Safeguarding adults
North East Lincolnshire

SAFEGUARDING ADULT REVIEW

“Mrs B”

Date of report: 29 October 2018

Contents **Page**

1. Incident Overview:

1.1 Mrs B was eighty years of age at the time of her death. She had osteoporosis (possibly also osteopenia) and dementia. She was described as having contracted legs that were reported to be in the crossed position.

1.2 On 27th February 2015 Mrs B was admitted to the Care Home for full 24 hour care. In the months prior to this she had a number of falls and a previous time in respite care. She had been displaying symptoms of dementia which appeared to be progressing.

1.3 Mrs B's sons' had a joint Lasting Power of Attorney for both financial affairs and health and welfare. This had never been verified by the Care Home and was not evident within Mrs B's health records.

1.4 The relationship between Mrs B's son and the Care Home was somewhat fractured and the Care Home described interaction between the two parties as difficult. This was concurred by the family.

1.5 On arrival to the Care Home she was mobile, at times utilising a walker, but within weeks of her being resident at the home her legs contracted and crossed and she became bedbound. She utilised a wheelchair and a hoist was used to transfer her.

1.6 The accounts from carers and family conflict in relation to her leg positioning. Some individuals state that Mrs B's legs were crossed at the ankles, whilst others state at the knees. Other individual's recollect that she couldn't move her legs at all whilst others state that she could cross and uncross her legs independently. Mrs B was turned or repositioned every two hours as part of her care plan.

1.7 On 31st March 2017 between 5am and 6.30am Mrs B was checked by the night shift carers at the home. They washed her and put a top on her before leaving her sat in bed with her legs crossed.

1.8 Later at about 9.30am three staff members entered Mrs B's room to dress her and provide personal care. Mrs B always wore trousers, as this had been her preference and was her family's request. One carer provided her with personal care and the other carers transferred her from the bed. They found Mrs B in bed with her legs uncrossed. Although they thought it unusual they did not note it as a concern.

1.9 Staff report that Mrs B was not complaining or displaying any signs of discomfort. The carers noted she was quiet which was unusual as she was normally agitated. One of the staff members wheeled Mrs B to the dining room for lunch.

1.10 At about 2pm two carers returned Mrs B to her room to provide her personal care. They hoisted her onto the bed and as they did so Mrs B exhibited pain. They lowered her onto the bed and removed her trousers. They immediately noticed a large lump on her left leg. The leg was bruised and was red/purple in colour.

1.11 The carers found the senior staff member on duty in the office and reported their findings to her. She inspected the injury and telephoned her manager, who was away from the home at an assessment, for advice. The manager told her to telephone the district nurse or an ambulance.

1.12 The carer attempted to telephone the district nurses, however there was no answer. She awaited the return of her manager later stating that she was unsure what to do and wanted the line manager to see Mrs B. The manager eventually returned and directed an ambulance be called, which was 3 hours from the injury being identified.

1.13 At 4.58pm an ambulance was called from the home. At 5.07pm a paramedic fast response vehicle arrived and this was joined by a double crewed ambulance with a further paramedic and a technician at 5:15PM. They recorded that Mrs B was not complaining of pain and was responding to staff as normal. They recorded that she had not had a fall and was unable to straighten her knee as the joint was solid. They immobilised her leg with a vacuum splint and transferred her to Hospital.

1.14 Mrs B arrived at Hospital and was examined within their Emergency Care Centre (ECC). X-rays showed a displaced fracture to left distal femur. Mrs B had a long leg backslab (half a cast which is bandaged to the leg) applied.

1.15 Mrs B was transferred to a hospital ward where staff recorded that she had a grade 1 pressure ulcer to her buttock and sacrum and a skin tear to her right elbow.

1.16 On 3rd April 2017 ward staff recorded that the pressure ulcer to the sacrum had worsened to grade 2 despite skin inspections, regular turning and provision of a specialist mattress.

1.17 On 4th April 2017 the Care Home and Hospital discussed Mrs B's discharge and return to the home. Initially the home was intending to place her in a downstairs room however Mrs B's family insisted she be taken back to her own upstairs room, as there were dementia residents downstairs who may wander into her room.

1.18 The only access to this room was via a lift which would not accommodate a stretcher. The home discussed and liaised with ECC staff as to how Mrs B could be transported to the upstairs room. The two parties came to conclusion that Mrs B would have to be taken to her room using the lift, whilst manually supporting her leg. This decision appears not to have been adequately risk assessed or considered as to whether this was in Mrs B's best interests.

1.19 On 5th April 2017 at about 3pm Mrs B arrived back at Cambridge Park. Ward staff noted grade 2 pressure ulcer to sacrum and grade 1 pressure ulcer to left buttock, blanching to right. SSKIN bundle completed at 14.00 prior to discharge. *(SSKIN bundle is a five step approach to preventing and treating pressure ulcers).*

1.20 The Care Home manager contacted the Safeguarding Adults Team (SAT) to report the fracture. After discussion, the safeguarding practitioner directed the manager to report the incident on her monthly low-level report and closed the enquiry to safeguarding.

1.21 On 6th April 2017 Mrs B's son telephoned the SAT as he was concerned that the enquiry had been completed over the phone and closed. The conversation was overheard by the Occupational Therapist who was intending visiting the home that day.

1.22 The OT expressed his concerns that the hospital had not sent a moving and handling plan on discharge and as a result he was going out that afternoon to carry out an assessment and intervention.

1.23 The OT also had other concerns surrounding Mrs B's discharge including an ungradable pressure sore that had not been included on the discharge summary and a referral to physiotherapy that had not been received by the physiotherapy team. The SAT advised the OT to put this through to safeguarding and they would review it.

1.24 The District Nurse contacted Physiotherapy with concerns that the cast was not adequately supporting the fracture and was causing discomfort. Later that afternoon the Physiotherapist attended the care home and examined Mrs B. On examination, the Physiotherapist felt that the cast was not high enough to immobilise the facture. An ambulance was called and a further safeguarding referral made.

1.25 At 5.28pm an ambulance arrived at the care home and returned Mrs B back to the Hospital. Staff in ECC noted that Mrs B was in distress due to the injury to her left leg and when the plaster of Paris was removed an open infected wound was seen.

1.26 Following examination of Mrs B the orthopaedic surgeon concluded that Mrs B now had an open fracture (fracture complicated by a wound) of the left femur.

1.27 Mrs B was admitted again onto a Ward and staff there noted she had a Grade 3-4 pressure sore on her left knee (which was under the cast) as well as the Grade 2 sore on her sacrum which was identified during her first attendance.

1.28 On 10th April 2017 clinicians from the hospital and Mrs B's son discussed what treatment options were available for Mrs B. These included the need for multiple operations or amputation and what would be in Mrs B's best interest. Mrs B's son agreed with the decision not to amputate and to make Mrs B comfortable.

1.29 On 18th April 2017 at 5.40am Mrs B died in Hospital. The cause of death was later attributed to – old age and frailty, open infected left femur fracture and Alzheimers.

1.30 On the 24th April 2017 as part of their safeguarding investigation, the SAT began making enquiries with Hospital staff to ascertain any physiological rationale or complication which may have compounded or contributed to how the fracture may have been caused.

1.31 On 3rd May 2017 the safeguarding practitioner sought advice from the Police as to how to progress the enquiries.

1.32 On 4th May 2017 all staff members were interviewed by the home management and the SAT. Following this, it was found that there was not enough evidence to determine how the fracture occurred. It was felt that on the balance of probability it was accidental as there is no indication from the history to suggest that it was non- accidental.

1.33 On the 15th May 2017 the case was referred to the Safeguarding Adult Review Group for consideration. The cause of death was reported as not being linked to the open fracture and as such did not meet the criteria for a SAR however the group delayed making a decision until the results of the safeguarding investigation and the Serious Incident review were completed.

1.34 On 25th May 2017 the enquiry was handed over to a new safeguarding practitioner due to the original SAT member leaving.

1.35 On 16th June 2017 police advised the threshold for a criminal investigation had not been met and the decision rested with the Coroner for any further investigation.

1.36 On 29th June 2017 the hospital reported on their own Serious Incident investigation of the events which looked at the pressure areas and also the accuracy of application of the cast. They concluded that the correct cast was applied but added that the technicians had difficulty with the application due to the position of the patient and manoeuvring of the leg. There is also the possibility that this slipped following application which can happen in some cases. The grading of the pressure ulcers had been clearly documented.

1.37 On 17th October 2017 the new safeguarding practitioner met with the Chair of Safeguarding Adult Review Group to discuss the case. During this meeting she highlighted the fact that the infected open fracture was a contributing factor in the death.

1.38 On 19th October 2017 the Director of adult social services directed the case be reviewed by means of a Safeguarding Adult Review.

2. Family Involvement with the Review:

2.1 Mrs B's son was informed of the intention to undertake a Safeguarding Adult Review and was offered the opportunity to contribute.

2.2 Mrs B's son met with the Chair of the SAR/SILP group to provide family background and share the family's experience. Mrs B's son was given the opportunity to raise any specific concerns or queries regarding Mrs B's care.

2.3 The key specific question provided by Mrs B's son was:

> ***Do you agree that the safeguarding the home initially did is not acceptable? This was only done over the phone with no investigation.***

2.4 During the course of the review, Mrs B's son was informed of any progress and emerging learning points by the Chair.

2.5 As per the SAB's Policies and Procedures, the report's findings have been shared with Mrs B's son on completion and following DASS and the SAB sign off, the whole report will be shared with Mrs B's son and permission sought to publish an anonymised copy on the SAB website.

3. Terms of Reference:

3.1 Specific issues to be addressed:

- How did Mrs B receive her injury?
- Was the care and support once her injury discovered satisfactory?
- Was the treatment she received in hospital satisfactory?
- Was the care she received post hospital discharge satisfactory?

This review is to determine if the care provided and actions taken were appropriate and in line with current guidance/protocol and ensure any learning opportunities are identified and shared appropriately.

3.2 Who commissioned the review (and at which level in the organisation):

- Director of adult social services on the recommendation of the Safeguarding Adult Board, Safeguarding Adult Review Group Chair.

3.3 Review panel/ Contributing Authors

Designated Nurse for Safeguarding CCG - Chair of SAR, SILP & GP Group
Head of Safeguarding, Acute trust
Named Nurse for Safeguarding, Acute Trust
Head of Safeguarding, Safeguarding Adult Team
Head of Safeguarding, Ambulance Service
Police representation
Safeguarding Practitioner, Safeguarding Adults Team
Chief nurse for community Health and Social care provider Contracts Officer, CCG
Specialist Nurse for Safeguarding, CCG
Head of Regional Operations, Care Home Provider
Registered Home Manager, Care Home
SAB Business Manager & DASM
Specialist Business Support Officer, Local Authority

3.4 Aims and objectives of the review and desired outputs:

Aim and Objective:

- To understand how and why the incidents occurred.
- To review the circumstances pertaining to the episode of care to be able to establish the facts, and contributory factors.
- Report on and record the outcomes of the review to all key stakeholders
- Determine how lesson learnt can be shared from this incident

Desired Outputs:

- To identify any changes required to existing processes or any new processes which need to be implemented.
- To minimise the risk of recurrence.

3.5 Scope and boundaries beyond which the review should not go (e.g. disciplinary process):

- The incident review will focus on 'what went wrong, not who went wrong'. However, any emerging performance or capability concerns will be managed in accordance with individual agencies policies and procedures.
- This will be an inclusive review with all agencies involved as members of the review team.
- The review will focus on the episode of care leading up to and after the incidents.
- Chronologies have already been provided by agencies prior to this review.
- Information sharing arrangements: All requests for information in relation to this incident will be dealt with in a timely manner and sent via the recommended and secure email domains.
- Any disagreements between the two parties which are not resolved through the joint meetings will be escalated to the Director of Adult Social Services as the commissioner of the review.

3.6 Limitations of the review

Ownership of the Care Home had changed since the incident occurred. The current manager was not in position at the time of the incident and therefore, was limited in the level of detail which could be provided to the review.
The care home records were not provided as part of the review.

4. Methodology Used:

4.1 Detailed chronologies and Incident Management Reviews (IMRs) were requested from each organisation involved and these were reviewed by the SAR, SILP and GP Group. The incident was reviewed by a panel consisting of all the agencies involved utilising the timeline to identify the care/service delivery problems, contributory factors and the key learning points.

4.2 In accordance with the Care Act Guidance, the review focused on "what went wrong" not "who went wrong" and for this reason the report has been anonymised although job roles are described to ensure that there is a context to the report.

4.3 Information used during the investigation included:

- Hospital nursing and medical records
- Mrs B's GP records
- Care Plus Group Records
- Ambulance Service records
- Adult Social care safeguarding records
- SAB Multi-Agency Policies

5. Findings:

5.1 The review team identified the following issues:

- How did Mrs B receive her injury?

  It is still unclear how AB received the injury. Medical opinion is not conclusive. The care home staff did not notice the injury when they were moving and handling Mrs B. The injury was only discovered when she was undressed. The issue of moving and handling techniques is a point of contention within the review. Mrs B’s family stated that staff would often transfer Mrs B from bed to chair and vice-versa without the use of hoists. Information provided by the Care Home holds the view that staff did use hoists. The review ascertained that the Care Home only stocked standardised hoist slings in differing sizes for use with their residents. Despite Mrs B’s mobility deteriorating and the development of contractures, there had been no review or advice or assessment sought from an Occupational Therapist prompting the need for a specialist sling. This could have contributed to the injury and is identified as a key learning point.

- Was the care and support once her injury discovered satisfactory?

  The delay to telephone for an ambulance was investigated by the Sec 42 safeguarding enquiry which looked at the reasons for the delay and dealt with these. The member of staff from the care home was not confident in escalating the incident and calling for the ambulance without this being corroborated by the care home managers. This initial delay appears not to have contributed to later complicating the injury, or contributing to infecting the later open fracture, although would have left Mrs B in pain for an extended period of time. The Care Home staff member involved with the reporting of the incident to the manager very quickly received one-on-one tailored training in crisis incident management provided by the care home organisation.

- Was the treatment she received in hospital satisfactory?

  The panel had concerns that the cast was not sufficiently long enough to immobilise the injury. Photographs taken show the end of the cast to be very close to the break. A serious incident investigation conducted by the Hospital noted that the technicians recall difficulty applying the plaster due to the contractures of the patient and the manoeuvring of the leg. Two technicians were required to assist in completing the application of the back-slab cast. Discussion was held with the clinician at the time regarding the cast, who deemed it was the correct cast – after reviewing the X-ray. However, the difficulty in applying this cast and the limited immobilisation of the fracture was not appropriately conveyed to the care home. Slippage of the cast was possible due to the complications of applying the cast to Mrs B’s contracted legs. It is accepted that the application of treatment on patients with contracted legs is difficult.

- Was the care she received post hospital discharge satisfactory?

There was a discussion between the hospital and care home prior to Mrs B’s discharge, however, this focussed on how the home could physically get her upstairs to her bedroom, as the lift was not of a sufficient size to accommodate a stretcher. The care home offered to move Mrs B to a ground floor room to facilitate easier access; however, the family wanted her to remain in her own room. The care home and hospital should have completed a thorough risk assessment as part of the discharge plan to ensure that any risk to Mrs B was considered and mitigated against, as well as any health and safety implications such as fire risk. Although the family had an LPA for health and welfare in situ and had decided Mrs B should return to her upstairs room, there was clearly a risk to Mrs B in physically get her there. The conflict between the family and care home may have managed better utilising the best interest process, analysing all risks and explaining these clearly to the family to reach a safe conclusion for Mrs B. It appears that the care home did not feel empowered enough to challenge the views of Mrs B’s son. Ultimately, should the difference of opinion and presenting risk of unsafely transferring Mrs B to her original room have continued, this decision could have been escalated to the Court of Protection.

Upon discharge, the hospital did not share any information or direction as to pain management with the care home. However, the care home also did not challenge or question this lack of information. Communication between the two organisations was not sufficient.

There was some discrepancy between the hospital trust with the Care Home and community nursing services with regards to Mrs B’s skin integrity. This was difficult to compare and determine due to a difference in the terminology used to record pressure damage. Some practitioners used descriptive terminology rather than clinical grading systems in their documentation, which the panel agreed was poor practice. This also made it impossible to robustly analyse the progression of pressure sores.

A grade 3-4 pressure sore developed under the cast. This was reviewed by the hospital under the serious incident framework and apportioned to the difficulty in applying the cast due to Mrs B’s contractures.

Mrs B required regular turning alleviate pressure and prevent worsening of her sacral pressure sores; however, the cast made it much harder to “turn” Mrs B without causing undue pain. With Mrs B’s overall physical decline, and the increased level of immobility, it is highly likely that existing pressure sores would worsen.

- **Do you agree that the safeguarding the home initially did is not acceptable? This was only done over the phone with no investigation.**

The panel agreed that the initial decision to record this injury on the low level log was an insufficient response. Upon initiation of a Sec 42 investigation, the interviews with staff were appropriately undertaken by both the Care Home and the SAT. The Safeguarding Adults Team have been part of this review and accept this decision. The Head of Safeguarding is to conduct a review of the procedure for assessing safeguarding concerns involving serious injury to ensure these cases are identified and given the appropriate response.

6. Contributory Factors:

6.1 As Mrs B's contractures progressed, moving and handling techniques within the care home were not reviewed, changed or adapted. Standard hoist slings continued to be used. Staff within the Care Home and Community Nursing did not recognise the need for a specialist assessment by Occupational Therapy (OT) as Mrs B's contractures progressed. Any moving and handling assessments or care plan reviews did not prompt a referral to OT.

6.2 The lack of review procedures for service users with significant changes in their health and wellbeing, affecting their mobility, including contractures, by the care home and medical staff are a source of concern.

6.3 Hospital discharge practice failed to alert the care home staff to adequate pain management for Mrs B. The hospital did not alert the care home to the pain management plan, and likewise the care home didn't challenge or escalate this upon Mrs B's return to the home.

6.4 The Care Home and GP practice were not certain of the arrangements of the Lasting Power of Attorney. As the family had not provided the care home with copies of the documentation, this cast some doubt over these arrangements and as such may have affected their actions and practice. However, this could have been easily resolved should the Care Home and GP practice sought verification from the Office of the Public Guardian.

6.5 Early discharges from Community Health Care, following the delivery of episodic task-focussed care, didn't allow for the identification of any emerging wider holistic issues.

6.6 The failure of both the care home and hospital to effectively challenge the family request for Mrs B to return to her upstairs room due to the potential risks may have contributed to the exacerbation of her injury.

6.7 The Care Home and hospital did not adequately risk assess the discharge back to the Care Home, despite identifying that Mrs B could not be safely transported to her room on the first floor. This unsafe transportation coupled with the lack of moving and handling guidance may have also contributed to the worsening of the injury.

7. Key Learning Points and Recommendations

<u>Care Home</u>

7.1 Ensure any LPA's are verified with the correct documentation or through the Office of the Public Guardian.

7.2 To ensure Care Homes undertake risk assessments prior to discharge from hospital receiving, considering any changes in needs and suitability.

7.3 Ensuring medication and any medical directions are received with the service user on discharge.

7.4 Ensuring correct moving and handling assessment is considered when service users conditions change/injury.

Community Nursing Team

7.5 Review the community nursing admission and discharge process of reviewing patients following hospitalisation.

7.6 Review organisational policies around contraction and review processes

7.7 Ensure that moving and handling care plans for patients who are non-ambulant are utilised where appropriate

7.8 Pressure sores must be documented using appropriate clinical grading systems

7.9 Review why there was no follow up of pain management by community nursing

Hospital

7.10 Discharge summaries must communicate all relevant information relating to the patient's condition, limitations of interventions, skin integrity, referrals to therapists and pain management. Wherever possible, this should be verbally communicated to the receiving care provider.

Safeguarding Adult Team

7.11 Review procedure for assessing safeguarding concerns involving serious injury to ensure they are escalated appropriately to a S42 enquiry

Safeguarding Adult Board

7.12 The key learning identified within this review will be disseminated as a 7 minute briefing available via the SAB website and disseminated to all partner agencies. The learning will be shared with the Workforce and Development sub-group for inclusion in any future training, as well as disseminated at the Provider Forum.

7.13 Staff across health and social care should be supported to be well versed in Lasting Power of Attorney's, verification of registration and escalation of concerns when dealing with decision not deemed to be in the service user's best interest.

7.14 Staff across health and social care providers should be supported in managing conflict with families to prevent relationships deteriorating and potentially negatively impacting on the provision of care to service users.

8. Conclusion:

Whilst the review has not provided a definitive cause of the injury, it was likely to have been caused by a contribution of factors; inappropriate methods of moving and handling causing pressure on her legs due to her contraction and her underlying osteoporosis.

The limitations in applying the cast prevented the injury being properly immobilised.

The physical difficulties in transferring Mrs B to and from her upstairs room in the lift is also likely to have further exacerbated the injury.

The limitations of the cast were not appropriately conveyed to the Care Home, neither was any support in further management of this.

Despite attempts to provide therapeutic interventions which included a return to hospital, an infection was already established. Mrs B’s death was certified as being due to old age and frailty with a contributing cause of an infected open fracture.

It is possible that Mrs B’s death may not have been avoided, as the cause of the injury remains unclear. The review has demonstrated that there are clear lessons to be learnt which may help to prevent reoccurrence and improve the future management of service users with contractures.