Trafford Strategic
Safeguarding Partnership

SAFEGUARDING ADULT REVIEW
In respect of Ruth

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NHS
Trafford
Clinical Commissioning Group

TRAFFORD
COUNCIL

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1.0 Introduction

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

1.2 Trafford Strategic Safeguarding Partnership decided to commission a Safeguarding Adults Review (SAR) on the grounds that Ruth experienced serious neglect and there was concern that partner agencies could have worked together more effectively to safeguard her.

1.3 A panel of senior managers from partner agencies oversaw this review and membership of this panel is shown in Appendix A. The methodology adopted for this review is also shown in Appendix A. David Mellor was commissioned to be the independent chair of the panel and author of this report. He is a retired chief officer of police and former independent chair of a Safeguarding Adults Boards. He has been the independent author of a number of safeguarding adults reviews and other statutory reviews and has no connection to services in Trafford.

1.4 Trafford Strategic Safeguarding Partnership wishes to express sincere condolences to the family and friends of Ruth.

2.0 Terms of Reference

2.1 The scope or timeframe for this SAR is from 1st December 2016 until 31st December 2017. Significant events which took place prior to this date will also be considered.

2.2 The lines of enquiry for this SAR are as follows:

- How effective was the care Ruth received at home in addressing her needs including continence, skin, psychological and emotional needs, difficulty in taking medication and cognition?

- When Ruth's needs changed, were her needs reassessed and her care plans adjusted appropriately?

- Between May and August 2017 Ruth was cared for in bed for a number of weeks due to delays in obtaining a replacement hoist and subsequently a replacement chair. This period of bed care appears to have adversely affected Ruth's health. What action did agencies take to address this situation?

- To what extent was Ruth's care package monitored by the commissioners of her care?

- How effectively did the services involved in providing her home care, particularly her independent home care provider, district nurse service and her GP, work together, share information and co-ordinate Ruth's care plan?

- To what extent did workload pressures impact upon the care provided to Ruth?

- Did the district nurses have access to both clinical and safeguarding supervision?

- When Ruth's condition deteriorated did the services involved in her care at home escalate concerns appropriately?

- How effective was the response to the adult safeguarding referral made by the Tissue Viability Nurse? Were there any other opportunities to make adult safeguarding referrals in respect of Ruth?

- To what extent was Ruth's voice heard and her wishes and feelings considered?

- Given the growing evidence of a decline in Ruth's cognitive impairment, did agencies work with her in a way which was consistent with the MCA. When she was assessed as lacking capacity, were decisions taken in her Best Interests?

- Have agencies got a Mental Capacity Act (MCA) policy in place supported by training?

- Were Deprivation of Liberty Safeguards correctly applied whilst Ruth was admitted to hospital?

- What support was provided or offered to Ruth's son as her primary carer?

- Explore the Continuing Healthcare (CHC) assessment carried out after Ruth's admission to hospital.

- How effective were hospital discharge planning arrangements in respect of Ruth's 'fast track' discharge home?

- How effective was the palliative care which was provided?

- Given the range of agencies involved in Ruth's care, how effectively was her care co-ordinated?

3.0 Glossary

Best Interests - if a person has been assessed as lacking mental capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests

Care Programme Approach (CPA) - is a framework to assess the care and support needs of people with mental health problems, develop a care plan and provide the necessary support. A care coordinator monitors the care and support provided.

NHS Continuing Healthcare (CHC) – NHS continuing healthcare, also known as NHS continuing care or "fully funded NHS care", is free care for outside of hospital that is arranged and funded by the NHS.

Deprivation of Liberty Safeguards (DoLS) were introduced in 2009 and protect the rights of people aged 18 or above who lack the ability to make certain decisions for themselves and make sure that their freedom is not inappropriately restricted. No one can be deprived of their liberty unless it is done in accordance with a legal procedure. The DoLS is the legal procedure to be followed when it is necessary for a resident or patient who lacks capacity to consent to their care and treatment to be deprived of their liberty in order to keep them safe from harm. The DoLS can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings, and for children aged 16 and above the Court of Protection may authorise a deprivation of liberty.

Independent Mental Capacity Advocate (IMCA) - The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a

process supported by conversations to a series of conversations supported by a process.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 came into force in 2007. It is designed to protect and restore power to those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol. The MCA also supports those who have capacity and choose to plan for their future. The MCA applies to everyone working in social care, health and other sectors who is involved in the support and treatment of people aged 16 and over who live in England and Wales, and who are unable to make all or some decisions for themselves.

Nil by Mouth is the term used when patients are restricted from eating and drinking, as a result of a variety of conditions and at different times in their treatment pathway, particularly during surgery.

Parkinson's Disease is a chronic progressive neurological disease chiefly of later life that is linked to decreased dopamine production and is marked especially by tremor of resting muscles, rigidity, slowness of movement, impaired balance, and a shuffling gait.

Pressure ulcers are areas of localised damage to the skin, which can extend to underlying structures such as muscle and bone. There are four grades of pressure ulcer severity ascending in seriousness from grade 1–4.

A **grade 2 pressure ulcer** is defined as partial thickness skin loss involving epidermis (the upper or outer layer of the two main layers of cells that make up the skin), dermis (the thick layer of living tissue below the epidermis which forms the true skin, containing blood capillaries, nerve endings, sweat glands, hair follicles, and other structures) or both.

A **grade 4 pressure ulcer** is defined as extensive destruction, tissue necrosis (localised death of living tissue), or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury.

Section 42 Care Act 2014 Enquiry by local authority

This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

4.0 Synopsis

4.1 This review begins with the June 2011 decision by Ruth's GP to refer her to Trafford Adult Social Care (ASC) as she was reported to be struggling to manage at home. She was eighty five years old. Little is known about her life prior to this point. It is understood that she was widowed and living alone. Her three children were grown up. She had worked for a local authority in Greater Manchester within the social care field. She was said to enjoy listening to music and particularly enjoyed praline chocolates.

4.2 The GP referral led to an assessment of Ruth took place in August 2011. Following the assessment, a support plan was agreed.

4.3 In March 2012 an ASC social worker visited Ruth and her daughter for discharge planning following a hospital admission for urinary tract infection (UTI). Parkinson's disease was also being investigated at that time. A return home with a package of care was considered by Ruth and her daughter, no prior support having been in place. Occupational Therapy (OT) had completed a home visit and equipment to support her to live independently had been ordered. Ruth was also considering a move to a residential home as a self-funder and her daughter requested a list of Trafford Council approved homes. However, Ruth's preference was to try returning home with carer support.

4.4 Following Ruth's return home a reablement assessment was carried out. This was followed by three visits daily from Reablement services for a period. However, Ruth was described at this time as very anxious, tearful and a little confused. She was said to have found it difficult to accept changes in her ability to cope and was said to be reconsidering a move into residential care.

4.5 By the end of April 2012 arrangements had been made by Ruth's son for her to move into a residential home near Altrincham for a 'four week trial'. This placement was arranged and funded privately but continued only until December 2012. At this time Ruth's son advised Trafford ASC that his mother had not settled in the care home and so she would be 'returning home' to live with him. He was adapting his house to accommodate her needs, including the fitting of a stair lift. The ASC social worker completed a capacity assessment which found that Ruth had capacity to decide where to live. The social worker arranged for domiciliary care in the form of three visits daily to support Ruth once she moved into her son's home.

4.6 In February 2013 ASC carried out a review six weeks after Ruth's move to live with her son. She was receiving 10.5 hours of support weekly which was said to be going well. No concerns were expressed by Ruth, her son or the care agency. Her

case was closed to Reablement and transferred to the Trafford ASC review team for an annual review. At that time Ruth's capacity was described as fluctuating when she was unwell. When she was well she was said to regain her capacity.

4.7 During November 2013 Ruth was admitted to hospital after experiencing what was described as 'increased confusion and decreased mobility'. At a multi-disciplinary team (MDT) discharge planning meeting held in January 2014 concerns were expressed about the risks of 'upstairs living' as her bedroom was situated on the first floor of her son's house. However, it was said that efforts would be made to eliminate or reduce those risks and it was considered to be in Ruth's 'best interests' to return home. Later the same month she was discharged home with a reablement package of care, which entailed two carers visiting four times daily until early March 2014. Following a six week review the morning visit was to be reduced to 45 minutes and the 'tea call' cancelled as Ruth's son was able to provide the necessary support at this time of the day. It is understood that Ruth's son was self-employed which enabled him to adjust his working hours when necessary. Ruth's case was again transferred to the review team.

4.8 During September 2014 ASC received a referral from the Community Rehabilitation Team reporting that Ruth had become 'very depressed' as a result of social isolation. (Trafford Community Rehabilitation service is provided by Pennine Care and sees patients in their own homes. The service provides a comprehensive assessment of rehabilitation need in order to enable patients to gain maximum independence with activities of daily living and mobility).

4.9 Later in September 2014 an ASC worker discussed Ruth's social isolation with her son and it was agreed that a befriending service would be preferable to day centre support due to the fact that the latter would involve Ruth being moved downstairs by her son each day to facilitate her transport to the day centre. It was said that the family did not feel this was good for their mother. A referral was made to the Cyril Flint Befriending Service which later wrote to Ruth to say they did not have enough befrienders available. No alternatives appear to have been explored. (Cyril Flint Befriending currently covers Greater Manchester and relies on volunteers to spend an hour a week to visit a person, usually in their own home).

4.10 In September 2015 an ASC worker undertook a review of Ruth's care and support needs via a telephone conversation with her son. The outcome was that services would remain unchanged. The care agency providing Ruth with domiciliary care was said to have resolved unspecified 'outstanding issues' regarding Ruth being cared for in bed. Ruth's case was closed to the Reablement team and was to be reviewed in twelve months by the ASC Central Community Team. The unmet need

of social isolation does not appear to have been considered as part of the September 2015 review of Ruth's care and support needs.

4.11 In January 2016 the One Stop Resource Centre (OSRC) Equipment and Adaptations Advice Line (EAAL) received a referral from an occupational therapist in the Dementia Crisis and Prevention Team for a specialist seating assessment for posture control and pressure relief for Ruth. (The One Stop Resource Centre (OSRC) is jointly provided by Trafford Council and Pennine Care and provides community equipment and adaptations to people who require help to improve daily living or assistance when recovering from an illness. The Dementia Crisis and Prevention Team (DCPT) is provided by Greater Manchester Mental Health NHS Foundation Trust and provides multi-disciplinary assessment, treatment and care for people diagnosed with dementia).

4.12 In response to this referral, an OSRC occupational therapist carried out a full general assessment including specialist seating in February 2016. No other issues apart from seating were identified. A joint seating assessment with Accora (a specialist seating company) was recommended. However, three unsuccessful attempts to contact Ruth's son by telephone in February and March 2016 were followed by a letter to the son asking him to contact the OSRC. No response having been received by 20th April 2016, Ruth's case was closed.

4.13 From 15th August 2016 Human Support Group (HSG) began providing care for Ruth. Human Support Group is a domiciliary care service which provides personal care and support to people in their own homes to help them remain independent.
HSG was commissioned to visit Ruth three times each day (morning for 45 minutes, lunch for 30 minutes and a bed time visit for 30 minutes). Two care assistants were involved in each visit. Ruth's care plan included support with all transfers using a hoist, personal care, medication prompts, pad care and skin monitoring. The care plan remained unchanged except for a decrease in time from 31st October 2016 (See Paragraph 4.16).

4.14 On 16th September 2016 Ruth was referred to the district nursing service relating to a 'break on her coccyx' which is presumed to relate to a pressure sore in that area of her body. The coccyx is a small bone at the base of the spinal column. Ruth was visited by the district nurse service for pressure area care for a period.

4.15 HSG carers became unable to transfer Ruth using the hoist due to thick carpeting, which led to her being supported in bed for a period. Discussions with Ruth's family led to the carpet being removed in October 2016. Showering also proved difficult as a result of a step into the bathroom over which the care assistants were unable to lift Ruth and her chair due to 'manual handling policies and

procedures'. The issue was resolved by a ramp being provided, although it is not known when this happened.

4.16 During November 2016 an ASC worker completed a statutory review in respect of Ruth which disclosed the following:

- A pressure relieving care system was in situ as well as a number of aids and adaptations to assist the provision of personal care and aid mobility.
- Activities of daily living were to be met by her son with whom she lives.
- Speech and Language Therapy (SaLT) recommendations indicated monitoring as required at meal times and some support with feeding.
- Carers were required to manage medication needs.
- The effect of cognitive impairment on Ruth's life was minimal, although both long and short term memory were said to be poor.
- Psychological and emotional needs were not impacting on her wellbeing.
- There were no issues with skin care.
- An issue was identified in relation to moving and handling due to the hoist and the carpet resulting in Ruth being cared for in bed. The outcome was to move the carpet to assist moving and handling.
- The level of care provided by HSG was to be reduced to 25 hrs per week.

Ruth was to be reviewed again in twelve months. No Mental Capacity assessment was completed at that time as there were no decisions which were required to be made in respect of Ruth.

4.17 A Parkinson's specialist nurse made a review visit to Ruth during December 2016. (Trafford Parkinson's Nurse service is provided by Pennine Care and offers clinical monitoring, medication review/advice, continuing point of support/contact in respect of patients with a confirmed diagnosis of Parkinson's).

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4.18 On 21st January 2017 a consultant physician in elderly medicine wrote to Ruth's GP expressing the view that she was highly unlikely to have capacity to make significant decisions about health, including decisions regarding resuscitation and that having such a discussion would be likely to induce significant stress. The consultant had taken a decision in Ruth's best interest that she would not be suitable for cardiopulmonary resuscitation in the event of cardiopulmonary arrest and the necessary DNA CPR (Do not attempt cardiopulmonary resuscitation) documentation was completed. The consultant also noted that Ruth had a fear of eating due to hallucinations that she was being poisoned.

4.19 The consultant also wrote to the consultant physician in rehabilitative medicine at Trafford General Hospital (TGH) (copy also sent to Ruth's GP) requesting that the

Community Neuro Rehabilitation team visit her at home due to her mobility limitations (bed/chair bound) and requesting that she was considered for botox on the little finger of her left hand due to a recent increase of rigidity in her left arm. The botox would have increased mobility in her finger and relieved pain. The consultant physician in elderly medicine would continue to review Ruth's treatment.

4.20 On 25th January 2017 Ruth's GP noted a local skin infection in between the third and little finger of her left hand. A prescription of flucloxacillin 500mg for five days was issued, swabs were taken which on 28th January 2017 confirmed a bacterial infection and sensitivity to flucloxacillin.

4.21 The Trafford Bladder and Bowel team assessed Ruth at home and provided products for incontinence. (This service which is provided by Pennine Care offers specialist nurse led assessment for people with bladder (lower urinary tract) or bowel problems. On completion of an assessment, treatment or care plans are agreed). Ruth appeared to have been referred to the team in October 2016.

4.22 During January 2017 the Parkinson's specialist nurse made a further review home visit to Ruth.

4.23 On 7th February 2017 HSG carers noted Ruth's left hand to be very swollen and sore as a result of her clenching her hand and her finger nails cutting into her hand. The wound appeared to be getting worse and so the carers contacted her GP and the district nursing service. Her GP prescribed a further course of flucloxacillin.

4.24 By 14th February 2017 Ruth's GP noted a slight improvement in her hand. After discussing the case with a local microbiologist, flucloxacillin was continued and Ruth was referred to the tissue viability nurse and district nurse service for a review. (Trafford Tissue Viability service is provided by Pennine Care. This small nurse-led service undertakes specialist skin and wound assessments and provides clinical advice, support, education and training for Trafford healthcare professionals in the holistic assessment and management of patients with acute, chronic and complex wounds).

4.25 Telephone contact took place between the tissue viability nurse and the district nurse on 20th February 2017. The district nurse had re-swabbed the finger wound and requested a blood test. The district nurse reported that Ruth was continually removing the hand dressing and contaminating the area. Wound dressing advice was offered by the tissue viability nurse and a joint assessment was arranged for 27th February 2017.

4.26 On 27th February 2017 the joint tissue viability/ district nurse assessment took place. Significant left hand contracture was noted making accurate assessment of all aspects of the left hand impossible. A photograph of the hand was taken for monitoring purposes and possible sharing with GP/dermatology to gain a differential diagnosis and ascertain the suspicious presentation and underlying cause of the finger wound. It was not possible to accurately ascertain pain levels as Ruth was agitated when disturbed and assessment of the hand attempted. District nurses were to monitor pain and discomfort and liaise with Ruth's GP regarding analgesia requirements.

4.27 As a result of the joint assessment it was recommended that a documented pressure ulcer prevention (PUP) plan was required for all staff to follow. The PUP plan was to include the following:

- The frequency of general and pressure ulcer (PU) risk assessments and action to take should skin deterioration occur at any point.
- Top to toe skin assessment and reviews to be conducted.
- District nurses to review the effectiveness of Ruth's pressure care equipment (mattress/cushion/associated mechanical pumps).
- District nurses to record her Waterlow (pressure ulcer risk assessment) PU risk score and review this on an on-going basis.
- District nurses to work with HSG care staff and her family regarding repositioning frequency and how to escalate skin concerns to district nurses.
- District nurses to review nutritional status, consideration to be given to any weight loss or nutritional concerns.
- District nurses to review continence care and perianal (situated or affecting the area around the anus) skin presentation due to incontinence and associated skin implications.

4.28 During the joint assessment, there was suggestion from the district nurses present that the care of Ruth was palliative in nature due to her advanced dementia. The district nurses were advised to document if care was palliative in nature, for symptom control or for hospital admission. A best interest decision making process was to be followed. Ruth's son was not present at the joint assessment but the district nurses were in regular contact with him. A meeting was to be convened by the district nurse with the family and GP which took place that day by telephone. As Ruth was prone to removing her hand dressings giving rise to the associated risk of contamination/ infection, a pragmatic wound management plan was agreed with the district nursing team.

4.29 On 28th February 2017 Ruth was discharged by tissue viability with an agreement that the district nursing team would re-refer to them should they have skin related concerns or if there was any deterioration.

4.30 No agency has provided any information about Ruth's care during the period from the end of February until mid-May 2017. There is an undated reference in the Pennine Care agency report to 'ongoing visits by district nurses for pressure ulcer care to sacrum/hand'.

4.31 On 16th May 2017 the GP had a discussion with Ruth's son who thought his mother had a UTI as her symptoms were similar to those she had experienced the previous year at which time she had appeared confused. Nitrofurantoin 50mg four times a day was prescribed.

4.32 On 19th May 2017 an HSG carer noticed that Ruth's hoist was not working as it was not possible to charge it when it was plugged into the electricity supply. Ruth's son was aware of the problem and said he would contact the OSRC the following morning. As a result of the hoist not working, Ruth was cared for in bed.

4.33 By 2nd June 2017 the hoist had not been serviced and Ruth continued to be cared for in bed. Concerns were raised by HSG staff in respect of Ruth's skin integrity. It is unclear whether the concerns about skin integrity were current or potential at that stage.

4.34 On 16th June 2017 HSG staff reported that the skin had broken on Ruth's bottom. Contact was made with Prism Medical, a company which provides ceiling track hoists, and which has a contract with the OSRC to supply, repair and replace hoists. They can be contacted via a 24 hour helpline and are expected to rapidly repair or replace hoists. It appears that there may also have been an issue with the rubber on the hoist's wheel. HSG stressed the urgent need to repair the hoist in order to prevent the risk of pressure sores. According to Prism records they logged a 'service call' on 2nd June 2017 (See previous Paragraph) which was not attended and subsequently cancelled on 7th June 2017. Prism are unable to explain why the call was not attended or why it was subsequently cancelled. Prism has no record of a call from HSG on 16th June 2017.

4.35 On 19th June 2017 HSG carers spoke to Ruth's son who told them that there had been a clerical error which had necessitated the re-order of a part for the hoist. The son was said to have contacted the district nurse service to request an increase in visits as a result of concerns that Ruth had been cared for in bed for several weeks. (There is no record of this request in the district nurse agency report).

4.36 On 21st June 2017 HSG again contacted Prism Medical for an update on the service of the hoist and the replacement wheel and were advised that the matter was being treated as an emergency. Prism has no record of this contact.

4.37 On 28th June 2017 the hoist had still not been serviced/repaired and Ruth had been cared for in bed for over three weeks. HSG carers spoke to Ruth's son who said that he hadn't heard anything. HSG then re-contacted Prism Medical to say that this delay was unacceptable and that the hoist repair was essential in order to assist Ruth out of bed. HSG were advised that an emergency hoist would be sent. Prism has no record of this contact.

4.38 On 29th June 2017 HSG staff noticed that skin had broken down in Ruth's groin area and contacted the district nurse service to request a home visit which was to take place the following day.

4.39 On 30th June 2017 an emergency hoist was provided after Ruth had been cared for exclusively in bed for a period of 28 days. (The hoist was first said to have been broken on 19th May 2017 which was actually 42 days earlier).

4.40 On 3rd July 2017 the Community Neuro Rehabilitation Team (CNRT) carried out an initial assessment of Ruth in response to the earlier referral (Paragraph 4.19). (The CNRT, which is provided by Pennine Care, helps rehabilitate adults with neurological conditions needing specialist rehabilitation in a community setting. The team includes the Parkinson's Specialist Nurse referred to earlier). The Parkinson's Specialist Nurse referred Ruth for a specialist seating assessment for posture control and pressure relief via the OSRC Equipment and Adaptations Advice Line (EAAL) the next day. This referral was allocated to an occupational therapist as an urgent case. Urgent cases are seen within seven working days.

4.41 On 17th July 2017 the OSRC occupational therapist carried out a full general assessment including for specialist seating. No other issues apart from seating were identified. The assessment identified that Ruth was being nursed in bed as her own chair was not suitable. Carers had tried using cushions for positioning but Ruth had been found slipping forwards and leaning over. A recommendation was made for a 'Hydrotilt' chair. OSRC stores were to be checked to see if a suitable chair was available.

4.42 The HSG chronology states that HSG carers were advised to care for Ruth in bed until a replacement chair was delivered. At this point there had only been 17 days during which it had been possible to transfer her from bed following the repair of the hoist.

4.43 On 24th July 2017 HSG carers reported that Ruth was distressed and in pain from her hand. The district nurse service was contacted and dressed the wound the same day.

4.44 By 25th July 2017 OSRC had identified a chair, placed an order and the delivery was booked for 8th August 2017.

4.45 During July 2017 the Parkinson's specialist nurse made a review home visit to Ruth.

4.46 On 7th August 2017 Ruth attended a plastic surgery outpatients appointment accompanied by her son. The treatment options for the raised lesion near the little finger of her left hand were discussed. Due to Ruth's current health, a local anaesthetic was not considered to be appropriate, whilst operating under a general anaesthetic carried risks. Ruth's son expressed concerns about surgical intervention and decided to discuss the matter with Ruth's daughters. Ruth was to return to clinic in one month for further review.

4.47 On 10th August 2017 HSG carers reported that Ruth's 'bottom' was very red and contacted the district nurse service who advised that they would visit as soon as they could. On the same date the OSRC occupational therapist carried out a follow up home visit to check that the hydrotilt chair had been delivered and that Ruth was being supported to use it. No chair was in place and after contacting OSRC administration, then stores, the occupational therapist was advised that that it had not been possible to deliver the chair to Ruth's upstairs bedroom because the size of the chair made it impossible to get it past the stairlift. The plan was to identify an alternative chair from stores.

4.48 The district nurse visited Ruth the following day and checked pressure areas and found that 'finger contraction' had caused a pressure ulcer to the palm of her hand.

4.49 On 15th August 2017 HSG carers reported that Ruth's 'bottom' was very red and sore. At this point the chair had still not been delivered and care was being provided to Ruth in bed.

4.50 On 17th August 2017 there appeared to be a difference of opinion between the district nurse service and HSG over whether the skin on Ruth's bottom had broken and whether it was a moisture lesion (district nurse opinion) or a pressure sore (HSG opinion). (A moisture lesion is caused by urine and/or faeces and perspiration in continuous contact with skin. Often misdiagnosed as grade 2 pressure ulcer, moisture lesions can occur where prolonged exposure to bodily fluids causes the skin to become increasingly permeable, making it weaker and less elastic, and more susceptible to physical damage from friction and shearing forces). The district nurse service discussed a moisture lesion care plan with the HSG carers. The district nurses were to visit weekly to review Ruth.

4.51 On 18th August 2017 a Configura Accora chair was identified in OSRC stores which could be delivered in two pieces. This was successfully delivered on 25th August 2017 but HSG carers reported that due to Ruth's moisture lesion she was unable to use the chair as there was insufficient pressure relief. On the same date the OSRC occupational therapist visited and was advised that the HSG carers had put Ruth in the chair but felt that she was slipping. Advice was given to the carers that the chair was not to be used until a follow-up visit by the occupational therapist had taken place.

4.52 On 22nd August 2017 the district nurse visited Ruth and checked the moisture lesion. Additional barrier cream was to be ordered and a note was left for the HSG carers in respect of application.

4.53 On 27th August 2017 the district nurses noted that Ruth had a sacral ulcer grade 2. (The sacrum is a triangular bone in the lower back formed from fused vertebrae and situated between the two hip bones of the pelvis. Pressure ulcers are areas of localised damage to the skin, which can extend to underlying structures such as muscle and bone. There are four grades of pressure ulcer severity ascending in seriousness from grade 1–4. A grade 2 is defined as partial thickness skin loss involving epidermis (the upper or outer layer of the two main layers of cells that make up the skin), dermis (the thick layer of living tissue below the epidermis which forms the true skin, containing blood capillaries, nerve endings, sweat glands, hair follicles, and other structures) or both).

4.54 The district nurses dressed the pressure ulcer using ANTT (Aseptic Non Touch Technique which is a tool used to prevent infections in healthcare settings) and barrier cream, which prevents skin damage from moisture exposure, was applied to her surrounding skin. Pressure ulcer assessment documentation was commenced. Ruth's dynamic (pressure relieving) mattress and cushion were checked and both found to be in working order with the weight setting correct and considered clinically appropriate. The district nurses reviewed all risk assessments. The Waterlow pressure ulcer risk assessment identified a score of 26 which indicated very high risk due to length of time Ruth spent in bed. All other pressure areas were found to be intact. Instructions were given to the HSG carers to wash Ruth's skin and reapply barrier cream and to continue repositioning her at each visit. Ruth's son was informed of the sacral pressure ulcer and advised that the HSG carers would reposition his mother at each visit to relieve pressure from the sacrum. An incident report was created on Pennine Care's incident reporting system. District nurse visits were increased to three times weekly.

4.55 On 29th August 2017 the OSRC occupational therapist was present whilst the HSG carers hoisted Ruth into the chair, which was considered to be suitable. The HSG carers were given usage instructions including the position Ruth was to be left in. However, it was identified that the existing table did not allow her to reach food or drink. The HSG carers were advised to only put her in the chair when family were present to provide food and drink until a suitable table could be provided.

4.56 On the same date the district nurse discussed the development of Ruth's category 2 sacral pressure ulcer and the management plan with her GP. The GP was also updated on the difficulty they were experiencing managing the wound on her finger and her hand due to joint contraction related to her dementia. The GP agreed to the frequency of the district nurse visits and the wound management plan. The following day, Ruth's GP referred her to a home physiotherapist to help her unclench her left fist and monitor for signs of infection.

4.57 On 1st September 2017 the OSRC occupational therapist was unable to locate a suitable table in stores and was advised to complete a 'statement of case' form which is required for non-standard stock orders. This was approved on 6th September 2017.

4.58 On 4th September 2017 the district nurse visited and noted that the sacral pressure ulcer was showing some signs of improvement and it was decided to reduce district nurse visits from three to two times weekly.

4.59 On 15th September 2017 the OSRC occupational therapist was contacted by HSG to request a risk assessment for the table, which presumably had now been delivered. Advice was given that no further assessment was required if Ruth could now reach food and drink.

4.60 On 25th September 2017 district nurses requested the GP prescribe oramorph (medication used to treat moderate to severe pain) to be used when changing Ruth's dressings as she experienced pain and distress due to contraction during dressing change. The medication was prescribed and was commenced on 28th September 2017. This allowed the district nurse to open her left hand and position a gel pad to prevent her nails digging into her hand. It was also possible to trim her finger nails. Her care plan was updated to reflect the administering of oramorph.

4.61 On 27th September 2017 Ruth was seen in burns and plastics outpatients once again. She was accompanied by her daughter. The lesion on her finger remained a concern. The surgeon believed it was likely that 'the fingers' may require amputation. Ruth's daughter said she would discuss this with other family members.

4.62 On 2nd October 2017 Ruth was visited by her GP. Her son was present who said that his mother had been constipated for months, and despite taking senna opened her bowels only once a week. She was said to be drinking 'OK' but not eating much. Lactulose 15ml twice a day was prescribed with a review planned for later in the week.

4.63 On 3rd October 2017 a referral was received by OSRC for a reassessment of Ruth's chair as her daughter stated that it was uncomfortable. (HSG reported that Ruth was 'screaming out in pain' when in the chair). A visit was booked for 5th October 2017.

4.64 On 5th October 2017 the OSRC occupational therapist carried out the home visit to check the chair. Ruth's daughter was present and said that her mother was uncomfortable in the chair and leaning to one side. A follow up visit was arranged with HSG carers to clarify how the chair was being used and how Ruth was being positioned as on a previous visit the chair was judged to be meeting her needs.

4.65 The following day the OSRC occupational therapist was present whilst HSG carers hoisted Ruth into the chair and no issues were identified with the chair but further advice was given on positioning. Advice was also given that Ruth should not be left in the chair for long periods and that she should be put into the chair at breakfast but returned to bed at lunchtime. Ruth had been left in the chair from lunchtime to bedtime previously which may have contributed to her discomfort.

4.66 On 9th October 2017 district nurses visited Ruth and found her sitting in the specialist chair and were therefore unable to administer the enema prescribed for constipation, review the sacral area or change the wound dressing. The district nurse was to visit the following day and a note was left for Ruth's carers requesting that she remained in bed to assist with review and planned treatments.

4.67 On 12th October 2017 the OSRC occupational therapist carried out a home visit to check on Ruth's positioning in the chair but she was in bed. HSG carers advised that Ruth was in bed not because of problems with the chair but was having 'a bad day'. Further follow-up visits took place on 13th and 18th October 2017 when Ruth was noted to be sitting in the chair in a good position and her case was closed to OSRC and the HSG carers were advised to re-refer if any further issues arose. The district nurses also visited that day for wound management of Ruth's finger and sacrum. No signs of infection were noted.

4.68 By 23rd October 2017 the district nurses observed that Ruth's pressure ulcer was responding to the prescribed treatment.

4.69 On 2nd November 2017 the district nurse noticed a deterioration in the pressure ulcer in the sacral area, which when measured was found to have increased in size. The dressing used was altered to a honey based dressing (medical grade honey has antimicrobial and anti-inflammatory properties and can be used for acute or chronic wounds). The wound now required to be de-sloughed (dead tissue removed). A new care plan was prepared. Ruth's pressure redistributing mattress was checked and found to be in working order. No clinical signs of infection were noted at this stage. There is no indication that risk assessments were updated to reflect the deterioration in Ruth's pressure ulcer.

4.70 On 6th November 2017 the district nurses reviewed Ruth's sacral pressure ulcer and noted a further deterioration in the wound. Visits were increased to three times weekly but there is no record of risk assessments being updated.

4.71 On 8th November 2017 the district nurses reviewed the sacral pressure ulcer and noted that the area surrounding it was red and swollen. A GP review was requested and a wound swab was taken. Ruth was commenced on Flucloxacillin 500 mgs to treat the signs of infection in the wound. Ruth was noted to be subdued the following day and district nurse visits were to be increased to daily over the forthcoming weekend (11th and 12th November 2017).

4.72 On Friday 10th November 2017 HSG carers contacted her GP as they were concerned about the right side of her face drooping. She was distressed which was attributed to constipation. An ambulance was called but when the paramedics assessed Ruth, they decided that hospital admission was unnecessary. They concluded that her symptoms were linked to constipation and her GP later visited and prescribed a phosphate enema.

4.73 On the same date the district nurses visited and noted that Ruth's sacral ulcer had further increased in size. The pressure ulcer documentation and care plan were updated and a further incident report was created on Pennine Care's incident reporting system. Ruth was also referred to the tissue viability nurse for an assessment. The district nurses visited over the weekend of 11th and 12th November 2017 and noted that the depth of the sacral ulcer had increased. All risk assessment, manual handling, skin inspection and pain assessments were updated. The Waterlow assessment continued to indicate a very high risk. Ruth continued to be nursed in bed with her HSG carers repositioning on every visit.

4.74 Ruth's GP visited her again on 13th November 2017. She was lying in bed with her lunch in front of her which she was not eating. She kept shouting "you are hurting me, why are you doing this to me?" despite not being touched. The GP

prescribed laxative for constipation but documented that the sacral pressure sore was not seen as the GP was unable to reposition Ruth.

4.75 The following day the GP discussed Ruth's case with the district nurse. The sacral pressure sore was said to be heading towards a grade 4 (extensive destruction, tissue necrosis (localised death of living tissue), or damage to muscle, bone, or supporting structures with or without full thickness skin loss) and Ruth was experiencing a lot of pain. She was spitting out the oramorph previously prescribed for pain relief and so it was decided to stop this medication and to try oxynorm and increase her butec patch from 20 to 25 mcg per week. Oxynorm and butec are strong painkillers. The district nurse discussed a bowel management plan with the HSG carers and a bowel chart was commenced to aid management of constipation. It was noted that Ruth was showing signs of increased agitation and some pain when being repositioned. The following day Ruth was turned to facilitate review of her sacrum without screaming but began screaming when returned to a normal position.

4.76 On 17th November 2017 HSG carers found that Ruth was struggling to take prescribed medications and were advised that her GP was aware and that medication in liquid form, where possible, had been requested. HSG noted that Ruth's son had previously assisted them to help his mother take medication.

4.77 On 19th November 2017 the district nurses noted that the depth of Ruth's sacral pressure ulcer had further increased. Care provision was reviewed in the light of the lack of improvement in the sacral ulcer. The district nurse records indicate that HSG were contacted to increase their visits to four times daily to aid repositioning. There is no reference to this request in the agency report provided by HSG and no increase in the frequency of HSG care visits occurred. The district nurses completed a further Pennine Care incident report due to the further deterioration in Ruth's sacral pressure ulcer. The tissue viability nurse referral made on 10th November 2017 was to be followed up on to establish when the assessment visit was planned to take place.

4.78 On 20th November 2017 the district nurse noted that Ruth's sacral wound appeared to be infected and contacted the GP. A joint district nurse/ tissue viability nurse assessment was arranged for the following day. An upgrade of Ruth's mattress to 'option 4' (high specification foam mattress which contours around the body, spreading the body weight and relieving pressure) was requested and promptly delivered.

4.79 On 21st November 2017 a joint tissue viability/ district nurse assessment took place which found that Ruth presented with a significant and infected unstageable

area of sacral pressure ulceration. The sacral ulcer presented as malodourous, highly exuding and was obscured by devitalised tissue, the surrounding skin was hot and inflamed with signs of spreading cellulitis evident. The district nurse reported that Ruth had been bedbound for several weeks. The tissue viability nurse noted that a fitted sheet was being used on the current pressure care dynamic mattress as well as a 'Kylie' type sheet (waterproof cover) and several incontinence pads under the area of pressure ulceration. The district nurse also reported that Ruth's nutritional intake was poor and that she appeared to have lost weight recently. She had a history of constipation requiring enema management from the district nursing team. Her pain was being managed with a 25mcg/hour butec patch and Gabapentin 100mg three times daily. The district nurse team had also been administering 5mg oramorph prior to wound related dressing procedures. Ruth appeared uncomfortable at assessment despite the administration of the oramorph and for this reason the cavity of the pressure ulcer was not probed to any degree as this would have inflicted additional pain and discomfort.

4.80 Ruth was unable to communicate with the tissue viability nurse or make informed decisions and was considered to lack mental capacity to consent to either the photograph taken of the wound or the assessment process. No family members were present at the time. The tissue viability nurse discussed the case with a district nurse sister and agreed to contact Ruth's GP to arrange hospital admission for management of the infected sacral pressure ulceration. Acute admission was agreed with the GP who arranged the process.

4.81 The tissue viability nurse also made an adult safeguarding referral in which she expressed the following concerns:

- Since August 2017 Ruth had developed a sacral pressure ulcer which had significantly deteriorated over the intervening period.
- The ulcer was so badly infected that hospital admission was necessary for intravenous antibiotics and adequate management.
- Ruth was not being repositioned regularly enough.
- District nurses were visiting daily but could not adequately meet her care needs during these short visits.
- HSG carers were visiting three times daily but could not adequately meet her care needs during these short visits.
- Ruth had several pads and a Kylie sheet between her and the mattress.
- Ruth was vulnerable because her son was out at work during the day meaning that she was alone for long periods of time.
- Ruth was immobile as a result of her dementia diagnosis, bed bound, unable to communicate and lacked capacity.

- Her bedroom was situated on the first floor and she would be unable to evacuate the house without assistance should this become necessary as a result of a house fire for example.

4.82 The ambulance service (NWAS) conveyed Ruth to Wythenshawe Hospital Emergency Department (ED). The crew noted that she was lying in bed when they arrived and that food had been left for her but she appeared to be struggling to feed herself. She appeared confused and was unsure of whether she was in pain or where any pain emanated from. Her stomach appeared distended.

4.83 On arrival at Wythenshawe ED, Ruth was placed on an air mattress. Concern was expressed that Ruth may have developed osteomyelitis (an infection of the bone which is a rare but serious condition). She was noted to live with her son and receive four visits each day (three actually) from carers and one visit daily (later established to be twice weekly) from the district nurse. Her DNAR form was updated to reflect the view previously expressed by the consultant that resuscitation was not appropriate (see Paragraph 4.18). She was noted to be bedbound and required two hourly turning to lie on her sides to avoid resting on her sacral wound. The sitting position was also to be completely avoided. A Waterlow risk assessment was carried out. Grade 1 pressure ulcers to both heels were noted as were two grade 3 pressure ulcers between the second and third, and third and fourth fingers of the left hand caused by contraction of her hand. These latter pressure ulcers had not been detected initially due to the contraction of Ruth's hand. She was unable to tolerate oral medication at that time. Ruth was Nil by Mouth and would need assistance when eating and drinking when well. A nutrition care plan was agreed.

4.84 The hospital made an adult safeguarding referral to Trafford Council and noted that a Deprivation of Liberty Safeguards (DoLS) authorisation would need to be applied for. The DoLS application was submitted on 23rd November 2017. (Trafford Council subsequently screened the DoLS application against the Association of Directors of Adult Social Services (ADASS) screening priority tool and deemed it to be of lower priority.)

4.85 On 23rd November 2017 a hospital occupational therapist telephoned Ruth's son to obtain her social history. It was established that she lived upstairs and was hoisted between bed, chair and commode. She was assisted by 'double cover' carers with all activities of daily living apart from cooking, shopping, cleaning and laundry which were done by her son who was also in full time employment. Ruth was said to be independent with feeding and drinking but sometimes needed encouragement to swallow as she suffered from anxiety. She had a walk-in shower in her bathroom with no equipment as she was wheeled into the bathroom with her commode and assisted with personal care by her carers.

4.86 The following day an MRI (magnetic resonance imaging) scan confirmed the presence of a significant pressure sore in the lower sacral region with an appearance in keeping with ongoing osteomyelitis (which was later confirmed).

4.87 On 27th November 2017 Ruth was seen lying on her back by the occupational therapist who reiterated advice that this position should be avoided. Ruth's granddaughter objected to her Nil by Mouth status as she said 'she very much enjoys her food'. This led to a SaLT swallow assessment the following day which recommended syrup thick fluid and a pureed diet. Staff were to provide full assistance and ensure that Ruth was sat up and alert when eating.

4.88 Clinical staff met with Ruth's son and granddaughter on 28th November 2017 when it was stated that she had advanced dementia, very limited consciousness and a significant pressure ulcer. To fully treat her pressure ulcer and osteomyelitis would require prolonged intravenous antibiotics and vascular and plastic intervention. It was felt that Ruth would not be able to withstand this level of intervention and that it may not improve her quality of life. It was agreed that the preferred option was for supportive end of life care at home to be urgently arranged.

4.89 Fast track NHS Continuing Health Care (CHC) funding was applied for. Ruth was noted to be comfortable and her life expectancy was estimated to be a small number of weeks.

4.90 On 4th December 2017 an adult safeguarding enquiry commenced following the safeguarding referrals submitted by the tissue viability nurse and subsequently by Wythenshawe hospital. It was noted that Ruth had been assessed as lacking mental capacity by the tissue viability nurse. Information was to be gathered for a planning meeting.

4.91 A package of CHC-funded home care was to be provided by I Care Solutions from teatime on 6th December 2017. Ruth was discharged from hospital on that date. Referrals had been made to the district nurse service and palliative care. Her GP was aware. A safeguarding plan was said to be in place although it has not been possible to establish what the plan contained. A new mattress had been delivered to Ruth's home address. Pain relief was via a patch as she continued to struggle to swallow tablets. The day prior to discharge it was noticed that Ruth had developed a new grade 2 pressure ulcer on her right elbow. (I Care Solutions Manchester is a domiciliary care service which provides care and support to people in their own homes to help them remain independent).

4.92 Ruth died within days of returning home.

5.0 Family contribution

5.1 Ruth's son was invited by letter to contribute to the Safeguarding Adults Review but did not respond. There is no obligation on any family member to contribute to a SAR. It is understood that Ruth's daughters live abroad.

6.0 Analysis

6.1 In this section each of the lines of enquiry agreed for this SAR will be addressed in turn.

How effective was the care Ruth received at home in addressing her needs including continence, skin, psychological and emotional needs, difficulty in taking medication and cognition?

6.2 It has been challenging to review the effectiveness of care received by Ruth as her district nurse records are not accounted for. However, Pennine Care conducted a Strategic Executive Information System (STEIS) root cause analysis (RCA) of the care provided by the district nurse service to Ruth. This investigation considered the period from 17th August 2017 until Ruth's admission to hospital on 21st November 2017. The STEIS report has been shared with this Safeguarding Adults Review, meaning that the SAR has been able to access the district nurse records for this period subject to the STEIS report. Outside of those dates the district nurse records available to this review are limited.

6.3 As a result of the joint tissue viability nurse/ district nurse assessment on 27th February 2017 it was recommended that a documented pressure ulcer prevention (PUP) plan was required for all staff to follow. Although the assessment had been prompted by concerns over Ruth's left hand, the PUP plan related to the prevention of pressure ulcers generally. From the information provided to this SAR it is unclear how central the PUP plan was to the care subsequently provided to Ruth. The pressure ulcer prevention plan is not referred to in the agency reports provided by the district nurse service, the GP or HSG.

6.4 It is not completely clear when the sacral pressure ulcer first began to develop. On 16th June 2017 HSG carers reported that the skin had broken on Ruth's 'bottom' (Paragraph 4.34) but it is not clear what action was taken. On 10th August 2017 HSG carers reported that Ruth's 'bottom' was very red and requested support from the district nurse service (Paragraph 4.47). On 15th August 2017 HSG carers again reported that Ruth's 'bottom' was very red and sore (Paragraph 4.47). Two days later there was a difference of opinion between the district nurse and HSG carers over whether the broken skin was a moisture lesion (district nurse opinion) or a pressure sore (HSG opinion) (Paragraph 4.50). On 27th August 2017 the district nurse concluded that Ruth had a grade 2 sacral ulcer. The prior references to 'bottom' by HSG carers are imprecise but the HSG registered manager has advised this review that when her staff referred to 'bottom' they meant the sacral area.

6.5 Following the identification of the sacral pressure ulcer, the district nurses took appropriate steps to treat it (Paragraph 4.54). Guidance was provided to the HSG carers including the need to reposition her at each visit. This means that Ruth would have been repositioned three times in each twenty four hours, i.e. at breakfast, lunchtime and bedtime. No information has been provided about repositioning during the night but it is assumed that Ruth's son would not have been able to manage this without training and the support of another trained person. NICE clinical guidance on *Pressure Ulcers: Prevention and Management* (2014) advises that where a person is assessed as being at high risk of developing a pressure ulcer, they should be encouraged or helped to change their position frequently and at least every four hours (1). At the time that Ruth's grade 2 sacral pressure ulcer was first noted, the Waterlow pressure ulcer risk assessment identified a score of 26 which indicated a 'very high risk' due to the length of time Ruth spent in bed. The HSG carers were only able to reposition Ruth three times in each twenty four hour period whereas the NICE clinical guidance indicates that she should have been repositioned six times in each twenty four hour period. It has been suggested that the district nurses may have been under the mistaken impression that the HSG carers were visiting Ruth four times each day which may be a partial explanation for why the insufficient frequency of repositioning was not flagged up as a concern at that stage. However, the district nurse service must have become aware that HSG were only visiting Ruth three times daily at some stage because it is recorded that the district nurses requested HSG to increase their visits to four times daily on 19th November 2017.

6.6 Initially Ruth's sacral pressure ulcer responded to the care and treatment provided by the district nurse service working closely with HRG carers, but a deterioration began on 2nd November 2017. Treatment and care plans were adjusted in response and district nurse visits were intensified but there is no indication that risk assessments were revisited at this time. Ruth found being repositioned more painful and became increasingly agitated. During this period Ruth's needs relating to her constipation became increasingly severe. Her quality of life had deteriorated markedly. By 14th November 2017 the sacral pressure ulcer was described as heading towards grade 4 and the joint district nurse/tissue viability nurse assessment was arranged which resulted in Ruth's admission to hospital.

6.7 During the period prior to the sacral ulcer beginning to deteriorate the OSRC occupational therapist reassessed Ruth's recently delivered hydrotilt chair after her daughter said Ruth had found it uncomfortable and HSG reported that she had been screaming out in pain when using the chair. The occupational therapist advised the HSG carers that Ruth should not be left in the chair any longer than the period from their breakfast to their lunchtime visit. The carers had apparently left Ruth in the chair from lunchtime to bedtime on one occasion. The district nurses do not appear

to have been involved in these discussions over the use of the chair. Although the chair benefitted from pressure relief, it is assumed that sitting in the chair with a grade 2 sacral pressure ulcer would not have been a comfortable experience and may have been the reason why Ruth was 'screaming out in pain'.

6.8 It had initially been thought that the lengthy delays in repairing the hoist and obtaining a suitable chair may have contributed to Ruth developing the sacral pressure ulcer. However, the tissue viability nurses who assessed Ruth on 27th February and 21st November 2017 both attended the practitioner learning event organised to inform this Safeguarding Adults Review and advised that the hoist and chair delays would primarily have adversely affected Ruth's quality of life and that nursing her in a chair would not have been advisable once the sacral pressure ulcer had developed.

6.9 The pressure ulcer plan prepared in February 2017 included a review of continence care (Paragraph 4.27) although the outcome of any such review is not known. At the time she made the safeguarding referral in November 2017, the tissue viability nurse noted that a fitted sheet was being used on the current pressure care dynamic mattress as well as a 'Kylie' type sheet (waterproof cover) and several incontinence pads were placed under the area of pressure ulceration. The HSG registered manager has contributed to this review and has advised that in an effort to keep the sacral pressure ulcer area as dry as possible, her staff had begun to use the 'Kylie' sheet and two incontinence pads, placed side by side, in the two week period prior to Ruth's admission to hospital. She added that the long periods between carer visits meant that it was difficult to keep her pressure ulcer dry. However, the district nurse service has advised this review that using two incontinence pads and the 'Kylie' sheet would have detracted from the pressure relief provided by the specialist mattress.

6.10 By the time she was admitted to hospital in November 2017, Ruth's nutritional intake had become poor and she appeared to have lost weight recently (Paragraph 4.79). The ambulance crew which conveyed her to hospital noted that she appeared to be struggling to feed herself with the food which had been left for her. The Pressure Ulcer Plan recommended by the Tissue Viability Nurse in February 2017 (Paragraph 4.27) envisaged that Ruth's nutritional status would be reviewed with consideration given to any weight loss or nutritional concerns. It is not known whether a review of her nutritional status took place or what the outcome of any such review was. Ruth's granddaughter advised hospital staff that she 'very much enjoyed her food' although a fear of eating due to hallucinations that she was being poisoned was noted earlier by the consultant physician in elderly medicine (Paragraph 4.18). Ruth's constipation appeared to become more acute towards the end of her life and it is possible that this may have affected her appetite.

6.11 Ruth became socially isolated after she left her placement in residential care and moved in with her son. Concern that isolation had left her feeling 'very depressed' led to a referral to a Befriending Service which lacked the capacity, at that time, to support Ruth. Social isolation was not identified in either of her subsequent annual assessments by Trafford ASC (September 2015 and November 2016) but spending lengthy periods alone was one of the concerns highlighted in the 21st November 2017 safeguarding adults referral made by the tissue viability nurse.

When Ruth's needs changed, were her needs reassessed and her care plans adjusted appropriately?

6.12 The last statutory annual review of Ruth's care and support needs was carried out by Trafford ASC on 4th November 2016. Therefore, by the time the safeguarding adults referral was made by the tissue viability nurse, Ruth was overdue her annual review. This Safeguarding Adults Review has been advised that Trafford ASC community teams invariably hold a number of cases which are outside of the twelve month review period at any one time due to the range of pressures on team resources and are therefore required to have a system for prioritising the reassessment of people which are outstanding. Trafford Council's target is to conduct 75% of annual reviews within 12 months.

6.13 Priority is given to people who are experiencing safeguarding concerns, who live alone and have a reduced ability to identify their own change in needs or raise the alarm. Additionally, priority is given where there are outstanding referrals due to current issues. As Ruth did not live alone, had a care package with input from district nursing and no concerns about her care arrangements had warranted contact with ASC, Ruth was not deemed a priority for reassessment. Holding a review within the required 12 month period would have identified that Ruth's needs had changed and would have led to her care plans being reassessed.

6.14 It is possible for the timing of an annual review to be brought forward if concerns arise that their care package is no longer meeting their needs or if a safeguarding referral was made for example. Trafford ASC became aware of referrals to the OSRC in July and October 2017 (Paragraphs 4.40 and 4.63 respectively) but neither of these referrals would have raised sufficient concern to justify bringing forward an annual assessment. As we have seen concerns about Ruth began to escalate from 27th August 2017 and the district nurses began to create incident reports on Pennine Care's incident reporting system but these incidents would not have been visible to Trafford ASC.

Between May and August 2017 Ruth was cared for in bed for a number of weeks due to delays in obtaining a replacement hoist and subsequently a

replacement chair. This period of bed care appears to have adversely affected Ruth's health. What action did agencies take to address this situation?

6.15 It is not known why it took so long to repair or replace the hoist. Ruth's hoist ceased working on 19th May 2017 and it was not replaced with an emergency hoist until 30th June 2017, a period of 42 days during which it is assumed that the hoist was not working. The HSG agency report states that their carers contacted Prism on 2nd June, 16th June, 21st June and 28th June 2017. Prism Medical has advised the review, via OSRC management, that they logged a 'service call' on 2nd June 2017 which was not attended and was subsequently cancelled on 7th June 2017. The extent of Ruth's son's contact with Prism Medical is unclear. He initially indicated to HSG staff that he would contact the OSRC (Paragraph 4.32) and later said that there had been a clerical error which had necessitated the re-order of a part for the hoist (Paragraph 4.35) which suggests that he had also contacted Prism.

6.16 Unfortunately, the delay in repairing or replacing the hoist was not addressed in the agency report which the OSRC submitted to this Safeguarding Adults Review and neither was the OSRC represented at the practitioner learning event organised to inform this review.

6.17 OSRC management have since advised this review that Prism Medical are contracted by Pennine Care to repair and replace hoists and can be contacted via a 24 hour helpline. The expectation of the OSRC is that any repair or replacement of a hoist would be accomplished very promptly. Prism are said to carry replacement hoists which can be swapped with any hoist which needs to be taken away for repair. When a hoist is initially delivered the patient or their representative is advised to contact Prism directly, using the 24 hour helpline, in the event of any problems or queries.

6.18 OSRC management describe the service provided by Prism as 'excellent', adding that no complaints about the service provided had been received. The HSG registered manager takes a different view, advising the review that it can sometimes take some time to arrange for a defective hoist to be repaired or replaced. OSRC management have advised this review that the quality of service provided by Prism is currently monitored via a monthly spreadsheet provided by the company. It is unclear whether these contract monitoring arrangements were in place in May/June 2017.

6.19 Whilst the delay in repairing or replacing the hoist was completely unacceptable, it does not appear to have been instrumental in the development of, and subsequent deterioration in, Ruth's pressure ulcer (See Paragraph 6.8).

6.20 Turning to the delay in replacing Ruth's chair, the OSRC has advised this SAR that the chair Ruth was using previously belonged to her and so the assessment was for new provision not a replacement. As specialist chairs are not standard stock items, there is always a lead time in provision. Once a chair is identified it may have to go for testing or cleaning before it can be issued. There was a delay in the occupational therapist being informed that it had not been possible to deliver the initial chair ordered which suggests that communication between units within the OSRC could be improved.

6.21 The OSRC has also advised this SAR that there is no single process for escalation where there is a delay in the repair of, or sourcing of an item, as this would depend on the particular item or problem. However, stores at the OSRC should inform the occupational therapist if there is a problem and OSRC stores should follow their procedures for dealing with the particular issue. The occupational therapist would be responsible for making any clinical decision regarding the client's safety following any delay or problem in repairing or sourcing an item.

To what extent was Ruth's care package monitored by the commissioners of her care?

6.22 The commissioners (Trafford Council) had no general concerns over the quality of care provided by Human Support Group during the period covered by this SAR. HSG are the largest provider in the Trafford Council area and are commissioned to provide around 3500 hours of care per week. There is no evidence of the care package provided to Ruth being monitored by the commissioners. It is assumed the primary route to reviewing the care package would be via the annual review of Ruth's care and support needs undertaken by Trafford Adult Social Care.

6.23 Trafford Clinical Commissioning Group (CCG) commission the district nurse service which is provided by Pennine Care. CCG monitoring of the service aims to identify themes and trends from which specific issues such as record keeping or pressure ulcers for example would be identified. Such issues would be discussed with Pennine Care at quarterly meetings along with key performance indicators such as timeliness of district nurse visits following referrals.

To what extent did workload pressures impact upon the care provided to Ruth?

6.24 The review has been advised that the district nurse service is under pressure as a result of contraction in the service due to financial and recruitment challenges. Additionally, demand on the service has increased.

6.25 A 2016 report from The King's Fund *Understanding Quality in District Nursing Services* found that whilst activity had increased significantly over recent years, both in terms of the number of patients seen and the complexity of care provided, there were significant problems with recruitment and retention of staff. Available workforce data was said to indicate that the number of nurses working in community health services had declined over recent years, and the number working in senior 'district nurse' posts has fallen dramatically, creating a growing demand–capacity gap (2).

6.26 As a result of the pressures described above, this review has been advised that narrative case recording by district nurses tends to be very brief but that these notes are backed up by care plans.

6.27 The district nurse service appears to have contracted at a time when a key trend is for people such as Ruth to be supported to live in their homes for as long as possible, which inevitably increases demand on district nurse services.

Did the district nurses have access to both clinical and safeguarding supervision?

6.28 Safeguarding supervision commenced for district nurses in July 2018 although the challenges of implementing and embedding this process has meant that they have not necessarily able to access it on the intended quarterly basis as yet. At the practitioner learning event, district nurses described clinical supervision as not yet being a formal process.

When Ruth's condition deteriorated did the services involved in her care at home escalate concerns appropriately?

6.29 There may have been an opportunity to refer Ruth to the tissue viability nurse earlier although her grade 2 sacral pressure ulcer initially responded well to the care and treatment plan. The district nurses referred Ruth for an assessment by the tissue viability nurse on 10th November 2017 (Paragraph 4.73) although this referral is not recorded in the agency report submitted to this review by the tissue viability nurse service. On 19th November 2017 the district nurses decided to follow up on the earlier tissue viability nurse referral to establish when the assessment visit was scheduled to take place. The tissue viability nurse agency report acknowledges the submission of an urgent tissue viability and support request by the district nurse service on 19th November although this was only available to them on the EMIS (electronic patient record) system the following day (20th November 2017).

6.30 The district nurses logged incident reports on the Pennine Care safeguarding system on 28th August (Paragraph 4.54 following the sacral ulcer grade 2 being noted), 10th November (Paragraph 4.73 size and depth of sacral ulcer increased) and 19th November 2017 (Paragraph 4.77 further deterioration in sacral pressure ulcer). An incident report would be reviewed by the service manager to quality assure the actions taken. The incident would also be reviewed by the Pennine Care safeguarding team and advice given to raise a safeguarding referral where appropriate. At the time of these incidents there were staffing deficits in the safeguarding team so it is considered unlikely that the incident would have been reviewed by the team at that time.

6.31 The Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry published by the Department of Health & Social Care provides guidance on when a safeguarding referral may be justified in respect of pressure ulcer care (3).

6.32 The guidance states that where concerns are raised regarding skin damage as a result of pressure there is a need to raise it as a safeguarding concern within the organisation. This was done by the district nurses on three occasions between 28th August and 19th November 2017. In a minority of cases the guidance states that concerns may warrant raising a safeguarding concern with the local authority.

6.33 The guidance contains a safeguarding decision guide assessment which consists of the following six key questions (the answers to the questions for Ruth are shown in brackets):

1. Has the patient or service user's skin deteriorated to either category 3/4/unstageable or multiple sites of category 2 ulceration from healthy unbroken skin since the last opportunity to assess/visit? (The stage 2 sacral pressure ulcer began to deteriorate from 2nd November 2017)
2. Has there been a recent change in their clinical condition that could have contributed to skin damage? e.g. infection, pyrexia, anaemia, end of life care (skin changes at life end), critical illness? (Infection was noticed on or around 20th November 2017)
3. Was there a pressure ulcer risk assessment and reassessment with an appropriate pressure ulcer care plan in place and was this documented in line with the organisation's policy and guidance? (Risk assessments were not initially updated when deterioration in the sacral pressure ulcer was first noticed. It was not possible for the carers, during three visits per day to reposition Ruth sufficiently frequently)
4. Is there a concern that the pressure ulcer developed as a result of the informal carer ignoring or preventing access to care or services? (A specialist

seating assessment did not take place in February 2016 after the OSRC was unable to contact Ruth's son)

5. Is the level of damage to skin inconsistent with the service user's risk status for pressure ulcer development? e.g. low risk –category/ grade 3 or 4 pressure ulcer? (The level of damage was consistent with Ruth's risk status once the risk assessments were updated)
6. Answer(a) if the individual has capacity to consent to every element of the care plan–Was the individual able to implement the care plan having received clear information regarding the risks of not doing so? (Ruth's capacity to consent to every element of her care plan does not appear to have been assessed. Formal Best Interests meetings were held rarely)
7. Answer (b) if the individual has been assessed as not having mental capacity to consent to any or some of the care plan - Was appropriate care undertaken in the individual's best interests, following the best interests checklist in the Mental Capacity Act Code of Practice (supported by documentation, e.g. capacity and best interest statements and record of care delivered)? (See answer to question 6 for Ruth)

6.34 Trafford Council's *Guidance on raising Adults Safeguarding Referrals and Incidents* which was revised in December 2018, now includes pressure ulcers as a potential example of 'neglect and acts of omission'.

How effective was the response to the adult safeguarding referral made by the Tissue Viability Nurse? Were there any other opportunities to make adult safeguarding referrals in respect of Ruth?

6.35 Safeguarding referrals were made by the tissue viability nurse on 21st November 2017 and by Wythenshawe hospital following Ruth's admission. On 4th December 2017 an adult safeguarding enquiry commenced. Information was to be gathered for a planning meeting. The poor diagnosis followed by the death of Ruth five days after the adult safeguarding enquiry commenced appears to have limited, if not terminated, any further direct response to the safeguarding referrals. Whilst there may be sound reasons for not taking the enquiry any further in such circumstances, there is a risk that any unsafe practice disclosed by the safeguarding referrals may go unaddressed. However, this risk was mitigated by the Pennine STEIS root cause analysis report and the decision to commission this Safeguarding Adults Review.

6.36 There may have been earlier opportunities to consider making an adult safeguarding referral in respect of Ruth as the issues highlighted in the tissue viability nurse's referral had been present since August 2017 when the grade 2 sacral pressure ulcer had been identified. Other concerns had been present for much

longer particularly Ruth's vulnerability due to her isolation, immobility and inability to self-evacuate the building.

6.37 It may have taken the 'fresh pair of eyes' of the tissue viability nurse to recognise that a safeguarding referral needed to be made and that over time the carers and district nurses may have become de-sensitised to the circumstances in which care was being provided and the difficulties in providing the expected level of care.

6.38 Additionally there may have been an opportunity to consider whether there were adult safeguarding issues arising from Ruth's son's lack of engagement with the specialist seating assessment. The need for this seating assessment had been identified by an occupational therapist in the Dementia Crisis and Prevention Team to assist in posture control and pressure relief for Ruth. Non-engagement with the seating assessment had the potential to expose Ruth to increased risk of pressure sores and falling from what appeared to be an extremely unsuitable chair.

To what extent was Ruth's voice heard and her wishes and feelings considered?

6.39 From the information shared with this Safeguarding Adults Review, there is little sense of Ruth's personality, voice or preferences. Sadly, obtaining a picture of the first eight and a half decades of her life has not proved possible.

6.40 During the time period on which this review has focussed, Ruth appears to have been supported in decision making by a daughter and then from the point at which she moved into his home, her son. As time progressed it appears that decisions were increasingly being taken by the family on her behalf. An example of this was the decision that Ruth should not access day care in order to help address her social isolation which had caused her to become 'very depressed'. It was said that the family did not feel it would be good for Ruth to be brought downstairs to enable her to be transported to the day centre. There is no indication of Ruth's views on the matter.

6.41 Ruth wasn't consulted as part of the review of her care and support needs in September 2015. There is no suggestion that she lacked the capacity to engage with the review at that time.

6.42 There are a number of deficits in record keeping by agencies involved in Ruth's care and a factor in this appears to be workload pressures. In these circumstances it may be that practitioners have not given priority to recording Ruth's wishes, feelings and preferences. However, the concern must be that if Ruth's preferences have not

been recorded, they may be because they have not been sought out in the first place.

Given the growing evidence of a decline in Ruth's cognitive impairment, did agencies work with her in a way which was consistent with the Mental Capacity Act. When she was assessed as lacking capacity, were decisions taken in her Best Interests? Have agencies got an MCA policy in place supported by training?

6.43 Ruth was described as a little confused prior to her move into residential care in April 2012 but when she left the care home to live with her son around the end of that year a mental capacity assessment was completed by a Trafford ASC social worker which established that she had capacity to decide where to live.

6.44 Early the following year (2013) Ruth's capacity was described as fluctuating when she was unwell. When she was well she was said to regain her capacity. She was described as experiencing increased confusion when she was admitted to hospital in November 2013. She wasn't discharged until February 2014 when a 'best interests' meeting was held. This doesn't appear to have been a formal Mental Capacity Act Best Interests meeting. At the heart of the Mental Capacity Act lies the principle that where it is determined that individuals lack capacity, any decision or action taken on their behalf must be in their best interests. A crucial part of any best interests judgement will involve a discussion with those close to the individual, including family, friends or carers. In order to avoid confusion, it would be advisable for the term 'best interests' only to be used when the meeting or discussion arises after the person has been assessed as lacking mental capacity.

6.45 Ruth's capacity was not assessed as part of her Trafford ASC annual reviews of her care and support needs in September 2015 and November 2016. The 2015 review was conducted via a telephone discussion with Ruth's son who appeared to have gradually been regarded by agencies as the prime or sole decision maker in respect of his mother's needs. The November 2016 review noted Ruth's cognitive impairment, describing both her long and short term memory as poor. However, the effect of this cognitive impairment on her life was said to be minimal. No formal Mental Capacity Act assessment took place at this time as it was said that there were no decisions which were required to be made in respect of Ruth.

6.46 By January 2017 Ruth was considered by a consultant physician in elderly medicine to be highly unlikely to have capacity to make significant decisions about her health including decisions about resuscitation. It is unclear whether a mental capacity assessment took place at this time and the use of the phrase 'highly unlikely' suggests it may not have done.

6.47 At the time of the joint tissue viability/district nurse assessment on 27th February 2017 Ruth 'incapacity' was referred to but there is no indication that an assessment of her capacity took place at that time.

6.48 Ruth's son and daughters appear to have been regarded as the sole decision makers when the possibility of surgical intervention was discussed at a plastic surgery outpatients appointment on 7th August and 27th September 2017.

6.49 From the point at which the district nurses and HSG carers, supported by the GP, began working more intensively together to treat her sacral ulcer from 27th August 2017 there is no record of any mental capacity assessment taking place until the tissue viability nurse assessed Ruth as lacking capacity on 21st November 2017. By this time there appeared to be a general assumption that Ruth lacked capacity to make decisions in respect of her care and treatment and that her son made all decisions on her behalf. It is possible that capacity assessments took place but went unrecorded. However, there is no evidence that any best interests discussions took place during this period. Had any such discussions taken place it seems possible that the impossibility of repositioning Ruth sufficiently frequently under the current care plan may have been addressed.

6.50 As stated above, on 21st November 2017 the tissue viability nurse found Ruth unable to communicate with her and assessed her as lacking capacity to consent to the photographing of her wound or the tissue viability assessment process.

6.51 Following her admission to Wythenshawe Hospital on the same date the only capacity assessment within the medical and nursing records was as part of the DoLS application. However, the hospital records clearly reflect that health practitioners caring for Ruth had reasonable belief that she lacked capacity in a number of areas, including nutritional support, treatment of her deteriorating pressure ulcers and treatment options.

Were Deprivation of Liberty Safeguards correctly applied whilst MW was admitted to hospital?

6.52 A DoLS application was completed by Wythenshawe Hospital two days after Ruth's admission. The MFT DoLS policy states that any person admitted to the organisation that meets the 'acid test' requires a capacity assessment for accommodation at the Trust and a DoLS application to be completed. (The 'acid test' consists of two questions; Is the person subject to continuous supervision and control? and is the person free to leave?)

6.53 Trafford Adult Social Care received the application and applied the ADASS screening priority tool which afforded a low priority to the application. This resulted in a procedural breach in respect of the deprivation of Ruth's liberty whilst a hospital in-patient.

What support was provided or offered to Ruth's son as her primary carer?

6.54 As previously stated Ruth's son did not contribute to this review. There is no obligation on family members to contribute to Safeguarding Adults Reviews. The son became Ruth's primary carer when she moved from residential care to live with him in December 2012. It is understood that he was self-employed which gave him a degree of flexibility over his working hours. The Human Support Group registered manager has advised this review that when Ruth's condition began to deteriorate in the second half of 2017, her son began going out to work very early in the morning so that he could return home in the early afternoon so that he was present at home during the lengthy period between the HSG carers lunchtime and bedtime visits.

6.55 The Trafford ASC annual review completed in November 2016 did not document consideration of the needs of the son as carer in any detail. Nor did an ASC worker enquire whether he would need additional support to care for Ruth when she was discharged home for end of life care in December 2017. However, he was offered, and declined, a carer's assessment at the time of the November 2016 assessment of his mother.

6.56 Although the son's work commitments appear to have prevented his presence at key events such as the two joint district nurse/tissue viability nurse assessments in February and November 2017, there appears to have been adequate communication between the son and the GP, district nurse and the HSG carers.

6.57 However, the review has highlighted some concerns about Ruth's quality of life after she moved to live with her son in December 2012. Although the son's home had been fitted with a stair lift, concerns about Ruth's 'upstairs living' were raised at the time of her discharge from hospital in February 2014 and when Ruth's social isolation was discussed with her son in September 2014, the option of day centre attendance was discounted because of the difficulty in moving her downstairs. It is assumed that by this time she must have been spending the bulk of her time in her upstairs bedroom and was said to have become 'very depressed'. Ruth's social isolation was a concern which contributed to the decision by the tissue viability nurse to make an adult safeguarding referral in November 2017.

6.58 A further concern arises from the difficulties encountered by the OSRC occupational therapist in arranging for a specialist seating assessment in February

2016 which eventually led to Ruth's case being closed and the seating assessment not taking place. The HSG registered manager has advised this review that the seat into which Ruth was transferred each day was a rocking chair from which the rocker rails along the bottom of the chair had been sawn off. Carers became increasingly concerned about Ruth's safety in this chair as the removal of the rocker rails left the seat of the chair very low to the floor. It was this sawn off rocking chair which was replaced by the specialist hydrotilt chair in August 2017. This chair was pressure relieving which the rocking chair obviously was not and could have been provided eighteen months earlier in February 2016.

6.59 Fulfilling the role of primary carer for a person with complex health needs is extremely challenging particularly whilst holding down a full time job. Practitioners providing care and support for Ruth appeared to communicate effectively with her son although there is no indication that questions were asked about Ruth's continuing social isolation or the uncompleted seating assessment.

6.60 When it became necessary for Ruth to be regularly repositioned in order to prevent her sacral ulcer deteriorating it is unclear whether the question was addressed of how the son could manage to reposition his mother alone during the periods when no carers were visiting i.e. from lunchtime until bedtime and from bedtime until breakfast.

Explore the Continuing Healthcare assessment carried out after Ruth's admission to hospital.

6.61 Some people with long-term complex health needs qualify for free social care arranged and funded solely by the NHS. This is known as NHS Continuing Healthcare (CHC). This can be provided in a person's own home as with Ruth.

6.62 Clinical commissioning groups (CCG) are responsible for assessing people who may need CHC. Usually, there is an initial checklist assessment, which is used to decide if a full assessment for CHC is required. However, if a person's health is deteriorating quickly and they are nearing the end of their life, a CHC fast-track pathway should be considered so that an appropriate care and support package can be put in place as soon as possible – usually within 48 hours.

6.63 In Ruth's case the request for a fast -track CHC assessment was received from Wythenshawe hospital on 1st December 2017 and was agreed three days later. The care plan to be funded by CHC involved a package of home care by two carers four times each day with district nurse and GP support. The district nurse service was to arrange night sitters if required and if there was availability. In developing the care plan it is unclear how much weight was given to the prior safeguarding concerns.

6.64 I Care Solutions were chosen as the care providers after an expression of interest request was circulated. It appears that Human Support Group was not considered as a care provider which seems unfortunate given that the HSG carers were familiar with Ruth's prior care needs and there was an existing relationship with Ruth and her son.

How effective were hospital discharge planning arrangements in respect of Ruth's 'fast track' discharge home?

6.65 A meeting was held on the 29th November 2017 with Ruth's son, granddaughter, medical and nursing staff. The documentation in the notes suggest that this was treated as a best interest meeting, although it was not completed using the MFT BI template. The alternatives of active treatment or maintaining Ruth's comfort with end of life care were discussed and all present agreed that the most appropriate option was end of life care at home. Multidisciplinary communication is noted in the records and appropriate referrals to the CCG (CHC funding) and district nurse liaison team were made. However, there is a lack of documentation to evidence any conversations with Ruth's son or other family members to inform the hospital's understanding of Ruth's social circumstances following her fast track home.

6.66 It is unclear what weight was given to the concerns highlighted in the safeguarding referral submitted by the tissue viability nurse and Wythenshawe hospital when Ruth's discharge from hospital was being considered. At this point her life expectancy was very limited and the family's wishes were that she should spend her final days or weeks in the familiar surroundings of the home she shared with her son. However, she was being discharged back to a place where concerns had been expressed about the viability of the care which could be provided in that setting, her isolation and her safety. Whilst the decision to discharge Ruth home for palliative care was not unreasonable, it would have been preferable for the decision to have been more fully documented, in particular the measures which were to be put in place to address the prior safeguarding concerns.

6.67 Additionally, Trafford Adult Social Care do not appear to have been involved in discharge planning. It seems that Ruth's needs on discharge were considered primarily from a health perspective and that the possibility that the local authority may have a statutory duty to meet Ruth's care and support needs under the Care Act may not have been fully discussed.

How effective was the palliative care provided?

6.68 I Care Solutions provided the home care package following Ruth's discharge from hospital and have not complied with a request to provide information about this brief period of care. The District Nurse notes in respect of the care provided to Ruth are unaccounted for.

Given the range of agencies involved in Ruth's care, how effectively was her care co-ordinated? How effectively did the services involved in providing her home care, particularly her independent home care provider, district nurse service and her GP, work together, share information and co-ordinate Ruth's care plan?

6.69 A large number of services were involved in providing the care and support Ruth needed to enable her to live in the home she shared with her son whilst maintaining her health and quality of life. On a day to day basis care was provided by HSG carers, the district nurse service and Ruth's GP practice. These services worked with Ruth's son who was her primary carer.

6.70 When the district nurse service became more intensively involved in Ruth's care they fulfilled a co-ordinating role. They communicated with the HSG carers on a face to face basis if their home visits coincided with those of the carers. If not, they left notes. The district nurses provided advice and guidance to the carers on key issues such as the care and treatment of Ruth's sacral pressure ulcer. The district nurse service made prompt and appropriate contact with Ruth's GP. There appeared to be much less communication between the district nurses and HSG management. The request that HSG increase their daily visits from three to four does not appear to have been made to HSG management or indeed Trafford Council as the commissioners of the service provided by HSG.

6.71 It is unclear whether the continence care for Ruth in the period immediately prior to her hospital admission on 21st November 2017, which may have undermined the care of her sacral pressure ulcer to an extent, was discussed and agreed by HSG carers and the district nurses.

6.72 Prior to the district nurse service becoming more intensively involved in August 2017, there appeared to be an absence of care co-ordination. The GP practice and district nurse service reacted promptly to concerns which arose about Ruth's health but HSG experienced some difficulty in escalating concerns in respect of issues such as the delayed response to the repair/replacement of the hoist. Whilst HSG made persistent and repeated efforts to address this issue and highlighted the risks the absence of a functioning hoist exposed Ruth to, there was a disturbing lack of

responsiveness by Prism Medical which suggest that issues raised by providers of domiciliary care may not carry sufficient weight.

6.73 There appeared to be little liaison between the OSRC and the district nurse service. During the period following the noting of Ruth's grade 2 sacral pressure ulcer, the OSRC occupational therapist visited Ruth on three occasions to check her positioning in the hydrotilt chair. Whilst the OSRC contacted HSG carers and family members during these visits, there was no contact with the district nurses who were co-ordinating Ruth's pressure ulcer care and who would have been able to advise on the appropriateness of Ruth being supported in the chair.

6.74 Sitting above this day to day care was Trafford Adult Social Care who carried out annual reviews of Ruth's care and support needs in September 2015 and November 2016. No annual review had taken place in 2017 prior to Ruth's admission to hospital in November of that year. Trafford Adult Social Care did not become aware of the deterioration in Ruth's health and the consequent change in her needs. Whilst the district nurses submitted incident reports to Pennine Care, these did not appear to receive scrutiny by Pennine Care's safeguarding team and were not shared with Trafford ASC.

Good practice

6.75 The following good practice is highlighted:

- HSG carers made persistent efforts to resolve the delays in repairing/replacing the hoist and securing a replacement chair. When making efforts to resolve the hoist issue they drew attention to the risks involved in nursing Ruth continuously in bed.

- When Ruth's grade 2 sacral pressure ulcer was first noted in August 2017 the district nurse service responded effectively and worked well with her GP and HSG to initially achieve an improvement in her condition.

- In November 2017 the tissue viability nurse made an adult safeguarding referral in which she appropriately expressed a number of concerns about the care Ruth had been receiving and her vulnerability arising from her isolation.

7.0 Findings and Recommendations

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

- There are several indications that the 'system' is under strain. For example, the district nurse service is under pressure at a time when demand arising from the desire of people to live at home for as possible is increasing. Additionally, adult social care does not have the capacity to conduct reviews of all people with care and support needs on an annual basis.

- The domiciliary care services provided to Ruth focussed on task based care within an allocated time window. When her needs changed, in particular her need to be more regularly repositioned to prevent her sacral pressure ulcer deteriorating, this 'time and task' approach to delivering her care was no longer sufficient to meet her needs over each twenty four hour period.

- Meeting the needs of a person with multiple care needs involves a wide range of services. Unless there is effective communication (human and information systems) and thoughtful co-ordination there is a risk that service provision can quickly become fragmented. The quality of multi-agency communication was variable in this case and care co-ordination was only evident when it became necessary to provide Ruth with more intensive support after her grade 2 sacral pressure ulcer was noted in August 2017.

- There was an absence of escalation of concerns. Trafford ASC did not become aware that Ruth's needs had changed since their November 2016 review of her care and support needs. Had they become aware of her deteriorating health they could have prioritised or brought forward the 2017 review. HSG did not appear to consider escalating their concerns to Trafford Council as commissioners of the care they provided to Ruth nor did Pennine Care appear to consider sharing the incident reports submitted by the district nurses with Trafford ASC. Staff caring for Ruth may have become de-sensitised to risk as it took the 'fresh pair of eyes' of the tissue viability nurse to recognise that Ruth's care at home had become compromised and submit an adult safeguarding referral.

- There was a fairly rigid approach to non-engagement, for example the OSRC response to lack of family contact to arrange the specialist seating assessment for Ruth in 2016. Discharge from the service appeared to be the standard response with insufficient attention paid to the risks to Ruth's health if the seating assessment did not take place.

- The interests of the service user were not always central to agency and partnership decision making. Ruth's preferences diminished in prominence over time.

- There was an absence of multi-agency meetings/discussions when the needs of Ruth escalated.

- Record keeping and record retention appears to be very variable.

Pressure Ulcer Care and Prevention

7.2 Whilst the operational responsibility for investigating pressure ulcers is largely health led, local Safeguarding Adult Partnerships (SABs) have a strategic interest in the prevalence of pressure ulcers across the sectors as one indicator of quality of care.

7.3 It is believed many pressure ulcers can be prevented when the right interventions are utilised and could be avoided through simple actions by staff, individuals and their carers. As well as causing long-term pain and distress for individuals, treatment is estimated to cost the NHS between £1.4 and £2.1 billion per year. There is a strong evidence base on how to prevent pressure ulcers from developing. There is a greater need to share and heed this evidence base and take action if we are to reduce the incidence of this avoidable harm. (5)

7.6 In Ruth's case, any pressure ulcer care plan drawn up by district nurses in February 2017 did not appear to be shared with her GP or HSG carers (Paragraph 6.3); once the grade 2 sacral pressure ulcer was noted in August 2017, Ruth was not repositioned sufficiently regularly (Paragraph 6.5); the risks to Ruth were not reviewed promptly when the pressure ulcer began to deteriorate in early November 2017 (Paragraph 6.6) and a proposed increase in daily visits by HSG carers did not appear to be communicated to HSG management or Trafford Council as commissioners of the domiciliary care (Paragraph 6.5).

7.7 Trafford Strategic Safeguarding Partnership may therefore wish to obtain assurance from Pennine Care in respect of pressure ulcer prevention, care and

treatment particularly care planning, risk assessment, care co-ordination and responsiveness to changes in needs.

Recommendation 1

That Trafford Strategic Safeguarding Partnership obtains assurance from Pennine Care in respect of the prevention, care and treatment of pressure ulcers including care planning, risk assessment, care co-ordination and responsiveness to changes in needs.

District Nurse Service

7.8 The district nurse service responded effectively to Ruth's grade 2 sacral pressure ulcer and working effectively with HSG carers and her GP, initially achieved an improvement. However, the impression gained from the contribution of district nurse management to this SAR, is that the service is under pressure. As a result, the service tends to be reactive and lacks the capacity to co-ordinate care with other agencies at times. Time for record keeping appears to have become compressed. As stated, the review has been advised that the service has contracted due to financial, recruitment and retention challenges. This is a local and national issue.

7.9 This contraction in the service has taken place at a time when demands upon the service are increasing. Supporting people like Ruth to keep well whilst continuing to live at home for as long as possible inevitably places heavier demands upon the district nurse service. In this case it was necessary to increase the number of visits to Ruth after her grade 2 sacral pressure ulcer was noted, including some weekend visits, whilst investing more time in co-ordinating with the HSG carers.

7.10 The contraction in the district nurse service increases the risk that care for people with complex needs could be compromised which may lead to safeguarding concerns. Trafford Strategic Safeguarding Partnership may wish to seek assurance about forward plans to address this issue from the commissioners and the provider of the district nurse service.

Recommendation 2

That Trafford Strategic Safeguarding Partnership seek assurance about forward plans to address concerns about the contraction of the district nurse service at a time of increasing demand from the commissioners (NHS England/ Trafford Council) and the provider (Pennine Care) of the service.

Annual Reviews of Care and Support Needs

7.11 There was a slight delay in conducting the annual review of Ruth's care and support needs in 2017 which does not appear to have had a significant impact on this case. However, Trafford adult social care did not become aware that Ruth's needs had changed and that her situation had begun to deteriorate quite markedly from the relatively stable picture derived from the November 2016 review. Pennine Care received a number of incident reports from the district nurses from August 2017 onwards which, had they been shared with Trafford adult social care, would have alerted them to the fact that Ruth's care and support needs had changed.

7.12 Trafford Strategic Safeguarding Partnership may wish to obtain assurance from Pennine Care that, where appropriate, incident reports submitted by health services (district nurses in this case) in respect of a service user will be shared with the commissioners of social care services for that service user (Trafford Council in this case).

Recommendation 3

That Trafford Strategic Safeguarding Partnership obtains assurance from Pennine Care that, where appropriate, incident reports submitted by health services (district nurses in this case) in respect of a service user will be shared with the commissioners of social care services for that service user (Trafford Council in this case).

Delay in repairing or replacing the hoist

7.13 Ruth may have been nursed in bed for up to 42 days continuously as a result in delays in repairing or replacing her defective hoist. Although this period of care in bed is not believed to have contributed to the subsequent development of her sacral pressure ulcer, it adversely affected the quality of her life. At the time of writing it had not been possible to obtain a satisfactory explanation for this delay. Prism Medical's provide the hoist repair/replacement service on behalf of the OSRC. OSRC management has advised this review that the service they provide is highly regarded but on the basis of this case, there are concerns about their response, their record keeping and the mechanism for disclosing and reviewing service failures such as the one disclosed in Ruth's case.

7.14 Trafford Strategic Safeguarding Adults Partnership may wish to seek assurance from Pennine Care in respect of the standard of the hoist repair/replacement service

provided by Prism Medical and the effectiveness of arrangements for monitoring the provision of that service.

Recommendation 4

That Trafford Strategic Safeguarding Adults Partnership seeks assurance from Pennine Care in respect of the standard of the hoist repair/replacement service provided by Prism Medical and the effectiveness of arrangements for monitoring the provision of that service by Prism Medical.

Safeguarding concerns

7.15 Safeguarding referrals were made by the tissue viability nurse and Wythenshawe hospital around the time of Ruth's admission on 21st November 2017. Whilst the majority of the concerns which prompted the safeguarding referrals related to the care of Ruth's sacral pressure ulcer, other concerns such as those relating to her isolation, vulnerability and inability to self-evacuate had been present for some time.

7.16 The dissemination of learning from this review will provide an opportunity to consider when safeguarding referrals are justified in cases of neglect arising from pressure ulcer care.

Recommendation 5

That Trafford Strategic Safeguarding Partnership widely disseminates the learning from this review which will provide an opportunity for practitioners to consider when safeguarding referrals are justified in cases of neglect arising from pressure ulcer care.

7.17 The extent to which the concerns which prompted the safeguarding referrals informed subsequent decisions to approve a fast-track package of CHC funded care and Ruth's discharge home for palliative care is unclear. Trafford Strategic Safeguarding Partnership may wish to gain assurance that the relevant agencies, NHS Trafford CCG (Personalised Care Department) and Manchester University NHS Foundation Trust (Wythenshawe Hospital), have reflected on the learning from this SAR in respect of considering, and documenting the consideration of, safeguarding concerns.

Recommendation 6

That Trafford Strategic Safeguarding Partnership obtains assurance from NHS Trafford CCG (Personalised Care Department) and Manchester University NHS Foundation Trust (Wythenshawe Hospital) in respect of considering, and documenting the consideration of, safeguarding concerns when making decisions on fast-track Continuing HealthCare (CHC) and hospital discharge, respectively.

Preventing social isolation

7.18 Ruth became socially isolated after she left her placement in residential care and moved in with her son. There was professional concern that this was adversely affecting her mental health but the response to this issue was not effective. Ruth's social isolation was not identified in either of her subsequent annual assessments by Trafford ASC (September 2015 and November 2016). However, isolation was a factor in the 21st November 2017 safeguarding adults referral.

7.20 There has been increased interest in social isolation in recent years and, in particular, the potential impact of social isolation on health and wellbeing (5) (6) (7) (8). Social isolation, which refers to the quality and quantity of the social relationships a person has at individual, group, community and societal levels is distinguished from loneliness which is a subjective feeling experienced when there is a difference between an individual's felt and ideal levels of social relationships. Taking steps to prevent social isolation has the potential to alleviate pressure on health and social care services (9).

7.21 Trafford Strategic Safeguarding Adults Partnership may wish to share this report with Trafford Health and Wellbeing Partnership as in Ruth's case, she remained socially isolated for a number of years, the resources available to address her social isolation appeared somewhat limited and subsequent assessments may not have been sufficiently attuned to social isolation as a need.

Recommendation 7

That Trafford Strategic Safeguarding Adults Partnership shares this SAR report with Trafford Health and Wellbeing Partnership as the resources available to address social isolation appeared somewhat limited and assessments and reviews of care and support needs may not be sufficiently attuned to social isolation as a need.

Emergency evacuation of people with complex needs

7.22 Ruth's social isolation also affected her safety. The tissue viability nurse making the safeguarding adults referral was concerned that if it became necessary for Ruth to be evacuated from her home in the event of an emergency arising from events such as fire, flooding, gas leak etc. she would not be capable of self-evacuating.

7.23 Services have statutory obligations placed upon them to ensure that plans are in place to facilitate the evacuation of people from premises in the event of an emergency. Had Ruth been placed in residential care she would have had a Personal Emergency Evacuation Plan (PEEP). Such plans are intended to identify the evacuation equipment required and the level of staff assistance necessary to evacuate a resident. PEEPs are included within the CQC inspection regime.

7.24 In Ruth's case, it is assumed that the owner of the premises, her son, would have responsibility for ensuring Ruth's evacuation but neither he, nor those providing care and support to her would be with her at all times. Indeed, Ruth appears to have spent several hours each day on her own.

7.25 The Civil Contingencies Act places responsibility for preparing for civil emergencies on Local Resilience Forums (LRF) which brings together agencies responsible for responding to emergencies. The independent author of this SAR is aware that many LRFs across the country have been working to address the issue of how to identify people who might be particularly vulnerable in an emergency. The population of people with complex needs who are being provided with care and support in their own homes represent a particular challenge for emergency planners. It may therefore be of value for Trafford Strategic Safeguarding Partnership to share the learning from this review with the Greater Manchester LRF so that it can inform their efforts to identify and support vulnerable people in emergencies.

Recommendation 8

That Trafford Strategic Safeguarding Partnership shares the learning from this Safeguarding Adults Review with the Greater Manchester Local Resilience Forum so that it can inform their efforts to identify and support vulnerable people in civil emergencies.

Mental Capacity assessments

7.26 Ruth's cognition gradually declined with both her long and short term memory described as 'poor' by the time her care and support needs were reviewed in November 2017. Agencies increasingly regarded her son as the sole decision maker

in respect of her care and support needs. Ruth's capacity was assessed at times but more often practitioners appeared to assume a lack of capacity, although it is possible that capacity assessments may have taken place but not been recorded.

7.27 The only indication that Best Interests meetings took place were at the time of her discharges from hospital in February 2014 and December 2017. Had Best Interests meetings taken place when appropriate this would have facilitated a stronger multi-disciplinary approach and Ruth's son would not have been treated as the sole decision maker in respect of his mother's care.

7.28 The conducting and recording of mental capacity assessments was the subject of much discussion amongst the practitioners who attended the learning event organised to inform this SAR. The consensus view was that assessments were frequently carried out but often went unrecorded. It was suggested that further guidance on the minimum recording of assessments required would be helpful. Trafford Strategic Safeguarding Partnership may wish to explore good practice in the recording of Mental Capacity assessments by partner agencies and disseminate best practice emerging from this exercise.

Recommendation 9

That Trafford Strategic Safeguarding Partnership explores and disseminates good practice in the recording of Mental Capacity assessments by partner agencies.

Record Keeping

7.29 Record keeping by several agencies involved in this SAR was sparse and/or incomplete. If issues relating to Ruth's care were not fully documented this could hamper monitoring and oversight of her care. Deficiencies in recording also has the potential to limit any subsequent review processes, including Safeguarding Adult Reviews.

7.30 Trafford Strategic Safeguarding Partnership may wish to obtain assurance from partner agencies in respect of the monitoring and, where necessary, improvement of the accuracy and completeness of record keeping.

Recommendation 10

That Trafford Strategic Safeguarding Partnership obtains assurance from partner agencies in respect of the monitoring and, where necessary, improvement of the accuracy and completeness of record keeping.

Single Agency Learning

7.31 Trafford Strategic Safeguarding Partnership may wish to invite the agencies which contributed to this SAR to reflect on the learning which has emerged and consider whether they need to make any improvements to single agency policy and practice.

References:

(1) Retrieved from https://www.nice.org.uk/guidance/cg179
(Pressure Ulcers: prevention and management)

(2) Retrieved from https://www.kingsfund.org.uk/publications/quality-district-nursing

(3) Retrieved
from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756243/safeguarding-adults-protocol-pressure-ulcers.pdf

(4) ibid

(5) retrieved from https://www.york.ac.uk/inst/spru/research/pdf/Lone.pdf

(6) retrieved
from http://hummedia.manchester.ac.uk/institutes/micra/Handbooks/Buffel%20Tine%20-%20A5%20Brochure%20-%20Social%20Isolation.pdf

(7) retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24897833

(8) retrieved from https://psycnet.apa.org/record/2010-21478-005

(9) retrieved from
https://www.researchgate.net/publication/46691501_Social_Isolation_in_Modern_Society

Appendix A

Membership of the SAR Panel and the process by which the SAR was completed

A panel of senior managers from partner agencies, chaired by the independent author, oversaw this review and membership of this panel is shown below:

- Safeguarding Partnership Manager, Trafford Strategic Safeguarding Partnership (TSSB)
- Deputy Chief Nurse & Designated Nurse Safeguarding Adults, Trafford CCG
- Head of Commissioning, Trafford Council
- Adult Social Care Lead Professional, Trafford Council
- Named Nurse for Adult Safeguarding, Manchester NHS FT
- Safeguarding Families Specialist Nurse, Pennine Care
- Senior Practitioner, Community Nursing, Pennine Care
- Registered Manager Human Support Group
- Detective Inspector, Greater Manchester Police
- Safeguarding Partnership Officer, TSSB
- Safeguarding Support Officer, TSSB
- David Mellor, Independent Author and Chair of SAR panel.

It was decided to adopt a broadly systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Chronologies which described and analysed relevant contacts with Ruth were completed by the following agencies:

- Human Resource Group
- Manchester NHS Foundation Trust
- NHS Trafford Clinical Commissioning Group (GP Practice)
- Pennine Care NHS Foundation Trust (District Nurse Service, One Stop Resource Centre, Tissue Viability Nurse)
- Trafford Council Adult Social Care
- Trafford Community Services (Tissue Viability Nurse)

A learning event took place, to which all practitioners involved in this case were invited. This proved valuable in understanding the part played by various agencies and services in supporting Ruth, although some key agencies did not attend.

As previously stated, Ruth's son was offered the opportunity to contribute to this review but declined.

Following the learning event, the independent author wrote a draft report. With the assistance of the SAR panel, the report was further developed into a final version and presented to Trafford Strategic Safeguarding Partnership.