NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD

Serious Case Review Executive Summary

Adult D

A report prepared for the

Nottinghamshire Safeguarding Adults Board

November 2010

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1. Introduction

Adult D was a 74 year old lady who lived with her husband until his sudden death. He was her main carer and they had two daughters who also gave them support. Adult D was a small, frail lady who was known to the district nursing services.

Adult D was admitted to a residential home the morning following her husband's death. The family placed Adult D in a residential home which was nearby so that they could visit regularly.

Adult D's general condition soon deteriorated. She was admitted to hospital and then discharged back to the residential home. During this time, she developed pressure ulcers. Following further deterioration, Adult D died in hospital in February 2007.

The Nottinghamshire Safeguarding Adults Board would like to offer their sincere condolences to Adult D's family for the loss of their mother and are grateful for Adult D's daughter's support during this investigation. Her comments and views have been taken into consideration.

2. The reason for the Serious Case Review

Adult D was referred for a Serious Case Review following the coroner's enquiry heard in July 2009. The coroner's summing up referred to the cause of Adult D's death as 'natural causes contributed to by neglect', but did not identify specific agencies. The cause of death was given as septicaemia, arising from gangrenous pressure ulcers. The coroner also commented that 'opportunities had been missed' but these may not have affected the outcome.

2.1 The Aim of the Serious Case Review

The aim of the Serious Case Review is to establish whether there are lessons to be learnt from the circumstances of the case where local professionals and agencies have worked together to safeguard vulnerable adults.

This is the summary of a serious case overview report commissioned by the Nottinghamshire Safeguarding Adults Board (NSAB). This report is based on information provided by the agencies, which has been analysed by the independent author. The

conclusions and recommendations are based on the analysis of the information provided.

3. Agencies involved in the Review

- Bassetlaw Community Health
- Doncaster & Bassetlaw Hospitals NHS Foundation Trust
- East Midlands Ambulance Service
- GP Medical Centre
- Nottinghamshire County Council
- Residential Home

4. The Scope of the Review

The period covered in the review is from December 2006 when Adult D moved into a residential care home until the date of Adult D's death in February 2007.

Following the terms of reference the main issues considered were:

- Were care plans developed, was it clear what was trying to be achieved and were risk assessments carried out?
- What was the quality of the assessment of Adult D's ongoing welfare, health and development?
- Were areas of risk appropriately identified and a plan devised to address these?
- Were appropriate contingency plans identified?
- Were the services provided appropriate to Adult D's needs and in accordance with the plans arising from assessments?
- What was the quality of the management oversight of the work undertaken?
- Was high quality pressure area care given and was it delivered in accordance with best practice?
- Were relevant plans of care S.M.A.R.T (Specific, Measurable, Achievable, Realistic, Time oriented)?
- Were these plans renewed, changed, adhered to and communicated, both to and by the relevant agencies involved?

5. Key Findings

- Some care plans were developed and some risk assessments were completed. When high risks were identified, the appropriate care was not always put in place, so Adult D did not always receive timely care. The assessments and care planning did not meet all of Adult D's needs and care plans were not always clear. Adequate regard was not paid to Adult D's deteriorating condition. She remained in residential care despite significant medical needs.

- The communication between agencies, both written and verbal, on admission/ discharge/ transfers of care was ineffective. At times there were discrepancies in the documentation relating to discharge. It is clear that a multi-disciplinary approach with all agencies caring for Adult D would have been beneficial, with an identified lead co-ordinating the management of her care. Agencies did not always work in an integrated manner to address Adult D's overall needs.

- An independent Tissue Viability opinion was sought from an external expert.

- Adult D was a frail, elderly lady with multiple serious medical conditions. Care plans for pressure area care were formulated, but risks do not appear to have been fully assessed. Specialist tissue viability equipment for Adult D was not identified as a need until a pressure ulcer had developed and was deteriorating. Pressure area care was not delivered in accordance with best practice.

- All relevant agencies involved did have access to some guidelines on pressure area care, but it is unclear whether these were adhered to.

- Adult D had a small appetite and a history of weight loss and weighed only 30kgs (4st 7lb) on admission to the residential home. However there was little recognition from all agencies of how Adult D's poor nutrition related to her weight loss, the healing process of the pressure ulcers and her overall vulnerability. Adult D was seen by the dietician and supplements to her diet were prescribed but this appeared to be done in isolation, with no co-ordinated, cohesive approach to her nutritional needs.

- The necessary professionals were generally involved in assessments and interventions. There is evidence that concerns were escalated appropriately however these were not documented. There appeared to be little management oversight across organisations, and little evidence of senior professionals having any involvement in Adult D's care. Ineffective communication did not support effective care.

- Generally, Adult D's wishes and feelings were taken into account. Adult D's mental capacity was never in question. She seemed able to make her own decisions.

- Although Adult D's disabilities were considered and mostly planned into her care, the implementation of this care was sometimes lacking. There was no apparent consideration of how her disabilities impacted on her overall care.

- It appears that safeguarding risks were not considered or recognised for Adult D. Although training was available at the time, awareness of safeguarding was not as developed as it is today. All agencies now have robust training programmes in place.

6. Independent Author's Recommendations

Recommendation 1

People in receipt of care should have their overall care co-ordinated by an individual professional. They should take responsibility for the overview, communication etc relevant to the person thus enabling actions to be followed through to a conclusion. This would enable a holistic approach (as opposed to task orientated) to ensure the whole package of care is managed appropriately.

Recommendation 2

All service providers should have clear appropriate escalation processes in place.
When escalation is required all service providers should take account of individual needs and ensure appropriate managerial processes are in place to give the required support.

Recommendation 3

All organisations should complete reviews and assessments in a timely manor. This will identify and prompt the need for additional care/change in management.

Recommendation 4

The Primary Care Trust (PCT) and Local Authority should jointly develop a check list for an early warning system that recognises deterioration in a person's condition on circumstances, thus identifying when to escalate to the relevant professional.

Recommendation 5

There should be effective communication systems between district nursing teams and residential homes so that deterioration or changes in need are acted on in a timely way.

Recommendation 6

All organisations should demonstrate a robust system of information sharing on admission, discharge and transfer of a person from one service to another.

Recommendation 7

All relevant care providers should demonstrate that tissue viability management is in line with best practice.

Recommendation 8

Organisations should review existing documentation on a regular basis to ensure that care planning is sufficiently descriptive, to enable an external agency to continue delivering the required planned care.

Recommendation 9

All organisations should review safeguarding adults training with specific emphasis on the vulnerability of people with complex needs.