Safeguarding Adults Review
Summary Report and Action Plan

Mrs. K

Review completed April 2018
Author – Mr. Clive Simmons

1. Introduction

1.1. Mrs. K (Aged 77 at the time of her death) lived with her daughter, DK, and grandson (in his early 20's) in a social housing flat in Roehampton. It is understood that DK was Mrs. K's daughter was the main carer and Mrs. K's grandson would provide care and support when DK was at work. There is little else known by agencies about Mrs. K's interests or lifestyle. Her medical history includes a recorded diagnosis of vascular dementia (although not confirmed), bi-polar disorder, paranoid psychosis and delusional symptoms, Parkinson's disease, hypothyroidism, poor balance and difficulty mobilising outside (and at times inside) the home.

1.2. During December 2016 Mrs K had a short stay in hospital following a fall at home and was discharged on 23 December 2016, Mrs K did not receive the community nursing and pressure relieving equipment (bed, mattress and cushion) she needed. On the 18th January Mrs. K was readmitted to hospital on due to a deterioration in her health, including multiple pressure ulcers, and she died in hospital on 20 February 2017.

2. Overview of SAR Process

2.1. A SAR referral was made by a Senior Social Worker (Richmond and Wandsworth Councils, Adult Social Services Department) on 17/03/2017.

2.2. The case was presented at the SAB SAR Subgroup on 20 April 2017. The meeting agreed that the criteria for a SAR, in accordance with The Care Act 2014, Section 44 were met because:

- An adult with care and support needs had died
- There is concern that partner agencies could have worked more effectively to protect the adult and prevent harm

2.3. The SAR Subgroups recommendation to undertake a SAR was endorsed by the SAB Chair on 25/04/2017.

3. Review findings

Finding 1 - Referral to Community Nursing

- The pathway to access community nursing and equipment was found unnecessarily complicated and unsafe, with a total of three contact points and four agencies involved to manage any referral. Failures in this system led to Mrs K's referral for community nursing and equipment not to be actioned leading to equipment not being delivered and for wound and nursing care not being provided and ultimately contributed to a deterioration in Mrs K's health.

Finding 2 - Consideration of mental capacity assessments

- No mental capacity assessment was undertaken at any time. Mrs. K was very unwell during her second hospital admission. Given the concern regarding cognitive impairment, the presumption of mental capacity without an assessment was therefore of concern.

Finding 3 – Personalised and inquisitive assessments

- Whilst individual agencies had responsive and purposeful contacts with DK, Mrs K's view was not always ascertained. Professional's responses to the case presentation lacked a fully inquisitive approach to explore how Mrs. K and her family were managing and whether they would benefit from and accept a social care needs or carers assessment.
- Mrs. K was under the care of a Neurologist and it is unclear from information received whether she was living with ongoing mental health concerns and whether there was a regular review and monitoring of her prescribed anti-psychotic and anti-depressant medication.

Finding 4 - Multi-agency information sharing

- Mrs. K had complex care needs that were met by family carers alone. Had information been shared between agencies this may have triggered for assessments to be completed and more support for Mrs K and her family.

Finding 5 – Hospital discharge assessment

- Mrs K was discharged from hospital on Friday 23 December and with no assurance that her nursing and equipment needs can be put in place in a timely manner to meet her needs. Both the timing of the discharge as well as system failures identified in finding 1 resulted in a poor discharge.

Recommendations and Composite Action Plan:

Recommendations/Findings	Additional comments, points of clarification and actions	Assigned Lead Agency Officer	Target Date
RECOMMENDATION 1: (Finding 1) **Put in place an effective, streamlined operating system to access Community Nursing.**	Urgent review of the current operating system to access Community Nursing and of staff compliance.	Wandsworth & Merton CCG	October 2018
RECOMMENDATION 2: (Finding 2 and 3) **Raise awareness of the Mental Capacity Act and of Personalisation.**	*Health and social care commissioners to offer the SAB assurance on compliance with training on the Mental Capacity Act and involvement of the person.* *Health and social care commissioners to demonstrate impact of learning though a sample audit of a current case* *To review and improve the completion of Carers assessments as part of the hospital discharge process, particularly at times of high pressure in the systems such as bank holidays.*	SAR Subgroup SAR Subgroup Assistant Director: Operations Richmond and Wandsworth Councils	November 2018
RECOMMENDATION 3: (Finding 4) **Develop a shared multi-agency risk assessment and management protocol.**	*SAB members to contribute to a shared understanding of effective management of pressure ulcers through the adoption of a shared protocol on pressure ulcer management.*	Richmond & Wandsworth Council, Head of Safeguarding and Professional Services Adult Social Services	February 2019
RECOMMENDATION 4: (Finding 4 and 5)	*Liaise with South West London hospital discharge group to identify learnings from across south west London and identify how*	Director Adult Social Care	October 2018

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Review hospital discharge procedures to ensure that detailed information is held to support effective discharge planning around weekends and public holidays.	*these can be applied to the local health and social care system.*		
<u>RECOMMENDATION 5:</u> (Finding 5) **Provide assurance that, on hospital discharge, Wandsworth & Richmond residents receive assessment, planning and delivery of services that meet their needs; including effective handover between acute and primary health care** (Hospital and Community Nursing)	*Sample audit of hospital discharge practice, including interface with both primary health care and community services, over a bank holiday period and identify actions to mitigate the risk.*	Director of Quality & Governance (Wandsworth & Merton CCG); Director of Quality and Safeguarding Lead (Kingston and Richmond CCG)	April 2019