City and Hackney Safeguarding Adults Board

‘It’s all about me’

Safeguarding Adults Review (SAR) – Ms F

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1. Naming of the SAR

The subject of this Safeguarding Adults Review (SAR) was consulted about how she would be referred to. She said that she would like to be referred to as Ms F. She felt that this title would ensure anonymity for her children. She said that she will choose to disclose that she is subject of the SAR where and when she wishes it.
After the workshop the reviewer met with Ms F to update her and Ms F said “it’s all about me”. The reviewer said that it was and that maybe we should name the report that and she said “yes”. Hence this is the title of this SAR.

2. Overview of the circumstances that led to the review

Ms F is a 44 year old woman who suffers from multiple sclerosis. She is cared for in her own home on a profiling bed. She is transferred from the bed via a hoist and she is unable to sit out in a chair for long periods, due to reduced head and trunk control. She requires assistance with eating and drinking, managing continence, and all other activities of daily living. Her communication can be difficult due to dysarthria, as this affects her speech muscles.
It is reported that, on 4th September 2017, Ms F’s mattress deflated and was later found to be irreparable. It took 7 days before it was replaced. Ms F was found to have a pressure ulcer and was admitted to hospital 4 days later for treatment, where she remained for many months. There was concern when she was initially admitted to hospital that the infection had reached into her bones and that she may need an operation. However she recovered from the infection.
The manager of the London Borough of Hackney who chaired the safeguarding meeting that resulted from the concern raised by The Homerton Hospital, regarding the pressure ulcer, informed Ms F of the SAR process. Ms F felt it appropriate that her situation should be looked into, to prevent future risks of a similar kind. The manager made the referral to request a SAR.

3. Statutory Duty to conduct a Safeguarding Review

Section 44 of the Care Act 2014 states:

1. "A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if,
    a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
    b) condition 1 or 2 is met.
2. Condition 1 is met if:
    a) the adult has died, and
    b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
3. Condition 2 is met if:
    a) the adult is still alive, and
    b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

4. City and Hackney Safeguarding Adults Board (CHSAB) Decision

The SAR subgroup of the CHSAB met on 5/3/2018 and recommended the commissioning of a Safeguarding Adults Review, as the above criteria was met:

a) Ms F's mattress deflated and it took 7 days to fix the mattress; Ms F suffered significant harm in that she incurred a pressure ulcer and needed hospitalisation for some time; and
b) Agencies or professionals did not recognise or respond appropriately to the risk and harm she incurred.

The Chair of the City and Hackney Safeguarding Adults Board agreed to the CHSAB SAR subgroup recommendation on 29/3/2018.

5. Terms of Reference

The objective of this Review was to establish:

- Learning from the event to ensure robust processes would prevent such a situation occurring in the future, guided by the subject of the SAR.

The terms of reference meeting agreed that:

- The Panel would be chaired by the Independent Chair of the CHSAB;
- The Panel would be made up of representatives from London Borough of Hackney Adult Social Care, the Head of Safeguarding in Hackney, Commissioning in Hackney, the City and Hackney Clinical Commissioning Group and Homerton University Hospital NHS Foundation Trust (HUHFT);

- The agencies that would be involved in the review were agreed as Supreme Care Services, Aquaflo Ltd, London Borough of Hackney, the GP and HUHFT);
- The agreed period for review was from August 1st 2017 to 30th September 2017, the reason was in order to evaluate the care she received prior, during and after the incident; and
- The methodology to use was 'Significant Event Audit'.

6. Methodology

The methodology for the review was as follows:

- Information gathering – Each agency (see above) was asked to provide records held on Ms F for the period under review for the reviewer to consider;
- A workshop - this involved fact-finding, analysis of the event and agreeing relevant recommended changes. Ms F's advocate co-ran the workshop with the SAR reviewer;
- A Panel Meeting reviewed the draft report and made further recommendations; and
- Ms F and her advocate coproduced this report with the reviewer.

7. About Ms F

Ms F is a black woman of Nigerian descent, who was born in the UK and has lived in Hackney for all of her life. She has two children who live with her, both of whom are adults. Her son has Cerebral Palsy and severe learning disabilities. He is supported by a live in carer, funded by the Integrated Learning Disabilities Services in Hackney. Her daughter reported that she herself suffers from depression and anxiety and that she also was recently diagnosed with multiple sclerosis. She works part time and attends university. All members of the family were vulnerable in some way.

Ms F was diagnosed with multiple sclerosis over 10 year ago. She was issued with a bed and profiling mattress in 2013. She requires turning in bed/ positioning and is at risk of developing pressure ulcers.

Ms F says that she has been a spectator in her life; things have happened to her that she has had no control over and she has not been able to accomplish much, for instance, she started college and could not complete it. She started driving lessons but hasn't learnt to drive. She is positive that she can live her life.

She said she is thankful for the support she gets and is not likely to complain. She said she does not want to be any trouble.
Her daughter told the SAR reviewer that there were no expectations of her to provide care for her mother or brother however she said she has been a carer since she was 7. She oversees care arrangements for Ms F and makes representations on their behalf to professionals.

Ms F can make more immediate and short-term decisions with support. Ms F has an advocate to support her with decisions about her long term care arrangements.
She has an advocate who is supporting her through the Safeguarding Adults Review.

7.1 Views of Ms F

Ms F was fully engaged with the process. The Reviewer met with her and her advocate through the process. Her advocate was part of the panel and also co-ran the workshop.
Ms F said that a review of the event was important in order to prevent such things happening to her, or others.
She wondered whether if she had consistent carers and carers who were not busy going from call to call, the mattress would have been repaired sooner and the pressure ulcer prevented. This question was posed at the workshop.

7.2 View of Family

Ms F gave the reviewer permission to speak with her daughter about the event. She informed that her son, although aware to an extent, would not be able to contribute to the review.
Ms F's daughter said that she advocates on behalf of her brother and mother in relation to their care and health needs. She said she does not provide direct care to them. She said that she had little involvement in the incident. She said that she was busy with college. She said that she had been taught to inflate the mattress but on this occasion it did not work. She feels that the lack of relationship between Ms F and carers who did not know her and were busy going from call to call, prevented them from going beyond their immediate tasks to being concerned for her mother, to resolve the problem of the deflated mattress sooner. This concern was raised at the workshop.

8. Services Involved with Ms F

During the period being reviewed, Ms F was in receipt of care that involved one week of double up care of 4 calls per day, alternating with a live in carer the next week. Supreme Care Services provided the double up care from 4th to 8th September, and Aquaflo took over live in care provision at 10 am on 8th September and remained providing care until her admission on 14th September.

Ms F had a Care Manager who had undertaken a reassessment of care. The assessment was not dated but was submitted as a record of the period under review. The decision was that Ms F's care could be managed by 4 calls per day, and the live in carer arrangements would be phased out.
Ms F's son had a live in carer. It has been referenced in the notes that there was an arrangement for joint funding between adult social care (ASC) and the integrated learning disability services (ILDS) however there was no evidence that the son's carer was expected to, or played any part in, addressing the concerns related to Ms F at the time of the incident.
The district nursing service care plan involved weekly visits to check Ms F's pressure areas and bowel movements.

The GP was very involved due to the symptoms experienced by Ms F in relation to her diagnosis of Multiple Sclerosis. There are various contacts and discussions listed in the period of the review to manage Ms F's symptoms and treatment.

9. Chronology

Date	Description
4th Sept	Ms F's daughter states that the mattress was deflated on this day. She said that Supreme were aware of it and had notified her. She said that she had been trained to inflate it and she had been doing this regularly during the time leading up to the incident. She said that on this day she was not able to re-inflate it. She said that the notice on the side of the mattress was worn out and not legible so she was not able to identify who to contact.
5th Sept	The issue was reported by the care coordinator at Supreme Care Services to London Borough of Hackney (LBH) Adult Social Care (ASC) Long Term Team 'duty worker', copying in managers of Supreme Care Services and LBH brokerage saying that the mattress cannot be inflated. It also stated "we are not aware of who the department to contact because the sticker on the motor has very limited information and does not suggest contact details for the repair. Please liaise with the correct department to address the issue". ASC records do not indicate any action in response to this email. GP's notes indicate a conversation with the daughter on this day about a different matter but the deflated mattress is not mentioned.
6th Sept	Care coordinator from Supreme Care Services sends another email to the duty worker copying in people as above and brokerage. The emails says 'The service user is suffering from MS. The bed was deflated and because of this she felt uncomfortable all night. She also complained to the care worker that she is in a lot of pain because she was left uncomfortable in bed. She requested for this to be sorted out ASAP'. Duty worker forwards the message to the allocated social worker.
7th Sept	No actions in response to this issue. No records that the matter was being pursued. Later it is said by Aquaflo that daughter reported that someone came out to fix the mattress but said they could not do anything. It is not known who sent this person to repair the mattress or which company they came from. Supreme continue to provide care on a deflated mattress.

8th Sept	Aquaflo take over caring at 10 am. Pressure ulcer is noted. They say they make several attempts to contact the social worker and failed to get through. They contact the GP. GP notes confirm the call stating mattress is deflated and has a pressure ulcer. GP states that they will make an "urgent referral to DN to attend over the weekend" GP called Homerton District Nurses (HDN) and also completed a referral form. There is no record on HDN files that the call was made or that the referral was received.
9th Sept	The HDN said they received the referral at 9.30 on the 9th. There is no record in their notes that this was received or whether any discussion ensued regarding the referral. Aquaflo say that they contacted the HDN (notes not seen) and HDN informs Aquaflo that they are booked to visit the next day. We have been able to clarify that this was a planned visit by the HDN and not a response to the GP referral. HDN notes do not have a record of this contact between Aquaflo and themselves.
10th Sept	HDN visits, treats ulcer and states they should have been notified but they were notified by the GP referral. ulcer is unstageable. Incident Investigation instigated by HDN.
11th Sept	Safeguarding alert raised by HDN. HUHFT incident investigation process opened and closed as the pressure ulcer was cited as non Homerton related HDN visits and dresses the wound.
12th Sept	HDN visits and dresses the wound.
13th Sept	No record of HDN visits. The GP visits in response to a call from the carer that Ms F was not eating. Ms F had sore around her lips and into her mouth. GP does not check the pressure ulcer as this is being dealt with by the HDN
14th Sept	Visit by HDN who consults with Tissue Viability Nurse. They recommend admission to hospital. Ms F is admitted to hospital where the pressure ulcer is graded as 4 and concerns were raised that the infection has reached into her bones.
15th Sept	HUHFT incident investigation process opened and closed as the pressure ulcer was cited as non Homerton related.
19th Sept	Aquaflo and Homerton Hospital make a safeguarding referral regarding the incident. Safeguarding process commences.
14th-30th Sept	Ms F was firstly in Homerton Hospital for treatment, then discharged to a Homerton run Nursing Home to recuperate. Ms F commends her care during this period

10. Workshop

The Staff who were directly involved in the case, and their managers, were invited to the workshop.

Staff and managers who were involved from Supreme had left the company, however they were represented by the new manager. The duty worker from LBH was not able to attend. The GP did not attend. The District Nurse senior practitioner represented the Homerton District Nursing Service. LBH Commissioning were invited due to their role in commissioning the equipment. The LBH long-term duty manager and their senior attended, as did the care worker from Aquaflo and their manager.

The reviewer and Ms F's SAR Advocate facilitated the workshop.
The workshop was run in a way to allow the story to be told from the beginning to the end of the incident. Each agency was asked to account for what happened and to reflect on what they would do differently. At the end of the event they were asked to make recommendations for improvements and to identify any facilitators and barriers to change.

11. Findings

11.1. Equipment Management

Ms F had a regular carer from Aquaflo who knew how to use the equipment. The inflation involved a press of a button. Ms F's daughter said that she was trained to inflate the mattress but on this occasion it did not work. Supreme Care Services notified the workshop that staff would not routinely be trained to inflate the mattress.
LBH Commissioning said that the person who has been issued with the equipment and their family would be notified that the equipment was issued, and what to do to report a repair. There are no expectations to notify anyone else. In this instance, all family members were vulnerable adults. The daughter was trained to inflate the mattress, an assumption being made that she would be able to appropriately address any unexpected issues. Understanding how to inflate the mattress would not have been sufficient to address the issue, as the mattress was irreparable. Staff will have needed to know who to contact. Supreme Care Services, Ms F's daughter, and Aquaflo did not know that they should have contacted the Homerton District Nursing Service.

LBH Commissioning informed the workshop that all information pertaining to repairs and maintenance is listed on a sticker on the equipment. However, in this case the number to contact on the equipment had faded.
LBH Commissioning said that the Provider is responsible to review the equipment as per the manufacturer's guidelines. The reviewer has not been able to obtain information about what the standards for review are, when the mattress was last reviewed and the date when the next review was planned or if any issues were reported. This is due to the fact that various agencies are involved in the process from commissioning, prescribing, reviewing, and monitoring equipment and there is no coordinated process from beginning to end that is easy to negotiate.

The workshop was informed that the Homerton District Nursing Service routinely check that the equipment is working effectively but they did not notice or reference the faded label in their notes.
The reviewer's conclusion is that a range of agencies are involved in the processes of assessment for, issuing of equipment, maintenance and replacing equipment. Whereas their part in the process is clear to each individual agency, there is no readily available written pathway that makes it clear to professionals, carers or service users what they should do when they come across a problem with equipment. Although there is a maintenance schedule attached to the equipment there is no one identified as responsible for monitoring it and checking that the equipment continues to be effective during the times between maintenance schedules.

11.2 Pressure Ulcer Care

Supreme Care Services provided 4 double up calls a day to Ms F from 4th September until 10 am on the morning of 8th September. On 5th September, it can be assumed (notes are not available) that care staff notified the care coordinator at Supreme Care Services that the mattress was deflated because the care coordinator sent a message to the LBH Long Term Duty Team, to inform them of the situation. Despite not receiving a response, Supreme Care Services did nothing further that day. On 6th September, the care coordinator sent another message to LBH Long Term Duty Team. Despite not receiving a response to this, they did nothing further. They sent this second message to the same people they had contacted previously, and did not escalate it, despite a lack of response. On 7th September there was no further communication from Supreme Care Services regarding the issue. They continued to provide care on the deflated mattress.
Supreme Care Services were not able to provide an account for the sequence of events or explain why they did not recognise the urgency of addressing the issue. They informed the workshop that all the managers and staff who were involved in the case have moved on and there are no records on the office files to describe what happened.

The emails did not mention that Ms F was at risk of developing pressure ulcers.

Ms F's daughter informed the SAR Reviewer that Supreme carers notified her of the pressure ulcer but that as care was provided behind closed doors she had no idea 'how bad it was'. She said since then she has been observing care closely.

Ms F's daughter said that a carer from Supreme attempted to address the concern about the mattress and the pressure ulcer, and she had reported it to her manager in writing.

LBH Long Term Team Duty did not respond to the first email on 5th September. They forwarded the email of 6th September to the Care Manager, marked 'urgent'. They did not contact the Care Manager directly by phone, in

view of the apparent risk to Ms F of incurring pressure ulcers and also the reference in the email to the fact that she was in pain. They did not copy the Duty Manager or the Care Manager's Manager into the message.
The workshop was informed that the LBH Long Term Duty Team can receive 100 to 200 messages in a day. The standard timescale to respond to a message is 24 hours. The team will respond earlier to a message marked important or urgent. The manager does not have oversight of all messages that come through duty due to the volume of messages. The duty workers are not qualified social workers but the workshop was told that they would be expected to and would know to assess risk. The duty worker does not demonstrate a full understanding of risk because there is no record of a discussion with his manager, a phone-call to the social worker or speaking with their manager to ensure this urgent matter was dealt with.

LBH Brokerage were copied into the messages from Supreme Care. This was for information only. They would not have a role in intervening in this situation.

Aquaflo contacted the GP on 8th September. The GP records state that they were informed of the deflated mattress and the pressure ulcer. However, they did not visit Ms F. Their records refer to sending a referral to HDN to arrange a visit over the weekend and their records state that they made a call on that evening to the HDN Service.

The GP referral does not have a date on it but the HDN Services informed the workshop that the referral was received on 9th September at 9.30 am. The referral records the priority as 'high' and requires that the patient should be seen within 24 hours. It contains information about the deflated mattress and the pressure ulcer.

The content of the referral itself should have highlighted the urgency and instigated an urgent visit but the district nurse visited on 10th September, a day after the referral was received. They attended as a planned visit, on a day and time that had been arranged prior to the incident. Aquaflo stated that they called the Homerton District Nursing Service to inform them of the need to attend due to the pressure ulcer and the HDN service replied that they were due to visit the next day.

Despite attempts by Aquaflo to address this issue by escalating it to the district nurse and the GP, the matter was not resolved in a timely way. Aquaflo contacted the Care Manager who they knew to be unresponsive (as stated by Aquaflo in the workshop), when they should have contacted their senior or LBH duty. Outside working hours, they could have also contacted the LBH Out of Hours services. They also could have called the ambulance due to the amount of pain that Ms F was in (as stated by Aquaflo in the workshop), the size of the pressure ulcer and that it was bleeding.

The reviewer's conclusion is that systems dictated how Ms F's care and treatment was managed and they did not adapt to this unique event. The Supreme Care Services carer told their manager who told LBH Duty, Duty told

the allocated Care Manager, Aquaflo told the GP, the GP told the District nurse. The District Nurse came at her appointed time.

Every agency did what their arrangements required them to do. Agencies did not adapt their arrangements in response to the unplanned event. No agency escalated the concern sufficiently to achieve a resolution earlier.
No agency recognised fully the risks to Ms F of continuing to lie on a deflated mattress.

11.3.1 Relationships

Supreme Care services were asked to provide a list of carers in order to ascertain whether there was continuity of care. This information was not forthcoming. However it has been established that it would have been difficult to achieve consistency since the carers visited during alternate weeks and therefore Ms F is likely to have had different carers, who were not always known to Ms F.
The LBH Care Manager would be expected to coordinate between relevant parties and with Ms F and the records show that they had very little contact with her, and no contact during the period of the incident

The records show that the Homerton District Nursing Service, instead of weekly visits as planned, saw Ms F three times in 6 weeks since 1st August. The last visit before the incident of 4th September was on 19th August.
The carer from Aquaflo was a regular carer and responded to the concerns by contacting relevant agencies to address the problem of the deflated mattress and to alert them to the pressure ulcer. It can be said therefore that the relationship resulted in a more vigorous attempt to address the concerns. Meeting needs and addressing risks in the absence of continuity whether of care or worker, and therefore a relationship, requires a contextual background that includes who the person is, their history, their abilities, wishes, needs and risks, from which should stem a personalised care plan. Such a care plan will inform not just what care is given but also how it is given so as to manage risk.

In Ms F's case it should have been clear to all professionals involved in her case that she as a person is grateful for the support she receives and because of this she would not make a 'fuss' (as told by her to the reviewer). It should have been known that she is likely to endure pain in the belief that the workers are doing all that they can. This is evident from the pressure ulcer that she had incurred, which was big and bleeding and on which she lay for some days, having informed staff that she was in pain on 6th September (the pressure ulcer was treated and the mattress was repaired on 10th September). This is also evidenced in the GP's notes when they spoke with Ms F about an aching arm and Ms F said that she had felt the pain for a long while before approaching them. Understanding that she would not represent herself should have ensured a proactive approach to checking if she was in pain. Understanding this about her would have entailed a personalised approach to providing care to prevent and manage risk.

Ms F's daughter said that this incident "could have taken my mother's kindness away. She is kind"

11.3.2 Pain Management

The care coordinator at Supreme Care Services had informed the duty worker in her second email on 6th September that Ms F was in pain. They had identified a pressure ulcer and had handed over this information to Aquaflo. Aquaflo said the ulcer was big and bleeding. The GP was aware that Ms F had a pressure ulcer and that the mattress was deflated. The District Nurses were notified of the concerns by the GP via a phone call on the 8th and a referral that the HDN Service say that they received on 9th. The District Nurse visited the following day, 10th September.

Aquaflo supported Ms F by placing clothing and duvets under her in order to cushion her back.

For at least 4 days, Ms F was cared for on an inappropriate surface with a large and bleeding ulcer but no health professional visited and the ambulance services were not called.

It took 4 days before Ms F was admitted to hospital. During this time she was visited by the district nurses. The GP visited on 13th September in response to a call from the carer that Ms F was not eating. Ms F had sore around her lips and into her mouth. On admission on **14th September** there was concern raised at the hospital that the infection pertaining to the ulcer had reached into her bones and that Ms F might need an operation indicating the seriousness of the ulcer.

It is apparent to the reviewer, from the email sent by Supreme Care Services on 6th September, and having viewed the photos of the pressure ulcer, and from the hospital records, that Ms F would have been in much pain.

11.4 Did the lack of consistency amongst carers and their busyness to go from call to call impact on early resolution and also empathy with Ms F and her pain?

Ms F asked the reviewer to look into this issue.

The Care Package was unusual in that Ms F had double up calls from two carers at a time for one week and a live in carer the next week. The notes state that the reassessment had concluded that Ms F's care could be met fully by 4 double up care calls and that the live in carer would be phased out. The arrangement of providing care in alternate weeks is likely to have impacted on the continuity of carers from Supreme Care carers, attending to Ms F although Ms F's daughter said that one of the carers was diligent in trying the address the concerns with their manager.

The carers from Supreme Care Services identified the pressure ulcer and this suggests they were doing their job effectively, but they did not have time to pursue this beyond alerting their managers. By contrast the carer from Aquaflo was there as a live in carer and could stay on top of the problem to try to resolve it.

The carers from Supreme Care rightly highlighted the concerns to their managers and they expected their managers to deal with the issue while they went on to the next call.

Aquaflo supported by their management appropriately informed the GP and chased up the District Nurses to attend to Ms F.

It is concluded that the failure to resolve the issue sooner lies with the management of Supreme Care, rather than the carers themselves, and with the statutory agencies who were made aware of the deflated mattress and the pressure ulcer and who had a responsibility to respond.

11.5 Recording

As with many SARs before, recording is again an issue in this SAR. Supreme Care had no records of any kind to submit for the SAR. It was rated as inadequate by CQC in October 2017, after the incident with Ms F but not in response to it and London Borough of Hackney Commission have worked with them to improve and they have done so. It is accepted therefore that this issue has been resolved through the Provider Failure Process. Otherwise the failure to cooperate would have been reported to CQC.

The care providers logbook is kept at the service user's home in order to exchange information between carers. Aquaflo explained that when the log book is full, it is brought back to the office to file. It is suspected that Ms F's logbooks are lost. Aquaflo visited to retrieve theirs and did not find the book. The manager of Aquaflo who attended the workshop explained that on previous occasions the logbook was found to be missing. Therefore information on the day-to-day care during this period was not available. It is a concern that there are no duplicate notes held elsewhere, which would serve not just as a record of work done but also as protection for the carer. In this instance the logbook will have told when Supreme Care noticed reddening of her skin, when her skin broke, what carers did about it and if this information was passed on to Aquaflo.
The Homerton District Nursing Service records show that Ms F was visited 3 times between 1st August and 10th September when they were expected to complete weekly visits. There is a note that a visit of the 4th of August would take place on the 5th but there is no record that it took place. The GP records state they rang the Homerton District Nursing Service on 8th September and Aquaflo also state they did the same on 9th September. These contacts are not recorded in the notes received from the District Nursing Service as part of this review.

11.6 Incident Reporting – Homerton Hospital

Homerton staff appropriately raised two incidents under their Incident Procedures which did not meet the threshold for a Serious Incident; one after the visit of the district nurse on 10th September to treat the pressure ulcer, and the other on her admission to Homerton Hospital. In both instances the forms state that the pressure ulcer came about due to the deflated mattress and were listed as 'Non-Homerton' acquired pressure ulcers. As the District Nurses had not visited for two weeks prior to the mattress being deflated, and Supreme Care Services records were not available it cannot be definitively stated that the pressure ulcer did not start before the mattress deflated and when the District Nurse did not visit as per care plan.

Furthermore in predetermining that the acquiring of the ulcer was not the responsibility of Homerton, the Trust missed the opportunity to investigate the District Nurses' compliance with Ms F's treatment plan and their recording of care provided and communications received.
The limited investigation therefore failed to note that according to records:

- Ms F was not visited weekly;
- The District Nursing records show that Ms F was visited 3 times between 1st August when her skin was intact and 10th September when they attended to treat her pressure ulcer;
- Previous to the visit on 10th September, they had seen Ms F on 19th August; and
- The last time that they checked her sacrum was on 1st August because on the following visit Ms F refused an inspection of the sacrum and
- On the 19th, the last visit before the incident, the district nurse visited when a carer was not present to assist with handling

They were not able to ask why the District Nurses has not visited urgently, on knowing that Ms F had an ulcer and the mattress was deflated.

11.7 Information Technology – Client data systems

The workshop identified that different Information Technology systems in different agencies remain a barrier to working effectively. It was thought that if it were possible for systems to communicate with each other or to be integrated then such a situation might be avoided. The reviewer considered that, whereas there are lots of reasons why integrated IT systems are ideal, these would not have helped in this instance because staff failed to act on information that was made available to them.

11.8 Good Practice

All agencies appropriately raised a safeguarding concern in response to the pressure ulcer; The Homerton District Nursing Service after their visit on 10th September, and Homerton Hospital again on admission to hospital. Aquaflo also raised a safeguarding concern in response to the pressure ulcer.

11.9 Facilitator for change

The workshop stated plans to integrate health and social care will hopefully enable effective communication, timely interventions and multiagency working

11.10 Shared Learning

This SAR provides some messages regarding areas for improvement e.g. medical equipment (mattresses), pressure ulcers, risk assessment, personised care and pain management.

12. Conclusion

Ms F had several agencies involved in supporting her. At the time when the mattress was deflated, every agency could have done better to resolve the problem quicker and to respond to her pain.

It is all about Ms F. The services exist to support her wellbeing**.**

Ms F's comment, 'Thank you for working so hard to prove what happened' The Reviewer informed her that its purpose was to learn so as to prevent a similar situation occurring. She said, 'It must not happen again. God, no!'

Recommendations

Pressure Ulcer Care

Recommendation 1. All agencies involved in assessing, responding to or treating a person prone to pressure ulcers should provide assurance that their staff are trained to risk assess and manage pressure ulcer care in order to prevent and address pressure ulcers in a timely way, including the management of equipment

Actions

1.1 All CHSAB partner agencies and Commissioned providers providing care to a person susceptible to pressure ulcers must know how to identify and escalate concerns about the effectiveness of equipment

1.2 Contractual arrangements should include monitoring of effectiveness of pressure ulcer management by care and treatment providers

1. 3 Above Agencies (see 1.1) will evidence the learning from the SAR pertaining to pressure ulcer care and management e.g. through undertaking an audit

1.4 District Nursing Service to provide evidence of improved record keeping regarding pressure ulcer care

Equipment Management

Recommendation 2. Commissioners and providers of equipment used regarding pressure ulcer care should ensure that it is properly maintained

Actions

2.1 The equipment Provider should undertake an audit to ensure that all equipment currently in use is properly labelled, and this is routinely undertaken.

2.2 Contracts should include a process for reporting and addressing faulty equipment and the requirement to spot check to ensure that the equipment is maintained as per manufacturer's instructions.

2.3 Commissioners should ensure there is in place, an appropriate risk matrix when contracts end or providers change

Risk Management and Escalation

Recommendation 3. All agencies should provide assurance that there is management oversight of patients at high risk of developing pressure ulcers

3.1 CHSAB partner agencies and Commissioned providers provide support arrangements for staff to identify patients at high risk of developing pressure ulcers, and arrangements to escalate risks to ensure that they are managed.

3.2 London Borough of Hackney Adult Social Care Service should audit whether Pressure ulcer risks are identified, as per expectations and requirements by Duty workers.

3.3 Homerton District Nursing Service to provide an account of processes in place to manage patients at high risk of developing pressure ulcers.

Person Centered Care

Recommendation 4. Agencies should promote a personalised approach, which includes recording and acknowledging who the person is, their history, their abilities, wishes, behaviours, and approach to risk in order to understand how to support them. Further understanding of this concept is available on the'sign up for safety' website https://www.signuptosafety.org.uk/ which informs what can be done to make cultures safer through kinder behaviours amongst staff.

Action

4.1. CHSAB partner agencies should provide evidence that they have embedded a personalised approach into front line service delivery.

4.2 LBH ASC Care and Risk Management Plans are reviewed to check if they are comprehensive/holistic and include the contributions of health and other partners, carer and the person's social network to supporting the person's wellbeing.

4.3 Staff are encouraged to understand and support patients with chronic pain to ensure that their needs are being met and the pain management pathway is accessed appropriately.

Shared Learning

Recommendation 5. Learning from this Safeguarding Adults Review should be shared and impact of learning evaluated

5.1 Improvements related to better working together should be incorporated into the ‘transformation’ agenda and related changes to future health and social care arrangements

5.2 London Borough of Hackney Commissioning services to should agree how information will be kept and made available as evidence to complete a SAR, and incorporate this into contracts (e.g. consider whether are ways that duplicate records of care provided in the home can be held at offices.)