Harrow Safeguarding Adults Board (HSAB)

Newsletter – issue number 21

(Summer 2018)

Welcome from the chair of the HSAB (Visva Sathasivam)

Welcome to the summer 2018 edition of the HSAB's quarterly newsletter. In the Spring the new feature about the learning from Safeguarding Adults Reviews (SARs) started and this time we look at "ZZ" which was carried out by Camden's Board. SARs provide valuable information to guide professional practice and in this case there are some important points for both assessors and providers about the management and risks for people who are reluctant to engage with services, leading to self neglect. If you and your colleagues are involved in supporting clients/patients in these challenging situations I would urge you to discuss the highlighted learning below in your Team. Any comments or suggestions for the newsletter can be sent to either Sue Spurlock (sue.spurlock@harrow.gov.uk) or Seamus Doherty seamus.doherty@harrow.gov.uk).

Learning from Safeguarding Adults Reviews (SARs): "ZZ"

ZZ (aged 79) was in receipt of a care package consisting of three calls each day commissioned by Camden Council Adult Social Care (ASC) from Plan Care (PC) home care agency. The care package included: personal care, support to prepare food and domestic tasks. ZZ's nephew also visited three times per week, bringing shopping.

One morning ZZ's two carers from PC contacted her GP to report that she was poorly – disorientated and weak, refusing to eat any food and barely drinking. London Ambulance Service (LAS) was called out, but ZZ refused to go to hospital and was deemed by LAS at this point to have capacity to make that decision. The GP was called to ZZ's home and on arrival found her to be incoherent, emaciated, unkempt and with grade 4 pressure ulcers on her sacrum and elbow and elsewhere on her body. When the GP asked paramedics to move ZZ from the sofa, the large stained dent suggested that she had been lying in the same position for a long time. The GP determined that at this point ZZ did not have capacity and urgent hospitalisation was in her best interests.

Later that day ZZ was admitted to Hospital where the nurses noted she was in the foetal position, with severe muscle wastage and extremely malnourished. They diagnosed 13 pressure ulcers at various sites across her body including hands, feet, chest, sacrum and legs. Nine of these were grade four and bones/ tissue were visible in places. ZZ died the following day and the post mortem found that she died of multiple organ failure due to septicaemia, caused by infected ulcers. The case was subsequently referred to the police under the category of wilful neglect.

Findings/discussion points:

- ZZ was lonely and isolated following the death of her partner the year before her death (and when he was in hospital). This was compounded by her long term condition of agoraphobia
- ZZ's reluctance to accept care, support and treatment had been a characteristic over a significant period of time and at some point in her final years tipped into self-neglect. The point at which this became a significant risk was never identified by front line carers who spent around two and a quarter hours with her every day. It was not identified by social care reviewers either
- there was little evidence of any connection with ZZ "the person" on the part of carers or professionals
- routine attention to the triggers, signs and symptoms that indicate a risk of skin breakdown for carers to escalate concerns (and to seek specialist advice) were absent. The GP practice did not identify that ZZ had not ordered repeat prescriptions, therefore a medication review was not triggered. Such routine checks and processes by the GP and the care provider might have triggered more proactive attempts at engagement

- the symptoms of the neglect were not identified and yet the condition in which ZZ presented at Hospital indicated that it had been going on for some considerable time. Carers who visited her several times every day failed to notice the steady and serious decline or the acute signs of neglect towards the end. ZZ weighed around 4 stone 10lbs on admission to hospital. She was covered in faeces and the extent and seriousness of pressure ulcers was extreme. Basic practice in assessment, care planning and review fell very short of expected standards with a lack of focus on risks. Supervision by managers should have provided scrutiny and challenge as well as support. It did not. Even where serious risks of malnutrition, falls and self-neglect were recorded on social care reviews/assessments these were not addressed or considered in any detail. Nor were they shared across relevant professionals
- ZZ was persistent in declining personal care and carers and professionals were consistent in the response that she had capacity and therefore was within her rights to do so. The duty of care owed by carers and professionals means that they must go beyond this response to an identification of the potential consequences of such decision making *alongside the service user* and an appraisal of the likely risks (potential harms) and possible ways of mitigating these. This was not evidenced in records. Responses may at times require coercive actions where the risk is substantial. This requires practitioners to understand and consider the legal framework within which they operate and to apply it where necessary
- in this context improvement in applying the requirements of the Mental Capacity Act (MCA) in practice are indicated as necessary by this review. In particular, the implications of principle two of the Act are significant. "The right for individuals to be supported to make their own decisions – people must be given all appropriate help before anyone concludes that they cannot make their own decisions." Practitioners must ensure that individuals have and understand all of the information required on which to make a decision and that this is recorded. This means at times confronting individuals such as ZZ with difficult information about the consequences of their decisions including details about issues such as pressure ulcers and including that decisions could lead to loss of life
- there was lack of respectful challenge and persistence in supporting ZZ's understanding of the risks
- care management closed this case except for annual review when what was required was persistence and continuity
- there was inadequate support and supervision for staff working in such challenging situations
- there was poor legal literacy and especially understanding the requirements of the MCA and the balance between choice and safety

HSAB annual report 2017 – 2018

The Board's latest annual report will be available next month. The headline message is that elderly people living in their own home are the highest risk group. In the context of the "ZZ" case above, this highlights the importance of all staff and volunteers visiting clients/patients at home being vigilant for any signs of concern. A "staff key messages" version of the annual report as well as an easy to read version will also be published next month.

Training 2018/2019

The Harrow Safeguarding Adults Board training programme for 2018/2019 is underway. All the courses are free and will be available for booking in the usual way through http://harrow.learningpool.com/