a chair were clearly known to the TVN. The panel thought that these risks should have been known to qualified nurses at Shawe House nursing home. If they were known they were not acted upon. This is a learning point.

5.2.8 On 22 June 2016, Mrs Green sustained an injury to her right hand whilst being transferred in a wheel chair. This was appropriately reported as a safeguarding alert by Shawe House.

5.2.9 On 19 October 2016, a review of Mrs Green's Continuing Health Care funding highlighted that she was not having bedrest as had previously been recommended. She had been tried on bed rest for nine days in June 2016, but this had been discontinued after a choking episode, following the wishes of her family who were resistant to the idea of their mother being nursed in bed. They firmly believed her best interests were served by sleeping in a chair as she had done for many years. The clinical view was that it was not in Mrs Green's best interests. This conflict between professionals and family over the best interests of a lady who did not have mental capacity to make her own decisions was difficult and challenging for all involved. However, her family did not have a power of attorney for health and wellbeing and therefore did not have the legal authority to make those decisions for her. The panel felt that an earlier discussion around these issues between the Nursing Home management and family would have been beneficial. The Nursing Home may have needed the support of other professionals to do this given the strong views of the family. This is a learning point.

5.2.10 On 25 November 2016, a GP noted further areas of skin breakdown on Mrs Green's buttocks. This prompted a best interests decision for her to be nursed in bed with which her family agreed. On 20 December 2016, Shawe House sought the assistance of the Tissue Viability Nurse team. The panel wondered if there was a missed opportunity on 25 November 2016, to obtain earlier specialist help for Mrs Green.

5.2.11 Between 21 December and 28 December 2016, TVN's spoke to Shawe House staff on a number of occasions to offer advice and guidance on managing Mrs Green's pressure sore. On 29 December 2016 a TVN visited Mrs Green and was concerned enough about what she saw to raise a safeguarding alert. Her seating cushion and pump were visibly dirty with urine present, taps were faulty hindering hand washing.

5.2.12 From 29 December 2016, until 1 February 2017, TVN's were regularly in contact with Shawe House to offer advice on managing Mrs Green's condition. Despite this advice her medical condition continued to deteriorate and there was evidence that the pressure sore had become infected. On 1 February a TVN visited Mrs Green and found that advice in relation to dressings had not been followed and the wound was significantly deteriorated

and malodourous. A further safeguarding alert was made.

5.3 Were there any opportunities missed to raise a safeguarding alert and hold a strategy meeting?

5.3.1 It should be recognised that three safeguarding alerts in relation to Mrs Green were made
24 June 2016 relating to an incident 22 June 2016 – made by Shawe House
29 December 2017 – made by TVN
1 February 2017 – made by TVN

These will be further analysed at 5.5

5.3.2 On 10 June 2015 following an application for DoLs, a Best Interests Assessor placed the following condition on the DoLs. 'The managing authority must formally request a care management review from Adult Social Care as the last identified review was in 2013' [The review should be annual]. Mrs Green's son had raised concerns that the family were having to provide support with feeding to ensure adequate nutrition and that the correct level of staff needed to be in place to ensure their mother's care needs were met. The panel thought that whilst this would have been useful intelligence for ASC it did not on balance reach the threshold for a safeguarding alert.

5.3.3 On 7 December 2015, a reviewing officer concluded that Mrs Green's care needs were being met. It was noted that her fingernails were very dirty and her son reiterated concerns about staffing levels. The panel thought that whilst this would have been useful intelligence for ASC and commissioning it did not on balance reach the threshold for a safeguarding alert.

5.3.4 On 21 March 2016, Mrs Green's daughter contacted ASC, concerned that her mother's care needs had increased as a result of the stroke. Her daughter did not feel that Shawe House was meeting her mother's needs and that daily family support was required to ensure adequate nutrition. The case was allocated to a community social work team. The panel thought that whilst this would have been useful intelligence for ASC it did not on balance reach the threshold for a safeguarding alert.

5.3.5 On 22 June 2016, Mrs Green's daughter contacted ASC and spoke to the allocated social worker. She reported that Mrs Green's hand had been injured whilst being transferred in a wheel chair. There is no record of anything being done with this information and a safeguarding alert should have been raised. In the event the clinical lead at Shawe House raised a safeguarding alert.

5.3.6 The safeguarding alert regarding the incident of 22 June 2016 caused ASC to trigger an enquiry under Section 42 of the Care Act 2014. The enquiry was allocated to the Nursing Home manager for investigation. A number of previous concerns had been raised about Mrs Green's care at this time and the decision to allocate the investigation to the Nursing Home manager meant that an opportunity was lost for a multi-agency strategy meeting to be held.

5.3.7 On 29 July 2016, Mrs Green's daughter spoke to the allocated social worker and raised concerns about her mother's access to medical treatment, the organisation of the nursing home and the care she was receiving. Given the number of previous concerns raised and the section 42 enquiry which had by now been substantiated the panel felt that this was a missed opportunity to raise a safeguarding alert.

5.4 Were any concerns raised about the quality of care provided in nursing home 1

5.4.1 Mrs Green's family raised their concerns about the care she was receiving on a number of occasions. Their concerns were around their mother receiving adequate nutrition without the family feeding her, staffing levels and that following her stroke the level of care provided no longer met her needs. The family considered moving her to another home and on one occasion when they raised their concerns with a social worker were provided with a list of suitable homes. This information about a relative being unhappy with the care provided at Shawe House was not shared with, commissioning or the Joint Quality Improvement group.

5.4.2 TVN's raised their concerns about the quality of care provided in the home and the physical environment. During December 2016 and January 2017 when TVN involvement was at its most intensive two safeguarding alerts were raised, both of which related at least in part to perceived poor quality of care and failure to follow advice and guidance that had been given. Concerns in relation to the physical environment which could impact on care included faulty taps, overflowing bins and a lack of hand towels. Mrs Green's pressure cushion was dirty and had to be replaced.

5.4.3 It is of note that whilst TVN's appropriately raised these concerns other professionals who visited Mrs Green during this period for example GP's did not. The panel wondered whether there was an opportunity to raise awareness with GP's of the need to raise safeguarding alerts in such circumstances.

5.5 What did agencies do about any concerns raised?

5.5.1 The first safeguarding alert, raised because of an injury caused to Mrs Green's hand during a wheelchair transfer was allocated to the manager of Shawe House for investigation. The investigation appears to have been appropriate and was substantiated. Shawe House were asked for an updated risk assessment and manual handling plan by the allocated social worker who correctly followed up the investigation, but there is no evidence that this was received. The panel thought that given the general concerns that had been raised by this point in June 2016 this was a missed opportunity to involve multi agencies in reviewing Mrs Green's situation.

5.5.2 The second safeguarding alert, made by a TVN on 29 December 2016, was screened by ASC, recorded as a safeguarding enquiry under Section 42 of the Care Act 2014 and was allocated to a community social work team. The Care Quality Commission and in house ASC commissioning team were notified. The senior practitioner of the community social work team sent the information to the Clinical Commissioning Group and TVN team asking how they wished to proceed as the concerns were health related.

5.5.3 The third safeguarding alert made after a TVN visited Mrs Green on 1 February 2017, was received by Adult Social Care on 2 February 2017 and recorded as a Safeguarding enquiry under Section 42 of the Care Act 2014. It was allocated to the same community social work team that held the previous Section 42 enquiry originating from the TVN visit to Mrs Green of 29/12/16. The senior practitioner of the community social work team linked the two Section 42 enquiries. Communication took place with health colleagues and a professionals' meeting was to be organised to address the issues. Sadly, Mrs Green died on 3 February 2017, before any action took place. The TVN could have escalated the issues within their own organisation by raising the issues in supervision. It would have been an option to have called a strategy meeting

5.6 **Did the Care Home, Local Authority and the CCG provide the CQC with accurate and timely information around the quality and safety of the care provision within the home to enable the regulator to fulfil their primary function?**

5.6.1 Adult Social Care provided information to the CQC on three occasions:

- 07.07.2016: Information provided to the CQC regarding the injury to Mrs Green's hand sustained on 22 June 2016 and reported to ASC on 24 June 2016. There were time delays in two aspects.
- The information was reported to a social worker on 22 June 2016 and no action was taken.
- There was a time delay in the screening and processing of the information when it was received into ASC of ten working days.

- 11.01.2017: Information provided to the CQC regarding safeguarding concern reported to have occurred on the 29th of December 2016.
- The information was received by ASC on 29 December 2016 but not screened until 11 January 2017 when it was reported to CQC immediately.

- 02.02.2017: Information was provided to the CQC in relation to a third safeguarding referral which initiated a Section 42 Care Act 2014 enquiry. The CQC were informed in a timely manner.

5.7 **What support was offered to the nursing home from primary care and community services?**

5.7.1 Mrs Green's GP practice provided support by visiting her as requested by Shawe House. She was prescribed with anti-biotics as required and referrals were made to podiatrist and Tissue Viability Nurse team.

5.7.2 The TVN team provided support in managing Mrs Green's condition by visiting her and providing support and guidance direct to staff at the home but also by a significant number of telephone contacts with the home. During the first telephone contact with the nursing home on 8 June 2016, a TVN immediately identified the heightened risk to Mrs Green caused by being nursed in a chair twenty fours a day.

5.8 **How did NHS commissioners, Adult Social Care and Care Quality Commission act to monitor the quality of care provided and support improvement? Have any changes been sustained?**

5.8.1 Trafford's Joint Quality Improvement work is governed by a multi-disciplinary Group which meets every month. This Group is co-chaired by the Chief Nurse from NHS Trafford CCG and the Director of All Age Commissioning from Trafford Council. Decisions, based on the evidence collated, are made regarding the level of support each provider requires and a plan of continuous improvement is developed with the provider, as necessary. The Group also has the authority to implement suspension of placements, or packages of care, within any service in Trafford. Trafford Healthwatch and CQC are core members of the Joint Quality Improvement Board.

5.8.2 Following Mrs Green's death, a Risk Summit was initiated which produced an action plan for improvement that included weekly visits to Shawe House. This commenced 22 April 2017. Ongoing Safeguarding advice and support was provided by a Senior Practitioner. Following a second Risk Summit meeting a notice of a three month suspension of further placements by Trafford CCG and Adult Social Care was communicated to the home. CQC re-inspected the home on 20 June 2017 and the overall rating improved from Inadequate to Requires Improvement. Changes were not sustained and a further suspension was applied to Shawe House and an improvement plan launched. Shawe House nursing home has now closed as the owners took the decision that it was no longer financially viable.

5.9 **How were the views of nursing home residents and their relatives taken into account by**

a. The nursing home.
b. NHS commissioners, Adult Social Care and Care Quality Commission.
c. The multi-agency quality management process

5.9.1 By the time period covered by this review Mrs Green could no longer communicate effectively and all her care needs had to be anticipated by others. Her family represented her interests to the nursing home, CCG and ASC.

5.9.2 Shawe House listened to and took action on the family's views of how Mrs Green should be cared for. Mrs Green had not been to bed for many years and the family thought it was in her best interests that she should continue to be nursed in a chair twenty four hours a day. This did not take into account the increased risks presented by her postural weakness following the stroke in February 2016. Whilst her family very genuinely had their mother's best interests at heart their view was not supported by medical opinion. Shaw House were slow to address this and the implementation of a bed rest regime in June 2016 lasted for only nine days.

5.9.3 The fact that Mrs Green's family did not have a health and wellbeing power of attorney in place meant that their view did not have legal validity and a best interest meeting regarding bed rest could have taken place much sooner.

5.9.4 The family view was taken into account by CCG staff who balanced it against their assessment of Mrs Green's clinical needs. They concluded that her best interests were served by bed rest to relieve pressure, but this was resisted and not implemented until late in November 2016.

5.9.5 The nursing home held monthly residents and relatives meetings. Relatives were able to air their views and there is evidence from a Care Quality Commission inspection in October 2016 that these were acted upon. The views were not recorded as formal complaints.

5.9.6 The Care Quality Commission [CQC] visited and inspected the home on 12 October 2016 and 14 October 2016. The inspectors spoke to five relatives. The outcome of the inspection was that the home was inadequate and it was therefore placed in special measures.

5.9.7 Trafford Healthwatch carried out an 'Enter and view' visit to Shawe House on 28 January 2017, this was part of a series of visits to care homes to discover what residents and their families think about the health and social services that are provided. The Healthwatch visitors spoke to a relative of a resident who was very happy with the care being provided to her relative. The report of the visit made three recommendations and highlighted an area of potential good practice.

Recommendations

Formalising the monthly Residents Meetings and posting notes from the meetings on the notice board will provide opportunity to communicate with all families and not just those who attend. This will allow Shawe House to raise issues with families that could benefit all residents as well as inform relatives of future developments.

Consider a programme of redecoration to improve the shabby appearance of the home and make it more welcoming to residents and visitors.

Work with the Agency providing relief staff to Shawe House to ensure a greater understanding of how to respond and care for dementia residents.

Good practice; Placing a butterfly transfer on to the door of a resident at the end of their life, indicating consideration needed by staff and visitors.

5.10 How effective were the multi-agencies in affecting change within this provider, were any changes sustained by the home?

5.10.1 During the period of suspension of placements and re-inspection by CQC the Adult Social Care quality team provided weekly support. This intervention supported the home manager to make changes and provided clear regulatory guidance and this is evidenced

by the improvement in the rating, from the previous 'inadequate' to 'requires improvement'. Unfortunately the improvements were not sustained.

6 Lessons identified

6.1 Introduction

6.1.2 Shawe House nursing home has now closed and this section of the report is therefore focussed on learning that could be helpful to residents of other nursing and care homes in Trafford. The panel noted that agencies identified some minor lessons and dealt with them in their recommendations which will appear in an action plan prior to the report going to the Trafford Strategic Safeguarding Board.

6.2 The Panel's learning

6.2.1 **Narrative**

Mrs Green suffered a stroke which severely restricted her movement and ability to reposition herself. Her care plan was not changed to reflect the deterioration in her physical condition and the additional risks that entailed.

Learning

A change in a person's circumstances may mean that they are at increased risk of developing other conditions.

6.2.2 **Narrative**

Mrs Green's relatives heavily influenced the care that she received by insisting that she continued to be nursed in a chair twenty four hours a day. There was no power of attorney covering health and welfare in place and for a significant period of time relatives views were prioritised over medical professionals' views of what was in Mrs Green's best interests.

Learning

Carers should clarify at the earliest opportunity what powers of attorney are in place when discussing a person's care needs with relatives.

6.2.3 **Narrative**

The risks to Mrs Green of being nursed in a chair twenty four hours a day were obvious to a Tissue Viability Nurse who had not even met or examined Mrs Green. If the risks were known to staff at the nursing home, they were not acted upon before pressure sores developed.

Learning

The risk factors which contribute to the development of pressure sores are well known and evidenced. Care providers should ensure that Nursing Home staff, including agency staff, are provided with an awareness of the risks and the appropriate action to take in order to manage those risks. Commissioners should seek assurance that this takes place.

6.2.4 **Narrative**

A number of concerns were raised in relation to Mrs Green's care by her family. Whilst most of these did not on balance reach the level of a safeguarding alert they should have provided intelligence about what was happening at Shawe House. On a number of occasions information was not shared within ASC/commissioning**.**

Learning

Concerns raised by family members which do not amount to a safeguarding alert are still capable of providing helpful intelligence if the information is recorded and shared appropriately.

6.2.5 **Narrative**

Information which should have resulted in a safeguarding referral was given to a Newly Qualified Social Worker and not actioned. Shawe House made a safeguarding referral in relation to the same information two days later.

Learning

Close supervision and support for Newly Qualified Social Workers should ensure that safeguarding and information sharing are routinely discussed.

6.2.6 **Narrative**

Tissue Viability Nurses raised two safeguarding alerts in relation to Mrs Green in December 2016 and January 2017. Both alerts were considered by the panel to be appropriate. Other professionals, for example a GP visited during this time and did not make a referral.

Learning

Professionals from different disciplines may have a different levels awareness of risk and what might amount to a safeguarding referral.

6.2.7 **Narrative**

Tissue Viability Nurses raised safeguarding alerts appropriately and could also have escalated the issues within their own organisation.

Learning

TVN's and other practitioners who routinely work autonomously should be afforded regular and formalised reflective supervision.

6.2.8 **Narrative**

District Nurses received a referral for Mrs Green from a GP regarding a pressure sore. This was rejected as District Nurses are not commissioned to provide a service to nursing homes. There was a significant delay until Mrs Green was seen again by a GP and the TVN team was contacted.

Learning

Delays in appropriate treatment can occur where referral processes are not accurately

followed. The rejection of a referral without appropriately redirecting it can also lead to delays.

7 Notable good practice

7.1 Tissue Viability Nurses immediately recognised that Mrs Green was at increased risk of developing pressure sores and provided appropriate advice. Later when she developed pressure sores they acted to provide support to the home. When her condition deteriorated further they made safeguarding alerts.

8 Conclusions

8.1 Mrs Green had a diagnosis of non-specified dementia with Parkinson's and did not have capacity to take decisions or consent to her care. She was largely unable to communicate effectively and most of her needs had to be anticipated by carers.

8.2 On 23 February 2016, Mrs Green suffered an ischaemic stroke which caused a significant loss of function and weakness on her right side. This in turn meant that she was unable to reposition herself to relieve pressure. She had for many years not gone to bed and preferred to sleep in a chair and this continued for some time following the stroke. There is no evidence that her care needs were reviewed, or the care plan changed to reflect the increased risk of pressure sores caused by Mrs Green staying in a chair twenty four hours a day after the stroke. The risk was immediately recognised by a Tissue Viability Nurse during a telephone call to Shawe House.

8.3 Mrs Green's family wanted her to be nursed in a chair twenty four hours a day and resisted advice that she should be allowed bed rest to relieve pressure and reduce the risk of pressure sores. Shawe House took account of her relatives' views and her care continued as it had been for several years. There was no power of attorney in place in relation to her health and welfare so although it was appropriate to take her relatives views into account their views did not have legal weight. A Best Interests Assessment may have helped the nursing home to manage the challenges that they received from family members. The issues were addressed by health care professionals in November 2016, following which Mrs Green received appropriate bed rest.

8.4 In late December 2016, following a referral from Shaw House, Tissue Viability Nurses became involved in managing Mrs Green's care. At a visit to her on 29 December 2016, concern about her care and the state and cleanliness of equipment was such that a safeguarding referral was made. TVN's continued to advise on Mrs Green's care and 1 February 2017 when advice had not been followed a second referral was made. No progress was made in dealing with the safeguarding referrals before her death on 3 February 2017 and the safeguarding process did not contribute to keeping her safe.

8.5 The panel discussed the level of care that had been provided by Shawe House nursing home to Mrs Green and concluded that the care she received fell below a standard that could reasonably be expected.

9 Recommendations

9.1 The TSSB should seek assurance that care providers have a system in place to review care plans following unplanned visits to hospital or a change in medical circumstances.

9.2 The TSSB should seek assurance from Care Providers that in relation to the service user they enquire of relevant individuals whether a power of attorney has been applied for, what powers it confers, and whether it has been invoked.

9.3 The TSSB should seek assurance from Care Providers that their staff understand what a 'Best Interest' decision is and can explain the principles to service users and their relatives.

9.4 Trafford Commissioners should ensure that their contracts with relevant service providers requires that they have adopted the Department of Health and Social Care document 'Safeguarding Adults Protocol – Pressure Ulcers and the interface with a Safeguarding Enquiry' [January 2018].

9.5 Trafford Strategic Safeguarding Board should seek assurance from ASC that information received via the screening team regarding safeguarding concerns in Nursing/residential homes [and allied services] is shared with 'Trafford Together for Health and Social Care'[8] and other relevant bodies whose function is to provide quality assurance to the TSSB.

9.6 Trafford Strategic Safeguarding Board should seek assurance in relation to the system, quality and impact of supervision for newly qualified social workers.

9.7 Trafford Strategic Safeguarding Board should seek assurance that training is available to GPs and primary care staff in relation to the raising of safeguarding alerts and referrals in nursing and care homes.

9.8 Trafford Strategic Safeguarding Board should determine whether autonomous practitioners are afforded the opportunity of regular and formalised reflective safeguarding supervision, and if they are not, consider what action needs to be taken to support them.

9.9 Trafford Strategic Safeguarding Board seeks assurance that GP's have information about the appropriate referral pathways for pressure ulcers and that the District Nurse team, Single Point of Access appropriately redirects referrals when a rejection is necessary.

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[8] Trafford Council and NHS Trafford Clinical Commissioning Group [CCG] officially came together on 1st April to combine their social care and health expertise for the benefit of the Borough's residents. Known as 'Trafford Together for Health and Social Care', the organisations will work through an integrated single management team and single strategic commissioning function.