SCIE Learning Together

social care institute for excellence

ISLE OF WIGHT
SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULT REVIEW

MRS X

Agreed by the SAB: 22 May 2015

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1. Introduction

1.1 Why was this case chosen to be reviewed?

The Care Act 2014 requires that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area with needs for care and support dies or suffers significant negative impact as a result of serious abuse or neglect (known or suspected) and where there is concern that partner agencies could have worked more effectively to protect the adult (The Care Act 2014, section 44).

In October 2014 the Isle of Wight Safeguarding Adults Board (IoW SAB) determined that the known facts of the case of Mrs X met the criteria that required a Safeguarding Adult Review (SAR) to be commissioned. Mrs X was a woman in her mid-eighties, who had died several days after being admitted to hospital from a Residential Care Home on the island in April 2013. A number of practice concerns emerged from the safeguarding investigation undertaken and from the Coroner's inquest that subsequently took place. The SAB decided to review this case using the 'Learning Together' systems methodology which was developed with the Social Care Institute for Excellence (SCIE). The review work commenced in February 2015, following an initial scoping day in November 2014. The findings were shared with the SAB on 22nd May 2015. Ownership of the final report lies with the Isle of Wight SAB as the commissioner of the review.

The Terms of Reference

The scoping process enables the commissioning SAB and the key operational staff involved with the case to specify the particular areas of practice and systems issues to be explored in more depth during the review. The following questions were identified:

- Practitioners highlighted the need to explore the complexities of managing the care of people prone to pressure sores where there are other pre-existing skin conditions, the challenges linked to the safe management of residents who have increased levels of need, when it is not possible or appropriate to move them from the home and the need to explore the implications of cases where requests for additional physical equipment cannot be met speedily.

- In her Regulation 28 report (12 September 2014) the Coroner highlighted the need to explore the staffing ratios at the Care Home, the need to explore the delay in staff at the Care Home being able to take Mrs X to the toilet on 30/3/14 and the need to explore issues of communication of safeguarding information at the hospital, specifically in relation to confirming when patients are already subject to an open safeguarding investigation and in relation to making a fresh safeguarding alert.

- The SAB were concerned that they had been unaware of the case until the Coroner highlighted it to key agencies as requiring attention, and wished to understand why the systems in place to recognise cases that require consideration as potentially meeting the statutory criteria for requiring an SAR, did not work in this case.

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Timeframe

The 'Learning Together' model, in line with systems models generally works best when reviewing a period of no more than two years, in order to discover how systems are currently or recently operating. Scrutinising the work of agencies further back in time is unlikely to achieve useful systems learning, given the inevitable changes in personnel, local arrangement and national guidance, regulations and legislation.

It was decided that the most valuable period for the SAR to focus on would begin with the months following Mrs X's move to the Residential Care Home (autumn 2013) until the period following her in April 2014. It was decided that the period would also include several months after Mrs X's death until the Coroner's inquest in September 2014, to additionally allow an exploration of the safeguarding responses following Mrs X's death.

1.2 Methodology and the process of the review

This case has been reviewed using a systems approach to understand multi agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the deeper underlying issues that are influencing practice more generally. It is these generic patterns that are explored as 'findings' or 'lessons' from the case. The process looks at the safeguarding system through the illustration of a specific case which provides a 'window on the system'.

In line with the requirements of the Care Act 2014 the model ensures that the workers involved and their operational managers play a major part in the review, in analysing how and why practice unfolded in the way it did and highlighting the broader organisational context. Data is gathered from a variety of sources including a review of existing documentation alongside data provided by front line practitioners and their managers. Within this report these professionals are referred to as the Case Group. The review is completed by a team of senior managers who did not have line management responsibility for the case, led by an independent Lead Reviewer, who form the Review Team.

A critical aspect of the review, using this methodology, is the perspective of the service user (where this is possible) and their family and friends. In this case it was not possible to involve Mrs X; however the perspectives of her family and friends are reflected within this report. More detail about the SCIE methodology used in this review is found at Appendix 1.

1.3 Succinct summary of case

In August 2013 Mrs X moved into the Residential Care Home. Mrs X was a woman in her mid-eighties with some physical frailties and a long standing skin condition, but full mental capacity. She settled well and appeared to be happy in her new environment. Two of her sons kept in close contact with her, visiting very regularly. There was some family friction. Concerns were raised by the Residential Care Home Manager in relation to the behaviour of one of her sons (son A) in terms of his

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management of Mrs X's property. Safeguarding alerts were also raised both by son A about the quality of care at the Home. Checks undertaken during this period into the quality of care being provided, by the Care Quality Commission (CQC) and by the Local Authority found no significant concerns.

Mrs X's serious long standing skin condition (inverse psoriasis) had previously been treated by the Dermatology Service, however treatment had ceased in 2011, and she had not received any follow up treatment. In December 2013 Mrs X's skin condition became worse and her mobility also began to decrease. She was seen by a District Nurse in relation to wounds on her sacrum but no follow up visit was made. In January 2015 her GP re-referred her to the Consultant Dermatologist. In February a District Nurse checked her buttocks, found a scratch and arranged on her system for a follow up visit to be undertaken the following week. The visit did not happen.

In mid-March 2014 Mrs X met the Consultant Dermatologist with her son. She was still walking at this stage and appeared well to the Consultant, although her skin condition was much deteriorated. The subsequent treatment plan involved medication (with potentially immune compromising side effects), blood tests to monitor effects and twice daily cream being applied. The Residential Care Home arranged the blood tests with the District Nursing service, but the arrangements do not appear to have been recorded at the District Nurse's office and so the initial arranged visit did not occur. However, following contact with the District Nursing Service by the Care Home a blood test was taken the following day.

Over the following two weeks Mrs X's mobility deteriorated significantly and she became doubly incontinent. An unexpected traumatic incident occurred at the Residential Home on 30th April when one resident sitting close to Mrs X (and her visitors) suffered a cardiac arrest. Paramedics were called and administered CPR, however sadly the resident subsequently died. Due to a combination of factors including the room layout, Mrs X's reduced mobility and the initial staffing levels; it proved to be impossible to move Mrs X, who remained present in the room throughout the incident. This had also led to a wait for Mrs X to be taken to the toilet. Mrs X's son subsequently raised a safeguarding alert alleging neglect by the Care Home.

The Local Authority safeguarding team undertook an unannounced visit to the Home in response to the safeguarding alert. They found no serious concerns in relation to the quality of care. The Care Home advised the Local Authority that they were struggling to be meet Mrs X's needs, as she now needed a hoist to be moved. That morning Mrs X had been found what appeared to be a small pressure ulcer on her buttocks by the Home Manager, who left a message for the District Nurse.

A week later it was noted by the Home Manager that Mrs X's condition had deteriorated noticeably. Her GP attended and was concerned that this might be due to treatment side effects and decided to admit her to hospital that evening. On admission Mrs X was found to have symptoms that suggested sepsis with complications linked to her treatment. She was also found to have two grade 4 pressure sores. Mrs X's son raised a further safeguarding alert alleging neglect by the Care Home. Mrs X died in hospital four days later.

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1.4 Key dates table

Date	Event/incident
August 2013	Mrs X moved in the Residential Care Home. She appears well and content in the environment. Mrs X has a serious long standing skin condition but her previous treatment had stopped, so her skin condition was not being actively treated at this time.
December 2013	Care Home Manager raised safeguarding alert following concerns about the management of Mrs X's property by her son (son A).
12 December 2013	Mrs X has bleeding from the sacrum. Residential Care Home request visit by District Nurse (DN2), who notes blanching and discoloured areas on each buttock.
2 January 2014	GP1 refers Mrs X to Consultant Dermatologist
14 January	Mrs X's niece raises concerns with the police about son A's management of Mrs X's property
29 January 2014	GP visits – Mrs X's physical and emotional health is not good.
29 January 2014	Son A raises concerns with GP that his mother has been refusing to be bathed.
12 February 2014	DN1 visits Care home and is asked to look at Mrs X's bottom. DN notes 2 areas of blanching and discoloured skin. She also notes a scratch of broken skin. DN returns to her office and makes a note on the system for a follow up visit the next week. The visit does not happen.
12 March 2014	Mrs X attends hospital for her appointment with Consultant Dermatologist, accompanied by son A. She appears well, walks into the room and is mentally alert. The Consultant prescribes cream twice a day and low dose methotrexate (which has potentially serious side effects) requiring close monitoring with blood tests. Consultant sends treatment plan to patient, GP and Care Home.
18 March 2014	Methotrexate treatment commenced by the Care home, Residential Care Home manager rings the DN service and books in 3 blood test appointments. The DN service did not attend to undertake the initial blood test, so the Home Manager reminded them and a Healthcare Assistant subsequently attended the following day.
30 March 2014	Mrs X has become doubly incontinent and unable to walk. She requires a hoist and a wheelchair. Care Home were concerned that they cannot meet her increasing needs.
30 March 2014 (17:44)	Emergency medical situation arises when one resident suffers a cardiac arrest late in the afternoon. Mrs X is sitting nearby. The staff summoned the paramedics. The usual staff ratio was 2 staff for 20 residents. Son A and his wife were visiting and noted that Mrs X had faeces on her face. It was not possible for the staff to attend to Mrs X immediately or to

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	move her from the room at this point due to the layout and the presence of the paramedics; they could not get a wheelchair into the room.
30 March 2014 (18:35)	The Manager and Deputy on call arrive to assist and are able to move Mrs X from the room (taking the wheelchair out through the garden) to the toilet.
31 March 2014	Son A raises a safeguarding alert alleging that the Home has been neglectful and had insufficient staff available.
1 April 2014 (9:00)	Residential Care Home morning handover – staff highlight that Mrs X still "off her feet", she had a more disturbed night than usual and was complaining of a "sore bottom". Home rang the GP. Home Manager takes opportunity to bathe Mrs X and note a small open area where the scratch had been, which she thought might amount to a grade 1 pressure ulcer. She records the concern and rings the DN service.
1 April 2014 mid day/pm	The Local Authority safeguarding social worker arrived (unannounced visit on response to safeguarding alert alleging staff ratios were neglectful) and checked records and spoke to staff and Home Manager. Devised a protection plan but had not serious concerns about the quality of care. Social Worker also spoke with Son A who was present.
1 April 2014 pm	GP arrives to see Mrs X with son A also present. GP unaware that there were any concerns relating to pressure ulcers.
2 April 2014	Blood test taken Health Care Assistant. Social Care Practitioner visited to review Mrs X's changing care needs.
5 April 2014	Continued deterioration in Mrs X's physical health. Residential Care Home ask GP to visit. GP awaiting results of blood tests as concerned Mrs X may be suffering from side effects of methotrexate.
7 April 2014 (pm)	Mrs X health deteriorated further. GP visits and awaits blood test results, which do not arrive. Mrs X is reluctant to be admitted. Home Manager calls her niece to sit with her and encourage her to take fluids. Early evening GP decides to admit Mrs X to hospital due to concerns about potential treatment side effects.
7 April 2014 (23:00)	Mrs X is admitted to hospital – she is found to have sepsis - symptoms likely to relate to the side effects of her treatment, query UTI and is also found to have 2 x grade four pressure ulcers on her buttocks.
8 April 2014	MAU staff make initial enquiries with the Care Home and District Nurses in relation to the pressure ulcers. Son A raises safeguarding alert alleging neglect by the Care Home in relation to the pressure ulcers, on the advice of MAU nurse.
9 April 2014	Safeguarding Team male initial enquiries and liaise with hospital Social Worker.
11 April 2014	Mrs X dies in hospital.
14 April 2014	Local Authority safeguarding team contact the hospital and discover that Mrs X has died. In the light of this news the safeguarding team decide not to proceed any further with their

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	investigation.
17 April 2014	Son A advises Coroner that his mother had been the subject of a safeguarding investigation at the time of her death.
9 September 2014	Outcome of coroner's inquest – death by natural causes contributed to be neglect; causes were a) multiple organ failure, b) septicaemia and c) infected pressure sores.

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2 The Findings

2.1 What is it about this case that makes it act as a 'window' on practice more widely?

The Findings convey a message to the SAB about how elements of the safeguarding system were working at the time. They state succinctly what was (and may still be) problematic about the system. Findings can also confirm that elements of the safeguarding system were working well. Statutory guidance requires that the SAR process should '*promote effective learning and improvement action … a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults'* (The Care Act 2014: 14.135). SARs should '*provide a sound analysis of what happened, why and what action needs to be taken to prevent a recurrence'*. The Care Act and requires that findings should be '*of practical value to organisations and professionals*' (The Care Act 2014 guidance: 14.149).

This case provided a useful 'window on the system' because it highlights how vital it is to ensure that management and governance systems are working well in every agency, and that risks to the quality of services being offered that are recognised by front line staff are escalated to managers who can respond.

This case also underlines the need to ensure that the local multi-agency system works in a joined up way that supports all parts of the system (including commissioners and Care Home Providers), so that pressures on one part of the system are not just passed to the another part of the system. The case demonstrates the widely experienced dilemmas experienced by front line staff and proprietors of Residential Care Homes, as they seek to provide the right level of support to older people within residential settings as their health needs become more complex.

2.2 Appraisal of professional practice in this case: a synopsis

This appraisal sets out the view of the Review Team about how timely and effective the interventions with the service users were in this case, including where practice fell below or above expected standards. This case illustrates some of the increasing challenges posed for professionals working with older people who are receiving health and social care services on the Isle of Wight (and more broadly across the country). The background themes which are relevant here are the challenges of finding safe and effective ways of managing services within the reality of tight budget constraints and increasing workloads. In addition to the need for joint working across agencies we also see how the particular geographical and demographic identity of the Island plays into the challenges for local services.

This synopsis is the link from the specific case chosen for the Safeguarding Adult Review to wider findings about the local adult safeguarding system for the Isle of Wight Adults' Board to consider. This synopsis of the practice also addresses why some things happened in this case and others did not.

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2.3.1 In August 2013 the Local Authority (Isle of Wight Council Adult Social Care Department) arranged and commissioned a placement for Mrs X within a local Residential Care Home. Mrs X was in her mid-eighties and had good mental capacity. She had a long-standing serious skin disease, inverse psoriasis (which causes lesions in body folds such as armpits and the groin). She had previously been treated by the Dermatology Services but it is understood that she had become 'lost to' the Dermatology service in 2011. Mrs X had moved from her own home into a previous Residential Care Home during that period. Usually the GP acts as a point of continuity for a patient's records and on-going treatment even if they are moving home. We are not able to draw any firm conclusions about how or why contact was lost in this case, but it would seem that the usual system to ensure continuity of treatment did not work effectively. We do know that by the time Mrs X was re-referred to the Dermatology Service in 2014, her skin condition had deteriorated significantly. On arrival at the Care Home she already had a pressure relieving cushion and was observed by staff to use it.

2.3.2 Staff at the Care Home developed a positive relationship with Mrs X, who was a popular resident. She had previously been an active member of her local community and continued to attend church regularly. Several family members visited very regularly including two of her sons and their wives. They noted that she settled in well, and that her mood and mobility increased as the placement suited her needs. However in December 2013 the Care Home staff found that Mrs X's mobility began to deteriorate and at times she required a frame to walk and the assistance of a carer. The deterioration in Mrs X's mobility was variable and may have been due to pain or changes in mood as well as possible physical factors. On 12 December the District Nursing service were called to attend to Mrs X who had a bleeding sacrum. The nurse noted two purplish coloured areas on each buttock; however they were both blanching (which indicates a normal skin response to pressure). The nurse noted in her recording in relation to monitoring 'weekly pressure areas'. The District Nurse (DN1) advises that she took a photograph of the skin condition to leave at the home, however no note of this was found in the care home notes and the photograph has not been located. While some elements of expected practice were followed, a written assessment of Mrs X was not started, and a pressure area care plan was not written for the care staff to follow. These omissions were contrary to usual Trust policy and practice expectations, however these deficiencies are directly related to the excessive caseloads that the District Nurses in that team had been managing for more than a year. The practice issues and the reasons behind them are explored in **Findings 1 and 3.**

2.3.3 A follow up visit from the District Nursing service did not take place. Although it has not been possible to confirm the exact reasons why no follow up visit was made it would appear likely that high workload may have been one factor, however there were also deficits in a number of the systems that were in places at the local District Nurses office. Evidence from both the District Nurses who submitted evidence to the review suggests that some of the systems in use were 'haphazard' (for example the system used to identify which patients needed a further visit the following week and the system used for deciding which cases were closed). The difficulties related in part to a lack of robust systems and also to the significant limitations of the IT system that was available in that office. The Review Team are aware that other professionals have experienced a similar sense of disorder in relation to key

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systems there. It is clear that the lack of follow up from the service to Mrs X at this point was a significant omission that might otherwise have afforded an opportunity for more proactive treatment of the pressure area. This concerning omission and the reasons behind it are explored in **Finding 1.**

2.3.4 Mrs X's GP1 visited several times in December and became increasingly concerned about the symptoms of psoriasis, prescribing anti-biotics and subsequently referring her to the Consultant Dermatologist on 2 January 2014. The GP1's decision to refer to the Consultant Dermatologist was very appropriate given the nature of her diagnosis, the increasingly severe symptoms and the fact that Mrs X was not receiving any on-going treatment to manage the condition. However the Review Team have questioned whether or not it might have been appropriate for the GP to have made the re-referral to the Dermatology Service at an earlier point.

2.3.5 During this period concerns were raised in relation to the management of Mrs X's finances and property by one of her sons. A longstanding disagreement between two of her sons became more serious, resulting in a prolonged period of estrangement between the two brothers. Unfortunately there was also an impact upon Mrs X who was quite distressed by the level of disharmony within the family, and allegations that had been raised. The worries and concerns that were generated by this issue impacted upon her mood. The Care Home Manager raised a safeguarding alert as she was concerned about the potential for financial and emotional risk to Mrs X. The decision to raise the alert demonstrated a sound knowledge of good safeguarding practice and a commitment to putting the needs of residents first, even if that might generate tensions between son A and the Home Manager.

2.3.6 Later in January Mrs X's physical and mental health deteriorated to some extent. She developed a chesty cough and further symptoms of low mood. On 21 January she told staff that she did not wish to see her GP and two days later she refused her weekly bath. The care staff became increasingly worried and despite Mrs X's reluctance, they contacted the GP and requested a visit. The GP visited on 29 January and prescribed an anti–depressant to help Mrs X sleep and to treat her low mood. The following day she was still unwell and refused her bath again. Mrs X was regarded by all professionals in touch with her as having retained full mental capacity and in line with the principles of the Mental Capacity Act 2005, her decisions, even if they did not seem sensible, did need to be respected[1]. However Mrs X's family noted that when she lived in her own home she would have daily baths which they felt had help to manage the symptoms of her skin condition. Family members acknowledged that Mrs X was not always keen to take baths and would usually need to be coaxed to co-operate. Carers are faced with the daily task of finding the right balance between respecting a person's decision-making and also ensuring they are fulfilling their 'duty of care' . Records suggest that the approach of the care staff towards Mrs X during this period was appropriate and in line with the principles of the Mental Capacity Act 2005, however the fact that during this period Mrs X did not receive regular baths will not have helped with the on-going

[1] Mental Capacity Act 2005, Code of Practice chapter 3

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management of her skin condition. At the end of January Son A told the GP that he was concerned that the Care Home was not bathing his mother.

2.3.7 In February the Care Home once again became concerned about the skin on Mrs X's buttocks. A District Nurse (DN2) was visiting the home on 12 February, and the home staff asked if she would also take a look at Mrs X. Despite having a particularly heavy workload that day, DN1 made the time to assess Mrs X. The Review Team noted that it was not good practice on the part of the Care Home, who should ideally make a more proactive appointment with the District Nurses where their input is required, rather than relying on the ability of the nurse to make additional time over their planned visits to accommodate the extra assessment.

2.3.8 The District Nurse found two areas of discoloured skin (though the skin was still blanching) and a small scratch of broken skin. (This was likely to have been caused by Mrs X due to the discomfort of the inverse psoriasis.) The District Nurse left brief notes at the Care Home. The Review Team felt that this was not an adequate response, and were concerned that no full assessment had been started at this point. However it is necessary to recognise the excessive workload that DN2 was managing, which would inevitably have had an impact on the quality of service she was able to offer. On the day that she saw Mrs X the nurse had worked 10 clinical hours, plus travel time, plus admin time and management tasks. The District Nurse was so distressed by the impact of the excessive workload on the quality of her service that day, that she subsequently took the action of writing her concerns to the Trust managers via the 'Listening into Action' project. The Review Team felt that this action by the District Nurse demonstrated both a high level of reflective practice and a clear example of her level of commitment to her patients.

2.3.9 On her return to the office DN2 recorded that a follow up visit should take place the next week. However this did not happen, which was a further significant omission by the District Nursing service. The exact reasons for this omission are unclear; however it is likely that the combination of inadequate systems, poor availability to IT, poor quality of IT systems and excessive workload were all a part of the picture. The issues are explored in more detail in **Findings 1 and 3.**

2.3.10 On 12 March the Consultant Dermatologist met and assessed Mrs X, who was accompanied by her son (son A) to the hospital. Mrs X appeared well to the Consultant and was able to walk with a little support, however he was very concerned by the state of her skin, which had deteriorated significantly since she had last been treated for the condition by the Dermatology Service in 2011. The Consultant took a history from Mrs X and ensured that she had both verbal and written information about the proposed treatment and potential side effects. He prescribed low dose weekly methotrexate, which is effective in the treatment of auto immune diseases, and safe in low doses, however requires monitoring due to the possibility for immune compromising side effects. Baseline blood tests were taken by the Pathology Department at this stage, and on-going blood tests were required approximately every 10 days to monitor the potential side effects. The Care Home commenced the

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treatment on 18th March once they had received the treatment plan. They promptly contacted the District Nursing service to arrange three blood tests as required; the first one was arranged for 1st April. In the treatment plan the Consultant also prescribed continued use of conotrane cream and dermol cream to be administered twice daily to affected areas. The treatment plan was not sent to the District Nursing service, as the Consultant had not realised they would be involved. He had been under the impression that the care staff employed in Residential Homes included qualified nurses who would oversee and implement the treatment plan. These issues of agencies working in isolation to some extent are explored in **Finding 4.**

2.3.11 Mrs X's physical health deteriorated significantly at this point. Her relatives have confirmed that Mrs X had experienced constant pain in her sacrum even when she was living in her own home; however the perception of her relatives was that Mrs X was now in more pain, at times even screaming out, which they found very distressing. It was noted for the first time in the care records on 30th March that Mrs X was "off her feet".

2.3.12 On 30th March, Mrs X's son (son A) and daughter in law visited her on Mother's Day in the mid afternoon. They found that Mrs X had excrement on her hands and face (this is likely to have been due to Mrs X having scratched herself due to the discomfort of her skin condition). Son A asked for staff to attend to Mrs X. A staff member came quickly to wipe her hands and face, however as Mrs X had become immobile, two staff were now needed to take her to the toilet safely. There were only two staff on shift, and one of those was doing the medication round and so they could not respond immediately.

2.3.13 The usual staff ratio in the Residential Care Home during the afternoon/early evening shift was 2 staff to support 20 residents. This limited number of staff had generally been found by the Care Home managers to be adequate for the relatively low level of needs of their residents. However members of Mrs X family have commented that they felt staffing levels were not adequate. Having only two staff on shift meant they were stretched and had limited opportunities to interact meaningfully with residents. Staffing ratios in Residential Care Homes are not specified by national regulatory requirements, but the Registered Manager must ensure that there are sufficient staff on duty to provide a safe and responsive environment for the residents[2]. In a small home such as this, the Responsible Proprietor and Registered Manager are both key to determining and funding the right balance of staff, and being responsive to any changing needs. On balance the Review Team felt that the staffing levels on afternoon shifts were poor as they did not facilitate staff being able to provide a high quality personalised response to residents or any flexibility to respond to unexpected incidents.

2.3.14 However before the two carers were able to take Mrs X to the toilet, an unexpected and severe medical emergency arose with one of the other residents who was sitting in the conservatory (where Mrs X and her visitors were sitting). The lady had appeared fine initially

[2] Health and Social Care Act 2008 (Regulated Activities), Regulation 2014 (Regulation 18 – staffing)

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but Son A and his wife became concerned and called the carers when she began to struggle to breathe. The two Care Home staff moved all residents who could be moved safely out of the area. Paramedics were called and they undertook CPR on the lady for over an hour, however sadly she died quite soon after they had arrived. It was not possible for the carers to get the hoist to Mrs X due to the logistics of the room and the position of the resident who was experiencing the medical emergency, so she had to remain in the conservatory.

2.3.15 The carers also summoned the on call Manager and Home Manager, who arrived while the paramedics were still there. The managers moved Mrs X using a transfer belt, taking her in a wheelchair out of the french doors into the garden and then back into the house. Their perception of Son A's behaviour at this point was that he was angry and threatening towards them and their staff. The view of the two family members present at the time was that the carers appeared panicked. It has been difficult for the Review Team to draw firm conclusions about the quality of practice of the carers during this incident, as the paramedics and care staff are no longer available to be interviewed. Taking into account the records and interviews with family members and the Care Home Managers who arrived later in the incident, the Review Team felt that given the particularly difficult and stressful medical emergency that arose, the carers coped well, requesting help as needed and doing what they could in the circumstances to preserve the dignity of the lady who was so unwell.

2.3.16 Records confirm that Mrs X had been immobile in her chair sitting in a pad for at least two hours. The view of the Review Team is that it is not possible to determine with any certainty the significance of the two hour period of immobility on 30th April (when Mrs X could not be moved out of the conservatory) on the subsequent serious deterioration in the condition of skin on her sacrum. As soon as it was possible for Mrs X to be taken to the toilet, she was taken, washed and had cream re-applied. The account of the Care Home Managers who took her to the toilet was that no signs of soiling were found and that Mrs X said she did not wish to go to the toilet. The Review Team noted however that the view of the family members present at the time was that the pad had been soiled. While is important to consider the potential implications for Mrs X of sitting for at least two hours in what may have been a soiled pad, it is also necessary to acknowledge that it is not possible to know exactly how long she had been sitting there or draw any definite conclusions about the effect it may have had on the condition of her skin. Periods of immobility do increase the level of risk of skin damage occurring, and we know that prior to this incident Mrs X's mobility had already declined significantly. Recorded notes made at the time and subsequently (along with verbal evidence submitted to this Review) consistently suggest that the skin on Mrs X's sacrum was not broken at this point. The development of a small open area occurred on 1st April, two days later.

2.3.17 The following day son A raised a safeguarding alert to the Local Authority safeguarding team, alleging that his mother had been neglected by the Care Home staff. The Safeguarding Team took the referral details to their daily team strategy discussion meeting the following morning and agreed that an unannounced visit should be undertaken that day. Their prompt and responsive management of the referral process was very good practice.

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2.3.18 By now the Care Home was struggling to meet Mrs X's increasing needs. They contacted the Local Authority to request a review of her needs, which was arranged for 2nd April. The Review Team noted that this was a swift response by the Local Authority. At the shift handover in the Care Home on 1st April, concerns were raised about Mrs X who had called for staff much more often than usual through the night. The Manager rightly decided to ask the GP to visit as they were concerned that Mrs X might be experiencing a delayed emotional reaction to having been present during the cardiac arrest of her fellow resident. Mrs X was also complaining of a 'sore bottom', so the Home Manager decided that she would bathe Mrs X and put cream on her in order to check how her skin was. The Manager noted that the treatment she had been receiving since mid March appeared to have helped many of the skin areas that were affected, however for the first time a small open area to the left buttock was noted and a tear in the crease where the scratch had previously been observed. According to records, this had developed since she had been washed by care staff the previous evening. The Manager documented this, completed a risk assessment, drew a body map, called the GP and also left a message for the District Nurses advising that there appeared to be a grade 1 pressure ulcer. The Review Team were impressed by the response of the Care Home Manager to the changes in Mrs X's presentation.

2.3.19 The Home Manager left a message with the District Nurses office requesting a visit and asking for an assessment for an airwave mattress and profiling bed. The fact that a call was made has been verified by independent documentation (telephone bill), although of course we are unable to verify the exact content of the call. The District Nurses have no record of the message being received and consequently did not arrange to visit Mrs X. Experience of professionals within the Review Team supports the view that the reliability of message taking within the District Nursing service on the Isle of Wight was at that time (and has continued to be) a source of concern. The serious issues raised by the lack of basic, robust and effective systems and tools at the District Nurses office are explored in **Finding 1.**

2.3.20 Later that morning staff from the Local Authority safeguarding team arrived at the home to undertake their unannounced visit. They examined case notes; support plans and staff shift details, and spoke with the Home Manager. While they were present, GP2 arrived to see Mrs X. Shortly after this son A also arrived and became agitated, shouting at the social worker. The safeguarding practitioners talked with the Care Home Manager about the staff ratios and outlined a protection plan with two action points relating to the need for some improvements to recording practice. They suggested that the Care Home should ensure they followed up telephone calls to the District Nurses office with emails. The safeguarding team did not feel that there were any safeguarding or quality issues that presented any immediate risks to the residents. No concerns were voiced in relation to the staffing levels. The view of the safeguarding team was that the combination of factors on 30th March had not been predictable.

2.3.21 The Safeguarding Social Worker did not meet with Mrs X as both the GP2 and son A were with her. While this is understandable, this was a missed opportunity to have engaged with

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the service user (who had full mental capacity), to have made her aware that a safeguarding investigation was underway and to gain a picture of her views and wishes. The Review Team felt that the safeguarding investigation had been both prompt and proportionate which was good practice. However no formal conclusions or investigation findings were relayed to the service user, the referrer (son A) or the Care Home Manager and Proprietor, which is counter to the multi agency safeguarding policy.

2.3.22 The following day the Care Home Manager noted that no Healthcare Assistant had arrived to take the first blood test which had been arranged for 1st April. The Care Home Manager followed up by speaking with the District Nursing service and they agreed to send someone the following day to take blood, which they did. Evidence submitted to this review indicates that the system within the District Nursing office for taking messages was not robust. It was not unknown for messages to be recorded on pieces of paper and then lost, which is explored in **Finding 1.**

2.3.23 On the same day the Local Authority Social Care Practitioner visited to review Mrs X's needs and explored possible options with her if her immobility continued; a move to a ground floor shared bedroom which could accommodate a hoist or the need to transfer to an alternative care home. At this point, understandably Mrs X was not keen on either option. The complex issues that lie behind the challenges for health and social care agencies to be able to respond promptly to support Residential Care Homes to be able to meet increasing needs of residents in a person centred way are explored in **Finding 2.**

2.3.24 The following days showed a further significant decline in Mrs X's condition both physically and mentally. Her mobility remained variable, however at times she would insist on being put to bed even in the daytime. She was very disturbed at night, sometimes calling out over twenty times. At times she would scream at staff, and family members reported to the Review Team that they felt she was screaming in pain at times. The Review Team felt that this period was of particular significance as the symptoms that had begun to emerge indicated important and worrying changes to Mrs X's mental condition which may have indicated serious physical complications related to the methotrexate treatment she was receiving. There was also a higher likelihood of negative impacts on her the condition of her skin as she was staying in bed for longer periods. The Review Team felt that there was an opportunity that was missed by all staff involved in Mrs X's care over this period, in terms of questioning what might have led to the changes in her mental state.

2.3.25 The Care Home felt they were struggling to cope. On 4th April the Home contacted the Local Authority social care practitioner for advice, who suggested that they liaise with the GP about the possible need for a mental capacity or mental health assessment. The GP visited on 5th April and advised that the initial blood test (taken on 2 April) had given an abnormal result; however the GP was awaiting advice from the Dermatologist and so did not take any immediate action. No funding decisions were made at this point by the commissioning authority in response to Mrs X's increased needs. The Review Team noted that this response from the Local Authority is understandable and correct in as far as they are signposting the Care Home to pursue medical input and assessment in relation to Mrs X's emerging health

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needs. However from the perspective of the Care Home and of outcomes for the service user, a more joined up response from the health and social care agencies (as the commissioner of the placement) involved would be more constructive in such circumstances. The implications of this are explored further in **Finding 2.**

2.3.26 Care Home records indicate that there were no visible signs of the small open area on Mrs X's sacrum having deteriorated further at this point. On the morning of 7th April the Home Manager noted that Mrs X's overall physical condition appeared significantly worse, the appearance of her skin had changed and she was refusing food and drink. GP1 attended and was concerned that Mrs X's symptoms might be the result of 'methotrexate poisoning'. The GP took a further blood test. Mrs X was adamant that she did not want to leave the home to go to hospital. The Care Home Manager rang Mrs X's niece, who came in to sit with her, to try to encourage her to take some fluid and to help her consider the possibility of a hospital admission. The Review Team felt that the actions of the Care Home Manager were very positive in terms of finding a way of alleviating some of the understandable fears that Mrs X must have been experiencing. By the early evening although Mrs X was still reluctant to go and the blood tests results had not returned, the GP felt instinctively that Mrs X required an urgent admission, and arranged for her to be taken to hospital. The GP's decision to in effect 'force' the admission decision was a sound one in light of the circumstances. While Mrs X's mental capacity had not been questioned until this point, the GP weighed up the extreme risks and came to the conclusion that Mrs X was not making an informed decision about what treatment may be needed. On admission to the Medical Assessment Unit (MAU) she was treated for methotrexate poisoning, and tests confirmed how seriously ill Mrs X was.

2.3.27 On admission it was also discovered that Mrs X had developed what appeared to be two grade four pressure ulcers. The development of usual pressure ulcers can be gradual, however often influenced by good care and so are commonly considered avoidable. When grade four (the deepest) pressure ulcers are discovered, it is not unreasonable to infer that a level of neglect may have been involved. The MAU nurses responded well by making some initial enquiries about the care provided by the Care Home and the District Nurses. However, one MAU nurse advised son A that he should raise a safeguarding alert to the Local Authority. Data given to the Review Team suggested that staff within the MAU may advise family members to raise safeguarding alerts in addition to any actions the nurses themselves take. In this case the nurses did undertake initial checks with the Care Home and District Nurses, however the practice of suggesting family members raise safeguarding alerts is counter to the multi-agency safeguarding policy. One of the nurses should have either raised the safeguarding alert directly to the Local Authority safeguarding team if they believed the threshold was met.

2.3.28 A second and very significant concern of the Review Team is that there are complexities in relation to how pressure ulcers are diagnosed that need to be considered before conclusions are drawn about whether they are the result of neglect. The broader picture that has emerged in this case has led the Review Team to question whether the wounds may in fact

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have been Deep Tissue Injuries[3] as opposed to more conventional pressure ulcers. The accounts and written records of the Care Home staff indicate that the development of deep open wounds which were graded as grade 4 pressure ulcers on admission, had occurred on the day prior to admission. This is typical of Deep Tissue Injuries but not of the more common pressure ulcers, which generally develop over a much longer period. The presence of purplish discolouration on the sacrum was noted by both the District Nurses who assessed Mrs X (on 12 December 2013 and 12 February 2014). This discolouration may have masked a further tell-tail sign of Deep Tissue Injuries, which is purple bruising.

2.3.29 Son A raised the safeguarding alert on 8th April. The Local Authority safeguarding team discussed the case. The task of gathering initial information was passed to the Hospital Social Worker who checked the medical notes, the District Nursing notes and liaised with the Care Home. The Social Work team returned to chase for information the following week, only to discover that Mrs X has sadly died on 11th April, three days earlier. Son A subsequently contacted the safeguarding team to advise that his mother had died. On 16th April the safeguarding Social Worker visited the Care Home to make final checks and felt that they had all the information they required, so the safeguarding team decided not to progress the safeguarding further. The safeguarding team were aware that the Coroner was going to investigate the cause of death, and there was limited guidance within the safeguarding policy on how to respond if an alleged victim dies while an investigation is on-going[4]. The Review Team felt that this was an oversight on the part of the safeguarding team. It would have been more appropriate for the safeguarding investigation to have continued in light of the fact that there were wider questions being raised about the service provided by the District Nurses and the Care Home staff which needed to be explored. There is a need to improve the formal multi agency guidance for staff in these situations. The Review Team also noted that it was unsatisfactory that the safeguarding team did not provide a response to the referrer (son A) or to the people who were regarded as potential perpetrators (the Care Home staff) in the allegations raised by son A.

2.3.30 Following Mrs X's death, the Coroner was concerned that she had not been informed by the statutory agencies (the hospital or the safeguarding team) that Mrs X had been the subject of a safeguarding investigation at the time of her death. The Review Team are not aware of any national or local guidance for staff in relation to their responsibilities to communicate with the Coroner in this kind of situation[5]. Concerns have also been voiced that following Mrs X's death, the safeguarding team did not make the Safeguarding Adults Board aware of the case, in relation to the potential for subsequent media interest or in relation to the possible need for a Safeguarding Adult Review (SAR) being indicated. The Review Team have found that at the time there was no formal guidance which the Safeguarding Team could refer to in relation to which cases should be escalated to senior managers or to the partners in the SAB, although this has now been rectified. At the time there was limited procedural guidance for staff outlining the criteria for case reviews generally and Safeguarding Adults

[3] Deep Tissue Injuries – for details please refer to Appendix 2.
[4] This point is picked up in the '2.7 Additional Learning' section.
[5] This point is picked up in the '2.7 Additional Learning' section.

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Reviews (or Serious Case Reviews as they were termed at the time) specifically. This situation has now been addressed and the Care Act 2014 has confirmed clear statutory criteria and requirements outlining which cases need to be considered for SARs.

2.3 The Findings

The Review Team has prioritised four findings for the Board to consider. They relate to categories of underlying pattern in the functioning of the safeguarding system. Many of the patterns are inter-linked, which is the nature of systemic patterns found within over-lapping systems.

Findings	**Category**
1. A combination of poorly developed systems and limited access to key IT tools within the District Nursing Service has increased the risk that patients may not be assessed or treated effectively.	Tools
2. The lack of a joined-up multi agency approach to the management of patient's health and social care needs has led to a mis-match of expectations between agencies and staff that has affected the quality of service delivery.	Communication and collaboration in longer term work
3. Governance arrangements for the District Nursing Service are lacking effective quality assurance processes to pick up deterioration in service delivery.	Management systems
4. Commissioners and providers of care on the Isle of Wight are struggling to provide a person centred response for older people who can be left stranded when their level of needs rises above a certain point.	Management systems

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2.4 Finding 1

Finding 1. A combination of poorly developed systems and limited access to key IT tools within the District Nursing Service has increased the risk that patients may not be assessed or treated effectively.

2.4.1 Some key systems and equipment used by the District Nursing service in Ryde were rudimentary and unreliable. Although the issues appear to have been particularly pronounced within the Ryde office, there is evidence to suggest that some of the concerns are also relevant in other District Nursing offices on the Island. Key clinical processes including the allocation of work, the prioritisation of work, the recording of referrals and visits, the handover of work and systems to ensure the appropriate closure of cases, were not functioning effectively.

2.4.2 How did this feature in the case ?

The limited level of access to computer terminals, laptops and computer based systems in the Ryde office did not support the nurses to undertake full and timely case recording. In the Ryde District Nursing Office there were two main computers in the office and two laptops shared between the teams. Nurses returning to the office would often find they had no access to a computer as their administrative colleague would use one computer terminal, and the other terminal was often already be in use by other nurses.

There was also an issue with connectivity in the area, which meant that the Trust caseload recording system which was used in other offices giving a 'live' caseload feed was not available in Ryde. Instead the district nurses relied on recording their caseloads via a desktop spread sheet system. This was a temporary measure put in place pending the implementation of the PARIS computer based recording system on the Island. It was originally envisaged that the delay in the implementation of PARIS would be for around 6 months, but in reality the temporary system has remained in place some three years later. The impact of this was visible in a number of ways, directly affecting the quality of work:

- The District Nurses had very limited access to any case history or paper case notes in their office, and limitations on what they were able to refer to in terms of paper files in the office. The District Nurses who were interviewed confirmed that the combination of having no case history recorded on the computer and access to limited paper files in their office resulted in a lack of reference to key case information that would normally be expected to inform clinical decisions. It is not clear why the access to written case notes was so poor in the Ryde office, given that it is known to be better in other offices. Anne Cooper, NHS England's Clinical Informatics Advisor for nursing has said the use of technology (such as mobile devices, online resources and electronic record systems) by nurses was essential for improving care.[6] However, consistent access to technology is crucial to provide improved outcomes such as better efficiency and records that are easily accessible to staff.

[6] Nursing Times.net 19th February 2015

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- In the case of Mrs X, there were two significant occasions when the Care Home rang the Ryde nursing service to request appointments and visits (on 17th March to set up blood tests and on 1st April to request a visit) when messages that were left for or were taken by the nursing service were not acted upon. The aims of the service to switch from a paper based system to an IT based system had apparently meant that the old recording system whereby notes of telephone calls were left in a message book had ceased to be used consistently by the District Nurses. One nurse stated that 'there was quite a problem for people ringing in'.

- The process in place for arranging follow up visits to patients was based on one nurse using the computer and calling out names from the list on the spread sheet. The other nurses present would indicate verbally whether there was 'no change' or whether a follow up visit was necessary. If a visit was required, this would be marked with an 'x' on the spread sheet. Evidence from members of the District Nursing Team indicated that the process used to decide whether or not visits should be continued to patients was "haphazard". There was no room to enter detailed narrative on the spread sheet, so often it would not be clear to nurses at a later date why a visit was required or how urgent the concerns were. Decisions to close involvement did not involve any cross checking with case notes or medical history. There were occasions when the decisions were based on the assessment of workload pressures undertaken by the individual nurse on that day, rather than on clinical needs, and could also be made without discussion with the nurse who had previously seen the patient, so again not sourcing any longer term picture or understanding of the patient's recent medical history. The Review Team were told that nurses would check the lists and take the names off if they thought that the patient had been discharged. It is understood that in addition to the limitations of the spread sheet system, there may also have been reluctance on the part of some team members to use the spreadsheet.

2.4.3 The situation was compounded by the context in which the District Nurses were working. The nurses were under extreme pressure in terms of the number of visits they needed to cover each day, and it was not always possible for nurses to return to the office to record the outcomes of their visits at the end of the day. On some days nurses were working excessive hours and returning back to the office very late if at all. On the day that DN 1 visited Mrs X (12th February 2014) she had undertaken 10 hours of clinical work in addition to the time taken for her travel, admin, emails, and management work.

2.4.4 <u>How do we know it is not peculiar to this case?</u>

The systems we have highlighted that were in use within the Ryde community nursing office did not just relate to the care of Mrs X. The lack of internet access, inadequate recording systems and poorly developed caseload management systems were used across the team's caseloads and were embedded in practice within the team, so the potential for large number of patients to be effected was, and in relation to the use of the desktop spread sheet and lack of internet access still remains present.

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2.4.5 How widespread is the pattern?

Some of the systems and practices outlined for example the use of a paper message book were specific to practice in the Ryde office; however other systems are in use in other teams elsewhere on the island. The delay in the commissioning of the computer based recording system (PARIS) which led to the introduction of 'temporary' methods such as the desk top based spread sheet system impacts upon all the community nursing teams. Unfortunately the PARIS system has still not been implemented and the 'temporary' measures are still in place.

The practice of using a digital camera to take photographs of symptoms that required monitoring and/or treatment occurs in a number of community nursing teams across the island, and it is known that nurses in the Ryde team are having to share one camera with another team, which limits access in at least two teams to the equipment that they need.

Feedback to the Review Team from another health professional supported the picture of difficulties in gaining responses from different community nursing teams across the island in response to telephone message left for them, suggesting this is an island wide problem, although it has been beyond the scope of this review to examine what factors lie behind that.

2.4.6 What are the implications for the reliability of the multi agency safeguarding system?

Reliable systems are essential to support good clinical practice. A number of key systems (both paper based and computer based) were not working effectively in the Ryde office (and more broadly across the island in relation to some aspects of the current computer based recording system in use. Technology as a tool to assist the District Nurses is only as effective as the systems in place to support it. Without clear procedures and processes in place to support staff using technology, computer based systems in themselves are insufficient to ensure that visits are properly prioritized or that patients cases are not closed prematurely. This applies both in relation to recording requests for visits, outcomes of visits, and in relation to how that information will subsequently be used to inform clinical decision making at handover meetings. Access to sufficient hardware and reliable internet connectivity are essential if web based IT systems are to be relied upon for recording purposes.

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Finding 1. A combination of poorly developed systems and limited access to key IT tools in the District Nursing Service has increased the risk that patients may not be assessed or treated effectively.

District Nurses on the Isle of Wight do not have sufficiently robust systems or IT support to properly support key areas of clinical practice. Some basic systems such as message taking, recording and processes that support allocation decisions are also not working consistently, which generates considerable risks for the patient and the system.

I**ssues for the Board and member agencies to consider:**

- Does the Board feel it would be useful for an audit of how key basic systems are working in different teams to be undertaken?
- Does the Board feel that the current IT arrangements and systems operated by the NHS Trust need to be reviewed?
- Are there any options available to improve IT connectivity to ensure consistence access to District Nursing teams across the island?

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2.5 Finding 2

Finding 2. The lack of a joined-up multi agency approach to the management of patient's health and social care needs has led to a mismatch of expectations between agencies and staff that has affected the quality of service delivery

When agencies work in isolation there is always more scope for difficulties with communication and reduced options to provide seamless services. It is less likely that a holistic response is offered to individual service users and patients. It is easier for a mismatch of expectations to develop between services, and for agencies to take defensive positions, particularly when they are trying to gate-keep scarce funding and staff time.

2.5.1 How did this feature in this case?

In the case of Mrs X, although she was known to have a complex, chronic medical condition, there was very little discussion between the key agencies involved about the management of her care. As Mrs X's needs increased the social care practitioner had reviewed her and was beginning to make contact with the GP, however this work had not progressed far by the time of Mrs X's hospital admission and death shortly afterwards.

Another opportunity for communication across disciplines that was not taken was between the Consultant Dermatologist and the District Nursing service. The Dermatologist had regarded qualified nurses as key to the implementation of the treatment plan he set up for Mrs X, however he was unaware that Residential Homes did not employ qualified nurses. He sent a copy of the treatment plan to the Residential Care Home but he did not send a copy of the treatment plan to the District Nursing service as he was not aware they would be delivering the nursing input required.

2.5.2 The other feature of this case that highlighted a missed opportunity for communication across disciplines was the approach taken in relation to the management of pressure ulcers. The tendency had been for GPs to regard the management of pressure ulcers as being the domain of the community nurses. In this case there was no discussion between the GP and the district nursing service about Mrs X's pressure sores or medical history.

2.5.3 How do we know it is not peculiar to this case?

Although we have looked in detail at how the limitations of communication across disciplines were at work in the case of Mrs X, it is also clear that the nature of the current systems and culture of practice in place in Ryde (and more widely on the island) has yet to take full advantage of the real benefits that a more joined up approach can offer.

On the Isle of Wight it is possible for the Dermatologists to make direct referral to the District Nursing service but this does not happen in practice. Similarly copies of treatment pans are not always sent to the District Nurses. Representatives from the District Nursing service were not surprised by this and they confirmed that Dermatologists on the island

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rarely communicate directly with the District Nursing Service. Instead local practice is for the Dermatologist to feedback to the GP of the patient who instructs the District Nurse in what is required. There are two Dermatologists on the Island but the Review Team felt that they do not always work in the same way in relation to the District Nursing service.

2.5.4 The misconception that Residential Homes employ qualified nurses seems to be widely held, with health members of the Review Team agreeing that staff working in the health settings may often be working under this false premise. District Nursing representatives confirmed that a District Nurse would only refer back to a GP if the general health of someone they are visiting deteriorates. District Nurses would not refer back to GP's about a pressure ulcer as GP's do not have any specialist knowledge, which was confirmed by the GP's interviewed. District Nurses are much more likely to refer a patient on to the physiotherapy service or to the equipment supplier.

There are no regular cross-disciplinary or multi agency meetings for health and social care professionals in the Ryde area to attend at present, reducing the opportunities for the development of a more joined up approach to service delivery on the ground.

2.5.5 <u>How widespread is the pattern?</u>

The vision both nationally and locally is for the development of more integrated health and social care teams, which will provide more opportunities for health and social care practitioners to gain from multi-disciplinary case discussion and decision making across disciplines and agencies. However at this stage the development of integrated services remains patchy across the country and research on outcomes is also at a very early stage.

On the Isle of Wight, there is already a strategic imperative towards developing integrated services. The Commissioning Strategy Isle of Wight 2009 – 2012[7] has as its first key message: *Place a much greater emphasis on integrated service delivery – including with social care, between physical and mental health care, and between primary, community and acute care delivery.*

In addition, the Island Health and Wellbeing Strategy 2015 – 2017[8] cites *My Life a Full Life*, the Island's integrated health and social care programme, which "has been the catalyst for driving change across a diverse range of stakeholders, bringing key organisations together to focus on enabling people to live healthier and independently".

2.5.6 It is recognized nationally that increased integration between health and social care brings benefits to those accessing services, as well as delivering efficiency savings.[9] To increase

[7] This strategy can be found at : https://www.iwight.com/council/committees/Adult%20Social%20Care%Scrutiny20%Panel/13-5-10/PAPER%20D%20-%20Community%20Services%20Overarching%20Commissioning%20Strategy%20(2).pdf

[8] This document can be found at : https://www.iwight.com/Meetings/committees/Health%20and%20Wellbeing%20Board/12-3-15/Paper%20C.pdf

[9] The Kings Fund –*Ideas that change health care,* "health systems that employ models of chronic care management tend to be associated with lower costs, as well as better outcomes…"

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integration the Vanguard pilot programme has been developed nationally. The Isle of Wight successfully bid to be part of the pilot to integrate primary and acute care systems – joining up GP, hospital, community and mental health services, which is being rolled out in 29 areas in England. The Vanguard on the Isle of Wight commenced in April 2015 with a partnership consisting of Isle of Wight CCG, Isle of Wight NHS Trust, Isle of Wight Council and the GP collaborative One Wight Health.

The focus will be on preventing people from becoming ill in the first place, using digital technology to its fullest advantage and giving people a single point of access to all their health and social care needs. Care will be delivered closer to people's homes, led by GPs and teams made up of many different disciplines, with less care in hospital and more in local communities.

This will mean a patient with multiple long term conditions, such as diabetes, will be supported to manage their condition enabling them to live the life they want to lead. This will include monitoring their condition and working with their GP practice to ensure they receive out of hospital care and are able to remain at work. However, the Vanguard programme is made of many different innovative schemes and it is recognized that not all of the pilots will achieve a successful outcome. This work is in a very early phase of development and implementation, so it is not yet clear what positive impact it will have on the integration of services on the Island.

However the Review Team referenced some pockets of integrated practice which already exist such as the integrated hub which incorporates the Crisis Team, Social Services Help Desk, Wight Care Out of Hours and mobile responders. The Isle of Wight NHS Trust Quality report 2014 found:

"good multidisciplinary and integrated working, with GPs, community teams and social care teams, to support people at home, avoid admission to hospital, and support early discharge… The trust was working to develop three locality-based integrated teams across the Island; teams and staff had said that this had already improved communication and joint working. However, community teams were under-resourced and there was ineffective caseload management and supervision…."[10]

2.5.7 <u>What are the implications for the reliability of the multi agency safeguarding system?</u>

The impact on services of the current position where there are few examples of joined up planning and delivery of services is that individual organisations are likely to be working with a narrow or limited view of the health and social care needs of the individual. This may lead to either a shortfall in meeting the needs of the individual, a lack of timeliness in delivery or duplication of services at some points, as individual organisations seek to meet the individual's needs in a piecemeal way. The Kings Fund – *Ideas that change health care,* cites the following evidence:

[10] The Isle of Wight NHS Trust Quality report 2014

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"Highly integrated primary care systems that emphasise continuity and co-ordination of care are associated with better patient experience[11]"

2.5.8 A lack of integration of health and social care services potentially leads to misunderstandings between professionals involved in delivering care to the individual as professionals may make assumptions about the what, when and how of services delivered by other agencies. This can result in the individual not having their needs met, and ultimately to a deterioration of the individual's general condition and avoidable hospital admission.

"Integration needs to provide preventive approaches. Social care can be important in supporting someone to recover, or helping someone whose needs have recently increased, to prevent a crisis and hospital treatment. High eligibility criteria for accessing social care can mean this support is only provided at crisis periods. Preventable hospital admissions, which disrupt lives, may be worse for people's health than the initial crisis itself.[12]"

2.5.9 If staff do not have all the necessary information about the needs and circumstances of the individual it becomes more difficult to prioritise effectively when resources are in limited supply.

Finding 2. The lack of a joined-up multi agency approach to the management of patient's health and social care needs has led to a mismatch of expectations between agencies and staff that has affected the quality of service delivery

Health and social care provision on the island is making steps towards developing some more integrated services but these developments remain at an early stage. Where services work in isolation, misunderstandings about what other agencies provide can easily lead to a negative outcome for service users.

Issues for the Board and member agencies to consider:

- What actions can the SAB take to support the development of integrated services?
- What scoping of the existing communication barriers and misunderstandings between agencies might be useful to move forward the wider work of reducing the negative impacts of agencies/organisations silo working?
- What processes could be reviewed to resolve requests for funding reviews in a more timely way?

[11] Starfield1998; Bodenheimer 2008

[12] National Voices - Integrated care: what do patients, service users and carers want?

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2.6 Finding 3

Finding 3. Governance arrangements for the District Nursing Service are lacking the effective quality assurance processes necessary to pick up deterioration in service delivery

2.6.1 It is essential that services incorporate adequate management oversight and support for staff, and that governance systems are in place to pick up and respond to problems with the quality of service delivery or the usual Trust and professional expectations. While management oversight and governance systems were in place, in this case those systems were not effective. Instances of excessive workload and systems that were not fit for purpose were not recognised or responded to by the senior managers who would normally have been expected to have been made aware of risks within the system on a regular basis. The Trust managers did subsequently become aware of the risks in part as a result of this case. A service review was undertaken (2013/14) resulting in changes to management structure and a new leadership team having been put in place.

2.6.2 How did this feature in this case?

The Trust implemented a locally developed workload weighting system in June 2014 which broke down interventions into clinical units of time, with one unit lasting 20 minutes. This system was designed to support clinicians and managers to allocate clinical time. However the evidence suggests that it did not alleviate the pressures for the District Nurses, which were at the time and have remained, extremely high. The nurses despite their best efforts were struggling to maintain quality in some aspects of the service they delivered. Evidence submitted by both District Nurses to the Review Team suggests that the demands of their workloads are still excessive. The Manager of the District Nursing Service (who sat on the Review Team) confirmed that the workload system is not able to function as it was intended to because of the high volume of work that the nurses are required to do.

2.6.3 Each week a RAG rating is produced to indicate what level of risk is present in terms of workload. The RAG rating has been at red or black for over a year indicating the immense and prolonged pressure that staff have ben under. In response to the issue, the Trust has found funding for 10 new nursing posts, however in practice this has not made a great difference because of the high rates of staff sickness in the Trust (and particularly within the community nursing service). Both of the District Nurses who spoke with the Review Team had used the Trust 'Listening into Action' project to highlight their concerns about the deficits in their systems and the personal and practice implications of high workloads. DN1 who visited Mrs X on 13 February 2014 had worked excessive hours that day, and subsequently highlighted the risks through the Listening in Action system. She reflected that she was slightly consoled by the response she received but that she felt that there was very little that the Trust could do to reduce the workload pressures. It is not clear what risk management response has been put in place by the Trust to respond to the implications for staff of managing this level of pressure over a substantial period of time.

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2.6.4 The two District Nurses who assessed Mrs X did not produce a formal written assessment or treatment plan for Mrs X which is counter to Trust policy and expectations. This omission was not picked up by any of the usual Trust management and governance systems that were in place, which suggests that the quality of work was not being checked. Whilst there was a clear Trust policy which required an assessment to be carried out and recorded at an initial visit, a lack of supervision and management oversight of staff failed to ensure that the policy was being adhered to. Members of the Review Team have acknowledged that understandably the chronic pressure on staff which has been a longstanding and continuing issue has resulted in some practitioner becoming more task focused rather than being able to maintain the level of person centred responses they would want to. Effective management and oversight of workload and adequate opportunities for staff to undertake reflection on their practice are critical requirements that do not appear to have been working in this team.

2.6.5 Feedback within the Review Team confirms that clinical supervision arrangements were not in place. An inspection by CQC in 2014 had also commented on this, which resulted in the Trust implementing changes to improve the supervision arrangements. However the District Nurse Manager on the Review Team confirmed that while it was assumed that the new supervision arrangements were now in place across the island, and there is a daily handover session which provides a level of peer support, her records indicate that there is not a consistent picture of implementation. Several teams including the Ryde Team do not have the new supervision arrangements in place, possibly because staff do not have protected time for supervision.

2.6.6 <u>How do we know it is not peculiar to this case?</u>

Although the particular issues of the community nursing service workload have been highlighted by the case of Mrs X, it is clear that the issues impacted on the Ryde nursing office and so affect a large number of nurses and other patients. More broadly, feedback submitted to the Review Team suggests that excessive workload pressures are a risk that affects many nursing teams across the island and that this is also a national pressure. District Nursing teams across the Isle of Wight were struggling with an increase in their workloads from 10 cases per day in 2003 to an average of 17 visits per day at the time of writing this report. The teams are seeing increases to 20/22 visits when there are staff shortages, and on occasion nurses have seen up to 27 people on one day.

The changing demographics nationally and locally are impacting, with higher proportions of older people and the increased tendency for people to live longer with more complex health conditions[13]. The Isle of Wight has the additional pressure of a shortage of Nursing Home placements. When older people are placed in Residential Homes, any nursing needs that they develop are responded to by the District Nurses, which is likely to have increased pressures on community nursing services.

[13] Please refer to demographic evidence in Finding 2 (Community Services Commissioning Strategy, 2009 – 11)

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2.6.7 There were a number of other key systems in place in the Ryde office (detailed in Finding 1) which were not functioning well. It is a significant concern that the level of management supervision that was operating in the Ryde office failed to recognise the potential risks that these ineffective systems generated for staff and patients.

2.6.8 How widespread is the pattern?

Workload management systems should provide work requirements that are realistic and manageable both for the staff members and the service users and patients who are on the receiving end of the delivery of those units of clinical time. The Trust had in place a 'Listening In to Action' scheme whereby all staff were able to raise concerns confidentially with senior management, which is positive, however the Review Team did not find any evidence that the Trust senior management acted on the concerns that were raised regarding high caseloads in the team.

High workloads are a national issue[14]. Nurses spend most their working day carrying out direct patient care, but this means that the computer work required to input their day's recording is often sacrificed, as they find it hard to prioritise this over visiting patients. Inadequate recording can also lead to managers failing to identify real workloads, and developing a false impression of what the nurses are actually doing and capable of achieving. National research by the Royal College of Nursing has found that, on average, District Nurses saw nine patients on a typical shift and that 25% of nurses in their survey reported that they saw as many as 12 or more patients on a shift.[15] However these figures are noticeably lower than the typical figures that nurses on the Isle of Wight have reported to the Review Team.

2.6.9 What are the implications for reliability of the multi-agency safeguarding system?

Where clinical supervision arrangements do not support staff effectively, there is a risk that the quality of service delivery will be affected and staff wellbeing, health and retention may also be impacted adversely. It is essential that systems are put in place to monitor workloads, and in addition that analysis of workloads takes place by managers to develop an accurate picture of whether the service is able to respond safely to local demands and whether the quality of the service given to the patient is acceptable.

The Review Team felt that there are risks attached to the system of workload management which has a primary focus only on available clinical time, which does not also allow sufficient time for administrative tasks such as recording. It does not encourage safe systems of recording which in turn can expose the service user and the service to risk.

Following the second Inquiry into the Mid Staffordshire NHS Foundation Trust (March 2013), there has been an increased focus on quality and patient safety not just activity. The

[14] 'The Queens Nursing Institute - 2020 five years on - reassessing the future of district nursing'

[15] Survey of district and community nurses in 2013 Report to the Royal College of Nursing June 2014, Jane Ball & Julia Philippou NNRU, King's College London, Geoff Pike & Jacqueline Sethi Employment Research Limited

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Government's response 'Patients First and Foremost' (March 2013) and the response from the nursing profession 'Compassion in Practice'[16] both highlighted amongst other things the need for strong leadership, consideration of staffing levels, support for staff and a focus on the quality of outcomes for patients.

Finding 3. Governance arrangements for the District Nursing Service are lacking the effective quality assurance processes necessary to pick up deterioration in service delivery

The effective management of high workloads within the District Nursing Service is crucial to ensure that the service user received a good quality of care. The governance arrangements that were present at the time of this case were inadequate. Subsequent changes to the management stricture and processes have gone some way to addressing these issues but do not appear to have yet achieved the outcomes they seek, due in large part of the excessive workloads that staff at all levels are carrying.

Issues for the Board and member agencies to consider:

- Would it be useful for some further comparison work to be undertaken to explore how the workloads of community nurses on the Island differ from national comparators?
- How much of a concern is it that following the recent re-structure and review of governance systems in the District Nursing Service, it appears that community nurses are still not all receiving regular clinical supervision?
- Is some further work indicated to understand the extent of and the risks attached to workforce sickness rates within the Community Nursing Services?

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[16] ('Compassion in Practice') DOH & NHS Commissioning Board Dec 2012

2.7 Finding 4

Finding 2. Commissioners and providers of care on the Isle of Wight are struggling to provide person centred responses for older people, who can be left stranded when the level of their needs rises above a certain point.

2.7.1 The geographical and demographic identity of the Isle of Wight generates some very specific challenges which complicate the general challenges that are more universally present for commissioners and providers of care. The number of residential and nursing homes beds available on the island has become an increasing issue in recent years, placing considerable pressure upon commissioners of care and local people when they are looking for a home to move into. People with higher needs are now being placed in and often are remaining in residential care (rather than moving on to scarce nursing home placements). This may be due in part to the limited number of available nursing home placements available for them to move to as their needs increase. In some cases the older person may wish to remain in a Residential Home setting with friends that they have come to know. However it is essential that as an older person's needs increase, there are effective systems in place to support commissioners and providers of care to be able to respond in a flexible and person centred way in line with the Care Act.

2.7.2 How did this feature in this case?

In this case the staffing levels at the Residential Care Home were relatively low (two people to support the needs of 20 residents during the afternoon shift). Historically this had been felt to be satisfactory by the care home manager and proprietor in terms of the safety of residents, because the level of physical need amongst the residents was relatively low. Visits from the regulator, the Care Quality Commission (CQC) and from the Local Authority commissioner of care, had not felt that the staffing levels presented an issue. However what became clear was that the staffing levels were only adequate if the physical needs of the residents remained relatively low. There was insufficient capacity to respond to an increase in needs, such as the one presented by Mrs X as her mobility became more of an issue. It also became clear that the staffing ratios in this case were not sufficient to give carers the flexibility to stop and spend sufficient time interacting with residents, which is such a vital part when providing high quality, person centred care.

Mrs X had a variety of changing needs. Initially these were principally mobility needs which developed in her last few months at the Home, but as her condition worsened Mrs X had increasing periods of full immobility when she required a hoist and wheelchair. In the final week of her time at the Home, Mrs X also developed what presented as symptoms of mental health problems. It is possible these were side effects of the methotrexate treatment she was receiving or of an infection. The message received by the Review Team from the managers and proprietor of the home was that they had asked for help from the Local Authority and the community nurses during this period but felt that the response they

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received did not really help. The managers felt they were left to struggle to meet a complex picture of needs that was beyond them. The sentiment expressed by the Registered Manager could be summed up in her statement "we really needed help and couldn't provide the care needed. We did everything we could - it was not enough. (Working) Together it would have made a difference."

Due to the mobility difficulties that Mrs X developed, she was faced with a stark choice, being advised by the social care practitioner and the home that she would need to move from her single room into a shared bedroom on the ground floor (which could accommodate the hoist) or would need to consider moving to a different care home (or nursing home). This illustrates the dilemmas that older people can face as their health deteriorates and the practical challenges for commissioners and proprietors as they try to offer meaningful choices to older people.

2.7.3 <u>How do we know it is not peculiar to this case?</u>

The issues relating to funding implications that were faced by the Care Home and by Mrs X as her needs increased are very typical of many situations faced by residents in Care Homes and older people in the community who may be awaiting their first package of care or an increase to their existing package. Local Authority funding mechanisms are not generally very responsive to fast changing needs. Typically a regular 'resource panel' exists to provide the relevant managers and budget holders to assess the applications for packages of care that are presented by the social care practitioners. The use of 'resource panels' generally creates an element of delay into the decision making process. The mechanisms used by the Local Authority on the Isle of Wight to arrange new packages or 'top up' funding can be quite demanding for providers, in terms of collating the necessary evidence. The process can take several weeks and in some cases longer than that and in the meantime the residential care home will generally have to 'soak up' the additional staffing costs. Feedback from providers indicates that the tools used are not sophisticated enough to recognise the financial implications for providers of caring for someone who may develop mental health problems such as dementia. However, Adult Social Services managers on the island said that in emergency situations, the decision to increase funding can be made in a matter of days.

2.7.4 We know that on the Isle of Wight (as in many parts of the country) there are increasing examples of cases where older people entering hospital are subsequently the subject of protracted funding related discussions about whether they can return to their home or existing placement, how quickly additional care can be agreed, funded and put in place to enable a safe discharge. On the Isle of Wight the particular shortage of Nursing Home beds is an additional factor. A recent case example shared with the Review Team outlined how pressure was applied to an older person who was admitted to hospital from a Nursing Home to move instead into a Residential Home upon discharge, despite having nursing needs.

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2.7.5 How widespread is the pattern?

The pressures on the number of placements available on the Isle of Wight is set to increase. The island faces a number of demographic challenges currently, many of which are predicted to continue as issues in the decades to come. An analysis of demographic projections shows that the Isle of Wight has a growing older population, due in part to it being a popular retirement destination for people from the English mainland. The table below shows a projected increase of almost 28% for those aged 65 to 75 years of age between 2009 and 2018. This is at the same time as a slight decrease in the percentage of working age people living on the Island, meaning a reduced pool from which to find qualified health and social care staff.

Predicted Isle of Wight population figures by age group between 2009 and 2018[17]

Age 0-19	Age 20- 64 (working age)	Age 65 – 75
1.2 % increase	2.4% decrease	25.7% increase

There is also a limited supply of other types of housing for older people on the Island. Currently there are only 10 Extra Care units on the Island, however discussions are currently underway with a private provider to increase this by a further 80 units.

One cause of the reduction in the number of Care Home on the island in recent years was due to the nature of the buildings which were being utilised as residential and nursing homes tending to be large, older domestic dwellings which had been adapted to serve as care homes. As subsequent national regulations were introduced in regard to room sizes, some homes were deemed to no longer be fit for purpose.

2.7.6 Members of the Review Team have also commented that although there is a bi monthly forum that brings together providers and commissioners, there is a lack of trust between providers of care homes and local authority commissioning services, and that negotiations about funding levels for 2015/16 are currently stalled.

Nationally and locally there are particular conflicts inherent in the commissioning of health and social care from two separate budgets, which can lead to protracted negotiations about funding between health and social care budget holders. It is these kind of situations that can leave the older person 'stranded' as their needs increase and the provider of care often find themselves 'stuck' in the middle of a painful wrangle between funding authorities. Financial pressures on social care budgets are also impacted by the fact that the Isle of Wight faces the additional challenge of ranking within the most deprived 20% of districts, for four of the six scores of deprivation in the South East. Deprivation is scattered, with areas of deprivation in all of the Island's towns and a gap of nine years between best and worst life expectancy across electoral wards. This results in an additional pressure on services for older people on the Island as they are more likely to present with multiple health and social care needs in their final years of life, coupled with an inability to pay for their care. In contrast, the New Forest in Hampshire, which also has a larger older population does not face the same

[17] Community Services Commissioning Strategy, 2009 – 2012 NHS Isle of Wight, page 7

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situation in terms of levels of deprivation, meaning that many of the older people in the New Forest will be self-funders when they enter the care system.

2.7.7 What are the implications for reliability of the multi-agency safeguarding system?

The providers of residential and nursing home care on the Isle of Wight are finding the pressure of providing good quality services more difficult to achieve due to the general lack of investment available. The key to the provision of good quality and most importantly, safe care is investment by providers in appropriate staffing levels with commitment to training and education, supported by quality assurance systems that are robust and constantly under review. Recent inspections of homes by CQC on the Island have demonstrated that even homes traditionally considered to be good or excellent are found wanting in certain aspects of their services. The continued availability and expansion of services will depend on future investment and an honest approach to defining the market on the Island.

2.7.8 An integrated partnership approach, based upon locality working, trust and understanding of what providers can realistically be expected to provide in terms of quality and level and expertise of service, is vital to ensure that providers can develop services that are safe for everyone who uses them. An effective working relationship and levels of trust between commissioners and providers is key to the provision of safe services, but recent high profile safeguarding issues within residential care homes on the island have put this relationship under increased strain.

Finding 4. Commissioners and providers of care on the Isle of Wight are struggling to provide person centred responses for older people, who can be left stranded when the level of their needs rises above a certain point.

There are additional pressures and challenges for the commissioners and providers of care on the island, over and above the national issues and the current economic climate.

I**ssues for the Board and member agencies to consider:**

- What measures can be employed to mitigate the difficulty in attracting qualified and experienced staff to the island?
- Is there a role for the SAB in considering the strategic implications that these issues could have on the safety of older people?
- What role does the SAB have in promoting resilience amongst providers?
- What measures could be taken to facilitate requests from providers for increases to funding to be actioned more swiftly?

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2.8 Additional Learning

This section highlights any additional learning points that have arisen through or as a result of the review.

- There is a need for additional practice guidance in relation to the management of cases which are already open to safeguarding enquiries when the adult dies.
- There is a need for additional practice guidance to support communication from hospital departments and safeguarding teams with the Coroner, in cases where an adult dies and the case is open to a safeguarding enquiry.
- Members of the Review Team who are often involved in leading smaller scale case reviews within their own agencies, have already started to employ some of the principles and approaches that they learnt about and used whilst they were undertaking the SAR.

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3 Appendices

3.1 Appendix 1 : Methodology and process

A 'Learning Together' review process is based on several key principles:

- Avoid hindsight bias – by seeking to understand the situation for the workers at the time, exploring their understanding of the case and the contributory factors that influenced their practice at the time.

- Provide adequate explanations – appraise and explain decisions, actions and inactions by the professionals who were working on the case. A systems approach understands performance as the result of interactions between the context of the case and what the individual brings to it. The review will gain an understanding of what happened and why.

- Move from the individual case to find learning that has a general significance – the process moves beyond understanding the specifics of the particular case to identify the 'deeper', underlying systemic issues that are influencing practice more generally.

- Produce findings and questions for the Board to consider – the process recognises the generic patterns (findings) allowing the Board to consider those issues and establish the actions they think are required to improve the local functioning of the safeguarding system.

- Analytical rigour – use of qualitative research techniques to underpin rigour and reliability.

The three main phases of the review process are:

- Reconstructing what happened – unearthing the 'view from the tunnel' from talking with the practitioners involved and understanding their 'local rationality'. to avoid hindsight bias and to learn how people saw things at the time

- Appraising their practice and explaining why it happened through the identification and analysis of Key Practice Episodes (KPE's). Team to understand the way that things happened and explore the contributory factors that were influencing the Case Group's working practice. This is known as the 'local rationality'.

- Assessing the underlying relevance and understanding what the implications are for wider practice – using the particular case as a 'window on the system' to develop generic findings.

The SCIE model uses a process of iterative learning, gathering and making sense of information about a case that is a gradual and cumulative process. Over the course of this review there have been a series of meetings. The review followed the process and meeting structures as outlined by SCIE.

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The Review Team

The SAR was carried out by a Review Team led by independent reviewer Alison Ridley supported by Karen Alexander (trainee Lead Review) and by Janet Paine (trainee Lead Reviewer). Alison Ridley is accredited to carry out SCIE 'Learning Together' reviews, and has previous experience of working as a Lead Reviewer. The Lead Reviewers did not have any direct involvement with the case prior to the review. The Lead Reviewers received supervision from SCIE during the review process to support the rigour of the analytic process and reliability of the findings.

The Review Team provide a source of high level strategic information about their own agencies as well as professional expertise in their fields. Together with the Lead Reviewers they collected data about this case, undertook interviews of the front line practitioners in the Case Group and family members, contributed to the analysis of practice and to the development of the findings from the review, and produced and agreed this report. No members of the Review Team had any direct case management responsibility in relation to the services offered at the time of the incidents that were being reviewed, although one member had met Mrs X briefly while she was in hospital. In total, the members of the Review Team met on 11 occasions, including 6 meetings which involved the Case Group members. The Review Team was made up as follows:

Name	**Designation**	**Agency/Organisation**
Linda Fishburn	Modern Matron, Medical Assessment Unit, Emergency Department.	Isle Of White NHS Trust
Debbie Morris	Service Manager	Isle of Wight Council, Community Wellbeing and Social Care
Glenn Smith	Clinical Nurse Specialist (Nutrition and Tissue Viability)	Isle of Wight NHS Trust
Maggie Bennett	Chair of Isle of Wight Residential Care Homes Association	Island Health Care Ltd.
Dr Dawn White	GP	NHS England
Sarah Johnston	Deputy Director of Nursing	Isle of Wight NHS Trust
Jennifer Edgington	Locality Lead Nurse, Community Health Directorate	Isle of Wight NHS Trust

Sources of data

Individual practitioners who were directly involved with Mrs X formed the Case Group for the review. Members of the Case Group were invited to share their experiences of working with Mrs X,

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in the context of their knowledge, systems and practice at that time. In total 11 practitioners were involved in individual face to face conversations with members of the Review Team, and one practitioner was interviewed over the telephone.

Name	Designation	Agency
Jamie Garrard	Registered Home Manager	Waxham Residential Care Home
Chantelle Salt	Deputy Home Manager	Waxham Residential Care Home
Helen Brangan	Social Worker, Safeguarding Adults Team	Isle of Wight Council, Community Wellbeing and Social Care
Lynn Turner	Team Manager, Safeguarding Adults Team	Isle of Wight Council, Community Wellbeing and Social Care
Mr Ramdany	Proprietor	Waxham Residential Care Home
Dr K Hauge	GP, Tower House Surgery	NHS
Marney Gibson	Senior Community Nurse	Isle of Wight NHS Trust
Jo Hudson	Staff Nurse, Medical Assessment Unit	Isle of Wight NHS Trust
Jane Goodyear	Social Care Practitioner, Review and Quality Assurance	Isle of Wight Council, Adults Department
Dr O Aziz	Consultant Dermatologist, St Marys Hospital	Isle of Wight NHS Trust
Dr R Hudson	GP, Tower House Surgery	NHS
Geraldine Wisson	District Nurse	Isle of Wight NHS Trust

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Data from Documentation

In the course of the review the Review Team members had access to key documentation including:

- The chronology submitted by the Isle of Wight Council Social Care Directorate
- The chronology submitted by Waxham House Residential Home
- The chronology submitted by St Mary's Hospital, Isle of Wight NHS Trust
- A small number of notes provided by the District Nursing Team
- The treatment plan sent by the Consultant Dermatologist
- The IoW Council safeguarding team referral notes from the alert raised on 8/4/14
- The Regulation 28 report issued by the Coroner on 12/9/14
- The minutes of the safeguarding strategy meeting held on 9/12/14
- The minutes of the safeguarding meeting held 15/1/15
- The safeguarding team's chronology in relation to the pressure ulcer
- The safeguarding team's notes of a meeting with the Manager of the Residential Care Home

- The referral from the IoW Council safeguarding team to the SAB requesting a Safeguarding Adults Review is considered.

Limitations in relation to data

During the review the following limitations on access to data were identified:

- The two support workers who had been on duty at the Residential Care Home on 30th March 2014 had both left and so were not available to be interviewed. Fortunately it was possible to interview the two managers who were also present later that afternoon and to examine the records written on the day. Son A who was also present that afternoon with his wife was also interviewed.

- The two paramedics who had attended the Care Home on the 30th March were also unavailable to be interviewed as they were no longer working on the Isle of Wight.

- It was noted by the Review Team that case notes recorded by the District Nurses for this period was were extremely limited. An exploration of the issues that lay behind this can be found in Findings 1 and 3.

- In relation to the membership of the Review Team, an excellent level of attendance and engagement was provided by several key branches of the health service. It was not possible to engage a senior manager from the District Nursing service until mid-way through the review process, however once she joined the team she was fully engaged in the process, and provided valuable insights.

Data from family members

Two separate meetings were undertaken by two members of the Review Team; involving two of Mrs X's sons, other relatives and family friends. It was very helpful to gain that level of direct involvement from family members and friends, and to hear from them more detail about Mrs X as a person as well as their experiences and views of the care she received. We found that there were useful lessons to be learned for all agencies that have direct involvement with service users, about ensuring wherever possible an open dialogue is maintained with families even where they may hold different and even opposed opinions to the professionals. Linked to this the Review Team also gained useful feedback from family members about how important it is for families to receive more feedback generally from professionals, and how distressing it can be for families if they feel they are not kept informed of key information they are entitled to have.

Other reviews of this case undertaken

The case was reviewed by the Coroner. The inquest was held on 9 September 2014. The Local Authority safeguarding team reviewed the case in December 2014 three months after Mrs X had died. The police also reviewed their won involvement with the case.

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3.2 Appendix 2 : Deep Tissue Injury

The National Pressure Ulcer Advisory Panel (USA) – white paper 2012

- Pressure related damage to sub cutaneous tissue under intact skin, with dangerous potential to deteriorate quickly.
- Unique form of pressure ulcer – initially looks like a deep bruise but may herald subsequent development of a stage 3-4 pressure ulcer even with optimal treatment (NPAUP, 2002)
- Usual staging of pressure ulcers is designed to represent the depth of the ulcer but with DPI there is not a known depth, so extent of damage is not always known
- Initial presentation of DTI may appear as a purplish bruise (which might be identified as intact skin, a minor problem - stage 1 ulcer) or blistering (can be blood filled blister) (which may be identified as a stage 2 ulcer) but if these injuries are actually DTIs then the usual methods of treating the condition (e.g. off-loading pressure) would not work.

Paper by Cynthia Fleck (Canada) 2007 ('Wound Care, Canada Journal, Vol 5 no 2)

- Caused by direct pressure to skin and soft tissue, muscle injury (e.g. from a fall, injury to membranes), not readily apparent, as other organs fail a patient is more prone to DTI
- Diagnosis of DTI is by tissue biopsy but this is risky to do
- There is usually non-blanching of skin
- DTI tend to occur on bony prominences particularly heels and sacrum where there is less good blood supply and less muscle, and patient has stayed in one position for a long time.
- DTI bruise generally develops in to a blister or skin tear that cannot be repaired

Stekelenburg, Anke et al 2008 - "Deep tissue injury – how deep is our understanding?" Southampton University

- DTI arises in muscle layer adjacent to bony prominences because of sustained loading
- Often not visible until they reach an advanced stage, at which time treatment becomes problematic
- Complex chemical reaction caused in tissues when blood supply has been limited to for a period and when the pressure is relived - causing more damage which can be irreversible
- Practice guidance issued 2009 by the European Pressure Ulcer Advisory Panel and the National Pressure Ulcer Advisory Panel (USA)
- DTI was added to the classification of pressure ulcers after a prolonger debate – contentious issue was whether or not it was a chronic wound.

Article in 'Advances in Skin and Wound Care' – "DTI: What is it really?" Feb 2013 vol 26, issue 2

- In the metabolically unstable patient this injury may make patients more vulnerable to the chemical onslaught, despite standard precautions to prevent pressure ulcers (taken from the Braden Scale for Predicting Pressure Sore Risks - Braden, B , 'Advanced Skin and Wound Care' 2012, 25:61)
- Raises idea that DTI is more correctly understood as a 'hypoxic reperfusion ulcer'
- Categorising it as a DTI is "not specific enough and opens the door to potential unfounded litigation issues".

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