Kent and Medway Safeguarding Adults Board

Safeguarding Adults Review

Mrs. C

Executive Summary

Lee Houghton. Independent Panel Chair and Overview Report Author. 5 June 2017
Commissioned by: Kent and Medway Safeguarding Adults Board

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Please note that this document has been anonymised by the use of pseudonyms to protect the identity of those concerned

1. INTRODUCTION

1.1 This is a summary of the overview report of a Safeguarding Adults Review (SAR) commissioned by Kent and Medway Safeguarding Adults Board following the death of Mrs. C on 1 May 2014.

1.2 Mrs. C was referred for a SAR by LA1's Head of Adult Safeguarding in May 2016. The referral was reviewed by the core group and it was agreed that it met the criteria. A SAR panel was established, with an Independent Chair appointed. The panel comprised of representatives from the following agencies:

- Hospital A
- Local Authority 1 (LA1)
- Trust1
- Clinical Commissioning Group
- Community Trust1
- Local Authority 2 (LA2)

1.3 Terms of reference for the SAR were agreed and Independent Management Reports (IMRs) were completed by the following agencies, who had provided care and support to Mrs. C:

- Local Authority 1
- Hospital A
- Local Authority 2
- Community Trust 1
- NHS England

1.4 The panel reviewed the IMRs, working through a chronology of activity of the involved agencies. An overview report of the agencies' involvement with Mrs. C's care and treatment was completed in June 2017.

1.5 At the time that Mrs. C was receiving care and the safeguarding concern was raised, relevant agencies were working to the "Multi-Agency Safeguarding Vulnerable Adults - Adult Protection Policy Protocols and Guidance for Kent and Medway" (amended January 2014). The social care context of this concern is that Mrs. C was known to Local Authority 1 (LA1) adult social care. She was ordinarily resident in the LA1 area, but in Hospital A which is in the Local Authority 2 (LA2) area.

1.6 Mrs. C's husband referred the case to the Parliamentary Ombudsmen. They made the decision to defer looking at this case until the outcome of the SAR was published.

1.7 Throughout the SAR, investigations continued around formal complaints that Mr. C made about the care of his wife. As appropriate, the outcome of these complaints were considered within the IMRs.

2. BACKGROUND TO THE REVIEW

2.1 Mrs. C was a seventy-two year old lady who had been living with her husband in their family home in town A; they had been married for 55 years and had two grown-up children. She had a history of high blood pressure, high cholesterol, Gastro-Oesophageal Reflux Disease (GORD), chronic back pain requiring epidurals, and diverticulosis. Mrs. C smoked and she was classified as obese.

2.2 Mrs. C was admitted to Hospital A on 23 December 2013 from her home in Town A. The discharge summary from Hospital A states that Mrs. C was admitted to the acute hospital with an ischaemic left foot. A left popliteal endarterectomy was undertaken on 24 December 2013. She was treated for cellulitis around the wound site conservatively after this. Mrs. C had an episode of deteriorating renal function, Clostridium Difficile (C.Diff), and episodes of urinary tract infection (UTI) during the admission. She had a split thickness skin graft to the left leg wound and larvae therapy was started on the left wound in April 2014; Mrs. C also had two other larvae therapy treatments in January 2014.

2.3 Mrs. C was discharged from Hospital A on 7 April 2014 to a residential care home (CH1) operated by LA1, and had input from the community nursing team. The purpose of going to CH1 was to enable Mrs. C to undergo a period of rehabilitation prior to returning home. During her stay in CH1, Mrs. C became acutely unwell, and developed pressure ulcers. She was readmitted to Hospital A on 16 April 2014.

2.4 Mrs. C died on 1 May 2014 at Hospital A. The cause of death was recorded as bronchopneumonia, and her death was due to natural causes. It was noted that Peripheral Vascular Disease contributed to the death, but that it was not related to the condition causing it.

3. ANALYSIS

3.1 The panel's detailed discussions and analysis specifically focused on:

- What was the care and treatment provided from September 2013 in the lead up to Mrs. C's admission in December 2013? Were there any delays in providing diagnostics/treatment?
- Was the discharge from the hospital to CH1 appropriate? Were there any concerns in the quality of the discharge information?
- Was CH1 an appropriate placement to meet Mrs. C's needs?
- Were there any delays in key treatment/medical tests whilst Mrs. C was at CH1?
- Was there a delay in arranging re-admission into hospital?

- Why was the safeguarding alert of 16 April 2014 not investigated until after Mrs. C's death? Did the alert follow safeguarding procedures and were all relevant people involved?
- Did hospital A follow safeguarding procedures and fully support the investigation and participate in planning meetings and case conferences?
- Was capacity and consent adequately considered when making decisions around Mrs. C's care and treatment?
- Was communication effective between professional/agencies, as well as with family members?

3.2 The analysis was grouped into the following main topics:

- Referral, Diagnostics & Testing
- Assessment & Treatment
- Record Keeping and Care Planning
- Pressure Care & Equipment
- Nutrition
- Capacity & Consent to Treatment
- Communication & Information Sharing
- Safeguarding Procedures

4. CONCLUSION

4.1 Since the death of Mrs. C, with the implementation of the Care Act (2014), there is now a statutory responsibility for safeguarding adults from abuse. Changes to the KMSAB's 'Multi-Agency Safeguarding Adults Policy, Protocols and Guidance for Kent & Medway' document (April 2016), as a result of the Care Act (2014), should prevent the confused safeguarding approach that occurred in this case. It is now clear that the local authority is the lead agency for initiating a Section 42 enquiry and it is no longer delegated. Hospital care management teams should support adult safeguarding processes if an adult is hospitalised, but lead responsibility will always rest with the host local authority. A host local authority can delegate the requirement for informal or statutory enquiries (Section 42) to be made, but the managerial oversight of satisfying (and signing off) the Section 42 duty rests with the host local authority.

4.2 Hospital A insisted that this case was not safeguarding, but transfer of care issues. Initially if the concerns were raised at the point of the inappropriate transfer to CH1, then this may well have been a transfer of care issue. However, the consequences of this inappropriate transfer of care led to serious safeguarding concerns, as it began the train of events leading to the safeguarding concerns. This includes:

- The lack of correct information from the hospital as to Mrs. C's wound and treatment for this
- Inaccurate transfer of care (discharge) letter
- History of C.Diff in hospital

- Lack of necessary pressure relieving equipment which led to pressure ulcers
- Lack of dressings
- Community nurses not being appraised of the need for wound care when the larvae treatment was in place
- Failures from the community nurses and the GP to provide adequate and timely responses to Mrs. C's deteriorating medical condition
- Poor record keeping and documentation by the community nurses
- Nutritionally compromised

4.3 Focusing on the specific questions as part of the Terms of Reference, the following is concluded:

4.3.1. Were there any delays in providing diagnostics/treatment in the lead up to Mrs. C's admission in December 2013?

The initial referral to the vascular clinic was rated the correct level of urgency, given the symptoms that Mrs. C presented with, in conjunction with the results of the Doppler tests. However, between the period of 11 November 2013 and 18 December 2013, the GP lacked professional curiosity into Mrs. C's change of symptoms, and there were missed opportunities to respond to these symptoms which may have changed the urgency for specialist input. Whilst the results from the ultrasound and Doppler tests in December were not abnormal, the sonographer responded correctly to Mrs. C's complaint of pain at rest, and this prompted the regrading of urgency of the case, which resulted in surgery.

4.3.2. Was the discharge from the hospital to CH1 appropriate? Were there any concerns in the quality of the discharge information?

The discharge to CH1 was not appropriate as Mrs. C was still having larvae therapy; she should have been discharged to Hospital B where the larvae treatment could have been managed. The discharge failed to ensure the timely involvement of the community nursing team when Mrs. C was at CH1.

Discharge information was incredibly poor and inaccurate, and contributed to Mrs. C's needs not being met within CH1, and the community nurses not being able to make a planned response to provide wound care.

4.3.3 Was CH1 an appropriate placement to meet Mrs. C's needs?

CH1 was not an appropriate placement for Mrs. C; she should have been in receipt of nursing care, not residential care. The support of the community nurses was not sufficient for the level of nursing care that Mrs. C required.

4.3.4. Were there any delays in key treatment/medical tests whilst Mrs. C was at CH1?

In terms of the Community Nursing team, there was clearly a lack of robust leadership in place. There did not appear to be a leader who was overseeing and coordinating the case of Mrs. C, hence the delay in ordering of dressings and pressure relieving equipment.

There were delays in blood tests being taken, and confusion in communications around this. When Mrs. C was rapidly deteriorating, there was a lack of professional curiosity to understand the reason behind her symptoms, and the community nurses failed to commence monitoring of her vital signs using the National Early Warning Score (NEWS); this was a missed opportunity.

There were also significant delays in the provision of pressure relieving equipment, which most likely contributed to Mrs. C developing new pressure ulcers whilst at CH1.

4.3.5. Was there a delay in arranging re-admission into hospital?

Failures in documentation, even minor things, stopped there building a picture of a greater need. There was some evidence of delay in the medical management of Mrs. C, as the GP was waiting on blood test results before they would visit (which was compounded by a delay in blood tests being done). The GP did respond well in trying to obtain more care for Mrs. C as her health deteriorated further. The community nurses should have executed their own professional expertise in determining how acutely unwell Mrs. C was, and escalated this accordingly. Having no-one allocated to have oversight of Mrs. C's care whilst she was at CH1 meant there was no-one taking responsibility for the ongoing suitability of the placement, particularly of concern when Mrs. C's needs were increasing and CH1 was becoming an unsuitable environment to meet her needs.

4.3.6. Why was the safeguarding alert of 16 April 2014 not investigated until after Mrs. C's death? Did the alert follow safeguarding procedures and were all relevant people involved?

The safeguarding process was very confused, and one of the alerts relating to 16 April 2014 was not even received until 1 May 2014. The relevant people were not involved. The procedure for Hospital A to lead on the safeguarding concern was in line with policies. However, LA2 were not notified of the alert, did not have the necessary oversight and did not countersign the CM32 (signing off adult protection case). There is some evidence of carer involvement (Mrs. C's husband) in the process, but no involvement of Mrs. C (who was alive at the time that the alerts were raised).

4.3.7. Did Hospital A follow safeguarding procedures and fully support the investigation and participate in planning meetings and case conferences?

The Kent and Medway Safeguarding procedures appear to have been followed appropriately at this time, in accordance with the 2014 version, with Hospital A initially leading on the safeguarding concern. However, the quality of the minutes were poor and the structure of the meetings did not follow the policy. Hospital A insisted the concerns related to transfer of care and not safeguarding, which meant they did not adequately engage in the safeguarding process when LA1 took the lead on the case. Mrs. C's care and treatment may well have been viewed differently since the implementation of the Care Act (2014), and the Kent and Medway Multiagency Policy Procedures and Guidance has also changed in line with the Care Act. Most notably, a meeting to discuss

safeguarding concerns would not have been led internally, and would sit with the local authority.

4.3.8. Was capacity and consent adequately considered when making decisions around Mrs. C's care and treatment?

The community nurses did not record consent from Mrs. C regarding the treatment and discussion about the medication with the GP, and there was no evidence of informing Mrs. C about the safeguarding referral made by the community nurses on 16 April 2014. Throughout the episode of care provided by the community nurses, there is little written evidence of consent gained from Mrs. C in regards to care and treatment, and no evidence that Mrs. C was involved in any decision making (i.e. being cared for in bed). Furthermore, after the initial assessment by the community nursing team, there was no evidence to suggest that at follow up visits Mrs. C was asked about her pain and the effectiveness of the analgesia that she had been prescribed.

The social care assessment, as part of the planning for Mrs. C's discharge to CH1, adequately considered Mrs. C's capacity to make decisions about her care, and planned the care in line with her wishes. Even though Mrs. C was deemed to have capacity around her care, there was no documented evidence of what her opinion was at the time of the DNAR decision by the clinical team, and when Mr. C did not agree with the decision, this was unlawfully disregarded.

4.3.9. Was communication effective between professionals/agencies, as well as with family members?

Communication between Hospital A and the Community Nursing Team was poor; the quality of the referral form was incomplete and not sent in a timely way to allow a planned response by the community nursing team.

There was effective communication between the Assessment Officer (from the Integrated Discharge Team) and Mr and Mrs. C as part of the discharge planning. Both of their views were taken into account during this process, and the Assessment Officer was meticulous in organising what the other agencies needed to do to facilitate the discharge; sadly these actions were not all implemented, causing the discharge plan not to be executed successfully.

There were gross failings in the communications around Mrs. C's discharge destination, with some staff believing she was being transferred to Hospital B. The status of Mrs. C's larvae therapy at discharge was miscommunicated between the hospital, CH1 and the community nurses. This meant that there was not a planned response for wound care by the community nurses, and Mrs. C was placed in accommodation that could not meet her needs.

There were communication deficits when Mrs. C was readmitted to hospital, which meant there was a delay in Mrs. C being reviewed by the vascular team.

Communication between agencies in response to the safeguarding alerts was poor. Hospital A believed that the case was not safeguarding but a transfer of care issue, so failed to communicate with other agencies effectively even when the decision was made to manage the case under safeguarding. The lead agency in managing the safeguarding referral should have been LA2, yet they do not have records of any direct involvement in the alert.

There was no evidence in the findings to suggest that Mrs. C was being discriminated in terms of her disability, cultural and faith matters.

With hindsight, it is likely that Mrs. C should not have been discharged to CH1. However, this is not a reflection on CH1, but because Mrs. C's needs exceeded the care that could be provided by this residential home.

5. RECOMMENDATIONS

1. Ensure staff within the agencies involved in this SAR are clear on the responsibilities and process for reporting and managing safeguarding concerns, particularly the new provider for Town 1 Community Nursing Service.
2. Ensure that all contacts relating to safeguarding within LA2 are recorded electronically, so that information can be appropriately accessed and used, and that there is robust management oversight within LA2 for safeguarding concerns raised in Hospital A.
3. All staff mandatory safeguarding training, for all agencies, to be checked for compliance.
4. All agencies to ensure that during handovers, safeguarding issues and actions should be actively discussed and documented.
5. Key operational staff in health and social care to work together to formulate a robust multi-agency care and treatment plan, including communication of all essential information, to ensure a safe discharge from hospital.
6. Assessment for hospital discharge must include the impact on the establishment the patient is being discharged to. To achieve this, there must be joint assessments between the care manager and the provider. This will ensure that the patient's needs are met, the skill mix of staff is in place, and any necessary equipment is available.
7. Review of the hospital discharge process to identify a lead professional within the hospital to ensure safe discharge, making sure that all necessary assessment and treatment is completed, and further follow up is clearly recorded and communicated.
8. The lead responsibility for the oversight of the person's care, following discharge to an assessment placement, needs to be discussed and agreed before discharge, so that all agencies are clear about their specific roles and responsibilities and relevant escalation procedures.
9. Specific follow up to be taken with regards to the GP responsible for Mrs. C's care prior to admission, to include: GP learning directed the management of Peripheral Vascular Disease and recognition and management of the ischaemic limb (and their practice deemed competent); refresher training in record keeping and an audit undertaken to ensure that records made clearly identify the rationale for actions and decisions taken.

10. GPs must ensure that their processes for engaging with partner agencies at practitioner level are robust enough to ensure that meaningful outcomes can be achieved.
11. Team leader/deputy team leader for the community nursing teams should have over-arching responsibility for the caseloads.
12. All care providers need to ensure consent is gained before treatment, and recorded on patients' notes.
13. All agencies to ensure that records of care need to be completed in a SMART manner (Specific, Measurable, Achievable, Relevant, Timely).
14. To assess competencies of all community nursing staff in relation to pressure ulcer, skin integrity and lower limb.
15. Ensure Hospital A deliver on the Transforming Care project, specifically in relation to the Nutritional Screening Assessment and Management of Malnutrition project and the Communication & Recording Keeping project.
16. Ensure Hospital A's Mental Capacity and Assessing Best Interests Decision training strategy is implemented, and the training is reviewed and audited to ensure quality assurance.
17. To share the learning from this SAR with the local teams involved in the care, and across the organisations, including the new provider for the community nursing service covering Town A.

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6. GLOSSARY

This glossary contains explanations of acronyms and terms that are used in the Report.

Acronyms/Abbreviations

CCG	Clinical Commissioning Group
CH1	Care Home 1
CPR	Cardiopulmonary Resuscitation
C.Diff	Clostridium Difficile
DNAR	Do Not Attempt Resuscitation
GP	General Practitioner
IMR	Individual Management Report
KMSAB	Kent and Medway Safeguarding Adults Board
NEWS	National Early Warning Score
SAR	Safeguarding Adults Review
SMART	Specific, Measurable, Attainable, Relevant and Timely.
UTI	Urinary tract infection

Bronchopneumonia - A severe inflammation or swelling of the walls of the bronchioles. The bronchioles or bronchioli are the passageways by which air passes through the nose or mouth to the alveoli (air sacs) of the lungs.

Cardiopulmonary resuscitation (**CPR)** - A life -saving medical procedure which is given to someone who is in cardiac arrest. It helps to pump blood around the person's body when their heart can't.

Care Act (2014) - The Care Act 2014 came into force on 1 April 2015, replacing and consolidating a number of previous laws and statutory guidance, to create a single, consistent approach to establishing entitlement to adult social care in England. It sets out duties for local authorities and partner agencies and introduces the right to an assessment for anyone, including carers, in

need of support. The Act promotes a preventative approach and aims to put individuals in control of their care and support.
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Clostridium Difficile (C.Diff) - A bacterium that can infect the bowel and cause diarrhoea.

Diverticulosis - Diverticular disease and diverticulitis are related digestive conditions that affect the large intestine (colon). In diverticular disease, small bulges or pockets (diverticula) develop in the lining of the intestine. Diverticulitis is when these pockets become inflamed or infected.

Do Not Attempt Resuscitation (DNAR) - DNAR is a decision not to attempt cardiopulmonary resuscitation (CPR), made and recorded in advance, to guide those present if a person subsequently suffers sudden cardiac arrest or dies.

A DNAR decision may be made and recorded:

- at the request of the person themselves;
- as a shared decision (made by the person themselves and their doctor and/or other healthcare team members) that the likelihood of CPR being beneficial in their current situation would not outweigh the potential burdens and risks of receiving attempted CPR;
- by the healthcare team, because CPR should not be offered to a person who is dying from an advanced and irreversible condition and therefore CPR will not prevent their death;
- by the healthcare team because the person themselves is not able to contribute to a shared decision and a decision has to be made in their best interests.

Doppler ABPI /bilateral arterial duplex – A comparison of the blood pressure in the arm with that of the ankle. A duplex ultrasound is a non-invasive evaluation of blood flow through arteries and veins.

Gastro-Oesophageal Reflux Disease (GORD)- A condition where acid from the stomach leaks up into the oesophagus (the passage by which food passes from the mouth to the stomach, sometimes known as the gullet).

Ischaemic – A limb-threatening lack of blood supply**.**

Larvae therapy treatments - Larvae therapy involves applying live disinfected maggots (fly larvae) to a wound to help it heal. Maggots can be used to treat dirty or infected wounds as they remove dead tissue and bacteria (germs), leaving behind healthy, disinfected, tissue that can heal.

Mental Capacity - A person's ability to make their own decisions. When a person makes a decision, they need to be able to:

- understand all the information needed to make that decision,
- use or think about that information,
- remember that information, and
- be able to communicate that decision to someone else.

Communicating a decision is not just telling someone. It can be communicated in any way, such as using diagrams or pictures. Making an unwise decision is different than not being able to decide.

Mental Capacity Assessment - A formal assessment of someone's ability to make their own decision. It will usually be conducted by a health or social care professional.

National Early Warning Score (NEWS)- A guide used by medical services to quickly determine the degree of illness of a patient. It is based on the six cardinal vital signs:

1 respiratory rate
2 oxygen saturations
3 temperature
4 systolic blood pressure
5 pulse rate
6 level of consciousness.

Peripheral Vascular Disease - (PVD) is a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm.

Popliteal endarterectomy - Surgical excision of the inner lining of the popliteal artery that is clogged with atherosclerotic buildup. (The popliteal artery is a deeply placed continuation of the femoral artery).