Safeguarding Adults Review Ivy: WFSAB response

Summary:

"Ivy always had a smile for people and always made people feel good about themselves"

Ivy was born in Walthamstow and lived there all her life, working in the local tin factory where she made kettles. After the war, she married Jim, from Hoxton and moved to the home they would live in for the rest of their lives and where she met her close friend and neighbour Brenda. Ivy and Jim had two children, a son and daughter, and a number of grandchildren, on whom Ivy doted and who spent much of their childhoods with her and Jim.

According to her daughter, Marilyn, Ivy's health began to deteriorate in 2014 when she broke her hip following a fall. Marilyn described her as having lost her confidence and having to use a walking frame. At this point Jim, Ivy's husband, took responsibility for the household and looked after Ivy and, with Marilyn's help, supported Ivy with her personal care. Brenda also provided a lot of care and support for both Ivy and Jim.

When Jim himself had a fall in 2015, and was in hospital for some weeks, both Jim's and Ivy's needs increased. Ivy was anxious about where she was and where Jim had gone. When Jim came home, he was no longer mobile and had to use a wheelchair to get around. This required Marilyn and Brenda to provide much more support, alongside good support from the council's in-house re-ablement and home care service.

In September 2015, a home care provider began providing care and support visits four times a day for thirty minutes each visit. Support was given around day to day living needs and assisting Jim with his personal care needs. Ivy was still at this point able to walk around.

In March 2016 Ivy was admitted to hospital following a decline in mobility and a Grade 2 pressure ulcer was identified. Ivy returned home and her care and support plan was increased to two carers for each visit four times a day, this included equipment. District nurses also provided care for the pressure ulcer. The pressure ulcer increased to Grade 3 in April.

Ivy was admitted to the Royal London on 3rd May 2016 with confusion and disorientation and there were concerns she had experienced a stroke. On admission it was identified she now had a Grade 4 pressure ulcer. Ivy died in the Royal London Hospital on 25th May 2016 related to:

- Bronchopneumonia
- Osteomyelitis (a bone infection resulting from pressure ulcer harm)
- Advanced dementia

The Safeguarding Adults Review (SAR) identified three findings and following discussion at the Board actions were agreed against each of the findings. The actions agreed are system wide and as such are assigned to appropriate leads across the partnership by the Waltham Forest Safeguarding Adults Board (WFSAB). The action plan is monitored by the One Panel on behalf of the WFSAB and reported to the One Panel on a quarterly basis.

Finding 1: Multi agency coordination of care assessment and planning following hospital admission

Questions for the Board:

1. Is the Board confident that discharge planning for people with complex care packages is seen by the partnership as a multi-agency activity?
2. Is the Board confident that systems to review community complex care packages are robust?
3. What are the strategies for vulnerable older people that relevant board agencies are pursuing?

Board response:

The WFSAB acknowledged that while discharge and review of complex care packages is seen by the partnership as a multi-agency process, there are improvements that need to be made. One of the issues for Ivy was that her care package was considered a restart and therefore her case was not allocated a six week review following discharge, but placed back in the system for an annual review. WFSAB agreed that improving coordination and leadership is essential to ensure consistency and embed re-assessment in hospital discharge as appropriate. WFSAB is aware that significant work is already underway to deliver the multi-agency hospital discharge improvement plan, through a working group and the findings from this SAR will influence and further inform this plan.

Adult Social Care (ASC) will refresh the review process and its focus and proportionality for residents requiring care packages following hospital discharge, particularly in circumstances where the resident lives alone and/or has complex needs.

The review findings in respect of how communication between teams could be improved will be progressed through the action plan for the multi-agency discharge working group

ASC will use the learning from this SAR and its findings in practice improvement workshops that will also include colleagues from NELFT and Whipps Cross.

Finding 2: Multi-agency approach to prevent and respond to pressure care in the community

Questions for the Board:

1. Is the Board confident that the action plans in place and the work that is in progress will be effective in addressing the issues of quality of care and knowledge highlighted in this review?

Board response:

The WFSAB priorities for 2017 - 19 include Quality and Standards, with a focus on quality in care delivery in care homes and to people living in their own homes and a separate group working on Pressure Care. Task and finish groups have been set up to deliver action plans in relation to these priorities. The WFSAB felt that the action plans in place directly address the learning in relation to quality in care issues and pressure care identified in the SAR. However, the WFSAB requested that the actions plans are reviewed to ensure that there is sufficient focus on: (a) evidencing impact from training and learning events; (b) communication to enable a more joined up approach between care providers and all agencies involved to ensure a shared understanding of pressure care and their responsibilities; and (c) support for staff to have difficult and challenging conversations with family members around the need for particular equipment. The WFSAB will monitor progress against the action plans and impact on a quarterly basis.

Finding 3: Identification, referral and response to safeguarding concerns

Questions for the Board:

1. Is the Board confident that the safeguarding process in ASC is now robust and fit for purpose following the recent changes? How is the Board going to monitor and evaluate the new changes?
2. Is the Board confident that the processes in the Local Authority, the Clinical Commissioning Group (CCG), North East London Foundation Trust (NELFT) and Barts Health NHS Trust in place to monitor provider agencies is effective?

Board response:

The WFSAB noted the significant changes that have recently been made in Adult Social Care. These including the new Mosaic ICT system and Safeguarding Adult operational procedures and guidance, which were developed in accordance with legislation, statutory guidance and Pan London procedures. These changes provide a robust framework, strengthen accountability and governance, and should lead to improved practice and enhanced outcomes for the residents of LBWF. This is being embedded through practice framework sessions, training, safeguarding adults, best practice forums and audits.

The new system has numerous checks and balances in place and is being monitored through a range of daily, weekly and monthly audits to review the appropriateness, robustness and timeliness of screening/ responses to safeguarding matters. The Board has requested monitoring of further indicators in relation to Adult Social Care, such as the number of concerns screened within the agreed timeframe and this will be reported on the quarterly SAB performance dashboard.

The board is mindful of how new the system is and that audits on timeliness and responses are insufficient measures of the quality of the response and the impact on the wellbeing of the individual. The board therefore requests update reports on the findings from Adult Social Care quality audits initially on a quarterly basis in order to evaluate the new changes.

In addition, the WFSAB will explore a multi-agency training offer for Enquiry Officers and Safeguarding Adult Managers across the local partnership.

The WFSAB will review and define the arrangements that are in place for safeguarding adults out of hours, such as over the weekends/ evenings to ensure these arrangements are sufficient and that referrers are clear about what to do during out of hours.

In regard to issues related to providers, the revised safeguarding adults' operational procedures guide practitioners to advise the inspectorate CQC, and the relevant commissioner. This is for any safeguarding adults concern or quality in care concern related to a commissioned service.

The Safeguarding Adult Manager is also responsible for ensuring an update is provided at the end of the safeguarding adults enquiry, in order to advise on the outcome and actions required. This is supported through templates and contact details within the operational guidance, along with mandatory fields in the safeguarding adults Mosaic episode to support this.