7 Minute Briefing – Martha

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Background: Martha, a 76-year-old woman who died on the 31st May 2020 having been admitted to hospital on 22nd May 2020. Martha was admitted to hospital with a grade 4 pressure sore, the care prior to admission was described as poor. Her condition was assessed as terminal, and she died in hospital as a result of complications relating to her pressure sore. Adult Social Services had been commissioning the social care services that Martha required for about 7 years until she died on 31st May 2020. She had received a diagnosis of Dementia because of Parkinson's disease, and it was understood by everyone that her heath would continue to deteriorate. During the seven years of offering community-based services, no safeguarding concerns had arisen regarding the care offered to Martha, the exception being the day before she

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Safeguarding concerns:

- The effectiveness of the care Martha received at home in addressing her needs.
- When Martha's needs changed, were her needs reassessed and was the care plan adapted appropriately?
- To what extent was the care package monitored by those commissioning her care?
- Were there opportunities missed to raise a safeguarding alert and hold a strategy meeting?
- Were the views of Marth considered and did they impact on actions taken?
- Did the Covid pandemic/national arrangements impact on the care Martha received?

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Key lines of enquiry:

All agencies involved with Martha's care contributed to the review.

- Ealing Adult Social Care
- Health care Trusts
- Police
- Community Care Provider
- Ealing Council Independent living and Learning Disability Services
- Ealing Council Health and Provider Trust

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Findings:

Martha was without her formal care provision from 24th March 2020, until it was re-instated on 07th May 2020.

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Practice implications:

1. Arrangements for commissioning care and support from external agencies should be considered, this includes a minimum expectation on the standards for record keeping, records should contain a degree of personalisation to the service user.
2. Care agencies should be required to submit evidence on staff training and awareness raising, for safeguarding and the key elements of providing care to adults living in their home setting. This will provide assurance of the senior leadership commitment to discharge the effective supervision and support of the workforce.
3. The recording of reasons for care discontinuing also need to be clear and explicit.
4. Commissioning of a standby or emergency service if care provision is not happening in accordance with what has been agreed.
5. All staff should be reminded of the threshold relating to raising safeguarding concerns.
6. Practitioners should communicate that pressure ulcers can be an example of acts of omission and neglect.

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Implementing change:

Reflect on the practice implications with your team or service and discuss how they can be implemented. Identify what you or your team might do to make changes or whether training is required.

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Resources and further information:

Pressure ulcers prevention and management - NICE Guidance

Helping to prevent pressure ulcers | Quick guides to social care topics | Social care | NICE Communities | About | NICE

Home care: delivering personal care and practical support to older people living in their own homes (nice.org.uk)