Safeguarding Adults Review

Mr A

Overview Report

Independent Author – David Byford

20TH February 2020

Chapter 1

1.0 Introduction

1.1 This Safeguarding Adult Review (SAR) for Mr A was commissioned by the Slough Safeguarding Adults Board (SAB) which, is now known as the Safeguarding Partnership (SP). Mr A was a 61yrs old, Polish speaking gentleman who lived alone. He was known for a period of time to health and community care providers and received services from a range of professionals.

1.2 Mr A had diabetes and had suffered a stroke and spinal cord injury and became a wheel chair user in 2013. He had a renal condition and was receiving dialysis three times a week at hospital. These physical conditions made him vulnerable to pressure sores and other health complications.

1.3 Mr A was taken ill at home and was admitted to hospital on the 4 November 2018, where extensive Grade 3 and 4 pressure sores were discovered. He died on the 4 December 2018 of renal failure.

1.4 His case was referred to the Slough Safeguarding Adults Review Panel (SARP) by Slough Adult Social Care (ASC) on the 17 January 2019. This was followed by a scoping exercise carried out by agencies represented on the SARP. A decision was made by the SARP on the 14 February 2019 to recommend to the SAB Independent Chair who subsequently agreed with the recommendation that Mr A's case met the criteria for conducting a SAR.

1.5. Slough Safeguarding Partnership want to learn about what improvements can be made to prevent serious pressure sores happening in the future and whether learning about improvements that can be made around partnership working to prevent such deterioration.

1.6. Executive Summary

The purpose of the Safeguarding Adult Review is not to re-investigate or to apportion blame. It is: -

To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work to support adults at risk.

To review the effectiveness of procedures.

To inform and improve local inter-agency practice.

1.7 Legislation ,Guidance and Definitions

1.8. The Care Act 2014, which defines the safeguarding duty as applying to any adult and, as in Mr A case, who: -

Has needs for care and support (whether or not the local authority is meeting any of those needs).

Is experiencing, or at risk of, abuse or neglect.

And, as a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

1.9. The Care Act 2014 is significant legislation for Adults. There were changes made to the legislation in April 2015 that includes responsibilities for promoting wellbeing, a focus on prevention, personal budgets, eligibility criteria and support for carers.

1.10. As it applies to Mr A, "SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult" (Care Act Guidance: 2014)

1.11. Voice of Mr A

1.12. The voice of Mr A is referred to within this review in Chapter 4.

1.13. Family involvement

1.14 There has been no involvement with Mr A's family directly by the SAR, but the voice of Mr A's son has been captured and is subject to a finding and recommendation in this review.

1.15. Mr A's first language was Polish and he had limited English. He found it difficult to communicate with practitioners. Efforts were made to communicate with him in Polish, but this was not consistent. This aspect has been addressed in this review. There are no other suggested diversity or culture issue identified.

1.16. Abstract of Findings

1.17. This SAR has identified the following findings which is also discussed within Chapter 3, the Analysis of Mr A's interaction with professionals (See Findings and SAR Overview Report in Chapters 4) as follows:

Finding 1. Recognising health concerns, neglect and assessing risk.
Finding 2. Quality of Recordkeeping, Communication and Sharing Information.
Finding 3. Capturing the Voice of Mr A.

1.18. Adult Safeguarding Principles – Sharing Information

1.19. There are six adult safeguarding principles practitioners need to take into account when dealing with a safeguarding adult case which are: -

- Empowerment - People being supported and encouraged to make their own decisions and informed consent.
- Prevention - It is better to take action before harm occurs.
- Proportionality - The least intrusive response appropriate to the risk presented.
- Protection - Support and representation for those in greatest need.
- Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability - Accountability and transparency in safeguarding practice.

Comment: There is evidence the six principles above were being applied by professionals but there was necessary learning identified and this is addressed within this SAR.

Chapter 2 - Initiation of the Safeguarding Adults Review

2 Terms of Reference (Summarised)

2.1. The SARP are concerned to establish if there are lesson to be learned about appropriate information sharing and agreed the review should explore whether any gaps may have contributed to or accelerated a deterioration in Mr A's condition. The group also agreed on the need to establish if the clinical implications of his diabetes, and renal problems were understood by all those working with him, in terms of the impact these conditions might have on his skin care and tissue viability. The group agreed that any areas of good practice should also be included in lesson learned.

2.2. Scoping Period.

The review focused on learning as described above. Individual agencies also learned about their own performance when carrying out their contributions to this process and have accounted to SARP members on their individual organisational learning. The focus is on learning about whether such situations can be prevented in future by improvements in partnership working. Collective impact on the life of Mr A is therefore a strong feature of this review. Each agency is accountable for its own performance and will address any performance issues in house. This review does not aim to identify deficits in individual performance, nor is it about blame. It is about collective responsibility to continually strive to work together on how we can improve.

2.3. Timespan.

The review timespan is from the 12 February 2018, when, upon admission to Wexham Park Hospital (WPH) the ambulance service noted that he had pressures sores and the review ends on the 18th December 2018.

2.4. Aim.

The SARP aim is to establish learning and deliver impact from the learning as rigorously and swiftly as possible.

2.5. Objectives.

At the end of the process the final report will have answered the following questions raised by the SARP on behalf of the SAB and putting Mr A at the centre of learning.

2.6. Key Lines of Enquiry (KLOE) –

The KLOE identified by the SARP for agencies to consider: -

Did Mr A have a multi-agency care plan?

What are the strengths and areas for development in how Mr A's care was set up and delivered?

Were all staff trained in tissue viability, and the implications of his diabetes and renal failure on his skin care?

Were Mr A's views established, clearly understood and acted upon?

Were there examples of good practice?

Can such situations be prevented in future by improving in partnership working?

How can this be achieved?

2.7. **Phase 1** involved agencies reviewing their contribution to Mr A's care and providing individual management reports to the SARP addressing the following questions;.

Were staff in your agency who provided a service to Mr A trained to understand the implications of diabetes and renal failure on his skin care?

Where your services communicating with other services being provided to Mr A, (if not, why not?)

Did professionals in your agency who provided services to Mr A establish Mr A's views and where those views recorded, understood and acted upon?

Where there examples of good practice seen in your agency?

How can your agency improve how it works with partner agencies?

2.8. **Phase 2**

A multi-agency analysis event was held in August 2019 and involved those agencies who provided reports and practitioners analysing the information provided with reference to the Key Lines of Enquiry.

2.9. **Phase 3** – Drafting of SAR

2.10 The SARP originally planned tat the Safeguarding Partnership Manager would draft the overview report. However, this was not possible and an independent reviewer was commissioned to do this. The Safeguarding partnership Independent Chair provided oversight to the process throughout.

2.11 Governance and Scrutiny and transparency. The report will be provided to the SARP for sign off and onwards to the SLG for final approval. It will published on the SAB website, remaining on the website for one year.

2.13. Phase four: Implementing the learning

2.14. Each agency is accountable for delivering the learning they have established as a result of their individual contributions to this review and will create action plans to reflect this. Following final sign off, these action plans will be shared with the SAB Quality Assurance (QA) sub-group who will monitor implementation for one year. Multi-agency recommendations will be similarly shared with the QA sub-group and monitored. The QA sub-group will provide updates to SARP at agreed intervals. Both groups will include this in their forward plans and appropriate learning will be incorporated into the safeguarding partnership strategic plan (replacing the business plan).

2.15. Independent SAR Author

2.16. Mr David Byford was commissioned as the Lead Reviewer for the SAR. He has no previous involvement in the case or with any person or agency concerned within the SAR process for Mr A.

2.17. Methodology

This Safeguarding Adults Review used a proportionate methodology and individual analysis by each involved agency with the involvement of a multi-agency practitioner's analysis event to encourage reflection and learning.

Chapter 3 – Analysis of Mr A's interaction with professionals.

3 Background

3.1 Outside the scoping period of this review (as recorded in the full SAB methodology), in May 2016, Mr A was noted to have a "Renal Injury." There has been no clarification submitted to this SAR to suggest it was as a result of abuse or physical violence as a possible cause.

3.2. Mr A was a pleasant person who was in poor health and he was wheelchair bound. He was married, but the relationship broke down during the scoping period of this review. He was living alone and required assistance with care. Mr A's medical condition was recorded as: 'Chronic Kidney Disease.' He had been diagnosed with Diabetes Type 1 since 2006. He was insulin dependent and self-administered this. He also had high blood pressure which medication controlled. He received dialysis in hospital three times a week with carers attending his home twice a week to help with his personal care.

3.3. A Strength Based Conversation Tool assessment was completed with Mr A by an ASC Social Worker (SW) on 12 December 2017. This followed safeguarding concerns being raisedduring August and November 2017 around his relationship breakdown and housing situation. The assessment identified that Mr A did not meet the eligibility criteria for support from Social Services at that time. Following an Occupational Therapy (OT) assessment, he was found to be independent with all transfers (except for transfers up and down the stairs to his first floor maisonette), personal care tasks, preparation of meals and safety around the house; but it was noted he was inappropriately housed and was unable to leave the property without the assistance of another person. Social work support provided assistance with his housing issues and he was approved for priority rehousing.

3.4. An ASC closure summary was completed in January 2018 identifying that a joint assessment with OT had occurred, liaison with Legal Aid and Housing Teams had taken place and Mr A had been assessed to be eligible for Band A Housing and prioritised on his housing need. It was concluded that no further action was required by the Social Work Team at that time.

3.5. In August 2018. Mr A agreed to move to new accessible accommodation but was also on the waiting list for Extra Care Housing at the point active SW intervention ceased. His next contact with ASC was when he had been rehoused to accessible accommodation. It is not known why he chose to accept this accommodation rather than an Extra Care flat.

3.6. The new home had difficulties for him but, with the provision of additional equipment, this would ease transfers and decrease the risk of a fall. As a result, a referral was made to the Reablement Service and an OT was allocated as Mr A reported he needed support with showering. He had a level access shower in situ but required equipment to enable him to use the shower independently and required adaption for his use. An assessment by a Reablement OTA (Assistant) was completed in September 2018 and actions identified including OTA plans to order equipment: a drop-down Devon grab rail; and also deliver and fit a bed lever. Risks are recorded in

the plan including a risk of self-neglect and breakdown in skin integrity, with any signs of redness to be reported.

3.7. Domiciliary care support with showering was provided through RRR twice a week, which commenced on 10 September 2018. It was initially recommended by an OTA to assist with three strip-washes for his personal care but two were carried out each week.. ASC inform this review that Mr A requested OT's to carry out two visits.

Comment: A drop down seat is classed as a minor adaptation which a Rehabilitation OTA can complete. However, the OTA allocated to Mr A was new in post so had not yet had the necessary experience to measure up for and order this equipment. The Long-Term team were asked to do this for Mr A. (This should be an agency recommendation for the Rehabilitation Service for future cases).

3.8. His carers were provided from Forever Care who assisted him to shower although he insisted on not removing his underpants. No observation was made or reported by the carers that Mr A had pressure sores, a significant risk due to his health needs. Mr A was admitted to hospital before a further and expected OT review took place.

3.9. There is a need to identify and apply professional curiosity and to have the information available and knowledge where, any concern could then be reported to appropriate health practitioners to assess his skin condition and refer to tissue viability services if necessary. The carers were not trained but OT's from the Reablement Service were aware he may have the risk of pressure sores due to his condition, but their care plan was not widely known or communicated to those providing care to him.

3.10. Mr A attended hospital for his dialysis three times a week. It was the opinion from the practitioner's event that at the time of his final hospitalisation in November 2018, he may have had pressure sores in September 2018 which may not have been identified. It was later identified he had Grade 3/4 pressure sores at a dialysis appointment shortly before he was hospitalised for the final time. (See Para 3.15 below).

3.11. Mr A did manage to communicate with his health and care providers, but this was not sufficient as English was his second language and most practitioners did not speak his Polish language. Agencies said he could communicate, and every effort was made to communicate with him by using Polish speaking professionals when available, but this was not consistent. Mr A himself relayed later whilst in hospital he found it difficult to communicate with his carers. This aspect is a finding and subject to a SAR OV Report Recommendation.

3.12. Throughout the period of the review, there was communication and care provided by ASC, health and care providers and his GP Practice. SCAS attended his home in February 2018 having received a call as Mr A was suffering with breathing difficulties. The crew completed observations and noted pressure sores to his bottom and buttock area. He was then admitted to WPH for treatment. This information was not further explored according to records. He was treated for pneumonia and reviewed by the psychiatric team as he reported and was assessed to be in a low mood. There

was good clinical evidence displayed with an understanding of Mr A clinical presentation and risks and the correct pathway followed by the hospital and SCAS.

3.13. Mr A was reviewed by the psychiatric team. He reported that he had experienced depression four years ago when he fell physically ill and felt unsupported by his wife. His G.P prescribed medication (Citalopram) and he took it for two years and felt better. He said he was happy to take it again. He denied suicidal ideation and was prescribed, as he wished to continue, with Citalopram. He was discharged home with a care package. and appropriate referral for management of pressure ulcers to prevent worsening and the dietician was appropriately informed, as nutritional status can cause exacerbation of the condition.

3.14. Events which led to Mr A's hospitalisation

3.15. On the 1 November 2018, the Windsor Dialysis Unit appropriately raised concerns regarding Grade 3 and 4 pressure sores and a urine infection he had. Anti-biotics were prescribed, and a review appointment was booked the next day with a referral to the District Nurses (DN) also made. This was only a few days from when he was admitted to the hospital on the 4 November 2018.

Comment: The pressure sores were identified, and action taken. The suggestion they could have been present from September as stated in the practitioner's event cannot be confirmed by this review but, his condition was sufficiently serious for staff within the Dialysis Unit to recognise the risk and to take necessary action.

3.16. The following day, a female who reported she was Mr A's daughter (ASC confirm he did not have a daughter, this was a close friend who could communicate in English better than Mr A) informed the GP that the DN's had visited the day before and told her to request a home visit from the GP as Mr A was very chesty.

3.17. A home visit to Mr A was carried out by the Paramedic the same day (who works at the GP Practice and does home visits to patients). Mr A did not answer the buzzer to the external door. The Paramedic rang Mr A's mobile and spoke to him. He refused to let the Paramedic in and requested her to come back the next day. The following day was a Saturday and home visits are not carried out at weekends so the Paramedic told Mr A she would come back on Monday 5 November 2018. The Paramedic double checked he understood due to his limited English and Mr A said that he did, understand. The Paramedic then advised Mr A to call 111 or 999 over the weekend if he needed to.

3.18. The Paramedic then telephoned Mr A's female friend informant (subsequently the GP was advised by ASC she was not his daughter) to inform her that Mr A had refused to see them and that he had been given advice of where to seek help over the weekend before the planned visit on Monday 5 November 2018 was carried out.

3.19. Hospital Admission and outcome

3.20. In the interim, on the 4 November 2018 at 4.24am, SCAS received a call from Mr A. A Polish translator was used to gain information from him over the telephone. Mr A had fallen from his bed onto the floor. The patient was getting frustrated due to the language barrier and upset regarding questions asked on the call. There was a

problem with the crew being able to find the address given and SCAS were unable to contact the patient as he was not answering his phone. Due to high demand in the area and problems finding the address the crew arrived at 7.24am. On arrival SCAS completed observations and helped the patient into his wheelchair. Mr A was reluctant to go to hospital. The ambulance crew completed a 'fall referral' as they stated this was the second fall the patient had that week. They recorded on the patient clinical record, 'patient – sepsis' and he was taken to hospital for inpatient treatment.

3.21. The Hospital Discharge Coordinator records Mr A was not medically fit, the Hospital OT was to assess him while he was being treated for his Grade 4 pressure sores allegedly acquired in the community. He was given debridement of the wound and was placed on a strict 2 hourly turning regime to aid healing of his pressure sores. The Ward raised a safeguarding alert relating to the pressures sores which instigated action for this SAR to be commissioned.

3.22. Despite dedicated care provided and treatment by the Tissue Viability Nurses (TVN) and Team for his pressure sores, Mr A's health deteriorated, and he was placed on palliative care. He was aware of the seriousness of his condition and knew as he informed medical staff, he was going to die which, medical staff confirmed he was (as detailed in the FHFT submission to the review). Communication was made with his son who was in Poland. His son had been to see his father following his initial admission to hospital but had to return to his job in Poland. He unfortunately arrived in the UK after Mr A had died on the 4 December 2018, where Mr A's final hours were comfortable and pain free under the palliative care team.

3.23. The death certificate for the Coroner records the cause of death as - End of stage of renal failure, Diabetic nephropathy and Complex soft tissue infection.

3.24. His son declined a post-mortem and Mr A's body was repatriated back to Poland.

Chapter 4 – Analysis of the Findings and suggested SAR Recommendations for the consideration of SSAB

4.0 This chapter outlines the findings identified from the analysis of professional practice and agency submissions to the process. They are produced for consideration by the Slough Safeguarding Adults Board to reflect and implement any learning from this SAR. The findings contain suggested SAR Overview Report Recommendations that overarch, encompass and support Individual Agency Recommendations which have come from the analysis of the chronologies, reports and from the multi-agency practitioner analysis learning event. The Findings and SAR Overview Report Recommendations are as follows: -

4.1. Finding 1 - Recognising health concerns, neglect and assessing risk.

4.2. What are the issues?

There is a clear consensus by professionals of the need to be able to understand and recognise in Mr A' s complex health needs, neglect and possible self-neglect issues. Mr A was a diabetic with renal failure and after his stroke in 2013 was wheelchair bound. He was receiving dialysis three times a week at hospital and care practitioners assisting him in the home did not identify any risk or neglect, nor did they appear to have the capacity to consider the issues affecting his health.. A care plan was set up by a qualified Occupational Therapist (OT) and an OTA involved with him spoke his native Polish language. Mr A was admitted to hospital in November 2018 with Grade 3/4 pressure sores (ulcers) to his buttock area. Unfortunately, his condition worsened, and he died due to his serious health complications relating to his pressure sores and renal failure.

4.3. Assessment of Risk.

A Strength Based Conversation Tool assessment was completed with Mr A by ASC South Locality SW on the 12 December 2017. This followed safeguarding concerns being raised in August and November 2017 around Mr A's relationship breakdown and housing situation. The assessment identified Mr A did not meet the eligibility criteria for support from Social Services at that time. A later OT assessment, outlined in Para 3.7, found he was independent with all transfers (except for transfers up and down the stairs to his first floor maisonette), personal care tasks, preparation of meals and safety around the house; but it was noted he was inappropriately housed and was unable to leave the property without the assistance of another person. The housing issue was addressed with Mr A's agreement. The new home had a level access shower so was believed suitable. Mr A said he had thought he would be able to manage independently when he first moved in, but then contacted ASC saying he needed some help to manage facilities which needed to be adapted. Obtaining an additional shower seat required was delayed, as referred to in the narrative in Chapter 3. It was not installed prior to his admission to hospital in November 2018.

The OTA noted the risk of skin breakdown on the Reablement Plan which suggests an awareness of the risk factors associated with his medical conditions and practitioners believe that it was highly likely he would have had noticeable pressure

areas in September 2018 but this cannot be confirmed and is discussed further in the Conclusions in Chapter 5. It would not have been the OTA's role to physically check his skin and they say he did not mention any issues himself despite being able to communicate in Polish with this worker. He was able; it is suggested to fully express his views and wishes. Capturing his voice is a finding also in this SAR (see below) where it is suggested more specific questioning around his diabetes may potentially have revealed some indication of problems.

4.4. What should be considered? Practitioners caring for a patient in the community should be supplied with key information, be conversant with any Multi-Agency Care Plan and be given the necessary training and capacity to recognise such concerns. Risks are recorded in the plan: risk of self-neglect and risk of breakdown in skin integrity with a notification for Reablement to report any signs of redness.

Mr A moved into a new flat where there was a need to adapt his shower to meet his care needs and this was delayed. Carers assisting him to bathe disclosed he insisted on keeping his underwear on. This is perfectly his right and decision but, considering his health concerns, applying professional curiosity to question the reasons why and whether there was a need to share the concerns with relevant health professionals, who could follow up with further assessment and treatment would have been the right approach. The 'Slough Multi Agency Risk Framework and Tool" was launched in 2019 for those at risk who do not access services.' This should be utilised to ensure practitioners are given the necessary support in understanding all aspects of neglect in carrying out their roles and duties and assessing potential risk. Slough piloted a 2-hour training session in December and have now advertised a further 8 sessions for all multi-agency partners to attend with sessions to be continued if necessary. Furthermore, a practitioner's handover sheet of current information for the client kept within the home as suggested in the practitioner's event should be developed as information on stand-alone personal equipment is not cross transferable between organisations. It would be another level of safeguarding in place.

The Reablement OT was allocated to review the externally provided care, but this was not prioritised for a review visit due to the pressure of other work. There is no evidence the Reablement Service sought feedback from Forever Care who were providing care to Mr A, or from Mr A himself, in order to determine how the care was progressing. This would have helped the level of priority for review to be determined based on factual information rather than assumption and must be promptly completed in future circumstances. Care Plans need to be joined up with effective communication and information sharing between practitioners. There were opportunities for supervision oversight to review his care that was not taken.

There is no specific training for Social Workers on conditions on skin integrity. More experienced staff would usually pick this up over time through their day to day work with service users, who may be affected by the condition and through supervision. An Adult Risk Strategy tool is currently being developed across Berkshire (Policy) and the local authorities (Procedure). It is suggested to address this finding the following action for learning should be carried out: -

4.5. Slough Safeguarding Adults Board Overview Report Recommendation (1) for All Safeguarding Health providers

It is recommended that all Safeguarding Agency Partners and relevant voluntary organisations within the Local Authority area concerned in the safeguarding adults review assure Slough Safeguarding Partnership that Agency and Organisation will ensure all staff concerned in providing care and support within the community, display professional curiosity and are: -

- Trained in the knowledge and understanding of recognising signs and symptoms of neglect including self-neglect which may impact on a patient's health.
- Able to conduct effective and prompt risk assessments and to reassess a risk if circumstances significantly change with supervision oversight sought for guidance if necessary.
- Supplied with health information and details of an agreed care plan where there is a likely risk posed to a patient's health and welfare.

- There is a review conducted on the best process required to ensure practitioners have a handover sheet of current and relevant information to be made available to all professionals and care providers outlining any potential risks, kept in the client's home for ease of access.

4.6. Slough Safeguarding Adults Board Overview Report Recommendation (2) for Slough Safeguarding Partnership

It is recommended Slough Safeguarding Partnership implements the Multi-agency risk Framework and tool for all partner agencies.

4.6. Finding 2 – Quality of Recordkeeping, Communication and Sharing Information

4.7. What are the issues?

There were recordkeeping and communication concerns identified at the practitioner event with an inconsistent understanding about when information can be shared which requires to be clarified. Records when, where and if Mr A had his catheter removed was unclear, with duplication of contact with the District Nurse. Email correspondence between his SW and a Housing Officer for Extra Care Housing shows the SW did not update the Strengths Based Assessment from December 2017 as no change in Mr A's needs had been identified. There was some missing information in the housing case notes as he was rehoused (address redacted) when he had been accepted on to the waiting list for the Extra Care Housing. Adult Social Care's understanding of Mr A's medical conditions was largely based on the information he himself shared with workers and information gleaned from Section 2's during hospital admissions. At no point following the hospital admission in February 2018 is there any record of ASC being notified that he had pressure sores. This should not deter ASC however, from seeking such information themselves if they are involved with Mr A at the time or subsequently.

There was however some efficient communication between agencies and services in Mr A's case, including when hospitalised in February 2018 with pneumonia where there was good communication between the GP Practice and health providers. In February 2018, SCAS attended and took Mr A to hospital and recorded he had sores on the buttock area. SCAS was unaware of partner agency involvement with him but did raise a safeguarding referral regarding his poor mobility and the use of a wheelchair up and down the stairs at his home, along with the fire risk posed at the address. Berkshire Fire and Rescue Service were notified of this risk along with ASC. Reablement recorded detailed support actions for his showing during the care provided on the two days (some records show it was three days care, but this is an error).

The Reablement OTA prepared a clear Reablement Plan, but this plan was not communicated in its entirety to Forever Care. Forever Care do not appear to have sought any more detailed information about Mr A's needs; neither did they communicate any concerns despite Mr A apparently declining their support at times. The issue with support plans not being shared with care agencies would benefit from being looked at further. It would be usual practice for there to be communication with Slough BC, PPBT by an agency which has any issues or concerns with a care package placed with them.

4.8. What should be considered?

Clearer pathways for Health sharing information with ASC are needed. Opinion of practitioners' state the situation seems to have worsened since the onset of GDPR and clarity around the circumstances when information can, and should be, shared is needed. Recordkeeping needs to be robust and significant issues between Health and ASC should be shared and where necessary clarity obtained to share information from supervisors if the information is likely to effect the health and wellbeing of a vulnerable person. There also seems to have been limited communication between the Reablement and Long-Term OT's to ensure the drop-down shower seat required for his bathing, was provided in a timely manner, as this was clearly emphasised by the Reablement OTA as a priority need. Installation of the seat would have triggered another review point as Mr A would have been visited by another OT, whether from the Reablement service or the Long-Term team. The sharing of Reablement or care and support plans with domiciliary care agencies also needs to be addressed. ASC have subsequently informed this review reablement plans are shared with agencies, but this is not evident in submissions to the SAR. It is important for agencies to understand exactly what is required of them when working with each individual service user, to avoid assumptions being made and the views and wishes of service users being marginalised. ASC's care plans are a key vehicle for this and should be fully utilised. These concerns need to be considered and addressed as follows: -

4.9. Slough Safeguarding Adults Board Overview Report Recommendation (3) for All Safeguarding Health providers

It is recommended all Safeguarding Agency Partners and relevant voluntary organisations concerned in the safeguarding adults review, assure Slough

Safeguarding Partnership all staff are reminded to comply with their own, Local and National policies and guidance regarding their organisations ensuring recordkeeping is effective, communication is compliant, and important information and care plans are effectively shared in safeguarding, health and wellbeing cases.

4.10. Finding 3 – Capturing the Voice of Mr A

4.11. What are the issues?

Communication with Mr A was difficult. Consistency of communicating should be improved to ensure Mr A understood communication with him, considering his native language was Polish. The Prevention Plan provided to Mr A by the Hospital Social Work Team (HSWT) in February 2018 was completed in English (not in Mr A's Polish language) regarding the availability of information and advocacy support delivered through Age Concern. This would therefore have not been helpful to him. It is not clear whether the practitioner saw him on the ward and discussed the information to be included in the Prevention Plan or whether this was based on information from the Discharge Coordinator without personal contact, as the finding above regarding recordkeeping. The records refer to Mr A's wife assisting him on discharge suggests there was no discussion with him about, or understanding of, the breakdown of this relationship and the potential impact this would have on him by either the Hospital OT, Discharge Coordinator or the HSWT worker.

In November 2018 prior to his hospitalisation and his sad death he asked about assessments and requested more help as he only had care twice a week. He also asked about an emergency alarm because he admitted "my health is worse at the moment."

When later in hospital during a visit with his son, (G), a conversation was held in the Polish language. Mr A is noted as being capacitated to agree to the information gathering and being able to express his views and wishes independently, although he struggled to recall things related to his daily routine at times. Mr A reported he found it difficult to communicate as his English was limited and none of the carers were able to speak his language (although this SAR is aware of some Polish speaking practitioners and efforts made in some circumstances to aid communication and understanding). He recalls a District Nurse attending to his pressure sores at some point, but he said they (DN's) then "disappeared". Mr A says that he was trying to live as independently as possible, but he needed more formal support especially with personal care and to have adaptations to his accommodation and pressure relieving equipment to keep him safe. Mr A said he did not get a response from ASC when he called them on a number of occasions. He wanted the safeguarding process to remain open to him.

Mr A's son expressed major concerns relating to the fact his father was receiving formal care at home and had been attending dialysis three times a week (Tuesdays, Thursdays, Saturdays) for 4 hours and 'no one had noticed and reported any of his pressure sores'. The son reported when he visited his father in August 2018, he called the Social Services department highlighting the need for OT involvement as Mr A had moved to a new house and required OT adaptations and equipment urgently.

The son stated his father's pressure sores started developing over a year before and he is asking: "why nothing has been done and no one reported these concerns as pressure sore Grade 3 or 4 would not develop overnight." He would like to receive answers on “why the system has failed his father and the professionals who were involved prior to his hospital admission have not reported or noticed the pressure sores and deterioration in his general well-being".

4.12. What should be considered?

When seeking domiciliary care support at short notice is not always possible to match the language skills of the agency practitioner to the needs of the service user. It would be expected the agency would report to PPBT with any concerns about language skills impacting on the delivery of the care and alternative measures considered. Forever Care does not seem to have raised any concerns with PPBT, despite carers not being able to communicate properly with Mr A and him declining their support at times. The fact Mr A openly stated he had difficulty communicating with his care providers and his son’s concerns why his father’s pressure sores were not identified. It is a failure and this SAR agrees, action is required to be taken with communication made earlier using an interpreter, a language line or other facility (some OT staff spoke the Polish language) as an absolute necessity. Language facilitates which are available were used on occasions, but this was not consistently applied. They must be considered and used to ensure the views of a vulnerable person is always captured including views of family members were necessary. Their voice and views must be obtained and where relevant acted upon. However, Hospital good practice took into consideration the socioeconomic factors surrounding Mr A in the likelihood of his demise and preparing him for that eventuality well ahead of time. This was carried out in a caring and sympathetic way with him and he was able to express his view. The following should be considered for action to be taken: -

4.13. Slough Safeguarding Adults Board Overview Report Recommendation (4) for all Health Care Providers

It is recommended that all Health and Care providers and relevant voluntary organisations within the Local Authority area concerned in the safeguarding adult review, assure Slough Safeguarding Partnership, when providing care both in a health setting and within the community, the voice and views of the person and family where relevant, must be captured and recorded, utilising interpreters and available language facilities to aid communication on all occasions.

Chapter 5 – Conclusions

5.1. Predictability and Preventability

5.2. It was predictable that Mr A would receive pressure sores/ulcers due to his diabetic health condition. The early identification of pressure sores and their expedient treatment would be expected if all practitioners were knowledgeable of the sign and symptoms of the potential risk as there is nothing to suggest there was any element of self-neglect. This review established in Finding 1, the need for health and care practitioners to have the awareness of such information for the future, to ensure prompt medical attention is taken to treat a patient.

5.3. It was suggested by professionals that Grade 3 and 4 pressure sores could have been noticeable in September 2018 (as it was mentioned by health professionals at the multi-agency analysis event). This is however an assumption and cannot be confirmed from information provided to this review. When being bathed by care providers, whether any sores were developing and were obvious, is not known. It could also be said, whilst attending his dialysis treatment three times a week, this was an opportunity for practitioners to notice the emergence of pressure sores much earlier, if they were present. What we can confirm is three days before he was admitted to hospital, Dialysis Unit staff on the 1 November 2018 noticed Grade 3 and 4 pressure sores and correctly referred it for action to be taken by District Nurses. Whether it would have been advisable to consider admittance to hospital for treatment at that stage is a professional judgement. It was obviously felt he could be treated within the community with the involvement of DN's and his GP Practice.

5.4. This review cannot determine however, if the failure to make an earlier identification of his pressure sores/ulcers before they became Grade 3 and 4, impacted on his eventual death. It is a medical fact Grade 3 and 4 pressure sores can develop very quickly, in susceptible people like Mr A, within one or two hours. The hospital staff on admission, immediately treated his pressure sores described as Grade 3, which is necrosis (death) or damage to skin layers and Grade 4 also necrosis or damage to the skin patch and underlying structures. Mr A was treated by TVN professionals with the use of maggot therapy which was unsuccessful. He was too weak for surgery and was kept appraised sympathetically of his failing health by caring palliative staff.

5.5. In the circumstances, Mr A's skin condition may not have been noticeable to those interacting with him, but in any case, awareness of the condition and risk may be relevant in future other cases which justifies the SAR Overview Report Recommendation in Chapter 4. Mr A's pressure sores were predictable, but it is unlikely they were preventable given his medical condition. It cannot be said, from the information provided to this review, the presence of pressure sores accelerated his death with his added renal failure and health complications.

5.6. Key Line of Enquiries

5.7. The following KLOE's were identified by the SARP for agencies to consider and address within their submissions to the review. They are further discussed and analysed within the narrative and findings in Chapter 4 as follows: -

- Did Mr A have a multi-agency care plan? (Mr A had a care plan completed by the Reablement Service which identified possible risk of pressure sores that was not widely known by all practitioners).

- What are the strengths and areas for development in how Mr A's care was set up and delivered? (These are identified in the Findings and SAR OV Recommendations in Chapter 4).

•Were all staff trained in tissue viability, and the implications of his diabetes and renal failure on his skin care? (Not all staff were trained, and this aspect is addressed within the Findings and SAR OV Recommendations in Chapter 4).

•Were Mr A's views established, clearly understood and acted upon? (This is a finding in this report as capturing his voice was not consistent with language difficulties for both Mr A and some practitioners).

•Were there examples of good practice? (There was some good practice, evident in the narrative in Chapters 3 and 4).

•Can such situations be prevented in future by improving in partnership working? (Yes, with effective communication and knowledge, situations in the future can be prevented, as outlined in the Findings and SAR OV Report Recommendations).

•How can this be achieved? (By implementation of the learning within the SAR Action Plan that will accompany this review).

5.8. Safeguarding Policies and Procedures

5.9. Berkshire Multi-Agency Adult Safeguarding Policies and Procedures, June 2016 have adopted the Association of Directors of Adult Social Services (ADASS) Pan London Multi-Agency Policy and Procedures . This state, "If a pressure ulcer is believed to have been caused by neglect it is reported as an adult safeguarding concern." Slough now have the Berkshire procedures on line for access and information.

5.10. There is a Serious Incident (SI) Framework which outlines how the NHS investigates pressure ulcers. Berkshire Safeguarding Adults also have a Pressure Ulcer Protocol to support staff in deciding whether to report as a safeguarding concern. If medical professionals identified the present of Grade 3 and 4 pressure sores/ulcers as happened in November 2018, it would be referred for treatment as required. The situation in this review is, practitioners need to have the necessary knowledge and display professional curiosity to make an early identification and referral in the first place if discovered or suspected. This will be another level of additional safeguarding to protect the health and wellbeing of a person.

5.11. In Conclusion

5.12. It must be appreciated, supporting vulnerable adults, often with additional complex health needs, can be a difficult process for practitioners. It is evident that every practitioner concerned in this review wished only the best for Mr A. He died with dignity and respect. The Safeguarding Adults Board, the SAB Independent Chair, SARP Group and all practitioners involved with Mr A and within the SAR, offer their condolences to his family at their great loss.

5.13. Submission of the Overview Report

5.14. This SAR Overview Report for Mr A is submitted to the Slough Safeguarding Partnership to consider the findings and recommendations and to promulgate necessary learning through the SAR Action Plan that will accompany this report.