



NOTTINGHAMSHIRE
SAFEGUARDING
ADULTS BOARD

Serious Case Review Executive Summary

Adult B

A report prepared for the

Nottinghamshire Safeguarding Adults Board

February 2011

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1. Introduction

Adult B was an 83 year old, white British woman who had suffered for many years with arthritis and indigestion. Her first language was English. During 2007 she had several falls at home which resulted in her being admitted to hospital for six weeks. On discharge she was admitted to a residential home, and then returned home with regular home care visits.

In June 2008, Adult B was admitted to a care home, whilst a kitchen was fitted at her home and general refurbishments were undertaken. At this point she was noted to be at risk of pressure sores. She was resident in the care home for some seven weeks. Adult B was able to return home for approximately two months, but was readmitted to the care home with weight loss and severe pressure sores.

Sadly, Adult B quickly deteriorated and died in September 2008.

The Nottinghamshire Safeguarding Adults Board would like to offer our sincere condolences to Adult B's family for this sad loss and are grateful for Adult B's daughter for her contribution to the investigation.

2. The reason for the Serious Case Review

Adult B's death was referred to the Nottingham Coroner's Office. The Coroner reached a verdict of death by natural causes but contributed to by neglect, with a recommendation that Nottinghamshire County Council and Nottinghamshire Primary Care Trust review their procedures for providing care to the frail elderly.

Consequently the Nottinghamshire Safeguarding Board determined that Adult B should be subject to a Serious Case Review.

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

- Care Home
- East Midlands Ambulance Service
- Home Care Agency 1
- Home Care Agency 2
- NHS Nottinghamshire County
- Nottinghamshire Community Health Trust
- Nottinghamshire County Council
- Sherwood Forest Hospital Trust

4. The Scope of the Review

The period covered in the review is from September 2007 when Adult B started to receive treatment for care of pressure sores until the date of her death in September 2008.

Following the terms of reference the main issues considered were:

- Was it clear what was trying to be achieved and how this would be assessed?
- What was the quality of the assessment of Adult B'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 B's needs?
- How were the issues of concern raised and was the response of agencies appropriate?
- 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 by and to the relevant agencies involved?

5. Key Findings

- Numerous assessments were carried out by different agencies. The assessments were not always comprehensive; therefore some of Adult B's needs were not met. These included effective pain management and adequate nutrition. Evidence of future care planning was also limited. Inter agency communications were too infrequent in ensuring coordinated care provision.
- The risks for Adult B, including nutritional needs, pressure care and falls prevention were not fully appreciated by care providers. An overall care coordinator could have improved the assessment process and reduced the risks to Adult B.
- Contingency planning for family carer absences were not sufficiently robust.
- Links between the services involved were not always robust. For instance, information exchange and transfer of care or discharge were sketchy and not sufficiently clear. Potential vulnerability and safeguarding issues were not recognised. It is not apparent whether Adult B's wishes were understood or taken into account.
- Concerns regarding Adult B's coordination were raised and addressed by a number of the agencies involved but these were considered in isolation.
- When Adult B's health was deteriorating, this should have been escalated to managers. Nottinghamshire County Council and the Home Care Agency all raised concerns but these were not addressed by management or the General Practitioners in a coordinated way.
- The District Nursing Service was not proactive in assessment and treatment planning with regard to prevention and provided a poorly coordinated response to the deterioration in Adult B's tissue viability. NICE 2005 Pressure Ulcer Prevention guidelines were not followed and the dressings used did not promote the optimal wound healing environment.
- Understanding the needs of the carer is an essential part of holistic assessment. This assessment did not take place and Nottinghamshire County Council Departmental procedures require that this should have been offered and documented as such.

6. Independent Authors Recommendations

Recommendation 1

Vulnerable service users over the age of 60 who have regular intensive multi-agency involvement should have a single robust assessment process in place which is shared between the agencies and coordinated by an identified care coordinator. The development of this role will require the commitment of both Health and Social Care organisations to provide an operational framework for this role to be effective. Note this role could also be used by vulnerable service users under the age of 60.

Recommendation 2

Care plans should have SMART objectives and be reviewed regularly. These should include nutritional needs, pain management, tissue viability/repositioning and risk management/contingency planning as core elements of a needs assessment.

Recommendation 3

All agencies should ensure that they have appropriate effective supervision process in place enabling staff to use clear mechanisms to escalate concerns and they are used.

Recommendation 4

Nottinghamshire Safeguarding Adults Board should review all serious case reviews of a similar nature to ensure constancy of approach with regard to recommendations.

Recommendation 5

Tissue viability care plans should be in line with current best practice guidelines.

Recommendation 6

Even in an emergency, arrangements which involve placement in residential care/nursing care, Health and Social Care agencies need to agree where best care outcomes can be achieved. This needs to be evidenced on either a check list or clearly documented notes.

Recommendation 7

Informal carers contributions to the package of care agreed to meet the individual's needs should be documented and updated in the care plans completed by the home care agencies and/or carer's assessments as carers circumstances change.