Overview Report

Safeguarding Adult Review into the Death of:

"Josie"

Date of Death: 09.02.2023

Independent Report Author: Allison Sandiford

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1. Introduction

1.1. At a meeting in September 2023, members of the Stockport Safeguarding Adult Review Referral Consideration panel agreed that this case met the criteria for a Safeguarding Adult Review under The Care Act 2014 - which states that '*Safeguarding Adult Boards must arrange a Safeguarding Adult Review when an adult dies as a result of abuse or neglect, whether known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult.'*

1.2. The circumstances that led to this review being undertaken are as follows; Josie, aged 76, was bedbound and living in a residential Care Home. In June 2022, staff from the Care Home referred Josie to the District Nurses as it had been recognised that Josie had developed moisture legions. By October 2022 the legions had developed into grade 2[1] pressure ulcers[2] and by December 2022, had become ungradable. It was confirmed during a safeguarding strategy meeting in January 2023 that a lack of communication between agencies could have contributed to the deterioration of the wound; staff at the Care Home were said to be unaware of the severity of the pressure ulcer as it was being treated by the District Nurses.

1.3. Josie sadly passed away on the 9th of February 2023 in hospital. The cause of death was noted as *"vascular dementia, not overtly septic but osteomyelitis from the pressure ulcer on balance of probability contributed more than minimally"*.

1.4. The purpose of a Safeguarding Adult Review is clearly defined in the Care Act 2014. It is to promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. The lessons learnt for the case should be applied to future cases to ensure continuous improvement of practice.

1.5. It is not the purpose of this review to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation.

1.6. The report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with no current links to Stockport Safeguarding Adults Partnership or any of its partner agencies. Allison gained experience in safeguarding whilst working for a police service. Since leaving the police in 2019, Allison has conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews.

2. Confidentiality

2.1. To protect the identity of the individuals involved, the subject of this review is referred to as Josie.

2.2. Once agreement for the final report has been given by the Stockport Safeguarding Adults Partnership and its partner agencies, this Safeguarding Adult Review report will be available on the council website. The report will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 1998.

2.3. Upon publication, partner agencies will be made aware, and the action plan will be shared with the agencies involved and the Adult Statutory Case Review Group.

2.4. The review has been assured that the learning will be disseminated by Stockport Safeguarding Adults Partnership Business Manager and Adult Safeguarding Training Manager who will deliver a learning circle and develop a 7-minute briefing. Other agencies will then disseminate via their own learning channels.

3. Methodology

Terms of Reference

3.1. The panel[3] identified the following key lines of enquiry for the review:

[1] Stage 2 pressure ulcers are characterized by partial-thickness skin loss into but no deeper than the dermis. This includes intact or ruptured blisters.

[2] Pressure sores/ulcers are localised areas of tissue necrosis that typically develop when soft tissue is compressed between a bony prominence and an external surface for a long period of time.

[3] See Appendix 1 for panel membership.

- How were Josie's care and support needs communicated to the Care Home when she became a resident in May 2022?
- How was Josie's care and support plan communicated multi-agency, and how was it coordinated and reviewed?
- How did professionals communicate with Josie's family?
- Explore the response and decision-making process with regard to the safeguarding referrals?
- How was information shared between the Care Home and the District Nurses and were there any barriers to communication?
- Identify areas of positive practice.
- What developments have been made to practice since the scoping period of this review?

3.2. It was agreed for the review to consider agencies contact/involvement with Josie from the 25th of May 2022 (when Josie moved into the Care Home) until the 9th of February 2023 (when Josie sadly died). However, in addition the report will include brief background information re any significant events and/or safeguarding issues prior to the scoping period that agencies consider would add value and learning to the review.

Involvement of Family and Wider Community

3.3. The Independent Reviewer and Stockport Safeguarding Adults Partnership would like to offer their condolences to Josie's family and friends.

3.4. The participation and opinion of family members of the deceased is an important aspect of the Safeguarding Adult Review process as their personal experiences of services provided to their relative, prove invaluable.

3.5. Stockport Safeguarding Adults Partnership contacted one of Josie's sons, to notify him of the review and gained permission for the Independent Reviewer to make contact. In preliminary communications with Josie's son, the Independent Reviewer explained the process and purpose of the review and offered the opportunity for family to participate. This offer was declined.

3.6. The reviewer and the partnership understand and respect the decision not to be part of this process.

Parallel Reviews

3.7. HM Coroner held an inquest in July 2023 which concluded that Josie had *"died from osteomyelitis where the deterioration of the sacral pressure ulcer was not recognised until she became very unwell and attempts to treat it were unsuccessful"*.

3.8. The Coroner issued a Regulation 28 Report to Prevent Future Deaths[4] to the Care Quality Commission and the Chief Executive of the One Stockport Integrated Care Board, who responded within the set time parameter with highlighted learning. This Safeguarding Adult Review aims to build upon that learning and evidence improvements being made to reduce the likelihood of recurrence.

Limitations to the Review

3.9. There have been some limitations to the review:

3.9.1. Stockport Safeguarding Adults Partnership requested Josie's archived files from the previous Care Home. These files remain outstanding.

4. Overview

This section of the report is factual and without analysis. It briefs the reader on the circumstances in the case during the scoping period:

[4] Under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

4.1. Josie was admitted into the Care Home in May 2022[5]. This review has been told that at this time, Josie had advanced dementia and was unable to retain any information or communicate. She was described as being bedbound, underweight, and requiring full assistance with all daily activities.

4.2. On the 9th of June 2022 Care Home staff requested an ambulance for Josie who was presenting as unwell. The attending ambulance staff communicated with the out of hours GP about Josie's presenting health (Josie was not taken to hospital).

4.3. The following day, blood tests indicated that Josie had a mild infection and the GP prescribed antibiotics. On the same day, staff from the Care Home observed that Josie had started to develop a moisture lesion and referred Josie to the District Nurses for a pressure ulcer check and the possibility of pressure relieving equipment[6]. This review has been informed that though it was recognised by the Care Home that Josie was at risk of developing pressure sores, there was no requirement to refer to the District Nurse team any sooner as Josie's skin was intact on arrival to the Care Home.

4.4. District Nurses began to oversee the management of Josie's wound from the 10th of June 2022. They attended to Josie weekly until September 2022 when visits increased to two visits per week. During this time, the nurses were changing Josie's dressings, and pressure relief equipment was provided. Care Home staff report that they had ongoing concerns; namely that changing the dressing twice a week was proving insufficient as owing to Josie being doubly incontinent the dressing was becoming stained and frequently falling off. Care Home staff report that they were worried that the wound was not healing.

4.5. Additionally at the end of August 2022, there had been a flood in Josie's room and Josie had to remain in a bucket chair for four hours until she was able to be transferred to an alternative room with a foam mattress. She remained in this room overnight with carers - who report that they repositioned Josie every two hours.

4.6. On the 14th of October 2022, District Nurses referred Josie to the Tissue Viability Nurses who confirmed via remote consultation with access to photographs[7] that Josie's wound was now a confirmed Category 3.

4.7. The following week, a Tissue Viability Nurse carried out a home visit and requested that District Nurses increase their visits for dressing changes to every two or three days. On this visit the Tissue Viability Nurse observed a discrepancy within the Care Home records of around nine to 10 hours during which there was no documentation of turning Josie. This was raised with Care Home staff to escalate back to a senior carer and the District Nurse Team raised a safeguarding concern to the hospital safeguarding team. There is no email trail to suggest that this concern was raised to Adult Social Care.

4.8. On the 13th of December 2022, on an occasion when Josie's dressing had fallen off, Care Home staff discovered that the wound looked infected. The Care Home is dually registered, and so their duty nurse was asked to review the wound. Josie's observations (heart rate, blood pressure, oxygen saturations) evidenced that she was stable. The following morning the Care Home Manager called the doctor - who commenced Josie on intravenous antibiotics[8].

4.9. Concerned by the deterioration of the pressure ulcer, the Care Home completed a safeguarding referral[9]. The Care Home manager also met with Josie's son who stated that he had not been previously informed about Josie's wound.

4.10. Later that week, due to Josie's ongoing raised temperature and raised white blood cells, the GP concluded that Josie needed to be admitted into hospital[10]. Because Josie had been admitted with an ungradable pressure sore[11] that queried infection, staff at the hospital also submitted a safeguarding referral.

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[5] This placement was made permanent under best interests in August 2022.

[6] The Care Home documented that they had been carrying out two hourly turns for pressure relief.

[7] It was established during the Coronial process that the photographs were of older images and therefore the remote review could not be effective as an updated image showing the deterioration had not been uploaded.

[8] Blood test results received by the GP on the 14th of December 2022 were consistent with infection.

[9] Received by the Safeguarding team on the 14th of December 2022.

[10] Josie was taken to hospital by ambulance.

[11] Ulcers covered with slough or eschar are by definition unstageable. The base of the ulcer needs to be visible in order to properly stage the ulcer, though, as slough and eschar do not form on stage 1 pressure injuries or 2 pressure ulcers, the ulcer will reveal either a stage 3 or stage 4 pressure ulcer.

4.11. A Strategy Meeting[12] which subsequently convened, concluded that a lack of communication between the District Nurses and the Care Home may have contributed to the deterioration of the wound.
4.12. Josie sadly passed away in hospital.

5. Analysis and Response to Key Lines of Enquiry

Following:

- examination of the information gained from the agency reports/documentation shared with this review, and
- discussions with professionals at a learning event[13], and
- discussion and analysis with panel members in meetings[14]

the following responses have been generated to the key lines of enquiry.
Lessons learned are stated, along with (where the lesson remains unaddressed) a question for Stockport Safeguarding Adults Partnership to consider; the answers to which will drive Stockport Safeguarding Adults Partnership and its partner agencies to develop an action plan that will respond directly to the learning.

How were Josie's care and support needs communicated to the Care Home when she became a resident in May 2022?

5.1. Prior to the scoping period of this review, Josie was resident in a Care Home which found itself no longer able to meet her needs; Josie's mobility had declined, and because she was unable to bend her knees when sitting in a wheelchair, it was no longer suitable to transport her in the lift. Therefore, it had become necessary for Josie to reside on the ground floor and due to limited accommodation, she was having to share a room with another resident.
5.2. The Adult Social Care Neighbourhood team were responsible for commissioning a new Care Home placement for Josie (and keeping her placement under review).
5.3. Josie was mentally assessed under the Mental Capacity Act by a Social Worker and deemed not to have the capacity to decide her accommodation for herself. Consequently the transfer was completed under a best interest decision.
5.4. The care assessment completed by Josie's Social Worker, was discussed by professionals who were in attendance at the learning event. It was agreed that the relevant information regarding Josie's care and support needs were clear, and adequately detailed to allow the receiving Care Home to effectively assess whether their resources and ability would meet Josie's requirements.
5.5. Notably, usual practice was disrupted at this time by the Covid Pandemic as the receiving Care Home would usually have visited Josie in her current residence and met with her face to face. Besides facilitating direct communications between the current and receiving Care Home, such practice allows the receiving Care Home to further assess their suitability for Josie. However, on this occasion, due to an outbreak of Covid at the Care Home from which Josie was moving, this was not possible.
5.6. Though there was reference on Josie's assessment to her being unable to manage her own pressure relief and her being at risk of pressure ulcers developing, when Josie transferred to her new Care Home, she was not reported to be currently under the care of the District Nurses. Consequently District Nurses did not visit Josie (within the scoping period of this review) until they received the referral on the 10th of June 2022 from the new Care Home who were concerned that Josie had no pressure relieving equipment in place and had marking to her skin. It was good practice that a District Nurse visited Josie on the same day as this referral was received to complete a skin review and assess Josie's requirements for equipment. The District Nurse identified Josie as being at 'elevated risk' and found that Josie had a deep tissue injury to her sacrum and a red heel. Consequently the District Nurse upgraded Josie's mattress from a high-risk foam to a Talley Quattro

[12] Attended by representatives from the Care Home, the Integrated Care Board, the District Nurse Team, and the NHS Foundation Trust Safeguarding Team.
[13] See Appendix 2 for details.
[14] 8.2.24, 19.4.24, and 5.6.24

air flow and also provided a heel offloading device to the Care Home. Josie was added to the District Nurse caseload.

5.7. This review has learned that when it became known to the District Nursing team who had been visiting Josie in her previous Care Home, that Josie was going to be moving into a new Care Home in another area, Josie was discharged from their care. This is not usual practice.

5.8. Usual practice would see a transfer of care to the new setting which facilitates a handover of care and needs between the District Nursing Teams and allows for the arrangement of any equipment to be moved and installed into the new setting. Had this practice been followed, the 16 day period in which Josie was not seen by District Nurses would have been avoided.

5.9. This review has been assured that the team lead for the previous District Nursing Team is addressing this practice within their team meeting and will ensure that correct process is discussed to safeguard this doesn't happen again.

Learning 1: There was a missed opportunity between the District Nursing Teams to handover Josie's care when Josie was discharged from the District Nursing team who covered the locality of the previous Care Home.

5.10. Discussion was had by the professionals in attendance at the learning event with regard to how this situation could further be avoided in future practice. It was suggested that the Adult Social Care assessment could include a direction for the assessing Social Worker to consult directly with the District Nursing team (covering the individual's area) in order to gain a better understanding of the individual's recent and present healthcare needs. It was concluded not enough to ask the Care Home as, on occasion, Care Home staff may be unaware of a District Nurses involvement.

5.11. Notably on this occasion, the Josie's Social Worker assessment reported that Josie had a *normal mattress* and that her *skin was intact* – but *vulnerable to breaks* as Josie is unable to reposition herself. If this is what was reported to the Social Worker by the Care Home, it is understandable that the Social Worker would not have anticipated District Nurses to have been involved in her care. However this is somewhat contradictory to the information provided on the patient transfer sheet when Josie was transferred to her new Care Home, which states that District Nurses had dressed Josie's leg nine days earlier and again the previous day (as she had a blister) and had advised weekly dressings.

How was Josie's care and support plan; communicated multi-agency, coordinated, and reviewed? And how was information shared between the Care Home and the District Nurses - were there any barriers to communication?

5.12. Professionals from many agencies/organisations were involved with the delivery of Josie's care and support during the scoping period of this review. Whilst it is recognised that each organisations' primary relationship was and should have been with Josie, working in partnership with each other was essential. Particularly as when a person (like Josie) is unable to understand and/or communicate their own care needs, it is imperative that time is taken to ensure that the correct overall care is being administered to help and support that person and to improve their quality of life.

Who was supporting Josie?	How?
Adult Social Care	Commissioned and reviewed Josie's placement.
Care Home Staff	Managed Josie's day to day care and support.
District Nursing team	Managed and dressed wounds and identified/provided pressure relieving equipment.
Tissue Viability Nursing team	Supported District Nurses with wound care.
General Practitioner	Completed a weekly 'board round' in which all the residents would be discussed (with the manager or senior nurse/carer) and residents with medical needs or for whom family/staff had raised concerns, would be seen.

5.13. Josie lived with long term conditions and had eligible social care needs. This necessitated that she have health and social care plans to lay out the level of support required, how the support should be given, the aims and goals of the care, and also include any other essential detail.

5.14. Individual agencies/organisations involved in Josie's care held individual care plans detailing their assessment of Josie's identified needs, and the support that their service was offering. The challenge therefore was making sure that all of the individual plans could work together.

5.15. The first health and social care plan created for Josie within the scoping period of this review was developed by Adult Social Care. This was then shared with the Care Home who, upon receiving Josie into their care, used it as a guide and began generating their own care plans, support plans, and risk assessment. This review has been informed that basic care plans were generated on the day of Josie's admission and a care plan was completed within 72 hours of admission. The Care Home has advised this review that their care plans comprise of personal care, nutrition needs, mobilisation, communication abilities etc, and explained that the care plans are fluid documents which consequently, in time, become more detailed to include, for example, any challenging behaviour, personal likes, sleeping patterns.

5.16. When the District Nursing team became involved with Josie, nurses developed their own care plans around pressure ulcer care, moisture lesion care and wound care. These care plans were also fluid and regularly updated by visiting District Nurses or as directed by a member of the Tissue Viability Nursing team. (The review learned that Tissue Viability Nurses wouldn't develop a care plan of their own but would instead make recommendations for the District Nurses care plan.)

5.17. The GP has informed this review that their discussions with the Care Home manager or senior carer about Josie's care would be recorded by the Care Home in their 'GP book'. Only advanced care plans[15] would be shared in hard copy and attached to an individuals' Care Home plans and Josie didn't have an advanced care plan.

5.18. Whilst the Tissue Viability Nurses and the GP would have access to the District Nursing team's case notes (which include their care plans), a holistic overview of who was supporting Josie and how, was only achievable by way of a central coordinated record. As the day to day care providers, the best suited organisation to hold such a record was the Care Home. It was therefore especially important that every professional supporting Josie, shared their care plans with the Care Home and that the Care Home ensured that their record contained the up-to-date information and directions accurately, regardless of the external procedures of the agencies that the visiting professionals work for.

5.19. In line with this, the Care Home's 'GP and Visiting Professionals Policy and Procedure' states[16] that visiting healthcare professionals are encouraged to document their visit, any relevant details, and any follow up actions in the individual's care plan but where this is not possible, care staff should communicate with the healthcare professionals and ensure that the care plan is updated. The policy and procedure also denotes that care staff will ensure that any relevant risk assessment and care plans are updated following the visit and any changes will be communicated to the care team at the Care Home.

5.20. This review has learned that whilst the District Nurses pressure ulcer and moisture lesion care plans should have been shared with senior care staff in the Care Home, the wound care plan would not be - as this care plan was applicable to nursing professionals only. Good practice would see the plans (which were to be shared) being printed in hard copy and taken into the Care Home - but discussions within the learning event indicated that this is not always done and wasn't done in Josie's case.

5.21. The Care Home report that their communication book, in which District Nurses were asked to write updates and details of the care provided, was not consistently completed with some visits not being documented and, on other occasions, only very brief notes being entered.

5.22. There was reassurance from the District Nurses that their plans were being shared verbally with Care Home staff (as per policy), but it is not possible for this review to confirm whether this was consistent or not. Also there was acknowledgement amongst the professionals of such verbal practice relying upon Care Home

[15] Advance care planning is a process of planning future care and support, including medical treatment, while a person has the capacity to do so.

[16] Paragraph 5.5

staff members to document the visit and detail the findings in the daily notes using their own words - which risked shared information being mis-repeated in translation and/or forgotten.

5.23. In addition to information around care plans, NICE[17] provide in their quality statement 3[18] that *older people with multiple long-term conditions and eligible social care needs* should *have a named care coordinator. The named care coordinator is the person, from among the group of workers providing care and support, designated to take a coordinating role…* In other words, the care coordinator plays a lead role in the care planning process and ensures that the individual and their carers have the information they need to manage the individual's conditions.

5.24. NICE explains what the quality statement requires of different professionals, and states that: the service provider (in Josie's case, the Care Home) should ensure that an individual has a care coordinator[19]; the health and social care practitioners (in Josie's case the District Nurses and GP) should ensure that they know who the care coordinator is and should share information with them, and it is the commissioner's (i.e. the local authority) responsibility to *ensure that there is local agreement on the role and responsibilities of a care coordinator, and that all health and social care staff support the care coordinator by contributing to care planning, sharing information, and agreeing joint working arrangements.*

5.25. Whilst the practice which has been reported to this review conforms with the quality statement and it was good that professionals at the learning event recognised the Care Home as the care coordinator, it is debateable whether the statement's aim was being achieved in a consistent and effective manner given that professionals cannot be sure that the District Nursing team were always sharing their care plans (which contained the information required to manage Josie's health conditions), with the Care Home in a fail-safe reliable way and/or that the Care Home was recording any verbally shared care plans efficaciously.

5.26. This is no criticism of the professionals working to support Josie, and it is relevant here for this review to acknowledge the increasing pressures that District Nurses are working under. According to new analysis of NHS England data, the number of district nurses has fallen by 47% since 2009, from 7,055 to 3,749[20]. In line with this, District Nurses in attendance at the learning event spoke of heavy caseloads that impact upon the time they have available for each individual patient. They also spoke of how it isn't always possible to locate Care Home staff within the short time they have with a patient, thus sharing a care plan isn't always.

5.27. Similarly, the challenges that Care Home's face with regard to staff recruitment and retention cannot be ignored. In December 2021, the Care Quality Commission introduced their Adult Social Care workforce survey. As of the 30th of June 2022, this survey had been completed over 5,500 times by their inspectors. It explored with Care Homes (and homecare providers) the impact of workforce challenges and staffing shortages on the services they deliver to people. In the survey, 36% of Care Home providers said that workforce challenges have had a negative impact on the service they deliver. For Care Home providers, of those that reported workforce challenges and went on to provide further information (2,820):

- 87% said they were experiencing challenges related to recruitment.
- 48% said they were experiencing challenges related to retention.

Two-thirds (66%) of Care Home providers that gave further information about their retention challenges said staff were leaving the sector.

5.28. This review has been assured that since the scoping period, measures have been put into place to improve communications between this Care Home and the District Nursing team; the Care Home manager now meets every month with the District Nurse senior team to review the Care Home residents who are receiving care from the District Nursing team. And new District Nursing team communication forms have been put in place, on which District Nurses can clearly state the management plan and instructions for care staff. The Care Home report that, in their opinion, communication has significantly improved.

5.29. However, it is clear that the policy and procedure followed in Josie's case did not provide a robust framework to ensure that her care plans were kept up to date and complete and further consultation is

[17] National Institute for Health and Care Excellence

[18] *Quality statement 3: Named care coordinator | Social care for older people with multiple long-term conditions | Quality standards | NICE*

[19] Attendees at the learning event all concurred that the Care Home was Josie's care coordinator.

[20] England's community nursing workforce down almost 50% | Nursing in Practice

required, particularly between the District Nursing Team and Care Homes, with regard to how practice can be improved.

Learning 2: Current policy and procedure with regard to documenting the details of professional visits to the Care Home in individual's care plans was not robust.

Question 1: How can Stockport Safeguarding Adult Partnership ensure that consultation is had to collaborate the development of a protocol to support professionals in Stockport to achieve robust multi-agency working when practitioners such as District Nurses are delivering care in residential settings within their locality? And how can partner agencies and Care Homes assure Stockport Safeguarding Adult Partnership that the protocol is thereafter promoted and shared?

5.30. The GP Practice explained to this review that within the Gold Standard Framework - which supports a patient nearing the end of their life, the District Nurses and Macmillan nurses will meet every two months to ensure the joined up coordinated care of a Gold Patient. This is positive practice that could be somewhat replicated for individuals who don't have the capacity to inform their visiting professionals of their care needs. I.e., the GP, Care Home and visiting professionals could meet (virtually) quarterly and discuss the individuals care to ensure a coordinated approach.

5.31. The Care Home has agreed that though this would require some organisation, it is something that it would welcome. Discussions between the GP Practice, the District Nursing team and the Care Home are currently ongoing and should be taken into consideration when developing the action plan in response to question 1.

5.32. Whilst there is no doubt that had Josie's care plans been more effectively shared during the scoping period of this review, communication between the Care Home and District Nurses would have automatically improved, multi-agency working goes beyond the sharing of care plans. There are times when agencies need to come together, listen to one another's concerns and plan future coordinated care - as effective multi-agency management is crucial in pressure ulcer care.

5.33. This review has heard of two-sided conversation between professionals, for example, between the District Nurses and the GP, the Care Home and the GP, and the Care Home and the District Nurses. However the Care Home has described to this review how they sometimes felt unheard and inferior when addressing other professionals. For example, they report having requested extra dressings from the District Nursing team for Josie because due to her incontinence, the dressings were frequently falling off. They inform that this request went unactioned (until they bypassed the District Nurses and asked the GP) and also that despite requesting additional District Nurse visits, the highest frequency ever attained was alternate days. The Care Home also reported an occasion whereby the manager had approached a senior District Nurse to request that Josie's needs be re-evaluated as she and staff had become concerned that Josie's needs had increased to the extent that she may have needed a nursing bed. The Care Home stated that this request was denied with the rationale that the District Nurses were meeting Josie's needs, and that she didn't need to be transferred.

5.34. It is not for this review to investigate the decisions made, but it is for this review to consider how professionals from different specialties and agencies communicated, heard one another, and worked together - as collectively they played the vital role in providing the optimal care for Josie.

5.35. Multi-agency team meetings are effective vehicles in which information can be shared and discussed[21] in order to support the identification and management of risk. Yet only one multi-agency meeting has been brought to the review's attention with regard to Josie during the scoping period of this review, that being a strategy meeting which convened in January 2023. Josie's care plan may have been more robust had multi agency coordinated care planning occurred earlier within the scoping period.

5.36. For example, whilst it is recognised that the Care Act 2014 states that concerns about the quality of a service provided are not automatically safeguarding concerns under section 42 of the act (and that this likely would not have reached threshold) when the Care Home was not satisfied by the District Nursing team's

[21] Consent should be sought to share an individual's information - following assessment, Josie would have been assessed to not have the mental capacity to consent to her information being shared in a meeting, hence professionals would have been required to make a 'best interests' decision which complied with the Mental Capacity Act Code of Practice.

response to their concerns, it would have been reasonable to convene a multi-agency meeting to discuss their concerns further and wider. This meeting (had it convened) may have potentially triggered an early review of Josie's placement from Adult Social Care.

5.37. Similarly, when the Care Home became concerned that Josie's needs had increased to such an extent that she had become more suited to a nursing bed, the Care Home should have communicated their concerns directly to Adult Social Care - as the commissioning body who had a statutory role in the coordination of services around Josie. This would have triggered a multi-agency meeting to plan the next steps and/or to discuss an ongoing package of care in the interim whilst a nursing assessment could be planned.

5.38. The Care Home report that this was not done due to the reassurance offered by the District Nursing team but given that the Care Home was in the best position to understand if and when Josie's needs were becoming greater than their Elderly Mentally Infirm residential care could provide, consultation with Adult Social Care should have been given greater consideration - the process of rearranging care for a person is a complicated process that involves much planning, hence the initial discussions need to be prompt.

5.39. The Care Home openly reflected how contacting Adult Social Care after the District Nurses had reassured them of Josie's care, would have felt like they were risking their working relationship with the team. However, problem resolution is an integral part of professional cooperation and multi-agency working, and it is inevitable that there will be differences of opinion on how to progress a case at times. Escalating concerns is a critical aspect of multi-agency work and should not be conceived as personal criticism.

Learning 3: Perceived differences in status and/or the experience of professionals, can affect the confidence of some professionals to pursue concerns.

Question 2: How can Stockport Safeguarding Adult Partnership support commissioned services (such as care providers) in their area with their escalation policy?

5.40. In the absence of the Care Home raising concerns, Adult Social Care had no reason to become concerned for the quality of care being afforded Josie (until later in the scoping period of this review when in December 2022 safeguarding referrals were submitted) and therefore, following their initial 'post transition' review, the care package would only have been reviewed annually.

Learning 4: When an individual's needs change and concerns are raised with regard to a Care Home's ability to provide adequate care, timely coordination of a plan to ensure that the individual is placed somewhere where they can receive the care and support that they need, is crucial.

Question 3: How can Stockport Safeguarding Adult Partnership seek assurance that Care Homes within their locality understand their responsibilities and have access to policy regarding the procedure to follow when a Care Home can no longer meet a resident's needs? The policy must recognise that when such a situation arises the Care Home must contact the commissioning authority to convene a multi-agency team meeting and review the situation in a timely manner. Furthermore, Stockport Safeguarding Adult Partnership should request that evidence of the policy's effectiveness in practice be provided at a later agreed date.

5.41. In October 2022 a Tissue Viability Nurse visiting Josie became concerned for the care Josie was receiving after noticing a discrepancy of around nine to 10 hours during which no documentation of turning could be seen in Josie's notes. This was raised with carer staff to escalate back to senior carer and the District Nursing team raised a safeguarding concern to the hospital safeguarding team. The hospital safeguarding team response is discussed in more detail in the next section of this report, but the question is, would it also have been appropriate to convene a multi-agency meeting? This would have ensured a multi-agency response and action plan.

Learning 5: By not convening a multi-agency meeting to plan Josie's pressure ulcer management and care, when an agency became concerned for the care she was being provided, professionals missed an opportunity to work within a multi-agency approach.

Question 4: How can partner agencies evidence to Stockport Safeguarding Adult Partnership that convening a multi-agency meeting, when concerns arise around the quality of any care being provided to an adult at risk, is being considered to address the concern and to action a safety plan with immediate effect?

5.42. Concerning the multi-agency communication later in the scoping timeline, NICE guidelines direct that in the event of hospital admission, managers of Care Homes should make sure that the admitting team have all the information they need about the individual. Examples include, amongst other things, care plans[22].
5.43. The ambulance service documentation does not evidence that any physical information or care plans were passed to them to transfer to the hospital with Josie.
5.44. However, the Care Home has confirmed that it has a policy in place, and that Josie was transferred to hospital with the

- Care Home's basic care plan,
- a brief description of needs,
- contact information,
- details of recent treatment, including what was known about the management of the pressure ulcer, which was accompanied by a letter from GP,
- the 'Do Not Attempt Cardiopulmonary Resuscitation' and
- Josie's personal belongings

in a red bag[23]. But, as previously mentioned, the Care Home information would not have included the District Nursing wound care plan as this was never shared with the Care Home.
5.45. With regard to the pressure ulcer, hospital staff informed this review that Josie was admitted into their care out of working hours and consequently staff were unable to obtain an update from the District Nursing team until the following day. It was acknowledged that the District Nursing team is a 24 hour service but noted that lower staffing levels overnight make it difficult to have contact with a member of the team by telephone.
5.46. However, it was also mooted that any delay between hospital staff and District Nurses communications would not have had any detriment upon Josie's care as hospital staff have expertise in wound care. Consequently, the important information required upon admission to hospital is health conditions, medication, information to support staff to understand the person's communication and cognitive ability and next of kin details. All of which would be contained within the Care Home's care plan.

Explore the response and decision-making process with regard to the safeguarding referrals?

5.47. The following safeguarding referrals were submitted with regard to Josie during the scoping period of this review:

	Date	Referrer	Concerns	Response
1	27.10.22	District Nurses	The District Nursing Team raised a safeguarding concern to the hospital safeguarding team around the care of Josie and support from the Care Home in repositioning her regularly.	Post assessment, the hospital safeguarding team did not escalate the concern to Adult Social Care.
2	14.12.22[24]	Care Home	The Care Home manager raised a safeguarding concern to Adult Social Care regarding Josie's pressure ulcer which had deteriorated to a grade four pressure ulcer[25].	Adult Social Care responded to this safeguarding concern and concern number 3 together.

[22] Moving between hospital and home, including care homes | Quick guides to social care topics | Social care | NICE Communities | About | NICE
[23] The Red Bag Pathway is designed to support care homes, ambulance services and hospitals to meet the requirements of NICE guidelines NG27: Transition between inpatient hospital setting and community or care homes. The red bag is used to transfer standardised paperwork, medication and personal belongings with the resident through their hospital stay and should be returned with the resident.
[24] 2 days later Josie was admitted to hospital.
[25] Stage four pressure ulcers occur when the hypodermis and underlying fascia are breached, exposing muscle and bone.

3	18.12.22	Hospital Staff	Hospital staff raised a safeguarding concern to the hospital safeguarding team after Josie had been admitted with ungradable pressure sores (queried infected), a deep tissue injury on her left toe, bilateral foot drop, and low Body Mass Index.	This concern was escalated to Adult Social Care who responded in conjunction with concern number 2.

5.48. With regards to concern number 1, the correct procedure is for the hospital safeguarding team, upon receipt, to collate as much information as possible and assess whether the concern is a safeguarding concern that warrants escalation to Adult Social Care or not. In this case, the concern was not escalated. This review has been unable to establish the exact rationale, but it is expected to have been because the District Nursing team undertook their own rapid review[26] into Josie's care - which is standard procedure undertaken when a pressure ulcer deteriorates to stage three (to determine whether there has been any lapse in care). The rapid review did not identify any concerns with regards to any lapses in care and therefore the hospital safeguarding team closed the concern without referring to Adult Social Care. However it must be remembered that the rapid review will have looked at the practice through the lens of District Nursing care and will not have focussed upon other learning which may have been there for external agencies or organisations. Not forwarding the concern to Adult Social Care resulted in a missed opportunity for such other learning to be considered.

5.49. In addition with regards to this safeguarding concern, the District Nurses report that despite being the referees, they didn't ever receive any feedback or update regarding its progress. They also reported that this is the norm. The hospital safeguarding team reassured that work is currently ongoing with regard to hospital staff being granted access to a platform through which it will be possible to track the progress of safeguarding referrals.

5.50. The team who responded to concern number 2 and 3 was a specialist team which is no longer, but which used to deal with safeguarding concerns regarding residents of Care Homes. In January 2023 Adult Social Care communicated with both referrers and with Josie's son to gather more information and a strategy meeting convened. Professionals at the meeting concluded that a lack of communication between the District Nursing team and the Care Home staff could have contributed to the deterioration of the wound. It was noted that Josie was currently being cared for in a safe setting (i.e., she was a hospital inpatient) and consequently no further safety planning was required until discharge was imminent.

5.51. During the learning event, Adult Social Care explained that whilst it was recognised that both the District Nursing team and the hospital safeguarding referrals were in line with policy[27], the problems and concerns around potential neglect and/or acts of omissions with regard to the deterioration of pressure ulcers, requires clinical expertise to be understood and resolved – which the Social Workers do not have. Consequently the decision as to whether there should be a section 42 enquiry can only be taken as informed by a clinician.

Learning 6: Safeguarding concerns raised with regard to the deterioration of pressure ulcers can be complex and require clinical knowledge.

[26] The Rapid Review identified the following immediate actions:
To discuss with the Nursing team the importance of following up any concerns or actions with the GP and not replying on the carers to ensure this is done.
To share the Rapid Review with the Victoria District Nursing Team for the purpose of learning.
And concluded the lessons learnt to be that; any concern around a patient must be escalated to the GP and documented within the nursing records on EMIS.

[27] The District Nurses had concerns regarding Josie's turning and repositioning as the record had not been completed, and as such were concerned that Josie had been subject to abuse in the form of neglect (Wilful Neglect - a crime introduced by the Mental Capacity Act [2005] for adults who lack capacity to make certain decisions, also had to be considered) - which is a safeguarding concern. And the hospital staff referred Josie in line with NHS Foundation Trust policy, which dictates that a person should be referred to safeguarding if they have significant pressure damage (such as stage three or four ulcers), unstageable ulceration, or multiple stage two ulcers.

5.52. It was suggested at the learning event that due to the complexities around safeguarding concerns concerning pressure ulcers, local specific guidance to support professionals to refer and address pressure ulcer safeguarding concerns would prove helpful. Such guidance could also incorporate the convening of multi-agency meetings with regard to pressure ulcer management.

5.53. However this review has been informed of current national guidance from the department of health and social care – Safeguarding adults' protocol: pressure ulcers and raising a safeguarding concern[28]. This guidance was updated in March 2024. The protocol is to support health and care organisations when developing their own guidance for staff in all sectors. The primary aim of the protocol is to provide a framework for practitioners when identifying pressure ulcers and the safeguarding interfaces.

Question 5: How can Stockport Safeguarding Adult Partnership seek assurance that there are multiagency procedures for the identification, management, and relevant enquiry for pressure ulcers in the Stockport system?

How did professionals communicate with Josie's family?

5.54. In order to achieve the Making Safeguarding Personal principle[29], professionals coming into contact with Josie needed to be able to learn of Josie's preferences, lifestyle, and choices instantly upon entry to her accommodation.

5.55. Though it is recognised that trawling through Josie's notes should achieve this, is it possible that Care Homes could start by producing summary 'life story wallcharts' to be displayed on walls or doors or by creating timeline books about a person's life? This is something that family could be involved in, and family could also include within the information how they wish to be kept informed of their loved ones care. In the absence of Josie being able to communicate her own wishes and feelings, it was important that the people closest to her were sought, consulted, and kept informed.

5.56. Family did not wish to engage with this review process and the review has therefore been unable to gain substance of Josie's personality, voice, or preferences, or establish for certain how family felt. However, one of Josie's son's correspondence with other professionals has suggested that he considered the communication with him to have been poor.

5.57. The care assessments completed by Adult Social Care at the beginning of this review imply that both of Josie's sons were consulted at this time. And the Care Home has informed this review that shortly after Josie's admission, the registered manager met with Josie's sons to ensure that they were happy with the placement and to advise that management was available upon request to address any issues that arise. In addition, the Care Home has reported that both of Josie's sons often visited Josie and that staff regularly communicated updates regarding Josie's care to them. Whilst staff did not maintain clear documentation to evidence these conversations, or detail the contents, the Care Home has reasonably raised that in regard to Josie's pressure ulcers and their management, the staff only had limited knowledge and consequently would only have been able to pass information that had been provided to them by the District Nursing team - that being that the wound was healing. When the physical condition of Josie did deteriorate, the Care Home manager contacted one of Josie's sons to discuss the management plan. This was when Josie's son informed that he had not previously been informed about his mother's wound and was unhappy.

5.58. It was the District Nursing team who was overseeing Josie's wound care. As mentioned, their initial contact with Josie within the scoping period was on the 10th of June 2022, and from this date until the 4th of September 2022, they visited weekly. From the 4th of September 2022, their visits increased to twice weekly

[28] https://www.gov.uk/government/publications/pressure-ulcers-how-to-safeguard-adults/safeguarding-adults-protocol-pressure-ulcers-and-raising-a-safeguarding-concern#consideration-of-safeguarding

[29] Making Safeguarding Personal is a way of working that should be seen across all practice areas, not limited to safeguarding, where practice is person-centred, outcomes focused, and strengths based. It is about seeing people as experts in their own lives and working alongside them with the aim of enabling them to reach better resolution of their circumstances and recovery. It requires gathering information about the extent to which this shift has a positive impact on people's lives. Congruent with adopting strengths-based approaches such as the 3 conversations model (Lyn Romeo, 2017), it involves a shift from a process supported by conversations to a series of conversations supported by a process. Making Safeguarding Personal toolkit (local.gov.uk)

as it had been identified that the wound had deteriorated from a category one to being unstageable. By the end of October 2022, Josie was being seen by District Nurses every other day. No one from the District Nursing team ever had contact with any of Josie's family. This review has been informed by Stockport NHS Foundation Trust that *there was some misunderstanding about whose job it was to inform the family about pressure ulcers, and this misunderstanding resulted in a lack of clarity regarding who was responsible for communicating with the family.*

5.59. Professionals in attendance at the learning event agreed that in particular when a patient does not have capacity to decide treatment for themselves, a District Nurse should, where possible and appropriate, make contact with the family. This contact should ideally be when the District Nursing involvement first begins and should include a conversation about how family would like to be kept involved and how much information they would like to know in the future. Conversations also mooted how there was a missed opportunity to communicate with the family and gather their views when the District Nursing team completed their own rapid review into the care that they afforded Josie.

5.60. A representative from Stockport NHS Foundation Trust informed this review that high caseloads within district nursing services would make maintaining routine contact with family challenging and the outcome of any rapid reviews would only be shared with family as per duty of candour[30] if any lapses in care were identified.

5.61. Stockport NHS Foundation Trust have further informed that their District Nursing team has since advised their staff about their responsibilities to liaise with the families of patients residing in Care Homes.

5.62. The Tissue Viability Nurses became involved in Josie's care in October 2022. Because their crucial role was to advise the District Nurses in wound care and management, it is understandable that they had no contact with the family.

5.63. The GP reported conversations with Josie's son in August 2022 regarding best interest decisions and covert medications, and later in December 2022 regarding hospital admission and Do Not Attempt Cardiopulmonary Resuscitation. The GP has confirmed that the sons would have been contacted more had the GP needed to discuss Josie's care with them and that because Josie did not have the capacity to decide her own health care, Josie's sons were welcome to contact the GP Practice to discuss her at any time. This review has no record of any other communications between the GP Practice and members of Josie's family, and it is not possible to establish whether Josie's sons were aware that they were able to do this.

5.64. The ambulance staff who transported Josie to hospital report that they had no involvement with Josie's family – their care and treatment was provided to Josie only. And hospital staff report that they considered their communication with Josie's family to have been good and there is nothing within the documentation to suggest that either son felt differently.

Learning 7: Professionals from all agencies must ensure that residents of Care Homes and (where appropriate) their families are included and kept up to date with care and support planning and are consulted and listened to.

5.65. This review has been informed that since January 2022, the Care Home has introduced a family liaison worker. The role is to support communication between the family and the Care Home. Four clients are now reviewed every week by a senior activity co-ordinator, who reviews the client's bedrooms, belongings and current needs. The staff then contact the family member, ensure they are aware of current needs, and the care that their loved one is receiving, and prompt them to bring more belongings if required or ask for additional items that they need. Staff ask the family member, if they are satisfied with the care and if they have any clinical questions, enquiry or concerns and, if needed, additional contact is then made by a registered nurse (to address the clinical needs), or the management team (to address complaints or concerns). This new process means that every client should now be reviewed / discussed with family every 12 weeks. The District Nursing service has suggested to this review that this process might be used to also update family of their

[30] The intention of Regulation 20: Duty of Candour (Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk)) is to ensure that providers are open and transparent with people who use services. It sets out specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

involvement, however the Care Home raised a concern that this could prove difficult if the District Nurse information is not clearly written for the liaison worker to convey and risks misinterpretation.

5.66. This review would recommend that the concerns around the District Nurses' communication with a resident and where appropriate, their families, be further considered within the action planning in response to question 1.

5.67. It was after Josie had been admitted into hospital that communications appear to have broken down between the Care Home and Josie's family. Whilst the cause is unconfirmed, conversation between Josie's son and Adult Social Care is indicative that the breakdown was as a result of the professionals' safeguarding concerns enquiries which caused the family to question the care Josie had been receiving.

5.68. This emphasises the importance of professionals who work within the safeguarding sector, having due consideration of the terminology they use with family when explaining safeguarding concerns. It is crucial that any complex or uncommon terminology be explained as safeguarding referrals and procedures, which are familiar to professionals, can feel alien and complicated to family members who may become confused by the process. Professionals at the learning event discussed the language that is commonly used around safeguarding referrals and what this may mean to members of the community. It was agreed that the term safeguarding referral could be construed by someone unfamiliar with the procedure as meaning that someone has failed their duty of care or has left a person in their care 'unsafe' and it was deliberated how this could cause tensions. One professional highlighted how when safeguarding children, the term 'multi-agency request for support' is used in place of safeguarding referral.

Learning 8: Professionals referring an individual for a safeguarding enquiry should ensure that those subject to the referral and where appropriate, their families are provided with the rationale as to why the process is necessary and what they can expect to happen next.

Question 6: How can agencies assure the partnership that they have systems and processes in place to support professionals to inform individuals and where appropriate, their families, of safeguarding referrals? And how can partner agencies evidence that processes are being followed?

6. Positive Practice

6.1. Discussion around Josie's care has highlighted examples of positive practice[31] from the professionals involved with her. It is important that such positive practice is highlighted and further encouraged. Examples are included within the body of the report, but the Independent Reviewer would like to add that the professionals who attended the learning event were commendably reflective and eager to debate how they could support one another to improve practice for the future.

7. Developments Since the Scoping Period

Agencies have already made some important amendments to practice since the scoping period of this review. These developments have been included in the body of this report.

8. Lessons to be Learnt and Recommendations[32].

8.1. The lessons learned from this Safeguarding Adult Review commissioned by Stockport Safeguarding Adults Partnership are highlighted in bold text throughout this report, but for reference are repeated here:

	Learning	**Has the learning been addressed?**		**Question**
1	There was a missed opportunity between the District Nursing Teams to	Yes: This review has been assured that the team		

[31] Positive practice in this report includes both expected practice and what is done beyond what is expected.

[32] By way of questions.

	handover Josie's care when Josie was discharged from the District Nursing team who covered the locality of the previous Care Home.	lead for the previous District Nursing Team is addressing this practice within their team meeting and will ensure that correct process is discussed to safeguard this doesn't happen again.		
2	Current policy and procedure with regard to documenting the details of professional visits to the Care Home in individual's care plans was not robust.	No	1	How can Stockport Safeguarding Adult Partnership ensure that consultation is had to collaborate the development of a protocol to support professionals in Stockport to achieve robust multi-agency working when practitioners such as District Nurses are delivering care in residential settings within their locality? And how can partner agencies and Care Homes assure Stockport Safeguarding Adult Partnership that the protocol is thereafter promoted and shared?
3	Perceived differences in status and/or the experience of professionals, can affect the confidence of some professionals to pursue concerns.	No	2	How can Stockport Safeguarding Adult Partnership support commissioned services (such as care providers) in their area with their escalation policy?
4	When an individual's needs change and concerns are raised with regard to a Care Home's ability to provide adequate care, timely coordination of a plan to ensure that the individual is placed somewhere where they can receive the care and support that they need, is crucial.	No	3	How can Stockport Safeguarding Adult Partnership seek assurance that Care Homes within their locality understand their responsibilities and have access to policy regarding the procedure to follow when a Care Home can no longer meet a resident's needs? The policy must recognise that when such a situation arises the Care Home must contact the commissioning authority to convene a multi-agency team meeting and review the situation in a timely manner. Furthermore, Stockport Safeguarding Adult Partnership should request that evidence of the policy's effectiveness in practice be provided at a later agreed date.
5	By not convening a multi-agency meeting to plan Josie's	No	4	How can partner agencies evidence to Stockport Safeguarding Adult

	pressure ulcer management and care, when an agency became concerned for the care she was being provided, professionals missed an opportunity to work within a multi-agency approach.			Partnership that convening a multi-agency meeting, when concerns arise around the quality of any care being provided to an adult at risk, is being considered to address the concern and to action a safety plan with immediate effect?
6	Safeguarding concerns raised with regard to the deterioration of pressure ulcers can be complex and require clinical knowledge.	Partly: This review has been informed of current national guidance from the department of health and social care – Safeguarding adults' protocol: pressure ulcers and raising a safeguarding concern. The protocol is to support health and care organisations when developing their own guidance for staff in all sectors. The primary aim of the protocol is to provide a framework for practitioners when identifying pressure ulcers and the safeguarding interfaces.	5	How can Stockport Safeguarding Adult Partnership seek assurance that there are multiagency procedures for the identification, management, and relevant enquiry for pressure ulcers in the Stockport system?
7	Professionals from all agencies must ensure that residents of Care Homes and (where appropriate) their families are included and kept up to date with care and support planning and are consulted and listened to.	Mostly: This review has been informed that since January 2022, the Care Home has introduced a family liaison worker whose role it is to support		

		communication between the family and the Care. The District Nursing service has suggested to this review that this process might be used to also update family of their involvement, however the Care Home raised a concern that this could prove difficult if the District Nurse information is not clearly written for the liaison worker to convey and risks misinterpretation. Therefore this review would recommend that the concerns around the District Nurses' communication with a resident and where appropriate, their families, be further considered within the action planning in response to question 1.		
8	Professionals referring an individual for a safeguarding enquiry should ensure that those subject to the referral and where appropriate, their families are provided with the rationale as to why the process is necessary and what they can expect to happen next.	No	6	How can agencies assure the partnership that they have systems and processes in place to support professionals to inform individuals and where appropriate, their families, of safeguarding referrals? And how can partner agencies evidence that processes are being followed?

9. Appendix 1

The Review Panel Members

- Independent Reviewer
- Business Manager of Stockport safeguarding Adults Partnership
- Business Support of Stockport safeguarding Adults Partnership
- Representative from NHS Foundation Trust
- Representative from Adult Social Care
- Representative from NHS Greater Manchester
- Representative from the Care Home
- Adult Safeguarding Training Manager (Stockport safeguarding Adults Partnership)

10. Appendix 2

Practitioner Learning Event

A face to face practitioner learning event was held and attended by professionals from:

- Ward Manager E2
- Tissue Viability Specialist Matron
- Tissue Viability Nurse Team Leader
- Tissue Viability Support Nurse
- Members of the Community Nursing team
- Ward Manager A1
- Head of Safeguarding, Stockport NHS Foundation Trust
- Head of Service Adult Social Care
- Adult Social Care Social Workers
- Care Home Registered Manager
- Stockport Safeguarding Adult Partnership Training Manager
- Representation from NHS Greater Manchester