Safeguarding Adult Review

The Case of HM

Executive Summary

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1. Introduction

1.1. This review has been commissioned by Havering Safeguarding Adults Board (SAB) in line with its accountabilities under Section 44 of the Care Act 2014.

2. Safeguarding Adult Review Process

2.1 This review process is based on individual case and appreciative systemic enquiry into the decisions and actions taken by relevant agencies in relation to HM and a review of those decisions in the context of real working conditions which existed at the time.

2.2 A Safeguarding Adults Review (SAR) is not an enquiry into how someone died or suffered injury or to find out who is responsible or apportion blame. Its purpose is to:

2.2.1 Look at any lessons we can learn from the case about the way all local professionals and agencies work together.

2.2.2 Review the effectiveness of safeguarding adults' practice, policy and procedures.

2.2.3 Inform and improve local safeguarding practice for all agencies involved.

2.2.4 Deliver an overview report with findings for consideration by the SAB.

2.3 The key outcome of a SAR is to improve the safeguarding of adults in future.

2.4 It is the aim of Havering SAB to further promote a learning culture by nature of this review and to effect maximum positive change in both single agency and multi-agency working arrangements to ensure the best outcomes for adults at risk and the wider community. It is equally important to highlight areas of good practice and to share that learning.

3. Background of the Case - HM

3.1 HM was a 91-year-old white British woman of Church of England faith.

3.2 HM had a medical diagnosis of dementia and a history of atrial fibrillation, high blood pressure and arthritis. She was bedbound and reliant on support for all her care and daily living tasks.

3.3 She resided with her daughter in a 2 bedroomed sheltered property situated on the first floor. This was provided by the local authority in May 2015. HM's daughter supported her mother with shopping, cleaning, finances and emotional support. She did not provide any hands-on personal care. HM was believed to lack the capacity to make decisions regarding her care and support needs. HM's care plan stated that she should receive 4 calls per day with double handed care.

3.4 This care, at the request of her daughter, was provided by Personnel Assistants (PAs) via a Direct Payment. It is recorded that HM was experiencing short term

memory loss in 2014. Further assessment documentation refers to HM's dementia as being 'advanced' in January 2015 and 'severe' in April 2015.

3.5 Over this period, she was admitted to hospital on a number of occasions.

3.6 On the 30th December 2016, the District Nurses raised a safeguarding concern after visiting on that day following concerns being raised to the GP by HM's visiting granddaughter. The District Nurses found HM to have 11 pressure ulcers at grade 4, some necrotic, with one measuring 12cm x 7cm.

3.7 On the 4th January 2017 during an urgent hospice admission, as a result of safeguarding concerns raised in the safeguarding referral and because of her identified health needs, HM sadly passed away.

3.8 The Coroner's report stated that the pressure areas were a contributory factor in her death. No concerns or medical attention had been sought prior to the District Nurses visit on the 30th December 2016.

4. Systems Referral Pathways and Practice Findings/ Lessons Learnt in the case of HM

4.1 PAs and carers would benefit from having access to mandatory training, i.e. the care certificate. This needs to cover pressure care recognition, and reporting and referral pathways.

4.2 Concerns and further assessments should have been undertaken when HM's daughter declined the hoist which was assessed as being needed, with no further exploration of how the needs of HM were being met in the absence of that equipment.

4.3 There was an over reliance on the views of HM's daughter. In terms of Care Act requirements for advocacy, this should be provided either where the person lacks capacity or where the individual has substantial difficulty participating in the process. Neither of these requirements are considered in the documents provided to the review.

4.4 Despite the statutory duty to offer a carer's assessment, there is no indication that one was offered and certainly not that one was undertaken.

4.5 This is evident in terms of confusion regarding the caring responsibilities or HM's daughter and the role of the PAs as well as queries raised by the PA about the daughter's ability to deliver care given her physical difficulties.

4.6 Within this review it is striking that the views, wishes or feelings – in other words, the voice – of HM are not referenced and there is no indication that anyone directly observed or consulted with her. As such it is hard to identify how assessments and interventions reflected the wellbeing principle of the Care Act which should underpin person-centred interventions and approaches.

4.7 No professional ever formally assessed HM's capacity in relation to any significant decisions relating to HM's care and treatment. This would have provided a framework to potentially safeguard HM and would have ensured that decisions being made regarding her care and treatment were made in her best interest linking her to risk assessment and management.

4.8 Throughout the journey of HM's care, there is limited risk assessment of a dynamic nature. Individual risks were considered in isolation and not joined up, for example in

relation to risk of pressure damage - there was no consideration across equipment, nutrition, hydration, transfers and hoisting and availability and delivery of care.

4.9 There was a lack of evidence in terms of collaborative multi-agency approach to HM's care, information sharing across agencies and holistic assessment of HM circumstances. This was a contributory factor in not holistically understanding the risks present. At the point in July 2016 when HM was assessed as having necrotic heels, she was discharged from hospital with no onward referrals or consideration of risk management or exploration of how the wounds had developed. Assumptions were made on the knowledge and skills of practitioners across agencies which impacted on effective risk assessment management and decision making. No safeguarding concern was raised.

4.10 There was limited evidence of professional curiosity in relation to risk assessment, carers needs and capabilities, dynamics around interactions with the PAs and daughter and indications of changing and escalating health social care needs, which required reassessment rather than a task focused review of the presenting issue.

4.11 Safeguarding concerns were not considered or raised in a preventative manner, which would have promoted multi-agency working; for example, in mid-2016 at the time of presentation to the Emergency Department (ED) with necrotic heels.

4.12 During an interview as part of this review with the nurse who cared for HM during the ED admission when necrotic heels were identified, she stated that she could not recall receiving any tissue viability training prior to going on maternity leave in early 2015. The tissue viability policy was updated in October 2015, whilst the nurse was absent from work, and the process had become more robust in her absence. Any pressure damage identified on a patient's skin during assessment requires an IR1 to be completed. The hospital tissue viability team log incidents and depending on whether the patient is admitted or discharged they either review the patient on the ward or contact the DN or the relevant tissue viability lead in the relevant borough.

4.13. The nurse caring for HM was unfamiliar with the mandatory reporting process, having recently returned to work on a part time basis after an extensive period of leave lasting 14 months. She recalls having no supernumerary or further induction period upon her return.

4.14 Safeguarding Adults training level 2 was mandatory for all clinical staff during the period under review. The IMR author was unable to establish whether the nurse caring for HM was up to date with this training. The failure of ED staff to complete the required process following the recognition of the bilateral necrotic heels resulted in the community clinicians being unaware of the changes to HM's skin integrity.

4.15 In the case of HM there is some, though limited evidence of supervision and management oversight, this becomes more robust once the safeguarding concerns are identified, however, prior to this, oversight does not identify the gaps or learning points above.

4.16 During the review it became evident that across the partnership there were varying views in terms of safeguarding definitions and when safeguarding duties apply in terms Care Act criteria. Practitioners felt that safeguarding templates compounded this difficulty; templates were deemed to not be intuitive, did not offer prompts to practitioners and in particular the wording around consent and capacity was felt to be confusing.

4.17 The review process highlighted issues relating to the quality of recording standards and templates used, which respective agencies identified and have addressed within their individual agency action plans.

4.18 Personal assistants recruited via Direct Payments have no framework for checks of skill or suitability, training or quality assurance and monitoring in line with the changing needs of individuals. The reliance being is the person managing the Direct Payment to ensure safe and effective delivery of care. There is not access to the same support and guidance for PAs as there is for commissioned services (formal or informal). Although the duty is to promote and offer the use of Direct Payments, the system is reliant on the professional judgement of practitioners to assess, identify and challenge when this may not be appropriate for some individuals, particularly those with complex health and social care needs.

4.19 IT systems operate independently of each other, therefore access to multi-agency information to inform of interventions is not possible. A clinical portal for health services is being developed to enable multi-agency access however, key agency information such as Adult Social Care (ASC) and Housing are at this stage not included.

4.20 There is an identified need for clear guidance on the expectation and standards of PAs and carers (commissioned by any route) on the recording of care delivery within the community.

4.21 HM was re-admitted to hospital within two days of discharge. This should have triggered a referral to ASC for a review of home and care circumstances and an assessment of needs.

4.22 Agencies believed that consent was required to make referrals even when the capacity of HM to give valid consent was questionable. When individuals have assessed care needs and carers refuse a referral or services, considerations of best interest for the individual need to be made.

4.23 The sharing of information within referral pathways is limited and, as a result, wider implications impacting health and wellbeing were overlooked. In the case of HM, when continence services become involved, the wider context of impact on skin integrity and tissue viability was not evidenced. It is not clear what advice and information or support was offered to HM's daughter or the PAs in terms of skin integrity and tissue viability.

4.24 In the case of HM, it took three months from the point of an overhead hoist being assessed as needed until it was delivered and then refused by her daughter. It is also not evidenced as to what action was then taken to review the impact of this refusal in HM's best interests. There was no clear risk mitigation plan in place to safely manage moving and handling during this period, potentially leaving both HM and staff at risk.

5. Recommendations to the Safeguarding Adults Board

5.1 Application of Statutory Frameworks

5.1.1 All agencies need to promote understanding of key statutory duties and powers under the Care Act 2014 with particular focus on Carers Assessments and the differences between reviews, reassessment and criteria for safeguarding. The Board may like to consider how agencies can demonstrate such assurance on the application of this understanding into practice and outcomes for people with eligible Care and Support needs.

5.2 **Implementation of Mental Capacity Act 2005**

5.2.1 The Board may like to seek assurance on compliance within agencies on application of the Mental Capacity Act to ensure that formal capacity assessments are being undertaken where required and recognising the requirement of advocacy for people with care and support needs to ensure their views wishes and feelings are appropriately represented and to ensure person centred interventions. This is inclusive of the consideration of advocacy where potential conflict of interests arises regardless of the persons capacity.

5.3 **Risk Assessment and Risk Management in practice systems and organisations**

5.3.1 The Board may like to seek assurance that all agencies have a quality assurance mechanism to measure effectiveness of dynamic and holistic risk assessment and its subsequent management within their own organisation and how this interface impacts within a multi-agency framework.

5.4 **Multiagency Working and Collaboration**

5.4.1 The Board should seek assurance that there are robust information sharing protocols which are reflective of balancing informed consent, mental capacity, public interest and vital interests and that agencies have mechanisms in place for disseminating changes in policy procedures and protocols. Assurance is required that referral pathways are streamlined and are outcome not process focused

5.5 **Professional Curiosity**

5.5.1 The Board may wish to consider how it can promote a positive culture of professional curiosity which supports effective multi-agency working and collaboration. This should be inclusive of its workforce development strategy and focus on achieving person centred interventions whilst discharging duty of care.

5.6 **Recording standards and IT systems**

5.6.1 In relation to the identified issues and developed action plans resulting from this review, the Board may wish to determine whether effective quality assurance exists to maintain standards of recording that evidences defensible practice and how IT infrastructures support this inclusive of existing local developments (Health IT project) and other key stakeholder agencies i.e. ASC and Housing.

5.7 **Direct Payments**

5.7.1 Whilst it is a statutory duty to offer direct payments where appropriate, professionals and organisations retain a duty of care to ensure eligible needs are being met regardless of the commissioning responsibility by an individual or their representative. Further assurance that professionals and organisations retain a duty of care to ensure eligible needs are being met

where direct payments are in place and to monitor risks in order to identify any shortfalls or arising safeguarding issues would be beneficial.

5.8 Individual Agency Action Plans

5.8.1 As a result of this review, all agencies have provided action plans to address both identified practice and systems issues within this case. It is recommended that the Board ensure they have a robust mechanism to monitor the implementation of Individual Agency Action Plans and to evaluate the subsequent impact as result of this learning

5.9 Review of Evidential Difficulties Regarding (potential) Carer Fraud:

5.9.1 In relation to the police investigation into suspected fraud by carers for HM following a submission of evidence to the Crown Prosecution Service (CPS) it was deemed to not have reached the evidential threshold for a realistic prospect of conviction. The Board may wish to review what the evidential difficulties were surrounding time sheets and practical record keeping amongst partners to ensure that future cases are as evidentially tight as possible and not a stumbling block to a successful Criminal Justice (CJ) outcome. This may also act as a deterrent moving forward.

6. Glossary

Adult Social Care (ASC)
Barking, Havering and Redbridge University Hospitals (BHRUT)
Community Nursing Treatment Team (CTT)
Crown Prosecution Service (CPS)
District Nurse (DN)
Direct Payment (DP)
Direct Payment Team (DPT)
Emergency Department (ED)
Independent Management Report (IMR)
(JAD) Joint Assessment and Discharge Team
(LAS) London Ambulance Service
North East London Foundation Trust (NELFT)
Occupational Therapist (OT)
Older Adults Mental Health Team (OAMHT)
Personal Assistant (PA)
Personal Budget (PB)
Safeguarding Adults Board (SAB)
Safeguarding Adults Review (SAR)
Urinary Tract Infection (UTI)