Tameside Adult Safeguarding Board Partnership

Safeguarding Adult Review

RE: Annie

Executive Summary

Tameside
Adults
Safeguarding
Partnership Board

1. Introduction

Section 44 of the Care Act 2014 stipulates that the Safeguarding Adult Board (SAB) has a responsibility to authorise the commissioning of a Safeguarding Adults Review (SAR). A review is required to be undertaken if the Board considers that there is significant learning to be gained across partner agencies.

Annie was an 84 year old lady who died from natural causes in hospital in Tameside in 2019. Request was made to Tameside Adult Safeguarding Partnership Board (TASPB) after some concerns were raised about the standard of care which Annie received in the final part of her life as to whether the criteria for consideration for a Safeguarding Adult Review had been met. A multi-agency panel reviewed information held by agencies who cared for Annie and decision was made that it was evident that lessons could be learnt about the care received by Annie.

2. Terms of Reference of Review

The review team agreed that the following elements needed to have further scrutiny so that learning could be made. These elements are:

- Record holding
- Communication
- Systems for sharing information
- Defensible decision making
- Discharge planning

The Review Panel was agreed by the Learning and Accountability Principle. The role of review panel members was to:

- Manage the process
- Interview practitioners involved
- Ensure learning is drawn from the case

3. Timescales

The decision was made that there would be a three month timescale for the completion of this review. In May 2020 the decision had been made by the Learning and Accountability Principle that the case did not meet the criteria for a SAR. It became evident, however, that further concerns had been raised which had not been shared with the Learning and Accountability Group at its earlier meeting. A second review of new information recognised that the criteria for a SAR had been met. Given that there had been a significant amount of information gathered about the concerns for the care of Annie, the decision was made that this was of sufficient quantity and quality for a SAR to be completed. The usual processes for gathering of information as well as practitioner event had already been undertaken by multi agency teams through other processes. It was therefore, agreed that the review would be complete within a three month period.

4. The Family and Background Information

Annie had been diagnosed with multiple sclerosis for a significant period prior to the time of this review. She lived in her own home. Annie was immobile and required some assistance with her daily living needs. A full care package was in place to meet her needs with attendance from carers, the district nursing service twice weekly. The care package had been in place for a significant period of time.

In March 2019 Annie's condition deteriorated and she was taken to a hospital outside of Tameside. After one month she was transferred back to the local hospital from where she was discharged back to her home for a very short period of time and then required admission to a nursing home. Her condition deteriorated again and she was readmitted to the hospital where she sadly died some days later. Cause of death at that time was believed to be aspiration pneumonia.

5. Analysis

Guided by the terms of reference for this review specific themes emerged following a systematic analysis of all the available information and with the review steering group. Exploration of each theme enabled rigorous examination of practice and identification of opportunities to improve multi agency adult safeguarding practice in Tameside.

6. Overall quality of support offered to Annie and family by agencies.

The Safeguarding Adult Review provides a significantly small insight into the overall care which Annie had received over the many years in which she had been receiving support from services and there was little information gained which would enable an overall opinion as to the quality of care overall which the family had received.

It is evident, however, that in the last three months of Annie's life the overall quality of care fell below a good standard. A key factor identified was that because respective services had been involved in her care for such a long period of time that there was belief by practitioners that they knew Annie so well and inadvertently carried out her care needs without consideration that those needs were potentially changing. There were no regular meetings to discuss and reassess her plan of care

on anything but an informal basis. The tasks which needed to be done were assessed as the task arose. There was little follow up to ensure that there was oversight of Annie's care or that the effectiveness of those interventions were monitored. There was confusion as to who was the lead agency for Annie's care.

7. Communication

There was clear evidence that there was significant sharing of information between practitioners who were undertaking tasks for Annie. Communication between practitioners was informal, however, and was not always recorded. Those who had cared for Annie for a long period accepted that any conversation about Annie's care would mean that it had been acted upon. Staff from agencies became comfortable in collaboratively meeting Annie's needs without recognition that those needs were changing. This resulted in advice being missed.

There is no evidence that there was a regular review of the effectiveness of interventions by all agencies being held. Sadly this practice continued with professionals until the time of her death.

8. Record Holding

The review identified that there was difficulty in agencies accessing information from each other's respective services with communication between practitioners largely using verbal communication rather than having a formal communication. Annie gave her own account of her health and care provision when she was admitted to a hospital external to the Tameside area rather than such information being transferred with her.

Hand held records were used by the agency providing carer support to Annie. Hand held paper health records, which are kept within the home of the client, have long been a feature of health care programmes for clients who have a long term chronic health condition. They aim to empower individuals and improve the communication between all those involved in their health care. They can also be used to identify additional health needs and contribute to improved treatment for individuals. Research, however has identified that there can be disadvantage to the service user if all agencies involved in the care do not have the same commitment to ensure that all information is documented within the hand held record.

Of significance and relevance to Annie once the episode of care had ceased or changed, there was no clarity as to which agency was responsible for ensuring that information within the record was transferred with the client and was not collected by agencies once they were no longer involved in the care. In the case of Annie hand held records were in place but were not transferred to the hospital when Annie was admitted. They were also not collected when Annie's care had ceased to be provided

by the carer agency. On Annie's death the family moved address and so the records became lost.

9. Discharge Planning Processes

It was evident that the discharge plan for Annie which was devised in May 2019 by the ICFT was thorough in ensuring that her needs could continue to be met within her own home. There, does not appear to have been recognition, however, that there had been significant change in those care needs and a deterioration of her physical health.

A contemporaneous home visit was not made. There is also no indication that Annie had been asked as to where she would prefer her care needs to be met. It is unclear who was informed of Annie's discharge from hospital and whether the key practitioner provider, i.e. the care agency had been informed of Annie's discharge.

Unfortunately when Annie was discharged home from hospital it was clear within a few days that there was a need for alternative care provision to be made.

10. Systems for Sharing Information

On admission to a hospital outside Tameside a safeguarding referral was made to Tameside Adult Social Care. This referral was not pursued by Tameside Adult Social Care and was closed. An anomaly for Tameside local authority is that referrals received are logged with the Safeguarding Board team who then monitor the progress of that referral. However, the alerting authority was external to Tameside and so were not aware that the safeguarding board would also need to be contacted.

11. Good Practice

There is evidence that Annie's care needs were delivered and that some practitioners were working collaboratively to ensure that needs were met. The fundamental flaw which occurred consistently in the last 3 month period of Annie's life was that practitioners did not appear to have systems in place the review the effective of the interventions or to consider the progression of Annie's ill health and the need to review what had become standard practice for her. When assessments were required to be carried out by agencies who were not normally involved with her care, the suboptimal quality of care for Annie was highlighted.

12. Learning

A number of key learning points for agencies who provide care to clients who have chronic health conditions have been identified in this safeguarding adult review.

Lack of communication between agencies as to the care which was being provided with no joint evaluation of its impact. Interventions were carried out on a routine basis. There was no evidence that her care was being appropriately evaluated.

The system currently in place in Tameside for raising safeguarding alerts and the investigation of concerns is currently under review.

The practice of hand held records being placed within the client's home has been reviewed.

13. Recommendations

Multi agency Review Meetings to be set up on a 3 monthly basis or sooner, for any client - regardless of whether any issues have arisen with the agency who has overall responsibility for the care of the client being identified.

Clear protocols in place for all agencies who practise the system of hand held records

Tameside to have one system to which safeguarding referrals are sent in line with systems used across GM with monitoring of clear outcomes of the referral.

Review of the discharge planning procedures when clients are transferred between services.

14. Conclusion

Annie had been in receipt of multi-agency care services for a significant period of time, requiring help with meeting daily living needs due to her chronic health condition. Her care needs appeared to have been understood by all who were involved in her care and practitioners believed that they knew her well. A key element of this review was that this implied familiarity between practitioners and client appeared to stop ongoing monitoring of Annie's health and care needs and so there was a failure to recognise that her overall health was deteriorating.

The requirement for one agency to take responsibility for the assessment, implementation and evaluation of the care needs of Annie did not appear to be evident. Work needs to occur in Tameside jointly between health services and adult social care services to ensure that care needs of clients are regularly reviewed and monitored and that changes required for the individual can be implemented in a timely manner.