

# 01 Background:

This Safeguarding Adult Review is about Mrs Hanson who until 17 January 2015 was living with her husband in unsupported accommodation owned by a housing association. It was reported she had not left the flat for about two years because of mobility problems. They were being supported by their son Tony. Additionally, Rochdale Council Adult Care Services commissioned a service to provide four daily visits to Mrs Hanson to assist her with personal care, the preparation of meals and to monitor her medication. Mrs Hanson was being treated for a urinary tract infection and on 17 January 2015 she fell three times in the flat. Tony called North West Ambulance Service because he suspected his mother had a serious water infection.

# Background:

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Paramedics attended and felt Mrs Hanson needed respite care and in due course this resulted in Mrs Hanson, accompanied by her son arriving at a care home about 1.00 am on 18th January 2015 for respite care. At that time Mrs Hanson was not known to have any pressure ulcers but the care home staff did note her bottom was bruised which they thought resulted from the falls. On 26 January 2015 a district nurse examined Mrs Hanson and discovered a grade 4 pressure ulcer. An ambulance was called and Mrs Hanson was admitted to Hospital where she died in the early hours of the following morning.

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## Questions?

How can I learn more about this SAR?  
The full SAR report has been published on the RBSAB [website](http://www.rbsab.org) and will be available for 12 months.

Learning is also incorporated into the multi-agency safeguarding training programme.

**More information at [www.rbsab.org](http://www.rbsab.org)**

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## Review:

A Safeguarding Adult Review (SAR) was held in 2017, to identify how agencies worked together and to learn from any lessons.

The report of the Review was published on 29 September 2017 and will be available on the [www.rbsab.org](http://www.rbsab.org) website for 12 months.



## Recommendations:

There are five recommendations in the Review, relating to the Safeguarding Adult Board, the Clinical Commissioning Group, Rochdale Adult Care and the named Care Home. The recommendations are:

**5** That Rochdale Adult Care Services reports in writing to Rochdale Safeguarding Adult Boards the arrangements in place for recognising and responding to changing circumstances which impacts of risk assessments for people it is providing services to.

**2** That the commissioners of care home places in Rochdale provide assurance to the Board that the care home has taken action that enables staff to identify and deal with developing pressure ulcers.

**3** That Board is similarly assured that record keeping in care homes is fit for purpose in that a resident's stay, including their qualitative experience, is accurately and fully recorded in the residents' care plans.

**4** That the Board satisfies itself that there is an effective process in place for identifying cases that have potential to be SARs, including those where the coroner has issued a Regulation 28 Notice, and for forwarding such cases to the safeguarding adult review screening panel.

**1** That Rochdale Adult Social Care provides written assurances to Rochdale Safeguarding Adult Board that the commissioners are only commissioning care homes where the residents receive a safe level of care that is relevant to their needs.

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