Trafford Strategic Safeguarding Board

SAFEGUARDING ADULTS REVIEW - RUTH

Learning Theme – Pressure Ulcer Prevention

- January 2016 referral for specialist seating assessment was not completed and her case was closed.
- Unclear how central to the care of Ruth was the February 2017 Pressure Ulcer Prevention Plan. Also unclear whether review of continence care or nutritional status envisaged by the PUP took place.
- Period without a hoist may have affected her skin integrity
- Once grade 2 sacral pressure ulcer noted in August 2017, she was not repositioned regularly enough.
- Ruth continued to be nursed in a chair which was inadvisable.
- Risk not reviewed promptly when the pressure ulcer began to deteriorate in November 2017

Learning Theme -Safeguarding concerns

- Significant deterioration of pressure ulcer and infection (osteomyelitis diagnosed in hospital)
- Not repositioned frequently enough (required two hourly turning and sitting position to be completely avoided). HSG 3 times per 24 hour period. NICE - at least every 4 hours when ‘very high risk’.
- District Nurses and HSG could not adequately meet her needs during their visits.
- Effectiveness of pressure relieving mattress compromised by use of Kylie sheet and several incontinence pads
- She was vulnerable because she was alone in the house for long periods of time
- She would be unable to self-evacuate in the event of an emergency

Learning Theme – Hoist repair/replacement

- Ruth nursed in bed for up to 42 days as a result in delays in repairing or replacing her defective hoist.
- Skin integrity concerns arose during this period although the Tissue Viability Nurses advise that this was primarily a quality of life issue allthough nursing in her chair was inadvisable once sacral pressure ulcer developed in August 2017.
- There are concerns about the response, record keeping and disclosure and review of service failures by Prism Medical.

Learning Theme – Annual Reviews

- Ruth was overdue her 2017 ASC annual review. Target is to conduct 75% of annual reviews within 12 months.
- Ruth did not meet the criteria to be considered a priority for assessment, i.e. safeguarding concerns, lives alone, reduced ability to identify a change in their needs or raise the alarm or outstanding referrals for current issues.
- Annual review can be brought forward but incident reports created on Pennine Care reporting system not visible to ASC, who did not become aware that her needs had changed.

Learning Theme – Social Isolation

- Ruth became ‘very depressed’ as a result of social isolation (Community Rehabilitation Team).
- Day Centre support was rejected by son as this would involve moving Ruth downstairs to facilitate transport. A referral made to befriending service which was unable to support her.
- Social isolation not highlighted by ASC assessments in September 2015 or November 2016. (First of these assessments done via phone contact with son).
- The TVN safeguarding referral highlighted the long hours she spent alone in the house as a concern and her inability to self-evacuate in an emergency.

Learning Theme - Communication

- District Nurses not involved in discussions with OSRC OT in respect of Ruth's chair at a time when they were co-ordinating her grade 2 sacral ulcer care and nursing her in the chair would not have been advisable.
- District Nurses requested an increase in the frequency of HSG visits to 4 x daily to aid repositioning but no record of this by HSG.
- November re-referral to Tissue Viability Nurse does not appear to have been received initially.
- Lack of responsiveness by Prism to HSG concerns re hoist.
- District Nurse/ HSG communication - either face to face or by leaving notes – no District Nurse/ HSG management communication.
- ASC unaware of deterioration in Ruth's health and consequent changes in her needs
- Risk of fragmentation if communication not effective

Learning Theme -Hospital discharge

- Unclear whether prior safeguarding concerns or Ruth's social circumstances informed the care plan.
- ASC not involved.
- Different domiciliary care providers commissioned.

Learning Theme - Capacity

- Assessed as having capacity to decide to leave her care home and move in with her son.
- Capacity later described as fluctuating when unwell.
- Ruth's son increasingly regarded as sole decision maker in respect of her care.
- Best Interests meetings only recorded at times of hospital discharges in February 2014 and December 2017. Had they taken place more frequently, they may have facilitated a stronger multi-disciplinary approach and her son would not have been treated as the sole decision maker.

Learning Theme – Earlier Safeguarding Referrals?

- Pennine Care safeguarding team should review incident reports and give advice on whether a safeguarding referral is justified but there were staffing shortages in that team at the time District Nurses began submitting incident reports.
- Details of the criteria for considering safeguarding referrals within the organisation concerned and to the local authority are highlighted in Para 6.33.
- Since December 2018 pressure ulcers have been included in Trafford Council's guidance as a potential example of 'neglect and acts of omission'.
- Some of the concerns in the Tissue Viability Nurse November 2017 safeguarding referral had been present for some time.

Good Practice

- HSG's persistent attempts to escalate repair/replacement of the hoist
- District Nurse initial response to sacral pressure ulcer
- Safeguarding referral made by Tissue Viability Nurse in November 2017.

Window on the ‘whole system’

- Under strain.
- ‘Time & task’ approach to domiciliary care did not meet Ruth’s changed needs.
- Without co-ordination & communication service provision can become fragmented.
- Absence of escalation of concerns at times.
- Rigid approach to non-engagement.
- Best interests of the service user not always central to decision making.
- Variable record keeping and record retention.

Recommendations

- TSSB obtains assurance from Pennine Care in respect of the prevention, care and treatment of pressure ulcers including care planning, risk assessment, care co-ordination and responsiveness to changes in needs.
- TSSB seeks assurance about forward plans to address concerns about the contraction of the district nurse service at a time of increasing demand from the commissioners (NHS England/ Trafford Council) and the provider (Pennine Care) of the service.
- TSSB obtains assurance from Pennine Care that, where appropriate, incident reports submitted by health services (district nurses in this case) in respect of a service user will be shared with the commissioners of social care services for that service user (Trafford Council in this case).

Recommendations

- TSSB seeks assurance from Pennine Care in respect of the standard of the hoist repair/replacement service provided by Prism Medical and the effectiveness of arrangements for monitoring the provision of that service by Prism Medical.
- TSSB widely disseminates the learning from this review which will provide an opportunity for practitioners to consider when safeguarding referrals are justified in cases of neglect arising from pressure ulcer care.
- TSSB obtains assurance from NHS Trafford CCG (Personalised Care Department) and Manchester University NHS Foundation Trust (Wythenshawe Hospital) in respect of considering, and documenting the consideration of, safeguarding concerns when making decisions on fast-track Continuing HealthCare (CHC) and hospital discharge, respectively.

Recommendations

- TSSB shares this SAR report with Trafford Health and Wellbeing Board as the resources available to address social isolation appeared somewhat limited and assessments and reviews of care and support needs may not be sufficiently attuned to social isolation as a need.
- TSSB shares the learning from this Safeguarding Adults Review with the Greater Manchester Local Resilience Forum so that it can inform their efforts to identify and support vulnerable people in civil emergencies.
- TSSB explores and disseminates good practice in the recording of Mental Capacity assessments by partner agencies.

Recommendations

- TSSB obtains assurance from partner agencies in respect of the monitoring and, where necessary, improvement of the accuracy and completeness of record keeping.