Northamptonshire Safeguarding Adults Board

# Learning from Safeguarding Adult Reviews

## Key findings and learning from Safeguarding Adults Review - 008 - Mrs Webster December 2019

**The Purpose of a Safeguarding Adults Review (SAR)** is to promote learning and improve practice where there is concern that partner agencies could have worked together more effectively to protect the adult. A SAR will not re-investigate or apportion blame but supports professionals to adjust practice in light of the lessons learnt from the review.

**Sharing Learning** from both local and national Safeguarding Adult Reviews (SAR) and other reviews is a key priority for Northamptonshire Safeguarding Adults Board (NSAB).

Following the Safeguarding Adult Review 008 – 'Mrs Webster', an action plan is in place with key multi-agency and single-agency recommendations and actions for organisations linked to the case. Progress will be monitored via the NSAB Quality & Performance and Safeguarding Adult Review Sub Groups.

This learning briefing summarises the key findings and recommendations from the review.

Managers should discuss this briefing with their teams to ensure that the learning is used to enhance existing good practice and to make improvements where necessary. Feedback will be sought from partner agencies via the NSAB Learning & Development Sub Group to ensure that the learning has been cascaded.

**The Safeguarding Adult Review - Mrs Webster** was recently published and is available on the NSAB website.

The review evaluates multi-agency responses concerning the sad death of 'Mrs Webster' who died in November 2017, aged 86.

Prior to her death and whilst living in a residential care home, Mrs Webster experienced a number of falls (including 34 in the 11 months prior to her death), including one that resulted in a puncture wound to her back. The cause of Mrs Webster's death was bronchopneumonia which was likely to have been exacerbated by her lack of mobility due to a neck collar following an earlier fall.

The period of the review was 1st January 2017 until the time of Mrs Webster's death on 28th November 2017.

Mrs Webster's family were actively involved in the review and discussed what they would like to see changed following their own experience leading to their mother's death.

## The Safeguarding Adult Review

The Safeguarding Adults Review was led by an independent author who undertook a blended/hybrid methodology using chronologies and Individual Management Reports (IMRs). The review examined the following key areas of concern:

1. Was the residential care home meeting Mrs Webster's needs and assessing risks in a person-centred way in relation to falls?
2. Was there external oversight of Mrs Webster's direct care and of the quality and regulatory/contract compliance of the residential care home?
3. Why were the staff involved in Mrs Webster's care not raising safeguarding concerns, given the number of falls she experienced?
4. Family involvement in multi-disciplinary discussions and meetings.
5. Why was there little recording of Mental Capacity Act assessments and Best Interest Assessments?
6. Why was the spinal injury not identified at the hospital?

Thirteen actions were accepted by Northamptonshire Safeguarding Adults Board (NSAB) following the review and an action plan is now in place to ensure learning is achieved to try to avoid similar circumstances from happening again in the future.

## Conclusions

### 1. Person-centred Care

Given the increasing number of falls, was Mrs Webster's death predictable and was it preventable? Were there any actions that would have prevented her death or the physical and emotionally painful circumstances in which she died?

*Risk assessments should have been undertaken with Mrs Webster and her family members to fully explore the reasons for her falls and to prevent the impact of further falls. Whilst the residential care home sought advice from the GP, and specialist health referrals were made, no-one arranged multi-disciplinary meetings.*

Using a Making Safeguarding Personal approach to assessing Mrs Webster's changing needs may have resulted in a more balanced assessment of her needs and her wishes.

### 2. Oversight of Direct Care

Why did Northamptonshire County Council (NCC) not fulfil their requirement to carry out person-centred case reviews in the residential placement, and why was there only one contact from Adult Social Care during the two years Mrs Webster lived at the residential care home?

*Care homes are subject to scrutiny from a number of organisations such as commissioning/contract/quality monitoring and the Care Quality Commission (CQC). Mrs Webster care/placement was reviewed by Northampton County Council (NCC) on 6th April 2016 where it was reported that she was happy and that the residential care home was meeting her needs.*

### 3. Raising Safeguarding Concerns

Why were the staff involved with Mrs Webster not raising safeguarding concerns despite her having 34 falls from 1st January to 10th November 2017? What would better practice look like and were there missed opportunities? Also, what sort of falls and how many should trigger a Safeguarding referral if they don't result in injury?

*Whilst the residential care home notified adverse incidents about Mrs Webster's falls to CQC, these were not identified as requiring a Section 42 safeguarding enquiry until mid-November 2017. If these had been notified earlier, the safeguarding concerns might have been identified at an earlier stage.*

### 4. Involvement of family in multi-disciplinary meetings

Why didn't agencies organise multi-disciplinary professionals' meetings involving Mrs Webster's family following her attendance at A&E?

*The report identified the missed opportunities of more formal family involvement.*

Following Mrs Webster's return to hospital and the discovery of the seriousness of her spinal injury, her family were more involved in the meetings, but they expressed concerns to the Independent Author over the lack of communication about the reasons the injury wasn't detected. They also felt not listened to.

### 5. Mental Capacity Act Assessments

There is very little evidence collated by the IMR authors that any agency recorded Mental Capacity Assessments (MCA) and subsequent Best Interest Assessments to support Mrs Webster's decision making and that of professionals involved with her. Given the number of examples where she was distressed/non-compliant when health/care/safety interventions were necessary, why is there little recording?

*It was noted that Mrs Webster's elder daughter had Lasting Power of Attorney for her mother's health and welfare and she should have been involved in any Best Interest Decision when her mother was assessed as lacking capacity to make her own decisions.*

### 6. Failure to identify spinal fracture

Why did the staff at hospital (1) not identify the significant injury to her spine and why as the relevant scan not forwarded?

*Hospital (1) acknowledged the error in relation to viewing the three scans when Mrs Webster was transferred for treatment to hospital (2) – this meant that she was moved without a fully informed risk assessment. The second hospital therefore made decisions about treatment and transport back to the residential care home without knowing about crucial information.*

Hospital (1's) Independent Management Report (IMR) indicated that the evidence pointed to 'individual error with regard to reviewing the correct images and not a systemic issue within the Emergency Department'.

## Recommendations

1. NCC senior managers should provide assurance to NSAB that their current actions to manage the identified shortages in assessment and review teams are having a positive impact in reducing waiting times for people as delayed reviews of care and support can have significant negative consequences.
2. NCC Quality Team should provide assurance to NSAB that the quality of all residential care homes is being monitored and that action plans are in place to ensure people are receiving appropriate person-centre support and risks to safety are assessed and managed.
3. NCC Commissioning Senior Managers should assure NSAB that measures are being taken to review the contractual relationship between NCC and all care providers to ensure that all residents using services are afforded the same level of scrutiny.
4. Hospital (1) should provide assurance to NSAB that it has implemented and is monitoring an action plan to prevent similar errors identified in the SAR.
5. All NSAB partner organisations should provide assurance to NSAB that the views (voice) of the patient/service user, in line with Making Safeguarding Personal (MSP), is heard and recorded in treatment and care interventions.
6. All NSAB partner organisations should review their training (access to learning opportunities as well as formal training) and practice in relation to MCA assessments and Best Interest decision making.
7. NSAB should assure itself that it is promoting, supporting and monitoring effective staff learning opportunities in the difficult area of mental capacity considerations within all organisations.
8. NSAB should arrange for the findings from this review to be widely disseminated, including through their standard post SAR learning event. Particular areas of learning that need to be shared include evidence based best practice in preventing and managing falls; effective use of mental capacity assessments; and hearing the voice of the person and their family, particularly in relation to shared risk taking.
9. Staff who have specific safeguarding responsibilities and who might be involved in, or supervise others involved in SARs, should have access to specific training/support and oversight including senior management sign off of the IMR report when an individual management review (IMR) is required.
10. NSAB should make its members aware of the Social Care Institute of Excellence (SCIE) draft SAR Quality Markers and consider their use in commissioning SARs and the design of SAR documents/templates.
11. Where staff in care homes have concerns about being able to meet all the needs of a resident appropriately, they should refer them to NCC for an urgent care review, and NCC should respond in an agreed timescale as delays can have serious consequences for residents with increasing/changing needs
12. In line with Regulation 9 of the Health and Social Care Act 2008, NSAB seek assurance that NCC's Commissioning Team ensure providers are providing person-centred care based on residents' needs and preferences and ensure that the communication with residents is heard and recorded.
13. Northamptonshire partners should consider re-instating the Countywide Falls Ambulance Service given the evidence of good outcomes.

## Good Practice

- Mrs Webster moved to the residential care home in September 2015. A care/placement was reviewed by the Local Authority in April 2016 which reported that she was happy and that the home was meeting her needs.
- There was some good practice of Mrs Webster's' health needs through her GP practice and other health professionals.
- Mrs Webster was known by staff at the residential care home and her daughter spoke positively about some members of staff and that her mother liked them.
- The risk of failing was recognised by the residential care home and assessment and support were sought from the GP practice and referrals were made to the NHFT Falls Service.
- The Care Quality Commission carried out an unannounced inspection of the residential care home on 4th April 2017. The findings rated the care home 'Good' overall.
- Whilst the residential care home notified adverse incident reports about Mrs Webster's falls to CQC, these were not identified as being of a level of injury/harm to require a Section 42 safeguarding enquiry until mid-November 2017.

## General Observations

- Mrs Webster's voice did not come through in any of the information gathered as part of the process and it was difficult to get a sense of her likes and dislikes.
- Using a Making Safeguarding Personal (MSP) approach for Mrs Webster might have resulted in a more balanced assessment of her needs.
- It is clear that risks to Mrs Webster's safety, such as fluctuating cognition, deteriorating eyesight, poor hearing, blood pressure drops, as well as reduced mobility and frailty, warranted regular multi-practitioner assessment and intervention to mitigate risk.
- Whilst there was some good practice taking place in mid-2017 to assess a number of Mrs Webster's health issues, no holistic assessment took place.
- Mrs Webster's family were frequent and attentive visitors to the residential care home and were involved with her medical oversight.
- Whilst there were references to Mrs Webster's cognition, the family believed she was sometimes forgetful and had periods of confusion, but their view was that her behaviour when in pain was put down to dementia when it was a normal reaction to pain.

## Key Points for Learning

- Practitioners should understand how the Mental Capacity Act can be used to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.
- Practitioners should understand the importance of a Making Safeguarding Personal approach to better support the needs and the safety of the individual.
- Where care reviews are not undertaken in a timely manner, care home managers need to escalate to NCC to ensure the needs of their residents are met.
- It is important that risk assessments are fully explored with the individual or their relevant family members, particularly with those who have Power of Attorney responsibilities for care and wellbeing.

You can find the published reports on the Northamptonshire Safeguarding Adults Board website – **www.northamptonshiresab.org.uk**

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