Safeguarding Adult Review: Adult R

Briefing paper for practitioners

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Background and context

Adult R, aged 82, died in hospital in August 2021. Three months earlier she had been hospitalised following a stroke and after treatment had returned home, in line with her wishes, where she received bed-based care. An inquest concluded that she died of natural causes: sepsis and an infected sacral ulcer in the context of severe coronary artery atherosclerosis.

Norfolk Safeguarding Adults Board (NSAB) has a statutory duty (section 44 (1-3), Care Act 2014) to carry out a Safeguarding Adult Review (SAR) when an adult with care and support needs has died or been seriously harmed as a result of abuse or neglect and there is concern about how SAB members or others worked together to safeguard them. NSAB commissioned this SAR in March 2023.

The two independent reviewers sought chronologies of agency involvement and asked agencies to evaluate their own actions in relation to key lines of enquiry: how well Adult R's needs and risks were managed; how her views and wishes were respected; how well agencies worked together; pressure ulcer care; provision of equipment; service structures and other organisational features. An online learning event drew practitioners and managers together to explore the ongoing challenges of providing safe care at home to people in similar circumstances and to consider what changes would help overcome those challenges. The review focused on the six months leading up to Adult R's death.

Summary of Adult R's circumstances

Adult R lived alone and had led an independent life. Her son had died three weeks prior to her stroke but she remained in contact with her stepdaughter. Her stroke significantly changed her living arrangements. Her mobility and strength were severely affected, and she remained bed-based, with little potential for rehabilitation. She was incontinent of urine and required assistance with personal hygiene, meals, fluids, medication administration, application of creams and a hoist to transfer to a wheelchair. She also experienced significant pain and was low in mood. She wanted to return home with 24-hour care, but this level of care was declined; the home care arrangements consisted of four double-up care worker visits daily, provision of equipment, support from her GP, visits by the community stroke team and pressure ulcer care from community nursing.

A subsequent transient ischaemic attack necessitated a second, shorter, hospital stay, following which she again returned home. During all of this period her skin integrity deteriorated. On her initial discharge from hospital she had a healing category 2 ulcer to her heel, but quickly developed pressure areas to her sacrum, which continued to deteriorate and

became infected. She became very unwell before a final hospital admission that preceded her death.

Learning from the review

Need and risks

At Adult R's first discharge, the hospital requested 24-hour care but was advised that she was not eligible for the continuing care funding this would require. Neither NCHC nor the local authority have been able to establish from their records how or by whom this decision was made, and no details of a continuing care assessment have been provided. This remains a concern going forward. The care provided was four daily care worker visits, community stroke team visits and community nursing.

While agencies supporting Adult R at home were providing active support and attempting to meet her needs, there were omissions and missed opportunities to monitor risk and to escalate action that could address it. Errors and delays in providing suitable equipment impacted on her safe care. It is not clear that her mental health needs related to the psychological impact of her stroke and to the loss of her son were recognised or addressed after hospital discharge. A prescribing error by the GP surgery resulted in her receiving the incorrect dose of morphine. Overall case coordination was absent. Each agency worked within its own remit; coordinating the *interaction* between the various aspects of Adult R's care was no-one's responsibility.

As her skin integrity deteriorated, there is no evidence that alternative interventions were pursued. ASC, having undertaken the initial Care Act assessment by telephone, did not have face-to-face discussion with Adult R. The earlier decision not to provide overnight care should have been revisited, as the length of time she spent without repositioning will have negatively impacted on her skin integrity. Several agencies believed respite care was needed but no-one pursued this. It is hard to avoid the conclusion that although all agencies were concerned about Adult R's declining health, they were (except the care agency) not sufficiently proactive in seeking an alternative intervention strategy to match the level of risk that she faced.

Adult R's views and wishes

Adult R expressed strong desire to return home following her stroke, and her wishes were respected. What is missing is evidence that clear information was shared with her about the risks involved and, as her condition deteriorated, that frank discussions were held with her about the risks of remaining at home without additional support. Continuous risk assessment should have resulted in the available options being revisited, with full explanation of the risks she faced and their potential consequences. In such a high-risk situation, her mental capacity to decide about remaining at home should have been explicitly assessed. This would have included exploration of her understanding of information relevant to that decision, such as the level of risk she faced. In the absence of such an assessment, questions remain about whether she really understood the seriousness of her condition.

Its impact on her life, however, is evident. Adult R's stepdaughter considers that Adult R started to fade away as she couldn't connect with real life and her state of mind suffered. She found it hard to be without support overnight and being unable to do things for herself made her feel

vulnerable and helpless. There is little evidence these feelings were recognised or addressed by agencies involved.

Safeguarding

Formal safeguarding processes were not effective in keeping Adult R safe. Two referrals that were made were not pursued in a timely way: the first (relating to the actions of a hospital health care assistant) was dealt with immediately by the hospital but was not triaged by the MASH until after Adult R had died); the second, raised by the care agency relating to pressure ulcer care by community nursing, was closed five days later with no contact being made with Adult R on the grounds that she was by then in hospital and assumed to be safe. There were times also when referrals might have been expected but were not made. Although her pressure ulcers were reported on Datix on several occasions, these were not escalated to safeguarding. No safeguarding referral was made by the hospital on her second admission with a category 3 pressure ulcer to her sacrum and a category 3 ulcer to her heel. A GP visited and observed her condition on the day the care agency raised a safeguarding concern, but again did not escalate their concern to safeguarding.

Pressure ulcer care and the impact of equipment

Adult R had both a hospital acquired pressure ulcer (to the heel, which developed during her first admission) and a pressure ulcer to her sacrum (which developed while she was being cared for at home). By the time of her second hospital admission she had category 3 pressure ulcers to both areas, which quickly became unstageable. By the time of her third and final admission, her sacral ulcer was a black/necrotic and infected category 4 ulcer.

Risk assessment, care plans, positioning charts and equipment had all been in place and her pressure ulcers had been recorded via the Datix reporting system. But none had been escalated to safeguarding, and key agencies were unaware of guidance on escalation in place at the time[1]. There was poor recognition of the interaction between her skin integrity, her incontinence and the positioning challenges caused by her pain levels. In addition, failures in equipment delivery, particularly of a tilt-in-space chair into which she could have been hoisted, resulted in bed-based care without respite. Although the care workers followed repositioning instructions, missing equipment meant that she would regularly reposition herself away from the recommended position between visits, and overnight she had no assistance at all. A TOTO turning system was considered unsuitable and it seems that no further consideration was given to how equipment might help solve this problem.

Working together

Practitioners were all working to provide safe care to Adult R, but agencies worked in silos. Information-sharing, a shared intervention strategy and effective coordination of the efforts of all involved were missing. Organisational features such as different record systems and

[1] Department of Health & Social Care (2018) *Safeguarding Adults Protocol: Pressure Ulcers and the Interface with a Safeguarding Enquiry*. London: DHSC. This guidance was withdrawn in June 2023 due to being out of date, but it was in place during the period under review. Although withdrawn, DHSC advise that local guidance based on its principles should still be followed.

messaging facilities impeded good communication. Pain management, pressure ulcer care, continence, positioning and personal care were each addressed separately and at no point did the whole network convene to share perceptions of risk and to devise a shared risk-management strategy. What was missing was holistic care management; no one agency took overall responsibility. This was a significant gap, resulting in limited co-ordination of services and care provision, causing fragmentation and frustration for agencies and, more significantly, a failure to pursue a shared risk management strategy. In the absence of this, those closest to Adult R – the care workers – sought the attention of others when they considered Adult R's condition warranted it, coming closest to acting as a coordinator but without recognition or a clear mandate for this, other than that of perceived necessity.

Escalation

Practitioners lacked awareness of suitable escalation routes through which concerns could have been raised, and even where awareness was in place, staff were not confident in using the pathways. The absence of safeguarding referrals, other than from the care agency, is one example, compounded by missing knowledge of guidance on escalation of concerns about pressure ulcers. Another is the absence of escalation by NCHC about persistent difficulties reaching the care agency. Escalation of concerns could have triggered important processes – review of Adult R's care and support, review of her turning plan, discussion of alternative care provision or ways of increasing its frequency, respite care, and review of her eligibility for continuing care to enable care to be provided overnight.

Service structures and organisational features

Communications were affected by service structures, IT and telephony systems. The GP surgery found that the removal of community nursing's physical presence from GP surgeries had impacted negatively on the flow of information and case management discussions. This had been exacerbated by community nursing's non-attendance at the surgery's multidisciplinary team meetings and by the use of different IT systems, which acted as a further barrier to information-sharing. NCHC's triage system, combined with lack of confidence by NCHC in the care agency's voice messaging system, resulted in persistent difficulties of communication between the two agencies.

There were organisational pressures from the Covid pandemic. The period of Adult R's care coincides with the tiered restrictions of the government's 'roadmap out of lockdown', operational between 8th March 2021 and 19th July 2021. Since early 2020, all agencies had been under extreme pressure from unprecedented demands due to the pandemic. In addition to severe staffing pressures, there were restrictions on face-to-face visits and constraints on the timing of visits and in team communications. In this context Adult R's care was nonetheless maintained.

What does this mean for practice?

Agencies have already made many in-agency improvements: ASC in relation to safeguarding processes, NCHC in relation to pressure ulcer care, the care agency in relation to its telephony system and the Integrated Care System in relation to patient record sharing. But challenges remain and the SAR makes recommendations relating to the following matters:

- hospital discharge and ongoing coordination of support to patients with complex needs;
- escalation pathways;
- pressure ulcer care;
- GP safeguarding policies and significant event analysis requirements;
- mental capacity assessment;
- access to shared care records;
- manual transcription of medication;
- provision of equipment to people receiving bed-based or fully hoisted care at home;
- interagency communication;
- safeguarding triage and the s.42 Care Act mandate;
- a learning event to disseminate the SAR findings, and an event one year on to report outcomes.

As practitioners, you can take some key steps to use the learning in your practice:

> ***Case coordination:*** If you are supporting an adult with complex, bed-based needs and their condition deteriorates or you become concerned about how agencies are coordinating their care, do use the NSAB Complex Case Management - Multi-agency Guidance to make a case conference happen: Practice guidance | Norfolk Safeguarding Adults Board
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> ***Continuous risk assessment:*** If a person's condition deteriorates, proactively discuss this with them and revisit the options available. If their decision leaves them at high-risk, including risk of death, ensure you assess their mental capacity and explore their understanding of the information relevant to their decision, including of the level of risk they face. View an example of an assessment here: Mental capacity & safeguarding | Norfolk Safeguarding Adults Board
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> ***Skin integrity:*** If a person's positioning plan is difficult to implement or is compromised in some way by lack of equipment or their own actions, raise this for review. Early, proactive escalation of these challenges is a positive action that care workers and others can take.

End.