Trafford Strategic Safeguarding Partnership

Trafford Strategic Safeguarding Partnership Safeguarding Adult Review

SAR 'Mrs Green'

Introduction

This summary/briefing is aimed at managers and practitioners working with vulnerable adults in Trafford. The key learning emerging from the Safeguarding Adults review and recommendations are presented.

Overview of report

This Safeguarding Adult Review, was about Mrs Green, a 95 year old lady who had been resident in Shawe House nursing home since 2010. In the period before her death she had a diagnosis of non-specified dementia with Parkinson's and did not have capacity to take decisions or consent to her care. In February 2016, Mrs Green suffered a stroke. This left her with weakness on her right side meaning that she was unable to support herself.

From March 2016, professionals began to express concerns about the breakdown of Mrs Green's skin on her heels and later on her buttocks and sacrum. She was visited and treated by a number of professionals and recommendations for her care were made to Shawe House.

A feature of her care was that she was nursed on a 24 hour basis whilst sitting in a chair. A Tissue Viability Nurse who attended believed that this contributed directly to Mrs Green's worsening pressure ulcers. Her family who were loving and supportive of their mother, making daily welfare visits, were aware that she had not slept in a bed for some years. They believed that sleeping flat in a bed elevated the risk of choking and would be generally distressing for her. Her family raised objections to bed rest via the home and social care asking that should this be required Mrs Green would need 1:1 support to make the practice safe. A compromise was reached whereby Mrs Green took bed rest when her family were visiting, but this was only for a few days in June 2016. Following a choking episode in June Mrs Green returned to sitting care against medical advice.
A Continuing Health Care funding review took place in October 2016. This noted Mrs Green's sitting care and the fact there was no medical justification for it. By November 2016 it was clarified that no power of attorney existed for family to make decisions about Mrs Green's health and welfare, and a best interests meeting concluded that bed care was necessary, her family now accepted this position.

The TVN service continued to provide support to Mrs Green in January 2017 and were not satisfied with the quality of care provided by Shaw House, resulting in 2 separate safeguarding referrals being submitted to adult social care regarding her pressure ulcers. Mrs Green died on the 3rd February 2017, her cause of death included her pressure sores.

Legislative Authority for Review:

S44 (1) of the Care Act 2014: 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-
the adult has died, and
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)

Trafford Strategic Safeguarding Partnership

Good Practice:

- 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.

What Happened

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.

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.

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.

The issues were addressed by health care professionals in November 2016, following which Mrs Green received appropriate bed rest.

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.

The level of care that had been provided by Shawe House nursing home to Mrs Green fell below a standard that could reasonably be expected.

Trafford Strategic Safeguarding Partnership

What the Independent Review Found

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

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

- 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.

Trafford Strategic Safeguarding Partnership

What needs to be done now to prevent similar incidents

- The TSSP 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. 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.
- The TSSP 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.
- 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].
- The TSSP should seek assurance from Adult Social Care that information received via the screening team regarding safeguarding concerns in Nursing/residential homes [and allied services] is shared with relevant bodies whose function is to provide quality assurance to the TSSB.
- The TSSP should seek assurance in relation to the system, quality and impact of supervision for newly qualified social workers.
  The TSSP 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.
- The TSSP 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.
- The TSSP should seek 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.

Trafford Strategic Safeguarding Partnership

Further Information

- The SAR overview report on the 'Mrs Green' SAR review and this briefing is available at: http://www.tssb.uk/Docs/Safeguarding-adults/SAR-Mrs-Green.pdf

- Published SARs are available from the SCIE SAR repository at:

https://www.scie.org.uk/safeguarding/adults/reviews/library

- TSSP multi-agency safeguarding procedures are available at:

https://www.traffordappp.co.uk/contents-tssb/

TSSP contact details:
Trafford Town Hall, Talbot Road, Stretford, M32 0TH
Tel: 0161 911 8687
Email: TSSP@Trafford.gov.uk
Website: www.traffordsafeguardingpartnership.org.uk