Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

SAFEGUARDING ADULT REVIEW
THEMATIC REPORT

Mrs A & Miss G

MAY 2020

Contents

1. Introduction

1.1 This report covers the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of the Lewisham Safeguarding Adults Board (LSAB), relating to the death of two adults in 2018 (referred to as Case 1 Mrs A & Case 2 Miss G throughout this report to preserve their anonymity).

1.2 The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Lewisham in the future.

1.3 The review was conducted in the light of the following legislation; Section 44, Care Act 2014 Safeguarding Adult Reviews.

The purpose of a Safeguarding Adult Review is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'.

The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

The Department of Health Care and Support Statutory Guidance – published to support the operation of the Care Act 2014, states[1]:

14.163 Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

14.168 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

1.4 Why were these cases chosen to be reviewed?

Initially the LSAB identified the case of Mrs A as meeting the criteria set out in the Care Act 2014 (S44) for commissioning a review in June 2019. This was due to the circumstances surrounding her admission and subsequent discharge from hospital to her own accommodation. Concerns were identified regarding the care she received and this prompted a Safeguarding Enquiry, under the Care Act 2014 (S42). Whilst information was being sought in relation to this review a further case (Miss G) was brought to the attention of the LSAB. This case shared many similar features as the Mrs A case, which were also a cause for concern. The LSAB therefore took the decision in July 2019 to review both cases simultaneously using one Safeguarding Adult Review process in order to explore potential common themes arising from both cases, as well as any issues identified in one of the cases.

[1] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

1.41 Brief summary of cases subject to review

Case 1 (Mrs A)

Mrs A was 102 at the time period subject to this review. She was of White British ethnicity and lived alone in an ex-council 2 bedroom flat. She was supported at home by her granddaughter who helped with shopping, cleaning and other tasks that Mrs A couldn't do at home independently. In addition she was also supported through a council funded package of care supplied by the Home Care Agency Care with four home visits a day by one carer. The carer assisted Mrs A with getting up in the morning, personal care, medication prompting and meal preparations, then going to bed in the evening. She was able to mobilise inside her flat with the aid of a walking frame at the beginning of the period under review, but lost her mobility during the days prior to her first hospital admission, and thereafter was largely cared for in bed only rarely being supported out to sit on the sofa for the rest of the review period.

Mrs A was partially sighted as a result of Glaucoma and Cataracts. She had a hearing impairment, as well as a range of other medical conditions including Hyponatraemia (Low sodium in the blood), Urinary Retention (inability to empty the bladder), Cellulitis (Bacterial skin infection) on her left foot, left hip dynamic screw operation (a type of orthopaedic implant designed for fixation of certain types of hip fractures), leaky heart valve, chronic kidney disease, Hypertension, pressure ulcers and a history of falls. There was no information indicating that Mrs A's mental capacity was thought to be in need of assessment during the review period, although concerns about her decision making ability were raised during this review.

Case 2 (Miss G)

Miss G was 73 at the time period of the review and was diagnosed with Small Vessel Disease (a condition in which the walls of the small arteries in the heart are damaged). The condition causes signs and symptoms of heart disease, such as chest pain, Angina and Lacunar Ischaemic Stroke (the most common type of Ischaemic Stroke, resulting from the occlusion of small penetrating arteries that provide blood to the brain's deep structures). She was at risk of falls and pressure ulcers. Her ethnicity was Black Caribbean and her religion was Jehovah's Witness. She lived alone and was supported by her son, who visited her regularly. There were also no indications that Miss G's mental capacity was assessed during the period subject to review.

She was in receipt of a package of care four times per day with tasks to support her with medication, personal care (very similar to those provided to Mrs A). Initially this was by one carer and provided through the Re-ablement Service. After her first hospital admission this was increased to two carers for each call and the service was re-commissioned from the Home Care Agency Care Agency. From this point onwards she was cared for in bed as the advice from District Nurses (DNs) was that she should not be transferred out of bed without the appropriate equipment to assist this. Although ordered by the DNs, this equipment was never supplied during the period under review.

1.5 Timeframe, Terms of Reference, Methodology and Scope

This review covers key periods of contact during the periods of January-April 2018 for the Mrs A case and April-December 2018 for the Miss G Case.

The methodology for this SAR was through a collation of Individual Management Reviews and Chronologies submitted by relevant agencies working with each case. The Independent Author

then collated a combined chronology from the individual submissions for each case. The combined chronologies were then broken down to several distinct phases of contact called Key Practice Episodes (KPE). The involvement of services during each KPE was then appraised and underlying factors affecting decisions and actions were then explored to explain the practice and contacts with both adults.

A practitioner-learning event was held (17/01/20) to discuss the Key Practice Episodes and discuss potential findings for each case, as well as to identify common themes for both cases. Representation and engagement at the learning event was good from both front line staff and management for all the agencies involved, to enable the experience of practitioners to also inform understanding of and learning from the cases.

1.6 Summary of Learning Event Model

The learning event was a valuable opportunity to gather the input and opinions of staff, as well as identify any further clarification and additional information for the review. For the purpose of the learning event, each of the cases under consideration was presented to the attendees, with subsequent analysis undertaken by small groups. An integrated chronology was compiled by the author for each case from all single agency chronologies and other reports before the event.

These were divided into five periods of the timeline around the major events for each case (KPEs 1-5). The whole group at the learning event was divided into five sub-groups, with multi-agency membership. Each group was then given a different period of the chronology (KPEs 1-5). The small groups evaluated the practice during these KPEs. Any learning was identified from each of the subgroups during a subsequent feedback and discussion phase of the learning event.

1.7 Individual Management Reviews

Individual Management Reviews are a means of enabling organisations to reflect and critically analyse their involvement, to identify good practice and areas where systems, processes or individual and organisational practice could be enhanced. They are key learning tools used in several of the Safeguarding Adult Review methodologies and other similar reviews such as Domestic Homicide Reviews and Serious Case Reviews.

1.8 Agencies that had involvement in the cases and submitted IMRs:

- Home Care Agency
- Lewisham & Greenwich District Nursing Service (Lewisham and Greenwich NHS Trust)
- University Hospital Lewisham (Lewisham and Greenwich NHS Trust)
- GP Surgeries for both cases
- London Ambulance Service
- Hospital Adult Social Care Team (London Borough of Lewisham)
- Safeguarding Quality Assurance Team (London Borough of Lewisham)
- Emergency Duty Team (London Borough of Lewisham).

1.9 Methodological comment and limitations

It was a significant challenge that the review did not start until over a year after the adults' died, and submissions of the IMRs were also delayed, with all the relevant information only supplied fully by partner agencies by the end of 2019. Further clarification and additional information was requested from some agencies upon receipt of the initial IMR submissions.

1.10 Reviewing expertise and independence

An Independent Consultancy undertook the SAR and appointed an Independent Lead Reviewer. All relevant documentation was then shared with and scrutinised by the Independent Lead Reviewer, to compile the Independent Overview Report. Mick Haggar is the author of this Overview Report, which has been completed on the basis of submissions of Individual Management Reviews and other reports (outlined above).

1.11 Acronyms used and terminology explained

Writing for multiple audiences is always a challenge. In Appendix 1 we provide a section listing any abbreviations used to support readers who are not familiar with these. In Appendix 2 language and terminology of medical and safeguarding work is explained and referenced. References are also made to key guidance or research in footnotes throughout the report.

1.12 Involvement of family members

The input and opinions of family members of the deceased is an important aspect of the SAR process, both to inform them of the review, and to include them to take account of their first-hand experience of services provided to them/their relative. The family of Mrs A were clear when contacted that they did not want to be involved in this process.

The son of Miss G had expressed interest in contributing to the case for his mother and has had an opportunity to contribute some information from his perspective of his mother's care. He has also had the chance to read and comment on a draft version of this report.

This is recognised to still be somewhat a gap in process for this SAR, which could impact on the material available for potential learning from these cases.

1.13 Structure of the report

To enable ease of reading each case is summarised and appraised separately in the following sections of the report (Section 2, 3 for Case 1 and Sections 4, 5 for Case 2). The common themes arising out of both cases are then considered for overall Findings with related recommendations presented to the SAR Panel in Section 6. Finally, Section 7 sets out a brief conclusion to the SAR, based on the learning from the materials in the context of local service delivery and national guidance.

2. Summary of Case 1 (Mrs A) and significance of Key Practice Episodes

The section below sets out a brief summary of the multi-agency chronology of service involvement in Case 1. The independent author collated this chronology from the IMRs, individual agency chronologies and other reports submitted on each case by the agencies participating in this review (see 1.9. above). As outlined above, the integrated chronology for the case was then divided into Key Practice Episodes (KPEs), which are set out separately along with the significance of practice during each KPE. These are then appraised and analysed further for learning in Section 3 of the report.

2.1 Key Practice Episode 1: (03/01/18-19/02/18) First admission, treatment and discharge from Hospital

Mrs A was living at home and receiving a package of home care when she became unwell with a suspected infection and was admitted to Oak Ward at University Hospital Lewisham (UHL). She had a wound on her left hip, which was assessed and treated by a Tissue Viability Nurse (TVN). She was seen by therapists whilst in hospital and an Occupational Therapist (OT) visited her property, after requesting her key safe code from Linkline to enable access.

No equipment or additional care needs were identified during this admission, there was no evidence of any discussion about potential skin breakdown of pressure areas and Mrs A was discharged home. However, the ward did refer Mrs A to the DN service for pressure area monitoring. Despite receiving this referral it was not acknowledged or actioned for allocation by the DN service.

SIGNIFICANCE

This period was a missed opportunity to reassess both Mrs A's increased health and social care needs in hospital, during and after her treatment for a suspected Urinary Tract Infection (UTI), and to arrange a more suitable level of care for when she returned home. The issue of the nature and status of her wound appears subsequently to not have been a pressure ulcer, but possibly as a result of an injury, although this was unclear at the time of her discharge and not communicated to the home care agency.

2.2 Key Practice Episode 2: (19/02/18-23/02/18) Restarting of community care and needs for nursing at home

Mrs A was discharged home, having had her wound/injury dressed in hospital who also sent a referral for District Nursing (see KPE 1). She was at risk of further skin breakdown and needed on-going dressings and assessment of her wound, as well as catheter care. However, this referral was not added to the DN allocations and not actioned. The Local Authority did restart her visits by one carer four times per day as per her previous package of care. Mrs A was noted to be far less mobile now, spending most of her time in bed. Mrs A's daughter contacted her GP a week after Mrs A's discharge to request a District Nurse, which was also not actioned by the DN service.

SIGNIFICANCE

Mrs A's needs for nursing and care in the community appeared to have increased but were not identified and therefore remained unmet during the week after her discharge from hospital, it was again requested by her daughter via her GP but did not result in contact from the DN service. Also, as an increase in need for home care had not been assessed or identified, her package of care was restarted rather than reviewed. This posed challenges for the carer, as Mrs A was now unable to get out of bed and it may have not been safe for one carer to attempt to help her transfer.

2.3 Key Practice Episode 3: (23/02/18-24/03/18) Cared for at home by a Home Care Agency, but no other agency were involved during this time.

Mrs A remained at home and continued to receive her home care service four times per day from one carer, although no agency had submitted any notes of this or any other contact during the month, therefore it was initially not known what actions were taken, or what concerns were identified during this time. It was queried why notes were not submitted from the Home Care

Agency at the learning event, where it was stated these had been summarised. After the learning event a full scan of all case notes during this period were subsequently sent through to the report author.

DNs made no visits to Mrs A during this time. It was not known whether the wound dressing which was on her hip after discharge from hospital had come off on its own accord, or whether it had been changed by anyone during this time. If it had come off it was thought the carers would have alerted the home care agency for them to refer to the DNs in a much timelier manner. It was speculated this might have been due to 'personal aspects' of the carers. The home care agency was unaware when/if the client's dressing was last changed and there was poor communication about this. More information ought to have been sent to the home care agency by the hospital about this issue.

The review of the daily logs that were subsequently submitted by the home care agency, identified that there were four case note entries per day, all of which were sent in for review. These are summarised for each of the four weeks of contact below:

23/02/18-29/02/18: Mrs A was usually on/in bed for all calls, catheter and urine bags were emptied and she was given food and personal care. Mrs A was moved to her chair at times, but found to be asleep during others. Always described as okay (OK) and made comfortable by carers. At times Mrs A didn't want anything and was left with tea and made Fortisip drinks by carers.

01/03/18-08/03/18: Mainly again described in home care notes as OK and in bed, given personal care, emptied urine bag, given meals and drinks, some reference to medications being given. She was given a strip wash, presumably in bed. Usually carers recorded that Mrs A was given a sandwich and cup of tea. She refused to eat on 06/03/18 and was described as confused on 08/03/18.

09/03/18-16/03/18: She didn't want to eat anything on one call, usual notes continued as above. Most mornings she had a wash in bed, her pad was changed and cream applied. 11/03/18 Mrs A was worried about her daughter as she was due to visit and hadn't. When fed this was nearly always a sandwich, or soup (same type of soup was given twice on one day).

17/03/18-24/03/18: The pattern of daily logs continued, as above. Family were there on one occasion, twice she did not want food. Carers always described Mrs A as OK and comfortable on the bed. No mention was made in the notes of any dressing, bandage, pressure sores etc., although she was washed and dressed by carers every day.

SIGNIFICANCE

It appears that Mrs A had now significantly decreased mobility and may have required additional equipment to safely get her out of bed, and/or health care to manage the risks to her pressure ulcers and catheter care during this period. The fact that Mrs A remained in bed throughout this time period was significant in terms of her pressure area care. DNs had not responded to the first two referrals, and carers were not identifying or raising any concerns about her during this month.

2.4 Key Practice Episode 4: (24/03/18-28/03/18) Referral and response by District Nurses

The Home Care agency made a referral to the District Nursing Service on Saturday 24/03/18, after Mrs A complained of pain to her carer. The DNs did respond to this referral and she was added to the case list for a visit the next day. However, the DN was unable to gain access to Mrs A as her

key-safe number had not been included in the referral. Due to communication difficulties between the agencies, Mrs A was not seen by a DN until Wednesday 28/03/18, at which point she was noted to have developed a number of significant pressure areas.

SIGNIFICANCE

Poor information sharing about access for patients in the community who have a key safe appears to have directly caused this delay in response to the referral. Also, during the preceding month presumably the pressure ulcers had developed while one carer attended to Mrs A in line with the care plan.

2.5 Key Practice Episode 5: (29/03/18-10/04/18) Concerns about pressure ulcer escalated and the second hospital admission

The District Nurse then ordered pressure-relieving equipment after the visit outlined above, but its delivery was delayed, partly due to a combination of communication and access difficulties. This order was then subsequently cancelled after a Tissue Viability Nurse recommended Mrs A should be admitted to hospital the following week (05/04/18). An ambulance was called and the crew noted that Mrs A was dehydrated, had not been eating, was incontinent, and had shortness of breath. She died in hospital four days later.

SIGNIFICANCE

The delay in Mrs A being seen by DNs in the community and her deterioration during the previous month appeared not to have been escalated appropriately by her home carers, and this may well have contributed to her subsequent decline at home. By the time she was seen and assessed her health was so poor that despite hospitalisation she died shortly afterwards.

3. Appraisal of practice and learning from Case 1

3.1 Appraisal of practice and Learning from KPE 1: (03/01/18-19/02/18) First admission, treatment and discharge from Hospital

Prior to the admission Mrs A was visited by a GP who noted that the home environment was very cold and that Mrs A's health had declined. This was queried as to why this hadn't been earlier identified by her carers, or her family, although there was good information sharing by her support worker during the visit with the GP. The ambulance crew noted that Mrs A had been unwell for nine days prior to the admission with the GP visit having occurred six days before, where he prescribed antibiotics for a suspected UTI.

Mrs A had effectively been immobile for four days before her admission and her increase in care needs was not picked up during this time, which raised the issue of this discrepancy of care needs not being met, and why this might have occurred but had not been escalated by her home carers.

There was a lack of monitoring of her medication, which she hadn't taken for three days (her ability to self-medicate during this time hadn't been identified/reviewed) and she hadn't eaten for four days. The potential impact on her health of this would have been reduced if action had been taken earlier. The issue of thresholds for hospital/community-based care were relevant to this decision, which was taken by the GP subsequent to the home visit. Also, the lack of clinical monitoring of her diet, hydration and the need for a review of her overall health was a gap in practice.

Professionals identified that aspects of the family dynamic affected their contact with them, and that her systems of support were not as robust as was thought, making the viability of her community support network doubtful/not viable and contributing to gaps in her paid care arrangements not being met by her family carers.

The issue of how her wound occurred was never clarified (whether the result of an accident/fall although she was immobile pre-admission), and there was no information about this at the time. It was speculated that she may have fallen prior to admission and did not tell anyone. However, personal care was still being given during the period pre-admission when she was immobile, so a carer should have noted this wound as it was subsequently readily identified at the point of admission by the inpatient nursing staff.

During the hospital admission there were some inpatient assessments of Mrs A and her needs for care on discharge. The outcome of these seemed to change during the admission, whereby an OT had stated she would need 2:1 care, but this was later changed to be 1:1 care and the issue of how/why this was reduced was unclear. It raised the broader point of the accuracy of inpatient assessments for health and social care needs upon discharge.

Although Mrs A had inpatient therapy assessments, the reliability of these was queried given that Mrs A was thought to have “gone back to her baseline”, when in fact her care needs had clearly increased and she was unable to weight-bear.

The role of the carers and the suitability of restarting the same care package were both questioned when her needs had changed, which wasn't reflected in this restart. Also, the need of carers to identify when this occurs was identified. Now the home care agency will be doing more thorough re-assessments themselves when care packages restart after hospital admissions.

This is partly as there was a resource issue, in that her hospital discharge did not indicate the need for a review or re-assessment by Adult Social Care Services. The decision making about her needs for health and social care services were not met prior to her discharge from hospital.

There did appear to have been an “OT Access visit” prior to her discharge, which would normally indicate concerns about the suitability of the environment for discharge, the appropriateness and outcome of this was queried as it was unclear what this was for from the notes.

Also, there is a broader issue of how the decision was made for Mrs A to be “Medically Fit” for discharge and the context within this decision is taken, with the pressure on hospitals to discharge patients as quickly as possible. This clearly raised the issue of how this impacts on safety in the decision-making and discharge planning by inpatient services.

Also, as no new equipment was thought to be required and no pressure-relieving mattress etc. was ordered by the OT prior to hospital discharge, this was not part of any discharge planning considerations. There were no changes to the home environment made, however the ward had referred her to DNs for pressure and wound care monitoring upon discharge.

Contact could not be made with Mrs A’s family prior to discharge and the discharge was delayed as a result of there being no response by the family. This was queried as to whether it was usual practice to not discharge prior to family being contacted, or how this decision is generally taken.

Prior to her admission Mrs A had been able to move from her bed to her chair to her bathroom etc., however afterwards she was not able to move, she was very distressed and in isolation in a

dark bedroom. There was a lack of communication about this by both carers and no contact from DNs, as they did not follow up on the referral from the ward.

The urgency of gaining access to Mrs A on discharge through getting her key code number was flagged up as agency nurses are not given access to the NHS secure email account. The DNs did acknowledge the referral from the ward but this was never activated or allocated for a visit, which showed up a weakness in the DN referral system, whereby when a referral is acknowledged electronically it disappears from the referrals inbox. The effect of this was that Mrs A was discharged with higher needs for both health and social care. These were unmet in the subsequent periods and contributed to her decline in an unsuitable home environment.

Summary of Learning from KPE 1

- Perceptions regarding the suitability of Mrs A's living environment were very different by the GP, who deemed it unsuitable, and by Carers who had not raised this as an issue.
- Home carers may not always rapidly escalate clients' deteriorating physical health, which can cause delays in getting appropriate medical assessment and care from both community and hospital services.
- During her first admission the relationship between her health and its impact on her need for more social care were not identified by the ward MDT, causing her previous level of home care to be restarted, rather than reviewed or reassessed on discharge.
- However, the increase in health care needs in the community were identified during the hospital admission which led to a referral to the DNs, although this was lost and not responded to when discharged, causing Mrs A to have both unmet health and social care needs when discharged home.
- Overall learning from this period showed that Mrs A's home environment was identified as unsuitable before she became unwell, and although her hospital admission did treat her UTI, it did not clarify the impact on her in terms of her needs for increased support to be set up prior to being discharged home.

3.2 Appraisal of practice and Learning from KPE 2: (19/02/18-23/02/18)

Restarting of community care and needs for district nursing at home

No equipment had been requested on discharge, and her care package was restarted as before with no extra information on Mrs A's increased needs and lack of mobility. The decisions taken on the ward did not convey the updated correct information. No ulcer was mentioned, and there was a 10-day delay in the second referral to the DNs following her daughter's referral to the GP that her mother needed a nursing assessment at home.

It appeared that Mrs A's community needs did not follow the "Discharge to Assess" pathway, but rather a straightforward restart of her care. It was questioned whether this was appropriate and how the decision was made, as it seemed significant in her needs not being reassessed upon discharge from hospital. The wrong form seemed to have been used by the ward MDT, as there is one to initiate a restart and one to request a re-assessment/increase in care. Due to this error upon discharge, no request was sent to Adult Social Care for a Social Worker to visit, and so her needs were not re-assessed. A social worker was not allocated to her case as there was no identified need to allocate one upon discharge.

The MDT didn't identify any change in needs and it was not clear why as her mobility had clearly deteriorated. The inaccurate discharge information included that her catheter was said to have been removed, but had in fact been left in place. It was queried whether the choice of discharge pathways was too complex for ward staff to identify the appropriate process.

It was noted that Mrs A did not have a pressure ulcer on discharge according to inpatient staff (this was thought to be a wound from an injury/fall), but she was still referred to the DN service by the ward staff for pressure area monitoring. As outlined above in KPE 1 the “lost” referral to DNs was also identified as an individual, but also system error. Furthermore, when her daughter then later requested this again via her GP this was still not actioned. There appeared to have been an error made at this point by the GP practice, although the details of this are not known.

Communication to the home care agency by professionals on the ward was minimal and it was left to the provider to take responsibility themselves to decide whether to assess Mrs A’s needs by a field supervisor. At the time of the review this was not routinely done but is now standard practice for any new package of care commissioned. It appeared when her care restarted, the carers did not take responsibility to escalate the deterioration in her condition over the hospital admission/discharge process to a field supervisor (i.e. the catheter being left in, the bed being too low, her inability to transfer, causing her to be unable to get out of bed either alone, or with one carer etc.).

The Support Planner did what they should have based on the information they had (i.e. restart care package). The carers did try to meet her needs and it was also recognised they have a time pressure, but also a duty of care and a better first-hand knowledge of Mrs A through daily contact with her. There were aspects of the client that are relevant to this, as daily logs showed she sometimes said, “Leave me alone”. There was clearly a delay in the escalation of her unmet needs, although this has now improved and is done through an electronic system, where the carer is required to contact the home care office, who then contact SCAIT whenever care was not provided, whatever the reason for this (i.e. where a client may refuse care offered).

Summary of Learning from KPE 2

- Mrs A continued to receive the same level of home care when she returned home, which was no longer sufficient to meet her needs and keep her safe.
- One carer was not sufficient to assist her out of bed putting her health at risk; in addition she also received no medical care at home.
- There was a failure in communication between the ward and the district nursing service, the consequences of which were that Mrs A was not seen by a District Nurse during this period.
- There was a further failure in communication after her daughter made a second request for DN input via Mrs A’s GP.
- This resulted in her wound and catheter care needs remaining unmet, whilst one home carer was trying to support her but could not move her safely out of bed.

3.3 Appraisal of practice and Learning from the KPE 3: (23/02/18-24/03/18)

Cared for at home by the Home Care Agency Carers, but no other agency were involved during this time

It was since speculated by the Home Care Agency Care staff that carers had presumed that nursing were involved, but there was a lack of communication between the agencies on this point.

It was also queried whether anyone else (for example her family) changed her dressing themselves. There had been a dressing on her wound, which covered the area where a pressure sore then developed, but this was not identified during this period by her carers.

Also, the same catheter was being emptied for a month, by her carers, without any nursing input, or assessment. There is now a “Catheter Passport” system in place from the hospital where it is given to the patient on discharge and also communicated with Next of Kin (NoK) where appropriate.

During this month carers continued to support Mrs A whilst she remained in bed, with no input from the DN service, despite two referrals having been made to the service (one from the ward during KPE 1 and one from her daughter via her GP during KPE 2).

Summary of Learning from KPE 3

- The situation outlined in KPE 2 continued for a further month, with one carer visiting and no nursing input.
- At times Mrs A didn't want to eat but was still described as OK in the home care logs and carers did not escalate any concerns, either within the agency management system, or to her GP.
- The second DN referral that had been instigated by her daughter via the GP did not result in any action, and so a DN did still not see Mrs A during this period.
- The impact of her being cared for in an unsuitable home environment by one carer, whilst in bed and without required DN input (which was clearly not appropriate), but despite this it continued for over a month.
- Information sharing did not occur between the DN service and the home care agency during this period.

3.4. Appraisal of practice and Learning from KPE 4: (24/03/18-28/03/18)

Referral and response by District Nurses

During this period there is a third referral to district nurses, this one by the care agency, which was prompted by the client saying she was in pain. This was received and actioned by DN service, but they were unable to access the client over the weekend due to the key-safe number not being available as part of the referral to the DN service. They were unable to contact either the referrer or the family over the weekend after receiving the referral, and so this was not responded to until the following week. One carer had the daughter’s telephone number and had a good relationship with her, but this was not a formal relationship and this information was not shared. There should have been a 48-hour review instigated by the agency irrespective of the pathway used for the referral (i.e. whether or not it was just a “restart”).

The conditions of her flat and general home environment were not suitable, but the carers did not escalate this. Her bed had no sheets, her bedroom was dark and cold. It was in the back of her flat, where it had no TV and she had a low bed, making it more difficult to care for her. Mrs A was distressed on every visit (although had been recorded on care logs as being OK by carers). Her bedroom was also cluttered, but as this situation was on-going and appeared to have been accepted by the carers as normal, it was deemed to be OK.

Linkline held the key-safe number to Mrs A's property, and also held a set of keys and will go to the property to open the door if requested to do so. As this did not happen, Mrs A was not seen for four days which delayed further the nursing input.

However, when she was seen her home environment was not judged as being adequate by the DNs, when they finally succeeded in gaining access (similar to the perception by her GP on his visit, in KPE 1). Basic wound management and the overall environment were generally poor and not suitable, and there was a need for specialist equipment. Mrs A was very isolated, being effectively in just one room of her flat. The referral didn't include all the information required, it didn't include key safe information, and there was no recognition of the overall risk due to interagency/professional practice. DN's were alarmed that due to Mrs A's immobility, she was stuck in her bedroom all of the time and had developed pressure ulcers.

The Home Care Agency care staff became too close to Mrs A, which meant trust barriers started to happen with staff in the Home Care Agency and more widely. Professional relationships became too informal so information wasn't equally shared, which is a personal and organisational/management issue.

Summary of Learning from KPE 4

- Mrs A reported to her carers that she was in pain and this prompted the agency to make a third referral to DNs, which could have been raised earlier.
- The DNs did receive this and respond, but were delayed for four days in accessing the flat due to a lack of information about the key-safe on the referral form, and difficulties contacting the client's family or the referrer over the weekend.

3.5 Appraisal of practice and Learning from KPE 5: (29/03/18-10/04/18)

Concerns about pressure ulcer escalate and second hospital admission

There was good practice by the DNs, which was timely once the referral was finally responded to, although it was noted there was a discrepancy about the pressure sores once they went in to see Mrs A. Sites of pressure sores were different according to accounts recorded by a Tissue Viability Nurse, the London Ambulance Service, and the District Nurses (TVN/LAS/DNs), which were due to the individual aspects of different agencies roles and poor communication between them. There was some good communication between the DNs and LAS. LAS identified that Mrs A's hospital discharge had been an unsafe discharge. This was due to the fact that they identified when they went in, that her home had not been set up suitably for her. At that point there was a consensus about the urgency of the situation and the severity of her health, and that her pressure ulcers needed in-patient management.

The equipment that had been ordered by DNs after the first home visit was not delivered, and there was insufficient knowledge of the key safe by all partners, due to inter agency communication issues. Again due to access problems at the home, pressure-relieving equipment was cancelled seven days after the DNs ordered it due to Mrs A's admission to hospital. During this time attempts were recorded to contact her family but not to get the access key code from carers, who must have had it. The lack of early escalation of the situation by carers during the preceding month was thought to be due to aspects of the carer's role, and the feeling that they had to get on and cope, even where this put the client at risk. The poor discharge identified by LAS was due to a lack of equipment having been ordered by inpatient staff at the point of, or even prior to her earlier hospital discharge.

On referral DNs usually try to conduct a home visit with the referrer, but in this case it didn't happen. The provider was commissioned to move her, but there was a problem with funding, and only one carer was going in to see Mrs A. Carers, DNs and the equipment service (Medequip) have to all coordinate visits to organise moving and handling issues once equipment is ready to be delivered, installed and safely used. This causes major complexities and demands on all services to visit simultaneously. There is a service to move furniture to allow equipment to be installed (Good Jim), which can be set up from hospital pre-discharge, but this wasn't identified as a need in this case. There was an issue with both space to install the equipment, and the fact that two plug sockets are needed to use a pressure-relieving mattress.

There may be a gap in contract provision to enable rapid installation of equipment in peoples' homes. Also when equipment is ordered no specific time is given for delivery and so professionals have to waste time waiting at the address for this to happen, which they don't have time to do. There was a misunderstanding of each other's roles and responsibilities to enable equipment to be installed safely and rapidly after it has been ordered, which also contributed to the delay in getting these in place. The factors affecting this were time pressures on discharge from hospital which was thought to be key in the initial mistakes in this case, which had repercussions throughout Mrs A's subsequent discharge and care at home, which was never sufficient nor safe.

Summary of Learning from KPE 5

- When DNs visited they identified serious concerns related to her health (dehydration, incontinence shortness of breath) and pressure ulcers.
- Equipment to enable Mrs A to be safely hoisted from her bed was ordered, but due to logistical constraints it did not get delivered prior to her poor health requiring a readmission to hospital. By this time her health was so poor that she died four days later.
- At no point in the case were concerns identified about her capacity to take decisions about her welfare and needs for support, despite concerns about the risks of her ongoing care in the community.

4. Summary of Case 2 (Miss G) and significance of Key Practice Episodes

4.1 Key Practice Episode 1: (25/04/18-07/06/18) First admission, discharge and then readmission to Hospital

Miss G was discharged from hospital and later the same day was found on the floor of her flat by her son having been left in a chair by her carers. Her son helped her to bed and this was reported to Adult Social Care Services via EDT. Two days later she was found again on the floor, having fallen from her bed and spent some of the night there. An ambulance was called and she was re-admitted to hospital.

Miss G's son has helpfully provided an email summarising his concerns of the key points during this episode which were relevant to both this incident and subsequent implications for her health and care needs both at the point of hospital discharge and when she returned home to her flat. This is included in full below;

"*After my mother was admitted to hospital on 26/04/2018 to UHL and discharged on 05/06/2018, she was transported to home by the hospital transport which she had to wait with the transport staff until my arrival as the hospital sent her home thinking she had someone there which there wasn't because she lived by herself which I had made clear to all appropriate staff.*

I waited for about an hour until the care assistant turned up then I left.

Around 9pm the same day I received a call from my mother saying she was on the floor in the front room, which I didn't understand why as I was made to believe that the carer was putting my mum to bed in the bedroom.

My girlfriend and I left immediately to get to her home which we found her on the floor next to the settee, when we helped my mother back up to the settee I asked her why she was in the front room, she explained that she told the carer she wasn't ready to sleep so the carer for some reason put a pillow and blanket on the settee and left her there, which the settee had no means to stop her falling etc.

We had to struggle with her to get her back into bed. The next morning 06/06/2018 we decided to visit my mother again say around 10:00am to find that no carer had come to see her meaning she had been left by the carer the day before around 7pm and no other carer saw my mother again until the next day around 11:30, so she had been laying in her own excrement and urine for all those hours, which I believe contributed to her bedsores getting infected. We also had to make her breakfast as no one had done so at the time.

I do not believe my mother should have been discharged on the 05/06/2018 as there was no hospital bed in place to stop her falling out, I was told by the hospital staff to go and buy a bed with my own money for her to have which was totally unsuitable as consequently she fell out the bed on numerous times. I provided new sheets pillows etc., any food my mum wanted and showed the carer at the time where everything was but I was constantly harassed on the phone by numerous carers saying they couldn't find anything and that there was no food. The carers did not know what medication to give my mother and always saying that she was feeling sick, which I said she has medication for that! Apparently the district nurse had what she was supposed to be given but didn't share with the carers."

SIGNIFICANCE

Two incidents of falls occurred very close together, whereby care was either not delivered as expected or not effectively. The risk of falls and safety of Miss G at home did not appear to have been assessed after the first incident. The safety of Miss G at the point of her first discharge was put at risk due to the hospital staff assuming she lived with her family when she clearly lived on her own. Further on her first night at home she was left at risk by the carer, who did not ensure her safety or put her to bed. This led to her first fall from her settee, which was clearly unsuitable as a bed and the lack of provision of any suitable hospital bed contributed to subsequent difficulties for her both at night and when carers did attend to her. Finally, the periods between carer visits alongside leaving Miss G in an unsafe position at night, led to her suffering avoidable harm and distress.

4.2. Key Practice Episode 2: (08/06/18-07/07/18) Second admission, discharge and then readmission to Hospital

There was poor communication and a lack of coordination of care services prior and subsequent to her second discharge. The overall mismanagement of this revealed it was unclear as to who was responsible to make sure all the bits of the jigsaw were in place and ready for her to go home safely.

Peoples “lives” appear to effectively end at the moment they are discharged as far as hospital professionals are concerned. Clearly primary responsibility for preparation for discharging vulnerable patients lies with inpatient staff. Some cases need close coordination in the early days after leaving hospital and going home. This was an example of a poor discharge and it was noted people might often fall between the gaps between inpatient and community services during and immediately after the process of discharge.

There was an appropriate re-assessment of Miss G’s needs during this admission and Miss G’s care package had increased to two carers four times per day. This was commissioned to be provided by a Home Care Agency. However, although there was a key safe in place (but not Linkline) the number was not included in the referral to the Home Care Agency. The impact of this was that the evening carer was unable to access her property, despite seeing Miss G waving from inside.

In these circumstances it was appropriate for the agency to contact EDT, but they were unable to assist, as they also didn't have the key safe number on LAS records. EDT attempted contact with Miss G’s son, but he was on holiday, so he was not available until the next morning. Furthermore it has come to light that Miss G’s son had given other family contact details for the Home Care Agency to get access to his mother’s property whilst he was on holiday. However, this information was not supplied from the previous service to the new provider when they took over the care package.

EDT also contacted the first provider in the belief that they were still the care provider, but the package of care had been transferred to the Home Care Agency, but LAS records on this were unclear at the time of review by the EDT worker. This appears to be a significant gap in practice by the first provider (an in-house Local Authority service), who did not update the new service when the contract was changed.

The next morning on the 7th July 2018 the carers met with Miss G, after her son had been contacted and the day time duty Adult Social Care service informed the agency of the key safe number and where it was situated.

This was a key stage, as the DN service ordered pressure relieving equipment that Miss G needed but it was reported as having never arrived and from this point on Miss G was not moved out of bed by carers, due to advice from the DNs and the apparent subsequent lack of suitable equipment. However, Miss G’s son has supplied further information that both an air mattress (although initially the wrong size) and a hospital bed were delivered by Medequip. It was not clear whether this occurred during this KPE or in KPE 3.

Also, the pressure ulcer was never measured, photographed, reported incorrectly as grade 2 when it was at least a grade 3.

SIGNIFICANCE

It would appear that care was not effectively in place prior to Miss G’s discharge, which put her at risk when she returned home. Furthermore, as access details of her key safe had not been part of the referral to the Home Care Agency, the carers were not able to see Miss G on the day she first returned home. The subsequent response was not sufficient to gain access to Miss G, resulting in her being left overnight on the floor, with no food or water. Miss G’s son has clarified that family contact details were provided to the carers and kept in the logbook. However, it was possible either

these details were not added to Miss G records, or not transferred when the new Home Care Agency took over the contract when she was discharged from hospital.

In addition the inconsistency of arrival times by carers compromised Miss G dietary and fluid intake, as outlined above. Finally the carers refusal to move Miss G out of bed (due to lack of equipment to safely transfer her from bed), as she had asked for led to her remaining in bed nearly all the time when she was at home during this and subsequent periods of the review.

Summary of Learning from KPE 2

- Increased package of care after 2nd admission with 2 carers set up from a different provider, but Miss G had 3rd fall immediately post discharge.
- Aftercare was appropriately increased but not effectively set up, as it could not be actioned, due to incomplete access details. Carers were not given the key safe code and so this delayed access when the new provider was commissioned.
- DNs advised not to move her without equipment, which was delivered, although unclear when this was in place. Care was given in bed but pressure ulcer care was not given.
- Learning from this case shows the importance of follow up for required equipment and the consequences for her care needs not being met where this does not happen.

4.3 Key Practice Episode 3 (08/07/18-25/07/18) Home Care service visits with 2 carers 4 times per day

It was noted that the Home Care Agency received insufficient information from the ward and there was no information on the referral about Miss G's pressure ulcer. This was significant as it affected Miss G and how carers could actually work with her, given that the DN advice was then not to move her until equipment was in place, as this was reported to have never arrived during this period she was only given limited care and remained constantly in bed without being moved. However, it would seem that equipment was in fact delivered by Medequip (either during or before this period of the review). It is therefore unclear as to why/whether this was not used to manage the risk of pressure ulcers at this time.

During this period the carer records reported everything informatively although they did not report to the office that Miss G had got physically sick and was vomiting on several occasions. The Home Care office could have escalated this if carers informed them. There were several reports of Miss G feeling ill during this period, which although logged by the carers on site were not flagged up or escalated as a cause for concern.

Proshield was being used by carers on Miss G's skin, but it was not known where this was applied (whether applied to Miss G's pressure area). The field supervisor did identify and escalate the need for the delivery of the air mattress, pressure cushions etc., which had been ordered but not arrived.

SIGNIFICANCE

Frequent personal care was given to Miss G whilst she remained in bed, due to lack of equipment she was not transferred from her bed during this period and the status of her pressure areas was not known/recorded. From Miss G's son's input it appears that equipment was in place, although it is not clear at what point this was set up by Medequip and raises the issue of why she had an air mattress and a hospital bed, but not a hoist to help her get out of bed. However, it would appear that this equipment must have been supplied at some point during this KPE, as subsequent

episodes cover Miss G's subsequent hospital admission. Furthermore it is a gap in reporting by other agencies that had not reported this as part of the review.

Summary of Learning from KPE 3

- The situation of carers going in but not being able to move Miss G out of bed continued for a month, with carers raising their concerns with adult social care and district nursing over the continued lack of hoisting equipment.
- A hospital bed and air mattress was delivered by Medequip, so unclear why no hoisting equipment was provided at the same time.
- Although carers described Miss G as fine in their case notes, she was also reported as sick and vomiting. This shows the disconnection between front line carers and professionals supporting an adult with multiple needs safely in the community.
- Learning from this period is that carers cannot deliver all care without the right equipment but cannot directly communicate with the suppliers of this equipment to make sure it is in place when needed, which delayed effective care being provided, despite which no action was taken to rectify this.

4.4 Key Practice Episode 4: (26/07/18-30/08/18) Third admission to Hospital and identification of Safeguarding Concerns

Miss G activated her pendant alarm, reporting feeling unwell to Telecare officers, who called an ambulance. Miss G was then readmitted to hospital for her third and final admission. At hospital she was diagnosed with Gastroenteritis and was further found to have an Unstageable Pressure Ulcer. This was despite having been described as 'fine' in the recent records by her carers, and having also had regular visits from the district nurses.

SIGNIFICANCE

There appeared to be a significant discrepancy between the reports of Miss G's care in the community by her home carers (as outlined in KPE 3 above) and her condition upon arrival at hospital. Due to this the hospital raised this as a Safeguarding Concern, which was then allocated for investigation initially by the Hospital Adult Social Care Service.

4.5 Key Practice Episode 5: (12/10/18-15/12/18) Third Admission, Health Records collated

A re-assessment of Miss G's moving and handling needs was completed whilst she was in hospital, and she was accepted for Continuing Healthcare funding, with a view to her being placed in Nursing Care upon discharge. However, she developed Pneumonia as an inpatient and subsequently passed away in hospital. There was a significant delay in the response to the safeguarding adults concern that was raised by hospital staff about the care Miss G had received in the community prior to this admission. The responsibility for the subsequent enquiry was transferred to the relevant Neighbourhood Adult Social Care team.

SIGNIFICANCE

Miss G became unwell in the community and was treated for her infection and pressure ulcer when readmitted to hospital, but acquired a hospital-based infection as well, and deteriorated during her admission before she could be safely discharged to a Nursing Home Placement.

5. Appraisal of practice and learning from Case 2

5.1 Appraisal of practice and Learning from the KPE 1: (25/04/18-07/06/18)

First admission, discharge and then readmission to Hospital

There was an error in the records which was a mistake by Adult Social Care recording on the client database (LAS), whereby home care was thought to have been already commissioned from and provided by the Home Care Agency Care, when in fact it was a service provided by the Local Authority Enablement Team. The Home Care Agency Care was subsequently commissioned to deliver care to Miss G from 06/07/18 (see KPE 2).

There was a care provider (Enablement) issue during this KPE, as it was unclear whether the care plan was followed. Miss G needed a Sara Steady to transfer so it was unclear how/why she was left in a chair by her evening carer. There may have been an issue of whether she had capacity to make decisions about where she spent her evenings, even if she said she wasn't ready to go to bed when left by the carers. There was no evidence that this was considered at the time by her carers.

During this period Miss G had also been left on a sofa overnight but fell again after her carers had left and was on the floor all night, clearly this was not good practice on the part of the carer, as Miss G was not able weight bare upon discharge from hospital. She had two falls in two days and spent a long time lying on the floor, which was clearly an avoidable risk to her health and wellbeing.

There was no evidence as to whether she ever had a falls assessment, so it was not known whether she needed falls sensors as part of her Telecare service. It was also not known how many falls she had whilst on Maple Ward, before her first discharge from hospital. The risks to her of falling appeared to have not been assessed either prior to, or subsequent to her discharge home.

When she then went home and was left on a chair by the carers in the evening the NoK were not contacted to let them know. If she had been left on the chair but needed help for transfers, it was unclear how the carers thought she was going to go to bed on her own, given she was unable to weight bear and transfer unaided. There was no evidence that anyone had been alerted to this issue at the time. This caused additional demands on the family to assist her off the floor when they found her.

LAS did respond in a timely manner when they were called after Miss G had been found on the floor. EDT also responded well when called by her family.

Summary of Learning from KPE 1

- The risk of falls and increased needs for social care support were not assessed during the first hospital admission, and on discharge Miss G had two falls in quick succession, before being readmitted to hospital.
- Miss G was left in an unsafe, seated position, by her evening carers not putting her to bed and not informing family of this prior to leaving Miss G.
- By the second occasion she was unable to weight bare or move from a chair to a bed, so this second fall was clearly avoidable. It does raise the issue of Miss G making an unwise decision to not be put to bed, but the risks of this decision were not shared.

5.2 Appraisal of practice and Learning from KPE 2: (08/06/18-07/07/18)

Second admission, discharge and then readmission to Hospital

There was poor communication and a lack of coordination of care services prior and subsequent to her second discharge. The overall mismanagement of this revealed it was unclear as to who was responsible to make sure all the bits of the jigsaw were in place and ready for her to go home safely.

Peoples “lives” appear to effectively end at the moment they are discharged as far as hospital professionals are concerned. Clearly primary responsibility for preparation for discharging vulnerable patients lies with inpatient staff. Some cases need close coordination in the early days after leaving hospital and going home. This was an example of a poor discharge and it was noted people might often fall between the gaps between inpatient and community services during and immediately after the process of discharge.

There was an appropriate re-assessment of Miss G’s needs during this admission and Miss G’s care package had increased to two carers four times per day. This was commissioned to be provided by the Home Care Agency. However, although there was a key safe in place (but not Linkline) the number was not included in the referral to The Home Care Agency. The impact of this was that the evening carer was unable to access her property, despite seeing Miss G waving from inside.

In these circumstances it was appropriate for the agency to contact EDT, but they were unable to assist as they also didn't have the key safe number on LAS records. EDT attempted contact with Miss G’s son, but he was on holiday, so he was not available until the next morning. EDT also contacted Enablement in the belief that they were still the care provider, but the package of care had been transferred to the Home Care Agency and LAS records on this were unclear at the time of review by the EDT worker.

The next morning on the 7th July 2018 the carers met with Miss G after her son had been contacted, and the day time duty Adult Social Care service informed the agency of the key safe number and where it was situated.

This was a key stage, as the DN service ordered pressure relieving equipment that Miss G needed, but it never arrived and from this point on Miss G was not moved out of bed by carers due to advice from the DNs and the subsequent lack of suitable equipment. Also, the pressure ulcer was never measured, photographed, and was reported incorrectly as grade 2 when it was at least a grade 3.

Summary of Learning from KPE 2

- An increased package of care was established after the second admission, with two carers set up from a different provider, but Miss G had a third fall immediately post discharge.
- Aftercare was appropriately increased but not effectively set up, as it could not be actioned due to incomplete access details. Carers were not given the key safe code and so this delayed access when the new provider was commissioned.
- The DNs advised that Miss G should not be moved without equipment, but this was never delivered. Care was given in bed but pressure ulcer care was not given.
- Learning from this case shows the importance of follow up for required equipment and the consequences for care needs not being met where this does not happen.

5.3 Appraisal of practice and Learning from KPE 3: (08/07/18-25/07/18)

Home Care service visits with two carers four times per day

It was noted that the Home Care Agency received insufficient information from the ward and there was no information on the referral about Miss G's pressure ulcer. This was significant as it affected Miss G and how carers could actually work with her, and given that the DN's advice was then not to move her until equipment was in place (which never arrived during this period), she was only given limited care and remained constantly in bed without being moved.

During this period the carer records reported everything informatively, although they did not report to the office that Miss G had got physically sick and was vomiting on several occasions. The home care office could have escalated this if carers informed them. There were several reports of Miss G feeling ill during this period, which although logged by the carers on site, was not flagged up or escalated as a cause for concern.

Proshield was being used by carers on Miss G's skin, but it was not known where this was being applied (whether applied to Miss G's pressure area). The field supervisor did identify and escalate the need for the delivery of the air mattress, pressure cushions etc., which had been ordered but not arrived.

Summary of Learning from KPE 3

- The situation of carers going in but not being able to move Miss G out of bed continued for a month, with carers raising their concerns with adult social care and district nursing over the continued lack of hoisting equipment.
- Although carers described Miss G as fine in their case notes, she was also reported as sick and vomiting. This shows the disconnection between front line carers and professionals supporting an adult with multiple needs safely in the community.
- Learning from this period is that carers cannot deliver all care without the right equipment and cannot directly communicate with the suppliers of this equipment to make sure it is in place when needed, which delayed effective care being provided, despite which, no action was taken to rectify this.

5.4 Appraisal of practice and Learning from KPE 4: (26/07/18-30/08/18)

Third admission to Hospital and identification of Safeguarding Concerns

Miss G initiated this third admission but may have had her Gastroenteritis illness for some time previously as her symptoms of diarrhoea and vomiting had been recorded over the preceding 3-4 days. The carers recorded that Miss G was unwell during this time but did not escalate any concerns or request medical assessment for her. One can only speculate how long Miss G would have been left in this condition had she not alerted the Telecare workers by activating her pendant alarm.

There was an issue with carers over the weekend after her admission, in that the Home Care Agency main carers knew Miss G was in hospital, but agency carers who were arranged to visit her continued to attempt to do so as they were not informed of her admission. This was a management issue but technology has since been improved to rectify this.

There was a Safeguarding Concern raised by the hospital about the quality of care provided by her home carers, prompted by missing information as to why Miss G had a pressure ulcer and the overall poor condition of Miss G at the point of her third admission. The MDT were concerned that Miss G had been left in bed for so long, which led to the safeguarding referral being taken on initially by the hospital adult social care team, and although an enquiry officer attempted a conversation with her, she was too unwell for this to be completed.

There were issues with the subsequent responsibility for undertaking this safeguarding enquiry as the concerns were about a possible lack of care in the community, but the case was transferred to the relevant Neighbourhood Team, and they did not follow this up adequately. This led to a significant delay in progressing the S42 enquiry. The initial referral was made on 31/07/18 with a letter sent to the home care provider requesting a report, which was sent by the Hospital Adult Social Care Team on 30/08/18 with a request to reply to the Neighbourhood Team. The report was requested by 21/09/18, but this was also delayed with the final report received in late November 2018 (see KPE 5).

Summary of Learning from KPE 4

- Miss G's third hospital admission only occurred after she used her pendant alarm due to her feeling unwell (and subsequently being diagnosed with Gastroenteritis), which hadn't been raised by carers although she had been showing symptoms of diarrhoea/vomiting for 3-4 days.
- At the point of her admission she had an Unstageable Pressure Ulcer despite visits from DNs, prompting the hospital to raise a Safeguarding Concern.
- Responsibility for management of her tissue care had been with DNs but their input was not recorded, so not known, which illustrates a gap in practice and/or recording.
- Learning from this period shows how the lack of timely escalation of deteriorating physical health (stomach bug and pressure areas) by carers delayed appropriate inpatient care.
- Also, the Local Authorities management of the safeguarding enquiry was significantly delayed due to the failure to effectively transfer responsibility from the hospital to the neighbourhood social work team.

5.5 Appraisal of practice and Learning from KPE 5: (12/10/18-15/12/18)

Third Admission, Health Records collated

Miss G remained in hospital, developing an infection during the admission. She was accepted for continuing healthcare funding and there were plans for her to be discharged to a nursing home, but she died without leaving hospital in December 2018. In November Linkline were informed Miss G had moved to residential care and so their equipment was removed from her house, this was a communication error, as she was never discharged from hospital.

She had hospital acquired Pneumonia and Sepsis, which were recorded as causes of death. There was concern that the Sepsis may have occurred due to her being left in a soiled condition, with faeces and urine combined with her Unstageable Pressure Sore possibly causing the Sepsis. Her pressure ulcer was treated and improved during the admission, which also raised the concern that this could/should have been better managed by District Nurses when she was in the community.

The failure to provide correct equipment and consequently that she remained in bed all the time she was at home was deemed to be neglectful, although the issue of why this happened was not clarified during the safeguarding enquiry, which was not good practice. Reports were finally submitted in November 2018 but not submitted for the review.

There was significant drift during this period in the safeguarding enquiry due to issues between hospital and neighbourhood teams not picking up responsibility for this in a timely manner. It was not clear what intervention was provided to Miss G by the DN service and why the required equipment had not been supplied prior to this final admission to hospital.

Summary of Learning from KPE 5

- Community and hospital acquired infections led indirectly to Miss G's subsequent death in hospital during her third admission.
- If the correct equipment had been in place Miss G could have been hoisted out of bed and received a more appropriate standard of care, and she therefore may not have developed such a serious pressure ulcer during KPE 4.
- Learning from this period shows the impact on Miss G's health of failures in her care at home, and the subsequent infections associated with unmet social and health care needs where Miss G was cared for whilst remaining in bed.
- Also, the improvement of her pressure area when she was treated for it in hospital shows that this could have been managed with the right equipment and more coordinated care in the community.

6. Findings and Recommendations

This section contains priority findings that have emerged from the SAR. The findings explain why professional practice was not more effective in protecting the adults in these cases. As this was a thematic review the issues identified that were common for both cases are summarised below, in the subsequent sections the findings and associated recommendations are set out in full.

6.1 Summary of Findings

	Finding
1	Problems may arise in the re-assessment of the needs for social and health care when older adults are admitted to hospital. Where mobility has decreased due to an infection or other illness this should inform a full re-assessment when patients return home.
2	Discharge from hospital may result in the restart of previous levels of care, which are no longer appropriate to meet an increase in care needs.
3	Discharge planning is not undertaken in line with the good practice standards, as set out in the Nice Guidelines, which led to subsequent risks for both adults when they returned home from hospital.
4	Home carers continue to attempt to meet clients' needs rather than escalate either difficulties with the delivery of effective care, or the impact on clients' health where needs are not met.

	Finding
5	District Nursing Services do not always respond appropriately or in a timely manner to referrals made by hospital or community services.
6	Equipment that is required to assist in delivery of care may not be ordered, delivered or set up, due to logistical and practical difficulties.
7	Access arrangements to enable carers or DN's to visit clients are not included when referrals are made to these services, which causes delays in responding to referrals.
8	Delays in practical aspects of setting up changes to care cause needs to remain unmet and this leads to serious health consequences for clients.
9	Decision making for older adults is not always assessed even when poor physical health can lead to concerns about their mental capacity and associated risks in the community.

6.2 Finding 1

Problems may arise in the re-assessment of the needs for health and social care when older adults are admitted to hospital. Where mobility has decreased due to an infection or other illness this should inform a full re-assessment of both health care and social care needs when patients return home.

Recommendations for the Board to consider

1. Review the current inpatient processes and responsibilities for re-assessment of both health and social care needs when an adult is admitted to hospital.
2. Ensure that any deterioration in mobility, or skin integrity identified during hospital admission (which remains after treatment), is adequately communicated to both community health and social care services before a patient is considered to be ready and safe to be discharged from hospital.
3. Consider a single document for a joined up health and social care plan for community services following inpatient re-assessments, with one lead professional identified for oversight of its implementation.

6.3 Finding 2

Discharge from hospital may result in the restart of previous levels of care, which are no longer appropriate to meet an increase in care needs caused by deterioration in an adult's health.

Recommendations for the Board to consider

1. Ensure that before an inpatient is considered safe to be discharged from hospital the correct pathway has been used to set up the required levels of care in the community.
2. If care is to be restarted upon discharge, rather than reviewed using the discharge to assess pathway, this recommendation is agreed by both the home care provider and the Social Worker after adequate information sharing of ward based assessments (as outlined in Recommendation 2, above).

3. If care needs to be re-assessed or increased, that this has been fully set up by hospital adult social care services, including all necessary equipment and access arrangements (e.g. key safe details) are in place so that care can commence on the day of discharge.

6.4 Finding 3

Discharge planning is not undertaken in line with the good practice standards as set out in the Nice Guidelines[2], which led to subsequent risks for both adults when the returned home from hospital.

Recommendations for the Board to consider

University Hospital Lewisham need to work to ensure that best practice is implemented in line with the relevant Nice Guidelines, with priority given to the following aspects of this:

1. "The hospital-based multi-disciplinary team should work with the community-based multi-disciplinary team to provide coordinated support for older people, from hospital admission through to their discharge home", as set out in 1.3.8. of the Nice Guidelines[3].
2. "The discharge coordinator should consider providing people with complex needs, their families and carers, with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge", as set out in 1.5.9. of the Nice Guidelines[4].
3. "The discharge coordinator should discuss the need for any specialist equipment and support with primary health, community health, social care and housing practitioners as soon as discharge planning starts. This includes housing adaptations. Ensure that any essential specialist equipment and support is in place at the point of discharge". As set out in 1.5.18. of the Nice Guidelines[5].
4. "Once assessment for discharge is complete, the discharge coordinator should agree the plan for ongoing treatment and support with the community-based multi-disciplinary team", as set out in 1.5.19. of the Nice Guidelines[6].
5. "A relevant health or social care practitioner should discuss with the person how they can manage their condition after their discharge from hospital. Provide support and education, including coaching, if needed. Make this available for carers as well as for people using services", as set out in 1.5.20. of the Nice Guidelines[7].

6.5 Finding 4

Home Carers continue to attempt to meet clients' needs rather than escalate difficulties either with the delivery of effective care, or the impact on clients' health where needs are not met.

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[2] https://www.nice.org.uk/guidance/ng27

[3] https://www.nice.org.uk/guidance/ng27 recommendation 1.3.8.
[4] https://www.nice.org.uk/guidance/ng27 recommendation 1.5.9.
[5] https://www.nice.org.uk/guidance/ng27 recommendation 1.5.18.
[6] https://www.nice.org.uk/guidance/ng27 recommendation 1.5.19.
[7] https://www.nice.org.uk/guidance/ng27 recommendation 1.5.20.

Recommendations for the Board to consider

1. Once home care has been restarted after discharge from hospital, the carers have support from the agency Fieldwork Supervisors to feedback whether this can continue to adequately meet clients' needs.
2. That a formal check is always done that care has been set up correctly and is still suitable to manage risks relating to skin integrity, moving and handling needs, personal care and medication.
3. Consider a formal feedback process, including a simple RAG (Red, Amber, Green) rating and risk assessment that carers can complete to identify the risks of providing care in line with the commissioned care plan.

6.6 Finding 5

District Nursing Services do not always respond appropriately or in a timely manner to referrals made by hospital or community services.

Recommendations for the Board to consider

1. Review the systems in place for both hospital and community referrals to the District Nursing Services, to ensure these will always be safely received and acted upon in a timely manner.
2. Audit a sample of referrals from different sources and identify any obstacles and delays in how these were dealt with by the District Nursing Services.
3. Consider whether District Nursing Services are currently sufficiently aligned with home care providers to ensure health and social care needs are being met for complex clients considered to be at high risk of pressure ulcers.
4. Ensure that effective monitoring of older adults intake of fluids and food is regularly undertaken to minimise the risks of physical health decline, and identify the need for regular clinical reviews by District Nursing Services as part of any referral to the service.

6.7 Finding 6

Equipment that is required to assist in delivery of care may not be ordered, delivered or set up, due to logistical and practical difficulties.

Recommendations for the Board to consider

1. If equipment has been assessed as needed to enable home carers and nurses to safely move a client, that arrangements are in place to ensure that it is delivered and installed prior to the care being restarted.
2. If care is already being delivered whilst equipment is on order, that the carers have a pathway to escalate the consequences of environmental factors which impact on their ability to comply with a care plan (see recommendation 9).
3. If there are logistical problems in the co-ordination of agencies, there is a suitable multi-agency plan in place, which includes commissioning a service to create a safe working environment for both clients and their carers.

6.8 Finding 7

Access arrangements to enable carers or DN's to visit clients are not always included when referrals are made to these services, which cause delays in responding to referrals.

Recommendations for the Board to consider

1. Where a client has a key safe for access to their property ensure that this information is always included before any referral is authorised and made to a community health or social care service.
2. Include updated key safe details on Local Authority client database, as part of the essential client information.

6.9 Finding 8

Delays in practical aspects of setting up changes to care cause needs to remain unmet and this leads to serious health consequences for clients.

Recommendations for the Board to consider

1. Once care needs have been reassessed and a revised care plan has been authorised, this continues to be overseen by the responsible professional who does not close a case until all practical arrangements for the plan's implementation are in place (such as suitable access and equipment needed to deliver the care plan).
2. If there are delays in implementing a revised care plan which put an adults' health and safety at risk, these are escalated and addressed with the relevant provider.
3. Where adults are being cared for in bed and carers are advised not to move them, ensure that district nurses continue to monitor the risks of skin breakdown, and communicate effectively with the home care provider.

6.10 Finding 9

Decision making for older adults is not always assessed even when poor physical health can lead to concerns about their mental capacity and associated risks in the community.

Recommendations for the Board to consider

1. Ensure that when older adults mobility and overall physical health declines (especially where they may acquire infections) the impact of this on their mental health and mental capacity is included during any clinical review of the person, whether in the community or in a hospital setting.
2. Where the risks of physical health deterioration are identified by community services which may impact on either an adult's insight of the need for and/or compliance with care plans, that a functional assessment of capacity is undertaken by a suitably trained professional in line with the Mental Capacity Act 2005 and Code of Practice (Functional Test for Mental Capacity)[8].
3. If the above functional assessment shows that the person is unable to take the decision then further assess whether the adult's poor physical health/infection may have caused

[8] https://www.scie.org.uk/mca/practice/assessing-capacity

confusion or some other impairment or disturbance of their mind/brain (Diagnostic Test for Mental Capacity).

4. If both of the above assessments indicate on balance of probability that the adult lacks capacity for their care and treatment, ensure this is recorded appropriately, that subsequent decisions are taken in line with their Best Interests, and where appropriate that consideration is given to include an Advocate (IMCA[9]) in this process.

7. Conclusions

Safeguarding Adult Reviews give an opportunity to look closely at practice issues and the systems in place which support good practice. They give a window on the system through which potential weaknesses are revealed. This review goes further and effectively gave two windows on the same systems. Both cases revealed very similar issues and consistently revealed common difficulties in these systems. At a time when resource constraints puts increased pressure on these systems weaknesses become exposed through detailed case analysis.

It was clear from this thematic review that the systems failed to appropriately support both the vulnerable single elderly adults in their home environment. Gaps were exposed in the processes for setting up suitable health and social care services, leading to both adults suffering from avoidable pressure ulcers when they were discharged from hospital. Information was not adequately shared by hospital staff about the increased needs for both adults at the point when they were discharged home. It is acknowledged that there is enormous time pressure on hospital services to rapidly discharge patients home, to free up valuable inpatient beds for new admissions to be accommodated.

Responsibilities to make sure that care can be accurately reassessed either whilst still in hospital, or after discharge are not always clearly met prior to the decision to discharge patients home. Decision-making is not always shared between hospital-based health and social care services, leading to frequent tensions between these services. This can lead to avoidable gaps in both the assessment of needs in hospital and the subsequent arrangements to meet these needs in the community.

This can lead to unqualified home carers attempting to meet the increased needs for people without adequate resources, either in terms of time, staff or the required equipment to safely care for people. As home carers are put under pressure they may then continue to attempt to deliver the care which has been commissioned, even though it leaves people at risk of either falls, or developing pressure ulcers where they cannot be supported to get out of bed. Carers do not always then escalate the problems which they face with the safe delivery of care to either their line managers or to relevant health and social care professionals. This situation puts both the carers at risk and more importantly their clients at risk of developing serious health problems.

Where these health issues are seen by home carers they continue to record that clients are ‘OK’ on their records but either do not have the skills or confidence to report when clients are at risk of, or are actually getting unwell, due to the care plans being inadequate to meet needs. This needs to include escalation of physical health issues associated with poor dietary, or fluids consumption and the clinical review of these. Where physical health deteriorates to a significant extent it can

[9] https://www.scie.org.uk/mca/imca

directly or indirectly affect an adult's mental health and impact on their Mental Capacity, which should also be kept under review and assessed where this is in doubt or is noted to be fluctuating.

Also, district nurses do not always respond to these reports or referrals even when they are made and through a lack of coordination and information sharing with home care services both agencies may not correctly identify the health consequences of caring for people while they remain in bed all day.

Furthermore these cases both revealed that when district nurses have visited and identified the need for specialist moving and handling/pressure relieving equipment to be supplied for home carers to use this does not always get supplied and installed in time to avoid people being left in bed and developing pressure ulcers. The process for delivery and installation of this equipment appears overly complex and time consuming, requiring the company to liaise with both nurses and carers to be onsite simultaneously when equipment is due to be delivered. This adds to the delays. A more streamlined approach and better coordination would enable this to be in place to potentially avoid illness and patients to be readmitted to hospital.

Rather than wait until a crisis point is reached for patients to then be readmitted because they have not been adequately cared for in the community, it is clearly important that this is avoided where possible. This review has shown that better coordination by community health and social care provider services could significantly improve the quality of care, making re-admission less likely to occur. This needs to form part of an improved process for subsequent pre-discharge planning involving both community health and social care services to ensure that adequate resources are identified and in place prior to discharging people back home.

Finally, the case also revealed that inpatient services appropriately use the adult safeguarding procedures to register their concerns about the condition of patients being re-admitted, once this crisis threshold has been reached. Whilst this is in line with procedures, it could also be avoided if more investment is made in preventing potential neglect occurring in the first place, rather than investigating it after the fact. The safeguarding enquiries in both cases were complex and delayed by the current system of beginning enquiries by hospital adult social care services and then transferring responsibility for these to be completed in the community by the relevant neighbourhood adult social care teams.

It is hoped that consideration of the findings and recommendations outlined in this report can assist in avoiding similar cases occurring again in Lewisham.

Mick Haggar

Independent SAR Report Author

19 May 2020

Appendix 1

List of Abbreviations used in the report

Abbreviation	Full Version	Explanation
LSAB	**Lewisham Safeguarding Adults Board**	The overarching purpose of the Lewisham Safeguarding Adults Board (LSAB) is to help and safeguard adults with care and support needs by: • Assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance; • Assuring itself that safeguarding practice is person-centred and outcome-focused; • Working collaboratively to prevent abuse and neglect where possible; • Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred; and • Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area. The Board meets four times a year and has an Independent Chair.
SAR	**Safeguarding Adult Review**	A Safeguarding Adult Review is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented.
DN's / DN	**District Nurses**	A district nurse will manage a team of nurses that may provide wound care, train carers to administer eye drops if individuals cannot do it themselves, support catheter care, and administer complex medication within a patient's home as well as immunisations.
KPE	**Key Practice Episode**	Building on the work of Charles Vincent and colleagues (Taylor-Adams and Vincent, 2004) we have coined the term 'key practice episodes' to describe episodes from the case that require further analysis. These are episodes that are judged to be significant to understanding the way that the case developed and was handled. They are not

Abbreviation	Full Version	Explanation
		restricted to specific actions or inactions but can extend over longer periods. The term 'key' emphasises that they do not form a complete history of the case but are a selection. It is intentionally neutral so can be used to incorporate good and problematic aspects. https://www.scie.org.uk/publications/guides/guide24/concepts/episodes.asp
IMR	**Individual Management Report**	Each agency involved in a SAR is asked to review their own agencies involvement in the case subject to review during a prescribed timeframe, with the aim of summarising and analysing their agencies practice, as part of an overall review of all agencies involvement with the case.
SCAIT	**Social Care Advice and Information Team**	The single point of contact for referrals to Lewisham Adult Social Care and advice point for the public, which is open during office hours.
TVN	**Tissue Viability Nurse**	A growing specialty that primarily considers all aspects of skin and soft tissue wounds, including acute surgical wounds, pressure ulcers and all forms of leg ulceration (Tissue Viability Society, 2014). However, tissue viability nurses (TVNs) have a multifaceted role, which has developed differently in each region to reflect local requirements. (https://www.wounds-uk.com/resources/details/the-role-of-the-tissue-viability-nurse)
EDT	**Emergency Duty Team**	A generic social work service for both adults and children in Lewisham during the 128 hours a week when offices close. There are six social workers in the team, including a manager. Only one social worker is on shift at a time, responding to social work emergencies and a manager for support or advice.
MAR	**Medicine Administration Record (MAR) Charts**	A MAR chart is a working document used to record administration of medicines. They are normally produced by the pharmacy on a monthly basis at the time of dispensing and are delivered with the medication. All medicines for a client should be listed on an individual MAR chart; items such as dressings with no medicinal content have no legal

Abbreviation	Full Version	Explanation
		requirement for MAR records to be kept, but it is good practice to do so for the purpose of creating a clear audit trail. http://www.pharmacy-xpress.co.uk/manuals/training-handbook/9-medicine-administration-record-mar-charts

Appendix 2

List of Terminology used in the report

Terminology	Explanation	Reference
Hyponatraemia	Low sodium in the blood.	https://patient.info/treatment-medication/hyponatraemia-leaflet
Urinary retention	Inability to empty the bladder.	https://www.medicinenet.com/urinary_retention/article.htm
Cellulitis	Bacterial skin infection that's treated with antibiotics. It can be serious if it's not treated quickly.	https://www.nhs.uk/conditions/cellulitis/
Small Vessel Disease	Small vessel disease is a condition in which the walls of the small arteries in the heart are damaged. The condition causes signs and symptoms of heart disease, such as chest pain (angina). Small vessel disease is sometimes called coronary micro vascular disease or small vessel heart disease.	https://www.healthline.com/health/small-vessel-disease
Lacunar Ischaemic Stroke	Ischaemic strokes are the most common type of stroke. They happen when a blood clot blocks the flow of blood and oxygen to the brain. These blood clots typically form in areas where the arteries have been narrowed or blocked over time by fatty deposits known as plaques. This process is known as atherosclerosis.	https://www.nhs.uk/conditions/stroke/causes/
Fortisip	Fortisip Drinks Bottle is a milkshake style supplement that is high in energy, containing	https://www.fortisipdrink.co.uk

Terminology	Explanation	Reference
	1.5kcal/ml (300kcal/200ml bottle) comes in 8 flavours; Neutral, Vanilla, Chocolate, Toffee, Banana, Orange, Strawberry and Tropical.	
Telecare	Telecare systems are designed to send a warning to a call centre or carer if there is a problem in the home – in risk areas such as falls, inactivity, fire, floods or gas leaks. By remotely monitoring an older person's activity and other factors in their home, the technology helps to keep them safe and independent.	https://www.which.co.uk/later-life-care/home-care/technology-to-keep-you-safe/telecare-an4ul6z1bvnl
Unstageable Pressure Ulcers	Pressure ulcers are localised areas of tissue necrosis that typically develop when soft tissue is compressed between a bony prominence and an external surface for a long period of time. Ulcers covered with slough or eschar are by definition unstageable. The base of the ulcer needs to be visible in order to properly stage the ulcer, though, as slough and eschar do not form on stage 1 pressure injuries or 2 pressure ulcers, the ulcer will reveal either a stage 3 or stage 4 pressure ulcer.	https://www.woundsource.com/patientcondition/pressure-ulcers-unstageable
Proshield	Proshield Plus Skin Protectant helps protect irritated skin associated with chronic diarrhoea, enzymatic drainage or incontinence. Use daily as a preventive measure for healthy skin.	https://www.woundsource.com/product/proshield-plus-skin-protectant