Safeguarding Adult Review

Overview report into the death of Elsie on June 2022

Date of report: June 2023

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Preface

The author and review panel would like to express their sincere condolences to everyone impacted by Elsie's passing and thank them for their support and contributions to this procedure.

A Safeguarding Adult Review (SAR) is a multi-agency statutory review designed to determine what the relevant agencies and individuals involved may have done differently to avert harm or death. For these lessons to be widely and correctly learned, it is necessary to determine what may be known from each person's death and for agencies to understand what happened in each case.

The author wishes to express gratitude to the panel and individuals who provided chronologies and material for their time, patience, and cooperation.

Glossary of Acronyms

Adult Social Care	ASC
Advanced Nurse Practitioner	ANP
Ealing Local Authority	ELA
Ealing Safeguarding Adult Board	ESAB
Care Quality Commission	CQC
Cardiopulmonary resuscitation	CPR
Do Not Attempt Resuscitation	DNAR
Negative Pressure Wound Therapy	NPW
Nursing Care Home	NCH
Royal Borough of Kensington and Chelsea	RBKC
Safeguarding Adults Board	SAB
Tissue Viability Nurse	TVN
Tissue Viability Service	TVS
West London NHS Trust	WLT

1. INTRODUCTION

1.0 Introduction

1.1.1 The review was initiated in response to Elsie's (pseudonym) death in June 2022. A rapid review meeting scheduled on 1 September 2022, by the Ealing Safeguarding Adult Board (ESAB), determined the case met the criteria for a Section 44: Care Act 2014 Safeguarding Adult Review (SAR).

1.1.2 A criminal investigation has been opened into the case. As a result, rather than the incident itself, the review focused on the care Elsie received while a resident in a Nursing Care Home (NCH) run by an organisation that is one of the largest providers of care for older people in the UK.

1.1.3 Section 44 of the Care Act 2014, a Safeguarding Adults Board (SAB) has a statutory duty to organise a SAR when:

a) An adult with care and support needs has died, and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect.
b) And when there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

Board members must work with and contribute to the SAR to identify lessons learned and ensure they are shared and utilised in the future.[1]

1.1.4 Elsie was a resident in the NCH since January 2018 and had numerous medical needs and needed assistance in all aspects of her life.

1.1.5 Her medication regimen was complicated, and she needed help with feeding and toileting; her diet was liquid, and she needed one-on-one assistance at mealtimes. She was fed via a syringe, feeding lasted 45 minutes to an hour.

1.1.6 She was incontinent of both urine and faeces and required two trained staff to meet her incontinence needs.

1.1.7 Elsie had bed rails as well as doubled up staff support. The bed rails were removed after a nursing review at the NCH because Elsie was unable to move independently. Her bed had been lowered, and crash mats had been placed on the floor. The crash mats are thin mattresses that are in place to keep Elsie from hitting the floor if she falls.

[1] https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

1.1.5 The review panel considered the six principles of safeguarding adults[2]:

Empowerment:	Understanding how Elsie was encouraged to participate in her care and make independent decisions.
Prevention:	The learning gained will be applied to prevent future harm to others.
Proportionality:	Agencies determine if the services offered to Elsie are least intrusive and proportional to the risk.
Protection:	The learning gained will be used to keep others safe.
Partnership:	Agencies will aim to understand how well they collaborated and apply what they learned to improve partnership performance and safeguarding.

1.1.6 The review examined agency responses and support given to Elsie, before her death in June 2022.

1.1.7 In addition to agency involvement, the review examined Elsie's final few years of life (April 2020 - June 2022) for any relevant history prior to her death, as well as any barriers to Elsie receiving support. The review's goal is to find appropriate solutions to reduce the risk of harm.

1.1.8 This review process does not replace the criminal or coroner's courts nor serves as a disciplinary procedure. Instead, it aims to determine how agencies may improve their practices by learning from this review.

1.1.9 In June 2022 it was reported that around 18:45 hours a nurse at the home, was alerted to shouting which came from bedroom one. When the nurse arrived, he found a care assistant sat on the floor holding Elsie upright by her arms, she requested help as she was unable to keep Elsie upright and it was clear Elsie was struggling. The nurse reported that Elsie appeared pale with bluish discoloration around the mouth. Her breathing was irregular including her carotid pulse.

1.1.10 The nurse phoned 999 at once. He was instructed to carry out CPR[3], however, stated that a DNAR[4] document was in place and valid. Accordingly, the emergency response requested that the nurse place Elsie flat on the floor, that the airway and breathing were checked. The information presented suggests that at this point the nurse noted that there was some fluid around the oral cavity and made the decision to carry out suction, this was successfully done.

1.1.11 Paramedics arrived at the scene, who confirmed the DNAR document and decided to also not carry out CPR. Paramedics attached probes on to Elsie and initial tracing found PEA (Pulseless Electrical Activity).

1.2 Case Summary

[2] https://www.scie.org.uk/safeguarding/adults/introduction/six-principles
[3] Learn how to do CPR | British Heart Foundation - BHF
[4] Do not attempt cardiopulmonary resuscitation (DNACPR) decisions - NHS (www.nhs.uk)

1.2.1 Elsie resided in at the NCH since January 2018.

1.2.2 The Care Quality Commission (CQC) - the national body in charge of regulating health and social care provision - regulated the NCH. As an independent regulator, the CQC's role is to register health and adult social care service providers in England and to inspect whether or not fundamental standards are met. The NCH was last inspected in September 2022, and the report was published in October 2022. The overall verdict was that it 'requires improvement'.

1.2.3 The CQC defines this as 'the service is not performing as well as it should, and we have told the service how it must improve'.[5]

1.2.4 There was an individual assessment of each criterion and found as follow:

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-Led	Requires improvement

1.2.5 Elsie's care package included two staff members to mobilise and transfer her as well as assist with her continence needs. Specialist staff to administer medication, and two staff members to anticipate and assist with incontinence care every 4-6 hours, or sooner if necessary. She required to be repositioned every two hours while nursed on an air mattress.

1.2.6 Elsie had been receiving visits from the Tissue Viability Nurse (TVN) due to pressure ulcer concerns. The nurses documented concerns about non-healing sacral sores in February 2022. The TVN notes that Elsie was wet and covered in faeces when she visited on 23 February 2022; subsequent visits on 14 and 18 March 2022 reported that the pressure sore was deteriorating further, and that Elsie was wet with the sore contaminated by faeces. The TVN documented communication with the GP as well as the agreement to catheterize Elsie to aid healing. However, these concerns did not result in the raising of a safeguarding concern or the completion of incident reports.

1.2.7 In the evening in June 2022, the nurse at the NCH called an ambulance to the home. Elsie sadly died in the NCH.

1.2.8 According to the NCH report, Elsie was fine all day, she had received a number of care episodes, and she had fed well. The care assistant reported at 16:40 that she went to change Elsie's pad on her own because the agency staff were on break - she did not record this or request support from other available carers. She returned at 18:40 and found Elsie wet, so she proceeded to change her alone, raising the bed to waist level.

1.2.9 The care assistant stated that Elsie fell, and the crash mat was not fully in place.

[5] Ratings - Care Quality Commission (cqc.org.uk)

The case has not been heard by the Coroner, although the cause of death has been recorded as

1a Blunt force trauma

1b Fall

1c II Dementia

1.2.10 A criminal investigation is still ongoing.

1.3 Equality and Diversity

1.3.1 Age, gender, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation, and disability were all considered by the review chair, author, and panel.

1.3.2 Age and disability are the relevant characteristics in this review.

1.3.3 Elsie was 85 years old when she died, and she had Vascular Dementia, Arthritis, Depression, and Anxiety.

1.3.4 An examination of SARs[6]: SARs were most frequently commissioned for people aged 50-69, with Elsie's age group ranking third in terms of the most SARs, with neglect and omissions of care ranking second. The majority of those subject to a SAR in Greater London had mental health or chronic physical health conditions.

1.3.5 However, according to the data[7] Elsie's age group was the most common where enquires were made in outer London under Safeguarding Adult Enquiries (Section 42: Care Act 2014). The majority of these enquiries in the London Borough of Ealing were for neglect and omissions of care. The alleged abuse occurred in the person's own home, which was followed by a care home and nursing home.

1.3.6 Vascular dementia is a type of dementia that is caused by decreased blood flow to the brain. It is estimated that approximately 150,000 people in the UK will be affected.[8]

1.3.7 The second most common type of dementia is vascular dementia. There are currently no specific treatments for vascular dementia.[9]

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6 https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

7 https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2020-21#summary

8 vascular dementia - NHS - NHS (www.nhs.uk)

9 What is vascular dementia - Dementia UK

1.3.8 People with dementia may be unable to protect themselves due to their needs.[10] Elsie was nonverbal and wholly dependent on the staff in the home for all of her care needs.

1.3.9 In addition, she had pressure ulcers, including a sacral pressure ulcer that did not heal and was graded four at the time of her death. Persons reliant on others are at a higher risk of abuse[11].

1.3.10 Due to her age and disability, Elsie falls into the vulnerable group for safeguarding.

1.4 Terms of Reference

1.4.1 This review attempts to identify the lessons learned from Elsie's case and to respond to those lessons to prevent safeguarding-related deaths.

1.4.2 The critical question to be addressed by the review was:

What can agencies learn from the case about the effectiveness of care and support of adults who are dependent on others for all their care needs?

1.4.3 The Safeguarding panel agreed on the following questions concerning Elsie:

1. There are significant issues relating to staffing at the time of the incident and the fact that care was offered single-handed, contrary to the Care Plan.
2. There are concerns about the physical conditions in which Elsie was sleeping. The presence of rails and crash pads, and the height of the bed, appeared at odds with the Care Plan.
3. The episode of care that led to the fall was undertaken without a crash pad on one side. Again, this needs to be understood.
4. The visits of the Tissue Viability Nurse (TVN) and the deterioration of the pressure ulcer and whether it should have led to safeguarding intervention need to be considered and understood.
5. The TVN visits concerning wound contamination need investigation, particularly the event on 23 February 2022.
6. The lack of reference to the Grade 4 pressure sore at the time of Elsie's death within the NCH submission needs to be explored.
7. Communication and information sharing with the commissioning authority to ensure they are aware of issues that need to be understood.
8. There is a gap in respect of the pressure sore and understanding of whether the pressure sore could have been avoided or prevented from deteriorating further.
9. Agencies have highlighted some gaps in the recording of vital information, including information relating to safeguarding and care logs.

[10] Safeguarding and dementia | Alzheimer's Society (alzheimers.org.uk)
[11] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/abuse-and-neglect-vulnerable-adults/

1.5 Methodology

1.5.1 A hybrid methodology combining root cause analysis and practitioner events was employed for a comprehensive and targeted review.

1.5.2 The first meeting of the review panel took place on 14 November 2022, during which panel members presented brief details concerning their agency's encounter with Elsie.

1.5.3 The panel originally set the review term between June 2020 and June 22. However, at the second panel meeting it was clear the timeframe needed to be expanded to include the onset of the pressure ulcers and updated the time frame to April 2020. The panel decided that this time frame accurately reflected the challenges discovered during scoping and consultation with relevant agencies.

1.5.4 The panel met a total of three times.

1.5.5 A practitioner event was held to discuss the work undertaken with Elsie and the themes from the report. Unfortunately, neither the NHC employees, home manager, deputy manager, regional manager nor the TVS practitioners were present.

1.5.6 All panellists were invited to share their thoughts on the recommendations they believed should be included in the final report. The panel discussed each of these recommendations.

1.6 Involvement of Family

1.6.1 The author and review panel recognised the critical role Elsie's family may play in the review.

1.6.2 To engage the family, the independent chair of the ESAB met with Elsie's family on 20 September 2022. They highlighted the following:

1. The issue of the Category 4 pressure sore was only ever described to the family as a bedsore that was healing.
2. The room that Elsie was in was only ever meant to be temporary, she initially was on the first floor where she could look outside from her bed. On the ground floor this was restricted
3. The family visited to celebrate the Jubilee only to discover Elsie's television was not working, something the family immediately replaced. But in a ground floor room, where she could not look out and with her TV not playing in the background you questioned the quality of care provided for her

4. The home was meant to be Dementia friendly, but in the light of 2/3 above, is that the case?
5. The family queried staffing arrangements.
6. Communication with the family was not always a complete picture.

1.6.3 Elsie's daughter-in-law contacted the author after receiving status update emails from the author. She confirmed the issues she would like addressed by the review and agreed to serve as the family point of contact.

1.6.4 The author received no further contact from the daughter-in law or the family.

1.7 Contributors to the Review

1.7.1 The following agencies and their contributions to this review:

Agency	**Involvement**	**Contribution- Chronology/IMR/Letter/Other**
GP Surgery	Patient	Chronology and IMR
Ealing Local Authority (ELA)	Safeguarding 2020 and referral for SAR 2022	Chronology
Nursing Care Home (NCH)	Resident since 18.01.2018	Chronology and IMR
Police	Only contact post death	Chronology and Summary
Royal Borough of Kensington and Chelsea Local Authority (RBKC)	Known to service since 02.04.2013	Chronology and IMR
West London NHS Trust (WLT)	Provided the Tissue Viability Service	Chronology and IMR

1.8 The Review Panel Members

1.8.1 The Panel members for this review were the following:

Name	**Role**	**Organisation**
Dr AA	GP	Independent Surgery
GE	Regional Manager	Nursing Care Home
Kate Aston	Designated Professional Safeguarding Adults	NW London Integrated Care Board
Linda Stradins	Head of Planned Care Ealing Community Partners	West London NHS Trust
Louise Butler	Head of Adult Social Care and Workforce Development	London Borough of Royal Borough of Kensington and Chelsea
MN	Home Manager	Nursing Care Home
Saj Hussain	Detective Chief Inspector	Police

Shani St Luce	Head of Service, Health, Safeguarding and Deprivation of Liberty Safeguards,	London Borough of Ealing
Amma Bedeau	Business Manager	Ealing Safeguarding Adult Board
Parminder Sahota	Reviewer	West London NHS Trust

1.9 Author of the Overview Report

1.9.1 Parminder Sahota is currently employed by West London NHS Trust as the Director of Safeguarding, Prevent, and Domestic Abuse Lead. She completed Root Case Analysis Training in 2014, SCIE Learning Together Training in 2016 and DHR Chair training by Advocacy After Fatal Abuse in 2021. She is a Mental Health Nurse who has worked in the NHS for over 20 years, specialising in crisis work.

1.9.2 The family agreed with ESAB's independent chair that Parminder would undertake the review.

1.10 Parallel Reviews

1.10.1 A criminal investigation is currently underway, to be followed by an Inquest after the investigation is concluded.

2. BACKGROUND INFORMATION

2.1 The Facts

2.1.1 One day before Elsie died, she received a review from the TVN, which revealed that the pressure ulcer was decreasing in size, retaining the same appearance as the previous observation, and displaying no clinical signs of infection. The TVN recommended twice-weekly dressing checks, and the TVN would examine the wound in three weeks.

2.1.3 Elsie's family visited her in the NCH on the day she died.

2.1.4 On the day Elsie died a care assistant was attending to her personal care needs on her own, which was contrary to the agreed plan, which stipulates that two people are required to assist Elsie with her incontinence needs.

2.1.5 Elsie had fallen from her bed and landed on the crash mat but struck her head on the hard wooden floor.

2.1.6 CPR was not administered in accordance with the DNAR. The paramedics pronounced Elsie dead at 1916 hours.

2.1.7 An active police investigation is in progress.

2.2 Background Information about Elsie

2.2.1 The family was kept informed throughout the review, but they felt unable to contribute to their bereavement. As a result, Elsie's voice is expressed through her interactions with agencies.

2.2.2 Elsie was a white British female who spoke English. Her religion was listed as Church of England, and she used to enjoy attending church services on a regular basis until her condition deteriorated to the point where she was fully nursed in bed.

2.2.3 Elsie's dementia worsened, she lost her ability to communicate verbally, and she became increasingly dependent on others to anticipate all of her needs. Her family was also fully involved, with her son acting as an advocate and ensuring that her views and wishes were taken into account.

2.2.4 Elsie was known to the RBKC Adult Social Care (ASC) Complex Case Team from 2 April 2013 until her placement in the NCH.

2.2.5 Elsie lived with her husband before being placed in care. Their two sons, Gary and Lee, as well as her brother, Terry, all lived nearby and were concerned about their parents' well-being.

2.2.6 Elsie had knee replacement surgery in 2013, and according to ASC records, her son noted that she started to go downhill' at that point.

2.2.7 From August 2017, ASC provided a community care package that included four double-up calls per day. Elsie' husband had his own health issues and was admitted to the hospital twice in August and September 2017 to treat a gangrenous foot, during which time ASC increased the package of care to include waking night support.

2.2.8 Elsie was admitted to the NCH in January 2018, after her and her husband's conditions deteriorated further. Elsie's placement was arranged in accordance with the best interest's process, as she was determined to lack capacity to make decisions about her care and housing needs.

2.2.9 Elsie's husband soon moved into the same NCH. Her husband died, according to the placement review report dated June 2020.

2.2.10 Elsie was subject to the Deprivation of Liberty Safeguards[12] (DOLS) while in the NCH; the authorisations were managed by the Bi-Borough DOLS Team, and the most recent authorisation was valid from February 2022.

[12] Deprivation of Liberty Safeguards (DoLS) | Alzheimer's Society (alzheimers.org.uk)

3 Key Events

Date	Event	Agency
22.04.2020	Elsie was referred to the TVN for a review and recommendations regarding a category four pressure ulcer on her sacrum and an unstageable pressure ulcer on her left heel. In April, June, and July of 2020, the TVN provided verbal and written guidance due to the Covid 19 pandemic.	TVN
29.06.2020	Safeguarding Adult Concern raised by the NCH concerning the pressure sore.	LBE
09.09.2020	Face-to-face visit by the TVN, completion of a datix (incident form), which identified the management plan (appendix I) and notification by the TVN and the NCH that a safeguarding referral had been made.	TVN
18.06.2021	GP Review: Moisture lesion on the right buttock in addition to the pressure ulcer. Elsie was chair and bedbound. A dressing and barrier cream applied and advised to reposition.	NCH
20.07.2021	Elsie had a puffy/swollen right eye with discharge, but the conjunctiva was normal. She was diagnosed with blepharitis and staff were told to clean and apply a warm compress BD.	GP
09.09.2021	Speech and Language Therapy (SALT) reviewed; and as a result of mouth holding Elsie was placed on a Level 3 liquid diet and level 1 slightly thick fluids. There was no obvious aspiration reported. There were no chest infections. Elsie was noted to react to verbal or tactical cues. Staff were aware that holding food in the mouth is a sign of dementia. Her weight was stable, and she was to continue with level 1 slightly thick fluid and level 3 liquidised diet. Staff were advised to use prompts in the form of words or actions to trigger a swallow and place an empty beaker to her lips. PLAN: no further SALT indicated; GP to discuss advance care planning with family.	NCH
09.09.2021	TVN Face-to-face review.	TVN
19.10.2021	GP - discussion about Elsie and intermittent episodes of food holding in the mouth, making eating and drinking more difficult. On 18/10, there was difficulty eating and drinking, but by 19/10, this had settled, and drinking was normal. There was no cough. She was otherwise described as stable. It was suggested that staff keep an eye on things.	GP
26.10.2021	Elsie continued to hold food in her mouth, requiring 45 minutes for staff to feed her. SALT was consulted, but they were unable to make any further changes due to behavioural/dementia changes. Staff reported that they attempted to administer fluid via syringe and did so successfully. The NCH reported that this be done on a regular but slow basis. Nurses monitored Elsie's weight to determine if she met the criteria for a dietician referral.	GP
09.11.2021	During personal care, the carer attempted to wash Elsie's hand while her fingers on her left hand were clenched, resulting in a 1cmX0.5cm	NCH

	skin tear. The next of kin was notified, a photograph was taken, a body map was completed, and a dressing was applied. Completed incident report, placed on GP list for review, and physio referral for a hand guard made.	
09.11.2021	NCH referral for assessment and advice on pressure ulcers to the sacrum.	TVN
12.11.2021	Elsie had recently developed an issue with her left hand - very tight fist/contracture, nails cutting into her palm. The hand had an unpleasant odour and was difficult to clean. The GP also noticed that her right hand was becoming contracted. Hand therapy was recommended.	GP
17.11.2021	The case had been assigned to the Placements Monitoring Officer for the annual placement review.	RBKC
18.11.2021	Elsie presented with a Category 3 pressure ulcer on the coccyx. Photographs and measurements of the wound were taken - 2cm x 1cm with undermining (undermining is defined as tissue damage beneath areas of outwardly visible wound margins, implying that the extent of tissue loss may be greater). The surrounding skin was found to be fragile. There was no evidence of oedema or redness. To manage the pressure ulcer, the nursing home staff was given skin care and wound care advice.	TVN
23.11.2021	GP rounds: the current stable condition was palliative but had improved. There was no DNAR form, but Marie Curie nurses discussed it in April 2020. GP to complete form, but given the improvement is for hospital for reversible conditions- Not for resuscitation, End of Life care plan, treatment of reversible conditions (including in acute hospital setting if necessary), but not for any ventilation or CPR.	NCH
20.12.2021	Annual Placement Review: There had been no change in health since the previous review. Elsie remained bed/chair bound and required a full body hoist for all transfers and personal care tasks. She preferred to spend her time in her room watching TV and did not socialise much when she was out and about. Elsie was unable to feed herself and required round-the-clock care to manage and maintain her nutrition. Due to her poor appetite and impaired swallow, she was on a level 3 liquids diet and a level 1 thickened fluid diet. Elsie's current needs were met by the unit. Nursing staff at the home monitored and reviewed her health, reporting any concerns to her GP. At this review, there were no concerns about her care or placement. Son received a phone call. He stated that he and the rest of his family are very pleased with the care and support that his mother received at the NCH, and that they believed she is in the right place and environment, with all of her needs met. He stated that he visited his mother in the home about two months ago and she was fine, but that they are currently unable to visit her due to the Covid-19 virus. They kept in touch with the home on a regular basis to get an update on her condition.	RBKC
23.02.2022	Elsie was incontinent of faeces during the visit, so she received personal care and had her pad changed. The ulcer to her sacrum was evaluated, and there were no obvious signs of improvement. The ulcer had 100% unhealthy granulation tissue	TVN

	but no clinical signs of infection. Measurements were taken at 2cm x 1cm with undermining reduced. The NCH staff were given wound-specific dressing recommendations and skin care advice. Photographs of the ulcer were taken. During the visit, no pain was felt. It was documented that while Elsie was bedridden, care staff repositioned her and documented it. A Walsall score of 29 was recorded. This is a risk assessment tool used to identify people who are at high risk of developing pressure ulcers. A score of 15 or higher indicates a high risk of developing pressure ulcers. The TVN had ordered a negative wound pressure therapy machine and planned to begin treatment as soon as it arrived. (Negative-pressure wound therapy, also known as vacuum-assisted closure -VAC, is a closed system used to draw fluid out of a wound to help it heal).	
25.02.2022	Elsie's next of kin informed TVN that she is no longer on bedrails because she did not move in bed; however, the bed had been changed to a low bed with a crash mat on either side. Staff closely monitored and reviewed if necessary; the next of kin was pleased with all of the updates.	NCH
28.02.2022	Elsie was observed to have a conservative dressing in place. The nurse on duty informed the TVN that the VAC dressing was leaking and that they were unable to change the VAC, so a conservative dressing was applied. The tissue viability service did not receive any emails or phone calls requesting advice or assistance with the VAC issue. The ulcer was described as being larger and macerated in appearance. The TVN restarted VAC therapy, and nurses were instructed to change the dressing on 03.03.2021. The TVN suggested inserting a urinary catheter to aid wound healing by reducing the risk of urine contamination of the wound due to incontinence.	TVN
07.03.2022	TVN came to examine the sacral pressure ulcer. It was discovered that the dressing was soaked in serous exudate. It is unknown whether there was exudate in the VAC dressing canister. The surrounding skin was macerated, but no changes were observed. There were no obvious clinical signs of infection, nor was there any pain. The dressing was renewed, and the TVN asked the staff to change it on 10.03.2021, and to review it again in one week. A urethral catheter had been inserted since the previous visit and was still patent at the time of the visit.	TVN
08.03.2022	Face-to-face GP review - staff were concerned after seeing sediment in the catheter bag. urine dip revealed only leucocytes, no nitrites, no blood. Otherwise, remained unchanged and eating and drinking. There had been no increase in confusion since the baseline. It was suggested that staff keep an eye on things.	NCH
14.03.2022	The TVN visited Elsie to review the pressure ulcer, and the nurse caring for Elsie stated that the pressure ulcer was worsening. The TVN talked about the wound healing process and how some wounds appear to worsen during the constructive phase of healing. The dressing was wet with exudate, and there was no fluid in the canister, according to the TVN. When increased exudate was observed, the TVN was informed that the dressing had not been changed. Due to the increase in exudate and deterioration, no messages or emails were sent to the tissue viability service for review and advice. If the dressings did not contain	TVN

	the levels of exudate, the frequency of dressing changes would be expected to increase. The TVN reiterated that if the dressing became wet with exudate, it would need to be changed more frequently. There were no obvious symptoms of infection. During the visit, there was no pain. The wound assessment revealed an increase in both wound margins and undermining. There were photographs taken. The nurse on the unit informed TVN that Elsie had recently experienced episodes of loose stool, which could have hampered wound healing. The TVN suspected a fungal infection and asked for a swab to be taken at the next dressing change. A letter was sent to the GP requesting cream to treat the fungal infection. Because there had been no improvement in the wound after two weeks of VAC therapy, the decision was made to discontinue VAC therapy and resume conservative dressings. NCH were not notified by the TVN that VAC therapy had ceased. Home Manager called the TVN service on 14.03.22 to query this- apology given and TVN said they would follow up with email confirmation.	
16.03.2022	TVN came to replace the dressing. The wound had not changed. A wound swab was taken. (On the electronic record, the microbiology result stated no significant growth on 18.3.22). Elsie's incontinence pad has faeces on it.	TVN
18.03.2022	The TVN observed that the dressing was wet and contaminated with faeces. The wound bed was described as mostly sloughy, with some granulation tissue around the edges. The dressing had been replaced. A message was sent to the NCH informing them that the TVN would be managing and dressing the pressure ulcer for the time being.	TVN
22.03.2022	Staff concerned sacral wound deteriorated, 4cm wound, deep? ungradable now, safeguarding referral had already been completed (the panel found no evidence of this). The wound was oozing less. Advised to re send a new swab. Monitor signs of infection and to follow TVN advice.	GP
One day before Elsie died	TVN visited Elsie. There is adhesive dressing in place but no packing. TVN emphasised the importance of packing the wound to the areas of undermining. There were no visible changes in the appearance of the ulcer bed. It was recommended that the dressing be changed three times per week. The TVN intended to conduct a review in four weeks.	TVN
One day before Elsie died	Visit to check on the pressure ulcer, which had been noted to be shrinking in size. Measurements are 2cm x 1.5cm x 1cm, and photographs were taken and uploaded. The appearance had not changed since the last observation. There were no clinical signs of infection. It was recommended that the dressing be changed twice a week. TVN intended to examine the wound in three weeks.	TVN
The day Elsie died	Family visited Elsie.	Family
The day Elsie died	Elsie died in a care home.	

4 Themes and Analysis

Pressure Ulcer

4.1.1 The GP and the Advanced Nurse Practitioner (ANP) reviewed Elsie's non-healing pressure ulcers face-to-face and remotely, and it was determined that she was being managed by the TVN.

4.1.2 Elsie was referred to the Tissue Viability Service (TVS) of West London NHS Trust (WLT) on 22 April 2020, and she was referred three more times between that date and 9 November 2021. At the time of her death, she was in the care of the TVS.

4.1.3 The Ealing TVS aims to assist service users in caring for complex and problematic wounds. They concentrate on preventing and treating pressure ulcers and leg ulcers in particular. To provide care and support, they collaborate closely with the service user, GP, district nurses, and other healthcare professionals.[13]

4.1.4 Elsie was referred to the service for assessment and advice regarding a nursing home acquired category four pressure ulcer to her sacrum and an unstageable pressure ulcer to her left heal.

4.1.5 A pressure ulcer is defined as localised skin and/or underlying tissue damage caused by pressure or pressure combined with sheer force. Pressure ulcers develop over bony prominences, but they can also be caused by a medical device or another object.[14]

4.1.6 They are sometimes known as "bedsores" or "pressure sores".[15]

4.1.7 There are six categories of pressure ulcer[16]:

- Stage I: non-blanchable
- Stage II: partial thickness
- Stage III: full thickness skin loss
- Stage IV: full thickness tissue loss
- Suspected deep tissue injury
- Unstageable: full thickness skin or tissue loss

4.1.8 Pressure ulcers can be serious and may result in life-threatening complications such as blood poisoning and gangrene; they are a key indicator of the quality and experience of care. [17]

4.1.9 In any given year, it is estimated that just under 500,000 people in the UK will develop at least one pressure ulcer. This is typically people with an underlying health condition; for example, approximately one in every twenty people admitted to the hospital with a sudden illness will develop a pressure ulcer. People over the age of 70 are especially vulnerable to pressure ulcers because they are more likely to have mobility issues and ageing skin.[18]

4.1.10 In June 2020, Ealing Local Authority (ELA) received a Safeguarding concern (Care Act 2014) regarding Elsie's Grade 4 pressure ulcer. This did not result in an enquiry (Section 42: Care Act 2014) because a protection plan was in place, CQC was notified, TVN was involved, the GP and

[13] Tissue viability service (wound care) :: West London NHS Trust
[14] Pressure ulcers: applying All Our Health - GOV.UK (www.gov.uk)
[15] https://www.nhsinform.scot/illnesses-and-conditions/skin-hair-and-nails/pressure-ulcers
[16] PowerPoint Presentation (nationalwoundcarestrategy.net)
[17] Helping to prevent pressure ulcers | Quick guides to social care topics | Social care | NICE Communities | About | NICE
[18] Pressure ulcers - Illnesses & conditions | NHS inform

family were notified, and a recommendation was made for the quality team[19] to initiate an investigation.

4.1.11 RBKC found no records on their system of the safeguarding documentation from the 2020 concern by ELA, nor evidence that the Placements Review Team was invited to participate in the decision to not proceed to an enquiry.

4.1.12 The ELA forms provide host and funding authority information and discuss the necessity of communication. The host authority, ELA, is responsible for coordinating the initial response with the funding authority.

4.1.13 The TVS provided skin care, wound advice and suggested dressings regime to the home in order to manage the pressure ulcer.

4.1.14 Skin care should aim to keep skin clean by using a pH balanced cleanser or emollient soap substitute, then gently drying and moisturising the skin. To keep incontinence-damaged skin from deteriorating further, use a protective barrier spray or cream.[20]

4.1.15 Pressure ulcers can be protected and heal faster with specially designed dressings.[21]

4.1.16 NICE recommendations[22] for pressure ulcer management include:

- Nutritional supplements and hydration
- Pressure redistributing devices
- Negative pressure wound therapy (NPWT)
- Debridement
- Systemic antibiotics and antiseptics
- Dressings
- Heel pressure ulcers

4.1.17 The NCH described Elsie's skin as dry and paper thin, and she was unable to reposition herself. She required the assistance of two staff members to reposition her from left to right every two hours, except during mealtimes. They advised any repositioning in bed should be done with a slide sheet rather than bed linen to avoid skin damage from sheer force.

4.1.18 Elsie was nursed on an air mattress with an automatic bed pump, and NCH staff were responsible for monitoring the air mattress and pump settings and reporting any problems to the maintenance department.

4.1.19 Pressure ulcer treatments include changing positions frequently, using special mattresses to reduce or relieve pressure, and applying dressings to help the ulcer heal. [23]

4.1.20 The TVS commenced NPWT on 23 February 2022. They advised the NCH nurses regarding the dressing regime and planned a review in five days' time. At the scheduled review, the TVS discovered that the dressing was leaking and was unable to change the NPWT, so a conservative dressing was applied.

4.1.21 NPWT seeks to improve the physiology of wound healing by using sub-atmospheric pressure to reduce inflammatory exudate and promote granulation tissue. It is mostly used to treat complex wounds that are either not healing or are at risk of not healing, such as diabetic foot ulcers or skin grafts. All medical personnel can use NPWT; however, specific training and a

[19] Quality Assurance – Commissioning Contract

[20] Management of pressure ulcers | Nursing in Practice

[21] Pressure ulcers (pressure sores) - Treatment - NHS (www.nhs.uk)

[22] 1 Recommendations | Pressure ulcers: prevention and management | Guidance | NICE

[23] Pressure ulcers (pressure sores) - Treatment - NHS (www.nhs.uk)

high level of expertise are required before use.[24] NCH confirmed they received training by the TVN in the use of the NPWT.

4.1.22 If NPWT is performed improperly, there can be severe consequences for the patient, and patient safety must be of paramount importance.[25]

4.1.23 During the five days prior to the scheduled visit, the home did not contact the TVS to request assistance with the NPWT. The TVS noted a larger and macerated pressure ulcer. They recommenced NPWT on 28 February 2022 and advised the NCH nurses to change the dressing on 3 March 2022, and suggested insertion of a urine catheter to facilitate wound healing and reduce the risk of urine contamination of the wound. A urine catheter was inserted.

4.1.24 Maceration is the result of excessive amounts of fluid remaining in prolonged contact with the skin or the surface of a wound.[26]

4.1.25 During a visit by the TVS in February 2022, it was observed that Elsie was incontinent of urine and faeces and was awaiting the arrival of carers to assist her with personal care. They noted subsequent visits the wound had increased, and the dressing was soaked in serous exudate. This did not result in the submission of an incident report or the discussion of a potential safeguarding concern. WLT definition of an incident is: *"An event which does or could cause harm (including psychological harm) to patients, staff or visitors; or loss or damage to Trust property."*

4.1.26 The inflammation or injury of a tissue increases the permeability of the blood vessels, resulting in the leakage or secretion of fluid from blood vessels into adjacent tissues; this fluid is called exudate.[27] Serous is a type of exudate that forms as a clear, thin, watery fluid with relatively low protein content, usually observed in acute or mild inflammation.[28]

4.1.27 18 March 2022, TVS assumed control of the dressings. However, this did not extend beyond 4 April 2022, despite the fact that the pressure ulcer care was not as instructed. Despite having concerns regarding the treatment of the pressure ulcer, the author did not receive an explanation for why the TVS withdrew.

4.1.28 There is currently no rigorous Randomized Control Trial evidence on the effects of NPWT versus alternatives for the treatment of pressure ulcers. The potential benefits or harms, or both, of using this treatment for pressure ulcer management remain unknown.[29]

4.1.29 NICE recommends, NPWT should not be used on adults unless it is absolutely necessary to reduce the number of dressing changes (for example, in a wound with a large amount of exudate).[30]

4.1.30 The TVS visits revealed exudate, Elsie was incontinent of urine and faeces, her pad had not been changed, and the pressure ulcers were not treated according to their recommendations. The GP and ANP note a safeguarding concern (2020) related to the deterioration of the

[24] Negative Pressure Wound Therapy - StatPearls - NCBI Bookshelf (nih.gov)
[25] Negative pressure wound therapy and nurse education - PubMed (nih.gov)
[26] https://www.nursingtimes.net/clinical-archive/tissue-viability/the-causes-and-prevention-of-maceration-of-the-skin-01-11-2001/
[27] Exudate - Definition and Examples - Biology Online Dictionary
[28] Serous exudate Definition and Examples - Biology Online Dictionary
[29] Negative pressure wound therapy for treating pressure ulcers - Dumville, JC - 2015 | Cochrane Library
[30] 1 Recommendations | Pressure ulcers: prevention and management | Guidance | NICE

pressure ulcer, and both they and TVS are informed that the NCH has raised the safeguarding concern.

4.1.31 The author anticipated that the external agencies would have raised a safeguarding concern to ensure their observations and details were reported, especially since the TVS had observed that dressings were not being applied as directed and the wound was exposed to fluid for extended periods of time (macerated).

4.1.32 The Department of Health and Social Care developed a protocol for Pressure Ulcers and the Interaction with a Safeguarding Enquiry.[31]

4.1.33 The decision process outlined in the protocol is incorporated into WLT Incident reporting system to aid practitioners in deciding whether to report a safeguarding concern.

4.1.34 The TVS service submitted one incident report dated September 2020 during their contact with Elsie. Despite observation and documentation, no additional incidents were reported. The September incident report did not contain the completed decision toolkit, which would have supported the decision making for raising a safeguarding adult concern.

4.1.35 Pressure ulcers have a significant impact on people's quality of life, frequently resulting in pain and distress. They also have a negative impact on the allocation of valuable health and care resources, accounting for roughly 71% of total NHS wound care spending. As a result, pressure ulcers continue to be a problem for both health care providers and patients.[32]

Nutrition and hydration are critical in wound healing.

4.1.36 Nutrition is important in pressure ulcer treatment because wounds require both macronutrients and micronutrients to heal.[33]

4.1.37 Fats, carbohydrates, proteins, and water are examples of macronutrients. Our bodies require more of these nutrients. Aside from water, each macronutrient provides energy to the body, allowing it to[34]:

- Develop new tissues and cells.
- Nerve impulses that allow us to sense and interact with our surroundings.
- New tissues are formed and repaired.
- Control vital bodily processes such as muscle fuelling, central nervous system regulation, enzyme production, waste elimination, and much more.

4.1.38 Micronutrients, also known as vitamins and minerals, are needed in small amounts by our bodies. Vitamins are necessary for normal growth, metabolism, and development. They also control cell function.[35]

4.1.39 Elsie was on a liquid diet and was drinking level one thickened fluid. All her meals were always fortified with butter and cream, she was given milkshakes or smoothies as directed by her dietician, and she was to be weighed weekly. Elsie's Body Mass Index[36] was 23, which is within the healthy weight range.

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[31] Safeguarding adults protocol: pressure ulcers and the interface with a safeguarding enquiry (publishing.service.gov.uk)

[32] https://www.nursinginpractice.com/cpd/cpd-prevent-and-management-of-pressure-ulcers/

[33] British Journal of Nursing - The impact of nutrition on pressure ulcer healing

[34] What Are Micronutrients and Macronutrients (rmhp.org)

[35] What Are Micronutrients and Macronutrients (rmhp.org)

[36] What is the body mass index (BMI)? - NHS (www.nhs.uk)

4.1.40 Level one is slightly thick liquid: Slightly Thick is commonly used where someone has difficulty swallowing thin liquids. Slightly thick liquids are slightly thicker than water but still thin enough to pass through a straw.

4.1.41 Food fortification is the addition of high energy foods to meals in order to increase the number of calories. This is a simple way to boost the calories in a meal and promote weight gain.

4.1.42 Smoothies contain a variety of vitamins and minerals.

4.1.43 The body will require a balance of nutrients at each stage of the wound healing process. This includes more protein, energy (calories), vitamins, minerals, and fluid.[37]

4.1.44 Furthermore, fluid is essential for the prevention and healing of a pressure ulcer, with the goal of drinking at least 1.6-2 litres of fluid per day.[38] The NCH maintained a fluid intake chart for Elsie. As evidence, the charts were sent to the author.

4.1.45 Elsie's wound healing required a high protein diet, which NCH kitchen staff had been informed of.

4.1.46 The GP was informed. Elsie was holding food in her mouth, following a review by the GP and the speech and language team her eating and drinking had improved with the use of the syringe.

4.1.47 Speech and language therapists treat, support, and care for children and adults who have difficulties communicating, eating, drinking, or swallowing.[39]

4.1.48 The care plan for Elsie's dietary needs indicated she was incapable of eating independently and required prompting and assistance. In addition, it stated that she was on a liquid diet and required a beaker for all oral ingestion. In addition, she was in a level one thickened fluid, and her food was constantly fortified. The care plan did not identify the use of a syringe.

Dependence on Carers

4.1.49 There are numerous pieces of legislation and government initiatives that govern safeguarding in care homes, such as the Care Act 2014, the Equality Act 2010, the Safeguarding Vulnerable Groups Act 2006, and the Care Quality Commission Regulations 2009.

4.1.50 In England, there are approximately 10,500 residential care homes and 4,200 nursing homes, which serve approximately 410,000 older people as well as many younger adults with disabilities, mental health issues, or complex support needs.[40]

4.1.51 According to CQC guidelines, it is a statutory requirement for care homes to have a designated safeguarding lead who has received safeguarding training and has the relevant skills and competencies to ensure the safety and protection of residents.

4.1.52 Two of the CQC's Fundamental Standards[41], which all providers must follow, are:

- Safeguarding from abuse, improper treatment, or neglect
- You must not provide unsafe care or treatment or put people who use your service at avoidable risk of harm.

[37] Prevention and management of pressure injuries | British Dietetic Association (BDA)
[38] Prevention and management of pressure injuries | British Dietetic Association (BDA)
[39] rcslt-what-is-slt-factsheet.pdf
[40] Safeguarding definition | Background information | Safeguarding adults in care homes | CKS | NICE
[41] The fundamental standards - Care Quality Commission (cqc.org.uk)

4.1.53 Elsie required the assistance of two NCH staff members to meet her personal hygiene, washing, and dressing requirements. She preferred a weekly shower/bath and a daily strip wash. The staff were advised to thoroughly wash and dry her, paying special attention to the skin folds, in between her toes, under her breast, and Elsie's right hand, as she had clutched fingers.

4.1.54 Elsie was attended to by one carer on the day she died. Unfortunately, Elsie fell to the floor and suffered blunt force trauma to the head as a result of this.

4.1.55 Elsie was subject to DoLS with RBKS undertaking the reviews. As the placement was funded by RBKC, the RBKC Placements Monitoring Team had the statutory responsibility to review the placement on an annual basis. Due to the virtual nature of the reviews, RBKC did not have access to the care plans. They requested that the NCH send these, but they were not received. RBKC accepted this should have been followed up on by ASC.

4.1.56 Elsie's, preferences were discussed with her family, she had no preference for male or female carers, and her family provided all toiletries.

4.1.57 Elsie preferred to dress in trousers or skirts with a blouse and cardigan and to have her hair done by a professional.

4.1.58 Elsie was unable to communicate her needs verbally. She wore glasses, had no hearing loss, and was able to hear and understand English. To meet Elsie's needs, the NCH staff were advised to use body language and eye contact in addition to verbalisation.

4.1.59 Adults can be abused in a variety of ways. Some groups, such as the elderly and the frail, are especially vulnerable to abuse and harm.[42]

4.1.60 Elsie's family stated the NCH staff in the room where Elsie was supposed to be temporary, as she was initially on the first floor where she could look outside from her bed. This was limited on the ground floor.

4.1.61 They also paid a visit to Elsie to celebrate the jubilee, only to discover that her television was broken, which the family promptly repaired. But in a ground-floor room where she could not see out and her TV was not on, the family questioned the quality of care she was receiving.

4.1.62 "It is hard to feel safe if we don't feel in control of what is happening in our life and hard to feel in control if we don't feel safe."[43]

Dementia

4.1.63 Dementia is a group of symptoms that can affect memory, problem-solving, language, and behaviour over time.[44]

4.1.64 Person-centred care and support for people with dementia should always be the goal. This means that it should be tailored to the individual rather than their condition as a whole. It should consider the individual's life history and background, relationships, needs, and preferences. Any decisions about the person's care and support should always include them.[45]

4.1.65 Elsie's likes, such as what she wanted to wear and how she wanted her hair done, were known to the NCH. However, as stated previously, the family felt that there were areas of person-

[42] Safeguarding Adults. Information on safeguarding adults | Patient
[43] Microsoft Word - Carers and safeguarding document June 2011.doc (adass.org.uk)
[44] What is dementia? | Alzheimer's Society (alzheimers.org.uk)
[45] Treatment and support for vascular dementia | Alzheimer's Society (alzheimers.org.uk)

centred care that were lacking. Elsie was bedbound and could not listen to the radio, watch TV, or look out the window, as a result, she was isolated.

4.1.66 Adults who are identified as 'vulnerable' or 'at risk' may be eligible for safeguarding. People with dementia, people with learning disabilities, people with sensory or physical disabilities, and carers are all examples of this. Dementia patients will experience cognitive symptoms that may put them at risk of abuse or neglect.[46]

4.1.67 Elsie was nonverbal and relied on others for all of her care, support, and well-being requirements. This could make it more difficult for her to protect herself and alert others to any concerns she has.

4.1.68 Dementia patients can be extremely vulnerable due to the nature of their condition. Early symptoms can impair communication and reasoning skills, leaving them unable to understand or explain what is going on to others.[47]

4.1.69 Elsie's family was involved in her care and communicated with RBKC during reviews, which found no issues with the quality of care provided at the NCH.

4.1.70 During Covid-19, however, the visits were conducted via phone or WhatsApp.

4.1.71 RBKC recognised the difficulties of virtual working and not having direct access to Elsie, and they were completely reliant on the NCH and family to ensure the placement was still meeting Elsie's needs and to identify any concerns.

5 Conclusions

5.1.1 This review aims to establish the circumstances surrounding Elsie's death in June 2022 and to describe life through her eyes.

5.1.2 The only source of Elsie's voice is agency communications with her. Prior to the commencement of this review, the family discussed their concerns and devised questions to which they requested answers. The reviewer made contact with the family, and a phone call with a family member revealed that they were still grieving Elsie's death, and that the manner of her passing was particularly difficult. Therefore, they were unable to provide background information about Elsie.

5.1.3 The responses to the family's questions:

1. The issue of the Grade 4 pressure sore was only ever described to the family as a bedsore that was healing.

   Pressure ulcers are also known as bedsores.[48] In June 2020, Ealing Local Authority was notified of a safeguarding adult concern, and they determined that plans were in place to address the concern and the concern did not progress to a Section 42 enquiry (Care Act 2014). However, it was clear from this review that Elsie's pressure ulcer was not healing, and the TVS was actively supporting Elsie and the NCH.

[46] Safeguarding and dementia | Alzheimer's Society (alzheimers.org.uk)
[47] Safeguarding people with dementia - SCIE
[48] Pressure ulcers (pressure sores) - NHS (www.nhs.uk)

2. The room that Elsie was in was only ever meant to be temporary, she initially was on the first floor where she could look outside from her bed. On the ground floor this was restricted.

Decision made outside the panel - There are no restrictions on viewing the exterior from the ground floor windows. Her room overlooked the grass. She could gaze out the window from her bed. The panel however concurred that the view from the first floor is superior.

3. The family visited to celebrate the Jubilee only to discover Elsie's television was not working, something the family immediately replaced. But in a ground floor room, where she could not look out and with her TV not playing in the background the family questioned the quality of care provided for her.

This was only brought to NCH's attention by family members. A maintenance worker works in the residence and attends daily meetings to discuss and address repairs.

4. The home was meant to be Dementia friendly, but in the light of 2/3 above, is that the case.

Every employee receives training on dementia, and two employees are trained as Dementia Champions. All employees have access to both a dementia strategy and a dementia manual.

CHESS, an approved companywide staffing tool, was in place at the time. The data entered into the programme by the NCH, which was pulled straight from the resident's care plans, calculated how many hours of clinical and care were required to meet the individual's needs, as well as an indicative staffing ratio per floor/home. This data would subsequently be correlated with the roster. The tool would be updated at least monthly, and the Regional team would keep an eye on it.

Rosters are accessible and managed by the Regional Team via our Careblox system. Where staffing numbers fall below the indicated ratio, agency personnel will be used to supplement- these are vetted and given by our approved provider, and the same staff will return for continuity. The Regional Team monitors agency employee utilisation and trends.

The NCH is in responsible for monitoring team efficiency, reviewing floor allocations to ensure they are proportionate, and ensuring that care is of high quality. Liaison with department heads via daily Flash meetings would be a manner of discussing and organising the day and any priorities.

5. The family queried staffing arrangements.

On this particular day, there were no staffing issues according to NCH. Measures are in place to ensure that the home is operating at safe and effective staffing levels. This is determined by a comprehensive tool that is used organisation wide.

6. Communication with the family was not always a complete picture.
   NCH communicated with the Family members via phone and during visits.

5.1.4 The critical question for this review was:

What can agencies learn from the case about the effectiveness of care and support of adults who are dependent on others for all their care needs?

5.1.5 Elsie was wholly dependent on others for her care needs. Four themes have emerged from the review findings, which are captured in the practice episodes. The themes were derived from the material shared with the author, including the practitioner event.

5.1.6 The themes identified Elsie's specific needs for assistance and the manner in which she received care, including the complexity of her treatments. The themes were discussed at the practitioner event together with a proposal for the recommendations.

5.1.7 One area of significance was to strengthen collaboration with agencies to protect the adult.

5.1.8 The panel agreed on the further areas to be considered:

1. There are significant issues relating to staffing at the time of the incident and the fact that care was offered single-handed, contrary to the Care Plan.
   The panel agreed that the care plan had not been followed. Since the case is currently under investigation, it was inappropriate to investigate this area further. A Root Cause Analysis process completed by NCH confirmed that there were no issues with staffing levels on the day of the incident or the specific staff allocation levels for Elsie.

2. There are concerns about the physical conditions in which Elsie was sleeping. The presence of rails and crash pads, and the height of the bed, appeared at odds with the Care Plan.
   Following a nursing review in which determined that appropriate to Elsie's needs and presentation the bed was lowered, and crash mats installed, the care home reported that the bed's side rails were removed. This was to ensure a least restrictive method was applied.

3. The episode of care that led to the fall was undertaken without a crash pad on one side. Again, this needs to be understood.
   This was not explored as a result of the ongoing criminal investigation.

4. The visits of the Tissue Viability Nurse (TVN) and the deterioration of the pressure ulcer and whether it should have led to safeguarding intervention need to be considered and understood.
   The TVN completed an incident report in September 2020, however no Safeguarding had been raised and the decision toolkit was not utilised. The TVN stated NCH had raised a safeguarding concern however the only concern raised was in June 2020. The TVS

reported concerns regarding the pressure ulcer's management (please refer to the timeline) and assumed responsibility for the ulcer's care. However, the concerns did not extend to the realm of safeguarding, as they were not deemed to fall under this remit. The panel agreed the TVN should have raised a safeguarding concern and did not follow their policy (Appendix IV Point 6.73).

5. The TVN visits concerning wound contamination need investigation, particularly the event on 23 February 2022.
   The TVS reported that the staff of the care home addressed the incontinence. However, it was evident that the wound was not healing, and incontinence would be a contributing factor. The TVS and the GP discussed a catheter to aid in healing. The panel agreed that the TVN should have raised a safeguarding concern.

6. The lack of reference to the Category 4 pressure sore at the time of Elsie's death within the Care Home submission needs to be explored.
   The pressure ulcer had no effect on the death and was unrelated to the incident. Consequently, this was omitted.

7. There is a gap in respect of the pressure sore and understanding of whether the pressure sore could have been avoided or prevented from deteriorating further.
   This has been explored in the themes.

8. Agencies have highlighted some gaps in the recording of vital information by NCH, including information relating to safeguarding and care logs.
   There is internal oversight of the NCH's governance process and records before they are sent externally, led by the Regional Manager. Additional personnel, such as a deputy manager, is in place and significant presence of the regional support manager. There is a chief data protection officer in place, as well as an escalation and complaints process via the NCH website.

5.1.9 The review was commissioned in the aftermath of Elsie's tragic death, but due to the ongoing criminal investigation, the circumstances of this were not explored. However, in order to facilitate learning, the panel agreed on timeframe to review. The themes that emerged from this highlighted the complexities of Elsie's care and the importance of ensuring that trained staff are available to meet her needs. Furthermore, care plans and risk assessments must be documented and shared with all staff to ensure adherence.

6 Recommendations to the Board

Recommendations to the board

Recommendation one: Safeguarding and Pressure Ulcers: The Department of Health and Social Care produced the Decision Toolkit for Safeguarding and Pressure ulcers[49].

1a The SAB must obtain confirmation from partners that their safeguarding policies reference the toolkit. The SAB should authorise the approval of a multi-agency guide to be shared with all partners to facilitate the toolkit's application.

1b The SAB to receive assurance of the toolkit's use through an audit of Safeguarding concerns related to pressure ulcers.

1c Partners of the SAB will collaborate to include non-healing pressure ulcers in their escalation protocol.

1d ASC to ensure that all relevant agencies are included in all pressure ulcer safeguarding discussions and that access to independent advice is available to ensure the adult is receiving appropriate care.

Recommendation Two: Nutrition

2a All organisations that use the Malnutrition Universal Toolkit must include the outcome in the care plan and share it with others, including family members, as appropriate.

2b To ensure that the adult's care plan reflects the Speech and Language Therapist and Dietician assessment decisions, including the appropriate feeding method.

Recommendation Three: Dependence on carers The overarching principle of safeguarding adults is "Making Safeguarding Personal". Therefore, the adult's voice must drive all of their care and support requirements and decision-making.

3a The SAB must be assured that partners have processes and procedures in place to ensure their staff are aware of the Mental Capacity Act and know how and when to apply this.

3b The SAB will determine with partners what mental health capacity data is necessary and how it will be provided and utilised.

3c Staff must be aware of legal literacy and safeguarding adults. The SAB will develop a multi-agency resource to help staff become aware of this and identify sources of support.

Recommendation Four: Dementia

4a Agencies working with persons with dementia must assure the SAB that they have access to and have received the appropriate training to assist them in providing care.

[49] Safeguarding adults protocol: pressure ulcers and the interface with a safeguarding enquiry (publishing.service.gov.uk)

At the time this report was written, the criminal investigation was still ongoing. Therefore, the review will not be published until the conclusion of the criminal investigation.

Ealing Safeguarding Adult Board will develop and monitor the recommendations.