Trafford Strategic Safeguarding Partnership Safeguarding Adult Review

SAR 'Ruth'

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, Ruth (not her real name) died in the home she shared with her son after developing a severe pressure ulcer and osteomyelitis. She had been receiving care and support from a range of agencies including a domiciliary care service, the district nurse service and her GP practice. Shortly before her death she was examined by a tissue viability nurse who arranged for urgent hospital admission and made an adult safeguarding referral as a result of concerns over the care provided to Ruth, her vulnerability and isolation. After being treated in hospital Ruth was discharged home with palliative care and died several days later.

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)

Good Practice:

- HSG carers made persistent efforts to resolve the delays in repairing/replacing the hoist and securing a replacement chair. When making efforts to resolve the hoist issue they drew attention to the risks involved in nursing Ruth continuously in bed.
- When Ruth's grade 2 sacral pressure ulcer was first noted in August 2017 the district nurse service responded effectively and worked well with her GP and HSG to initially achieve an improvement in her condition.
- In November 2017 the tissue viability nurse made an adult safeguarding referral in which she appropriately expressed a number of concerns about the care Ruth had been receiving and her vulnerability arising from her isolation.

What the Independent Review Found

In reviewing the care and support provided to Ruth, this SAR sheds some light on the 'whole system' for safeguarding people with complex needs who are being supported to live at home.

- There are several indications that the 'system' is under strain. For example, the district nurse service is under pressure at a time when demand arising from the desire of people to live at home for as possible is increasing. Additionally, adult social care does not have the capacity to conduct reviews of all people with care and support needs on an annual basis.
- The domiciliary care services provided to Ruth focussed on task based care within an allocated time window. When her needs changed, in particular her need to be more regularly repositioned to prevent her sacral pressure ulcer deteriorating, this 'time and task' approach to delivering her care was no longer sufficient to meet her needs over each twenty four hour period.
- Meeting the needs of a person with multiple care needs involves a wide range of services. Unless there is effective communication (human and information systems) and thoughtful co-ordination there is a risk that service provision can quickly become fragmented. The quality of multi-agency communication was variable in this case and care co-ordination was only evident when it became necessary to provide Ruth with more intensive support after her grade 2 sacral pressure ulcer was noted in August 2017.
- There was an absence of escalation of concerns. Trafford ASC did not become aware that Ruth's needs had changed since their November 2016 review of her care and support needs. Had they become aware of her deteriorating health they could have prioritised or brought forward the 2017 review. HSG did not appear to consider escalating their concerns to Trafford Council as commissioners of the care they provided to Ruth nor did Pennine Care appear to consider sharing the incident reports submitted by the district nurses with Trafford ASC. Staff caring for Ruth may have become de-sensitised to risk as it took the 'fresh pair of eyes' of the tissue viability nurse to recognise that Ruth's care at home had become compromised and submit an adult safeguarding referral.
- There was a fairly rigid approach to non-engagement, for example the OSRC response to lack of family contact to arrange the specialist seating assessment for Ruth in 2016. Discharge from the service appeared to be the standard response with insufficient attention paid to the risks to Ruth's health if the seating assessment did not take place.
- The interests of the service user were not always central to agency and partnership decision making. Ruth's preferences diminished in prominence over time.
- There was an absence of multi-agency meetings/discussions when the needs of Ruth escalated.
- Record keeping and record retention appears to be very variable.

Learning Themes

1. **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

2. **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

3. **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 although 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.

4. **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 Themes continued

5. 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.

6. 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

7. Hospital Discharge

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

8. 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 Themes continued

9. 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.

What needs to be done now to prevent similar incidents

- TSSP obtains assurance from Manchester Foundation Trust (formally 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.
- TSSP 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 (MFT) of the service.
- TSSP obtains assurance from MFT 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).
- TSSP seeks assurance from MFT 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.
- TSSP 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.
- TSSP 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.
- TSSP 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.
- TSSP 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.
- TSSP explores and disseminates good practice in the recording of Mental Capacity assessments by partner agencies
- TSSP obtains assurance from partner agencies in respect of the monitoring and, where necessary, improvement of the accuracy and completeness of record keeping.

Further Information

- The SAR overview report on the 'Ruth' 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