Safeguarding Adults Review (SAR)

'Nancy'

LIVERPOOL SAFEGUARDING ADULTS BOARD

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1.0 Introduction

1.1 Nancy was a 78-year-old white British woman who had several long-term medical conditions including heart failure, and hypothyroidism. She had limited mobility and used a Zimmer frame to mobilise around her home. On the 19th of August 2022 Nancy was admitted to Whiston Hospital via the Emergency Department (ED) following an unwitnessed fall the previous day. Nancy had also been seen three days earlier by her GP and prescribed oral antibiotics for an infection in her left lower leg. Nancy spent 40 days in hospital before being discharged by the hospital back to her own home with equipment felt necessary at the time of discharge planning to manage her significantly decreased mobility which had not improved during her hospital stay.

1.2 Liverpool City Council (LCC) Adult Social Care (ASC) had commissioned a package of home care to support Nancy and her family in caring for her four times a day based on information provided to them by hospital staff. Nancy was also being reviewed and managed by the District Nursing (DN) service who were treating a pressure ulcer to her sacrum thought to have occurred on transfer back into her own home. She spent 12 days at home before being transferred into the Royal Liverpool University Hospital (RLUH) with sepsis and an ungradable pressure ulcer[1] to her sacrum. Following debridement of the wound in the operating theatre Nancy's health continued to deteriorate despite appropriate interventions, she sadly died on 26th of October 2022.

1.3 Nancy's death was referred to His Majesty's Coroner (HMC) by staff at RLUH. Following receipt of information from Nancy's hospital records and statements and from those involved in the recent care of Nancy, an inquest was held on 28th of May 2024. Following consideration by HMC of the evidence heard at the inquest the cause of Nancy's death was given by the coroner as:

Ia Sepsis

Ib Infected pressure sore

II Heart failure, Atrial Fibrillation

1.4 HMC delivered a lengthy narrative verdict at the conclusion of the inquest the latter section of which is below:

"Having identified 2 specific gross failures which clearly amount to neglect it is found that the accumulation of the catalogue of errors and missed opportunities throughout the care and treatment of Nancy by those involved in her care, namely the acts of omissions mentioned have as a whole also amounted to neglect".

[11] An ungradable pressure ulcer is an ulcer that is caused by prolonged pressure on the skin, which cuts off blood flow and oxygen to the tissue

2.0 Commissioning of the Safeguarding Adult Review

2.1 Liverpool Safeguarding Adults Board (LSAB) has a statutory duty under the Care Act 2014[2] to arrange a Safeguarding Adult Review (SAR) involving an adult in its area with care and support needs (whether or not the local authority has been meeting any of those needs) if a – there is reasonable cause for concern about how the Safeguarding Partnership, members of it or other persons with relevant functions worked together to safeguard the adult and b – condition 1 or 2 is met.

- Condition 1 is met if:

a. the adult has died, and

b. the Safeguarding Partnership knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

2.2 SAR panel members must cooperate in and contribute to the review with a view to identifying the lessons to be learned and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work together and independently, to help and protect adults with care and support needs who are at risk of abuse and neglect and are unable to protect themselves.

2.3 An initial SAR referral was submitted by Liverpool City Council, Adult Social Care on 26th of July 2023. Screening took place on the 25th of September 2023 to review summaries of partner agencies involvement consider the referral. Concerns were identified as below:

- Potential poor discharge planning by Whiston hospital
- Potential poor communication around changes to equipment and care plans following hospital discharge
- Delay in wound management by the DN service
- Inadequate pain relief following discharge
- Missed opportunity to initiate an MDT meeting by all practitioners when problems were identified.

2.4 The subgroup attendees agreed that the criteria for a mandatory SAR had been met. The Independent Chair of the LSAB agreed to progress the SAR on 13th of November 2023

2.5 North West Ambulance Service (NWAS), Merseyside Fire and Rescue (MFRS) and Merseyside Police held little or no information about Nancy relevant to the review and it was agreed that they did not need to sit as panel members. A representative from NWAS responded to any additional points of clarification that came up as the review progressed.

2.6 The first panel meeting was held on the 10th of October 2024 to agree panel membership, Terms of Reference and timeframe for the review which was agreed as being from October 2022 to October 2023 when Nancy sadly died. The independent author and chair for the

[2] Care Act 2014 sections 44 (1), (2) and (3) https://www.legistlation.gov.uk [Accessed October 2024]

review agreed to consider which methodology would establish the learning the LSAB was seeking.

2.7 A second panel meeting was held on the 25th of November 2024 to discuss the first draft report content for factual accuracy and to agree the scope and attendees at the Practitioner Learning Event (PLE). Further methods of trying to engage Nancy's family in the review were also discussed.

2.8 The PLE was held remotely over Microsoft Teams on the 12th of December 2024 to maximise the engagement of staff from all the agencies involved in the SAR. The discussions at the PLE have helped to form the SAR findings and the subsequent questions for the LSAB and its partner agencies to consider.

2.9 A third panel meeting was held on the 21st of January 2025 to discuss the final draft report and to agree both the findings and the questions which would be posed following the SAR conclusion. To confirm the final draft report and agree the learning outcomes a fourth panel meeting was held on 27th February 2025.

2.10 The SAR report was agreed in full by all panel members on 23rd May 2025. Excepting the panel member from Knowsley SAB who represented Knowsley MASH, who agreed the report findings with the exception of 12.10. Further details contained within the report below.

2.11 The Independent Author and Chair for this SAR is/was Michelle Grant who is an independent SAR author. Michelle has a health background working in acute hospitals for 20 years and latterly for 12 years in a Clinical Commissioning Group (CCG) and an Integrated Care Board (ICB) as the Designated Nurse for Adult Safeguarding and Mental Capacity Act (MCA) Lead. She has undertaken SAR author training in 2016 and has since authored several Safeguarding Adult Reviews across the Country.

2.12 The independent author and chair has no links to the LSAB or any of its partner agencies.

3.0 Methodology

3.1 The methodology for the review was an adapted version of a SAR in Rapid Time, summary of agency involvement reports by the agencies who knew Nancy were provided, alongside the LSAB's Safeguarding Adults Review Recommendation Form. These documents were reviewed by the independent author and several additional information requests for clarification from agencies were requested by the author. In addition to the above the independent author had access to:

- HMC inquest verdict
- MCFT Serious Incident (SI) report
- MWLTH Equipment Summary, Therapy Action Plan, and statement for HMC
- Transfer of Care Document completed by social worker ASC
- Knowsley Multi Agency Safeguarding Hub (MASH) Standard Operational Procedure (SOP) requests to Health Agencies for S42 enquires v6 Dec 2023
- Community Step Up to Hubs SOP v3 Aug 2021
- MCFT Use of bedrails SOP v6 Jan 24

4.0 Panel Membership

Role	Agency involvement with 'Nancy'
Independent Author	
Head of Safeguarding and Assurance	**Liverpool City Council – Adult Social Care (ASC) managed the 2 safeguarding adult concerns made relating to the care of Nancy**
Learning and Development Lead	**Knowsley Safeguarding Adult Board – received notification of the safeguarding concern about care at Whiston hospital**
Designated Adult Safeguarding Lead	**Integrated Care Board (ICB) Knowsley Place - shared information held by the GP surgery**
Assistant Director of Safeguarding	**Mersey and West Lancashire Teaching Hospitals NHS Trust (MWLTH) - managed the care of Nancy during her inpatient episode at Whiston hospital**
Named Safeguarding Adults Nurse	**Mersey and West Lancashire Teaching Hospitals NHS Trust (MWLTH) - managed the care of Nancy during her inpatient episode at Whiston hospital**
Head of Therapy Services	**Mersey and West Lancashire Teaching Hospitals NHS Trust (MWLTH) - managed the care of Nancy during her inpatient episode at Whiston hospital**
Adult Safeguarding Lead	**Mersey Care NHS Foundation Trust (MCFT) - provided the District Nursing (DN) Service to Nancy following her discharge from hospital until her readmission to Liverpool University Hospital NHS Foundation Trust**
Registered Manager	**Independent Community Care Provider - were commissioned by ASC to meet Nancy's care needs following her discharge from Whiston Hospital until her readmission to Liverpool University Hospital NHS Foundation Trust**

Board Manager	**Liverpool Safeguarding Adults Board hosted by Liverpool City Council (LCC)**
Minute taker	**Liverpool Safeguarding Adults Board**

5.0 Equality and Diversity

5.1 Throughout this review process, the panel has considered the issues of equality. In particular, the 9 protected characteristics under the Equality Act 2010[3]. The independent author and panel members concluded that there was no evidence to suggest that Nancy was discriminated against under any of the protected characteristics during her care and treatment as part of this review.

6.0 Terms of Reference

- How did Nancy's care and treatment plan during her inpatient episode at Whiston Hospital reflect a person-centred approach?
- How did this care plan inform the Discharge 2 Assess document that was sent to ASC to commission a care package on Nancy's discharge from hospital?
- Did the provision of equipment to allow Nancy to be cared for in her own home following her discharge from hospital meet her care needs and respect her right to make decisions about what equipment would to allow her to maximise her independence?
- Did the hospital discharge follow the expected process from a nursing and therapy perspective? If not, what learning can be taken by the Trust from the discharge of Nancy from Whiston Hospital?
- What were the communication issues between the hospital staff, care provider, community nursing team and GP, how can communication be improved?
- Was Nancy's pressure area care in line with expected practice when she returned home and if not, what learning can be taken forward to improve practice?
- Was there appropriate escalation taken by agencies when Nancy's skin condition appeared to break down and she reported that her pain relief was not effective?
- What were the barriers to agencies calling an MDT to discuss management options for Nancy in October 2023?
- Where safeguarding concerns raised appropriately and in line with LSAB's policy and procedures?

7.0 Family Engagement

7.1 The primary purpose of a SAR is to set out how professionals and agencies worked together, it is important that the views of the individual (where possible), their family and details of their engagement with the SAR are included in the report. This would evidence that the principles and practice of Making Safeguarding Personal, a core value signed up to by all

[3] The Equality Act 2010 https://www.legislation.gov.uk/ukpga/2010/15/contents [Accessed June 2024]

agencies working as part of the LSAB were demonstrated. Despite several attempts to engage the family of Nancy via her daughter who gave evidence at the inquest of Nancy no response has been received. These attempts were made via letter, e-mail and telephone call.

7.2 The independent author and panel members respect the wish of Nancy's daughter not to engage with the review. The independent author and panel members are mindful of the comments made by Nancy's daughter once she had the SI report completed by Mersey Care shared with her that 'she wouldn't want another family to go through what her family have gone through'. She also made the same comments at a safeguarding meeting and to the social worker who coordinated the enquiry. The SAR will endeavour to provide assurance to both the family of Nancy and the LSAB that learning has been identified, and questions posed to agencies in relation to how the learning and system changes can be embedded. The learning aims to strengthen hospital discharge planning, pressure area care and wound management by DN's in the community, as well as using the benefits of an MDT approach when care issues arise.

8.0 Key Episodes in the Care and Treatment of Nancy

8.1 A summary of Nancy's care and treatment from 19th of August to 28th of September 2022 at Whiston Hospital.

8.1.1 On the 19th of August Nancy's daughter rang NWAS concerned that her mother's breathing was laboured, she was very sleepy, was struggling to mobilise and had spent the previous night sat in a chair. The initial ambulance response was cancelled because Nancy herself stated that she was on antibiotics, was not concerned about her symptoms and did not want to go into hospital. Worsening advice was provided.

8.1.2 An hour later NWAS were contacted by Nancy's daughter again, expressing her concern for her mother's health. NWAS staff attempted to call Nancy back on two occasions, but the call went to voicemail. An ambulance attended at Nancy's home and after speaking to Nancy they concluded that she should be transferred to hospital for assessment, Nancy agreed.

8.1.3 Nancy was transferred to Whiston Hospital Emergency Department (ED) it was documented that Nancy had an unwitnessed fall the day before at her home address, since the fall she had struggled to mobilise. She had been seen by her GP 3 days previously and prescribed oral antibiotics for an infection in her lower left leg. Symptoms on admission were documented as being lethargy and feeling generally unwell. It was recorded that Nancy stated that she usually mobilised with a Zimmer frame, but this was more limited in the last two weeks and that she was now chairbound during the day.

8.1.4 A Maelor score assessing the risk of Nancy developing a pressure ulcer was documented noting that she was at high risk, Nancy was moved from the ED corridor into a stretcher triage zone where it was documented that Nancy had refused her consent to let staff check her pressure areas. The following day Nancy was transferred onto a hospital bed and an air flow mattress[4] to relieve pressure on her sacrum. At this time, it was documented that Nancy had

[4] An airflow mattress has cells running horizontally that are filled with air in which the pressure alternates at different times to relieve pressure on the body

a urinary catheter inserted and that her sacrum and buttocks were intact, but the skin was noticeably reddened. She was also being given diuretic medication to manage her heart failure.

8.1.5 On the 22nd of August Nancy was transferred to a general medical ward. Her Maelor score was recalculated and reduced on the basis that the risk of tissue damage was lessened. Nancy was also referred to the therapy team, the referral indicated that Nancy was currently bedbound but had been mobile previously at home.

8.1.6 Nancy was reviewed by the therapy team the following day, documenting the outcome as being that Nancy was currently unsafe to transfer to a commode but to reassess to see if she could transfer to a wheelchair. Nursing staff documented Nancy's skin had evidence of a moisture lesion[5], therefore barrier cream was applied to protect the skin. On the 24th of August it was documented by nursing staff that Nancy's other pressure areas were intact, but the moisture lesion was still present on her sacrum.

8.1.7 During her admission Nancy had several nursing assessments and reviews documented including a falls risk assessment, moving and handling assessment and a pressure ulcer risk assessment. Nancy was noted to be at risk of falls, of pressure ulcer development and required 2 people to reposition her. Throughout her admission Nancy remained bedbound and was hoisted as required when she needed to use a commode during the day. She remained nursed on the airflow mattress with bed rails attached at her request to assist her in repositioning herself on the bed and because they made her feel 'safe'.

8.1.8 From the 24th of August to the 6th of September all care interventions were conducted by nursing staff according to Nancy's care plan. The urinary catheter was removed on the 31st of August following medical review. Nancy became doubly incontinent thereafter and staff used incontinence pads with net knickers to prevent further risk of skin breakdown. Overnight she was reviewed by nursing staff as part of intentional rounding which is a structured process where healthcare professionals check on patients at regular intervals to address their needs, this supported the management of her continence and to manage her moisture lesion if necessary.

8.1.9 On the 6th of September Nancy's risk of developing pressure sores was reassessed and identified as being high again this was because of several factors including oedema, ongoing bladder and bowel incontinence and Nancy expressing pain in her sacral area. Later the same day staff recorded moisture lesions between the buttocks, a wound assessment chart was completed, barrier cream continued to be applied, as necessary.

8.1.10 Nancy was reviewed again by physiotherapists on the 7th of September, it was reported by staff that Nancy had been sitting out daily in a recliner chair. A standing aid was placed in front of Nancy to see if she could stand from a sitting position. She required the assistance of two staff to be able to lean forward and reach the equipment and lost her footing when she

[5] A moisture lesion is skin damage caused by exposure, over a period of time due to urine, faeces, or other bodily fluid over a period. https://www.nice.org.uk>guidance>conditionsanddiseases>skin>conditions Clinical Guideline 179 Published April 2014

attempted to stand. As a result, she began to feel unwell her oxygen saturations dropped which improved with a low flow of oxygen via a face mask. Physiotherapy staff discussed her progress with her and advised that she was showing minimal improvement and was limited by medical problems. She was informed staff would continue to review her, and the hoist would continue to be used to sit her out of bed.

8.1.11 The following day Nancy was reviewed by an occupational therapist (OT) and assistant, Nancy reported that she felt fatigued but agreed to therapy. Again, she struggled to stand from a sitting position with the assistance of two using the stand aid, and again her oxygen saturation levels dropped. Her knees were noted to be unable to flex enough to enable her to stand. Despite being willing to engage in therapy to increase her mobility it was felt she was making minimal progress, staff discussed with her the option of returning home with community therapy follow up due to her slow progression in hospital.

8.1.12 On the 9th of September Nancy was assessed as being unsafe using the commode due to several episodes of drops in her oxygen saturation levels and her inability to safely position herself on the commode. During her admission Nancy also lost a substantial amount of weight the reason for which was unclear, but which increased her risk of developing pressure ulcers.

8.1.13 Nancy was reviewed again on the 12th of September by therapy staff, she was unable to progress further than sitting on the edge of the bed with support before being returned onto her bed. She was seen again on the 13th of September by therapy staff and discharge planning was discussed again. Family who were present were also included in the discussions, they felt that a rehabilitation placement would be better than returning home but would await their mother's decision. A rehabilitation placement would mean residing in a care home setting, after discussion it was agreed by Nancy that she would want to choose this option and so the referral was made, as it was confirmed by the medical team that Nancy was now medically fit for discharge.

8.1.14 The following day Nancy was reviewed by a Physiotherapist who was informed that Nancy had decided that she would now prefer to go home with a referral for community therapy and a package of care. Family advised staff that the access to the room in the property was tight as a cupboard limited space resulting in a request for ambulance transfer, there were no issues raised by the family about the use of the hoist.

8.1.15 A hoist, slings, slide sheet and commode were ordered by therapy staff on the 14th of September in preparation for Nancy's return home. Prior to discharge family confirmed that the bedroom had been cleared therefore the bed and mattress were ordered. On review by therapy staff on the 22nd of September it was documented that a medium sling would be required rather than a large. This was communicated to Nancy's daughter, and the moving and handling plan was documented.

8.1.16 The social worker assessment was carried out on 21st of September 2022 with a view to what care was required at Nancy's home address. The outcome of the assessment was to commission a care provider that could provide 4 calls a day with no overnight needs being identified.

8.1.17 The Transfer of Care Document completed by the social worker reflected that Nancy was experiencing low mood, frustration with her decline in mobility and was suffering from intermittent incontinence, she was wearing absorbent pads to manage this. Due to her decline in mobility, she required hoist transfers with the assistance of two staff and would require a wheelchair to transfer longer distances. Support and encouragement would also be required with washing and dressing and oral hygiene. It was documented that Nancy had recently been diagnosed with sleep apnoea[6]

8.1.18 On the 23rd of September photographs of Nancy's sacrum were obtained with her consent and uploaded onto her electronic patient record these images reflected superficial tissue damage to her buttocks and natal cleft. It was documented the following day by the nursing staff that the moisture lesion had progressed to a grade 2 pressure ulcer. The Tissue Viability Nurse (TVN) reviewed the images and documentation and was confident that this was not a pressure ulcer, it was wrongly classified by the nursing staff and remained a moisture lesion.

8.1.19 During the discussions with Nancy about equipment that could be provided for her return home she stated that she did not feel safe in bed without bedrails and would want these on her bed at home. Due to hospital staff not being allowed to order an airflow mattress and bedrails from their community equipment store due to an inferred incompatibility issue a static mattress was ordered. The risks of entrapment with bed rails and without 24-hour care were discussed with Nancy which she demonstrated an understanding of. Alternative bed wedges were suggested to raise the sides of the static mattress and make her feel safer which Nancy gave her consent to. Both types of mattresses were suitable to provide the appropriate level of pressure relief.

8.1.20 The day prior to discharge from hospital it was recorded that Nancy's sacral area was photographed again, the images demonstrating that there had been a significant improvement in the moisture damage and redness. On the day of hospital discharge Nancy requested a bedpan for use at home there was therefore no time for assessment in hospital with this piece of equipment. Staff agreed to order one and advised Nancy that she shouldn't use it until a risk assessment had been completed at her home.

8.1.21 Throughout her admission Nancy was prescribed varying amounts of a diuretic to relieve her heart failure which resulted in increased urine output. This was stopped for a short period of time during this in patient episode and recommenced at a maintenance dose of 20mg the day before discharge. On the day of discharge the hospital discharge team e-mailed the continence team informing them of her discharge and the requirement to supply further incontinence products. Staff also referred Nancy to the District Nurses (DN) for management and oversight of her moisture lesion, a review being requested for the day after discharge on the 28th of September.

8.1.22 Nancy was transferred home by private ambulance staff on a stretcher as she was unable to flex at the knees and would not have been able to support herself in an upright

[6] Sleep apnoea is when your breathing stops and starts while you sleep

position in a wheelchair. She was also accompanied by 2 therapy staff, once at Nancy's home there was no stretcher access from the hallway to the bedroom where Nancy was to be cared for.

8.1.23 The access to Nancy's bedroom where the cupboard was situated limited the turning space, therefore the private ambulance crew transferred Nancy from the stretcher to wheelchair in order to access the room. This was eventually achieved using a sling, after this transfer Nancy reported that she was in too much pain to be sat upright for long in her existing chair and so she was transferred onto her bed. Following being placed on her bed Nancy reported to her family that she felt pain in her low back area and felt a tear to her sacral skin may have occurred.

8.1.24 During the follow up visit by the therapy staff it was acknowledged that the chair that Nancy had was not going to be suitable due to the amount of pain she experienced when sitting in it, and that a recliner chair would be required. An in situ sling was ordered to reduce the amount of times Nancy would have had to have the sling removed and then replaced when hoist transfers were required. Until this new equipment was delivered, she would need to be cared for on her bed. At this visit the therapy staff were informed by Nancy's family that their mother now has a sacral skin tear and that the DNs would be managing this.

8.1.25 The homecare provider made their first visit to Nancy that afternoon and received instruction verbally from the therapy team that Nancy was not to be hoisted onto a commode or sit out in a chair, she should be cared for in bed until further equipment was delivered.

9.0 Findings following this key episode of care and treatment

9.1. Staff Factors

9.1.1 There was insufficient documented evidence of the moisture lesion to Nancy's sacrum being evaluated daily by the nursing staff during this admission, having a moisture lesion, being doubly incontinent and losing weight all increase the risk of developing a pressure ulcer. However, it was evidenced prior to discharge that the moisture lesion did appear to be healing.

9.1.2 It is unclear whether nursing staff discussed Nancy's nursing needs and how these would be met when formulating her nursing care plan. There is no evidence to suggest that during her admission Nancy lacked the mental capacity to give her informed consent to her care and treatment. Her compliance with her nursing care was viewed as giving her consent. The therapy staff who engaged with Nancy explained what they wanted her to try and do during their visits to her, again there was no reason to believe she was not willing to try and regain some of her mobility, she stated she was keen to do this, however struggled with motivation to achieve this consistently.

9.1.3 Nursing staff incorrectly assessed the damage to Nancy's sacrum as being a grade 2 pressure ulcer during her inpatient care when following a review by the TVN this was categorised as a moisture lesion again. As such the use of barrier cream to treat the skin was

compliant with the National Institute for Clinical Excellence (NICE) guidance[7] on the prevention and management of pressure ulcers.

9.1.4 There is no evidence to support that Nancy was given any information about the importance of relieving the pressure on her sacrum to prevent the likelihood of a pressure ulcer developing during her inpatient care.

9.1.5 The Discharge 2 Assess[8] (D2A) form sent by the hospital discharge team made no mention of the fact that the diuretic medication would potentially increase urine output and that the 2 hourly checks by staff on the ward overnight had meant that the moisture lesion had been receiving appropriate care and any episodes of incontinence were managed as required. At the PLE it was confirmed that the social worker had not spoken to the nursing staff who could have provided information on the care needs of Nancy overnight, the hospital team should have ensured that information on the D2A document was thorough in describing Nancy's 24 hour needs As a result, the social worker commissioned a home care provider that would provide 4 calls a day but no overnight visits.

9.1.6 The wrong e-mail address for the continence team was used by the hospital discharge team and there was no acknowledgement of the referral. This was a missed opportunity to ensure Nancy received input from a required service.

9.1.7 When the social worker made their assessment of Nancy's needs on the 21st of September 2022 there is a difference of opinion over whether or not the social worker spoke to the hospital therapy team about Nancy. During the inquest the social worker confirmed under oath that the conversation took place, the coroner noting that there was no need to dispute this. Also, under oath at the inquest the therapists gave evidence stating that there was no conversation between them and the social worker about Nancy's care needs. The therapists further stated during the inquest that the therapy team would not have been best placed to answer the question relating to whether Nancy had any overnight care needs as they were not involved with Nancy out of hours. The ward nursing team would have been better placed to answer this question. The hospital has no record of the social worker speaking to the ward team to establish overnight care needs.

9.2 Team Factors

9.2.1 An environmental visit to Nancy's home was not undertaken by therapy staff prior to Nancy's discharge from hospital, had one been undertaken this would not have identified the issues with transferring Nancy from the private ambulance stretcher into the chair in her bedroom using the equipment available, an environmental visit would only have considered the available space to utilise equipment in.

9.2.2 The private ambulance staff should have been contacted by the hospital team to discuss the requirements and access issues on the transfer of Nancy to her home to allow the ambulance staff to consider their own environmental risk assessment. This was a potential

[7] ibid

[8] The discharge to assess pathway is a program that helps patients leave the hospital when they are clinically stable but still need some care?

missed opportunity to consider a safer transfer home, or to have considered an MDT discharge planning meeting.

9.2.3 A bedpan had been ordered by the therapy team on the day of Nancy's discharge at her request which was not on her original moving and handling plan, and as identified earlier resulted in no risk assessment of its use being possible. Therapy staff informed both Nancy and her family that the bedpan should not be used until this assessment could be carried out. When therapy staff contacted the care provider to advise them that Nancy was to be nursed in bed until further equipment was provided to facilitate safer transfers by hoist the carers were not informed that the bedpan should not be used. This resulted in the bedpan being used at Nancy's request on two occasions and which might have contributed to the damage to Nancy's sacrum. It was not until the 30th of September that the carers were informed not to use the bedpan again, and the therapy staff arranged to have it collected. There was also a failure to communicate the referral to the DN service made prior to hospital discharge to the social worker and so this information was not documented in the Transfer of Care Document and was not passed on to the care staff either.

9.3 Care and Service Delivery Factors

9.3.1 The family of Nancy raised their concerns with the social worker that their mother's discharge was in their view 'unsafe'. The concern was passed to the hospital safeguarding team who responded stating that in their view this was a safe discharge. It is not clear whether any contact with those involved in this discharge was sought prior to this conclusion being reached.

9.3.2 The discharge of Nancy back to her own home proved to be difficult due to limited space for turning equipment which would not have been identified if an environmental visit had taken place. Nancy's electronic patient record did not document the discharge plans and detail how this had been arranged.

9.3.3 The original manual handling plan was correct when shared with the social worker to support the formulation of the Transfer of Care Document resulting in the care package being commissioned. The manual handling plan was shared with the Single Point of Contact (SPOC) discharge administration team who didn't share this document with the community care provider. The amended moving and handling plan was not shared with the care staff as it was never completed, all the required assessments were not carried out. The replacement recliner chair was not delivered until after Nancy was readmitted to hospital.

9.3.4 Although Nancy was found not to have a pressure ulcer to her sacrum on discharge and this was being managed as a moisture lesion the service has concluded that the team should receive an update on the management of pressure ulcers and risks to patients of these deteriorating.

9.3.5 There was poor communication with the MDT and family when considering and implementing the discharge plan and equipment.

9.3.6 Nancy had been nursed on an airflow mattress with bed rails during her inpatient stay. Due to the provision of equipment arrangements across Liverpool the supplier of the

equipment to Nancy's home address was not authorised to provide bed rails with an airflow mattress. This resulted in Nancy being provided with a static mattress and wedges to relieve her pressure areas when she returned home. A risk assessment was undertaken which evidenced that this type of mattress when used with bed wedges would be sufficient to manage what was then a moisture lesion on Nancy's sacrum. Once the moisture legion became a broken wound the mattress suitability should have been revisited.

10.0 A summary of Nancy's care in her own home between the 28th of September and the 10th of October 2022 following discharge from hospital

10.1 Nancy was discharged from hospital on the 28th of September 2022, care staff had been instructed to commence support from the teatime call that day. In the afternoon they received a telephone call from an OT at Whiston Hospital to state that the moving and handling plan had been changed and that Nancy was to be nursed in bed only because staff could not get her comfortable in the existing chair and a different sling would be required due to Nancy requesting an alternative, the one in use she did not feel comfortable with. On discharge Nancy was nursed on a static mattress suitable for someone with up to a category 2 pressure ulcer as identified earlier.

10.2 The evening carers changed Nancy's bedding as she had been incontinent of urine following arrival back at home. The following day the carers felt that the moisture lesion was in fact a tear to Nancy's skin that would require DN input to manage, a request for their support was made. The carers requested a call to the continence service to check a referral had been made because the net knickers Nancy had been discharged with the carers felt were too small to be used to maintain the position of the incontinence pads. Both the incontinence pads and the net knickers were the same as the ones that the hospital staff had been using without difficulty. The carers contacted the continence team based at MCFT via telephone and a message was left as they felt that the pads provided for Nancy were not sufficiently absorbent to manage her continence needs.

10.3 A welfare call to Nancy was completed by a Liverpool social worker on the 29th of September as per the D2A pathway. The social worker was advised by Nancy's daughter that they had identified what they believed to be a tear to their mother's skin on her sacrum caused by the incorrect sling and moving and handling methods during her mother's transfer onto her bed. Nancy herself reported that she was in a great deal of pain and had not been able to sleep properly. Nancy's daughter also informed the social worker that the moving and handling plan that was provided by the therapy staff to the social worker was going to be amended following the difficulties in positioning Nancy comfortably in her own chair at home. The carers also reported their concerns about the skin on Nancy's sacrum to the DNs on the same day.

10.4 Nancy's daughter contacted the social worker again on the 30th of September to report that her mother's medication had been dispensed in blister packs. Care staff would however administer her prescribed medication, but her daughter felt that it would be safer to have these in a weekly dispensing box. The advice given was that Nancy's daughter should purchase a dispending box until the medication could be dispensed appropriately.

10.5 During the follow up visit carried out by therapy staff on the 30th of September the use of the bedpan was discussed with Nancy as she had declined advice to keep using the incontinence pads and there had been no opportunity to assess the use of the bedpan in the home environment. An assessment was made of the in situ sling during the hoisting of Nancy into her own chair, this sling was left at Nancy's home to be used once the specialist seating had been delivered and assessed for suitability at a further follow up visit. Attempting this transfer would have been difficult for the carers due to the angle required to position Nancy in her existing chair, Nancy was also finding the transfer uncomfortable. Nancy being nursed in bed until an alternative reclining chair was discussed with her and her family with all agreeing this was the best option. An urgent request for an appropriate chair was made by the therapy staff following this visit. Telephone details for the continence team were also shared with Nancy's daughter at her request.

10.6 The DN referral received from the hospital was to support with pressure area care and management of the moisture lesion. There was no reference to Nancy's lack of mobility on the referral or the fact that she was almost bedbound. An airflow mattress had been discounted by hospital staff on the basis that bed rails could not be ordered with this type of mattress from the equipment store, and wedges would provide the safety Nancy felt when the bedrails had been used. Due to the lack of upper body strength of Nancy she was unable to reposition herself overnight and remained in the same position for considerable lengths of time, her care package providing no overnight support. There was no discussion between hospital staff and community staff about the discharge in relation to equipment, wound management, location, and severity of the moisture lesion.

10.7 DNs felt that Nancy required overnight care to manage her needs particularly in respect of pressure area care. Overnight care was not commissioned based on the information gathered by the social worker when care needs were being established.

10.8 As identified earlier a bedpan had been ordered by the hospital at the time Nancy was to be discharged home and without the opportunity to risk assess its use. Utilising this potentially caused further damage to Nancy's sacral area because the care provider had not been informed by hospital staff not to use this, this advice was only shared with the family and Nancy herself. The carers struggled to manage Nancy's incontinence with the pads and net knickers provided to them. Nancy was regularly saturated in both urine and faeces which contributed to the further deterioration in her wound during her care at home.

10.9 On the 2nd of October having had to change bedding at visits due to it being soaked through with urine the carers asked Nancy to call the DNs as the sacral dressing was peeling off and they had observed that the wound was black. At the teatime call the carers found the DN's present and redressing Nancy's wound. Nancy also contacted NWAS that afternoon to report that she had a "bed sore that was turning black". Nancy was referred to the GP out of hours service (Primary Care 24 – Liverpool). On the 3rd of October a call was made to the office of the care provider by the DN service confirming that they had instructed the carers not to use the bedpan.

10.10 A DN spoke with their safeguarding team on the 3rd of October 2022 in relation to the moving and handling of Nancy with the equipment provided on discharge from hospital. The difficulty in moving Nancy following her discharge from hospital following the advice from the OT to the carers not to use the hoist and commode and the subsequent use of the bedpan by the carers at Nancy's request had potentially caused further trauma to her sacral area. A safeguarding concern to LCC was subsequently made, no requirement to hold an MDT meeting was suggested.

10.11 Over the following days both the carers and the DNs were aware that the wound was deteriorating, the carers made attempts to relieve Nancy's pressure areas using the wedges provided and to maintain the hygiene of her skin at the visits they made to her home.

10.12 A reposition chart was provided by the DN team to support carers documenting the repositioning of Nancy to ensure adequate pressure relief was given and that the DNs to know what side they were to reposition Nancy in on their visits. The carers were also advised not to use the bedpan due to the risk of further damage to Nancy's skin. The DNs directed the carers to support with repositioning Nancy on both her left and right sides to avoid her lying on her back as much as possible.

10.13 The initial safeguarding concern was raised by the family of Nancy when the social worker attempted to contact the hospital safeguarding team to discuss the discharge that they felt was 'unsafe'.

10.14 Over the next few days concerns were regularly shared by the carers to the DNs that the incontinence pads that were provided were not adequate, they were regularly finding Nancy in a urine-soaked bed which also caused the wound dressings to start to peel off on her sacrum, allowing urine and faeces to contaminate the wound. The DNs asked the carers to try to hoist Nancy to occasionally relieve the pressure on her sacrum. These concerns were not shared with the GP there was a further missed opportunity to request an MDT meeting to formulate a plan to address the concerns.

10.15 On Tuesday 4th of October the social worker sought support from a team leader in ASC as the existing care provider could not cover overnight support for Nancy and no other care agency had come forward. The social worker was advised to contact the Integrated Community Reablement and Assessment (ICRAS) team[9] to see if they would accept Nancy into one of their intermediate care beds. The Transfer of Care document was sent across to the ICRAS team. This was subsequently transferred to the emergency ICRAS therapists to assist who accepted the referral.

10.16 The social worker was contacted on the 6th of October and advised by the emergency ICRAS team that they declined to assess for treatment due to Nancy being bedbound and no enablement goals being identified. This outcome was shared with Nancy and her daughter. This was another missed opportunity to request an MDT to review alternative options or escalate concerns to managers. On the same day NHS 111 were contacted by Nancy's

[9] ICRAS provides nursing and therapy treatment or interventions for people in their permanent or temporary place of residence using an MDT approach

daughter to report that her mother was not passing urine, an NWAS clinician assessed the concern following Nancy refusing to attend at a treatment centre. Staff were informed that Nancy had since passed urine and felt her bladder was now empty, worsening advice was again given and the incident passed to the GP for information.

10.17 On the same day Nancy received a medication review and an alignment by the Pharmacist over the telephone following the discharge plan from Whiston Hospital, blood tests were also requested. A home visit by the GP surgery's Advanced Nurse Practitioner (ANP) was also undertaken because of the referral from NWAS. The ANP attempted to encourage readmission to hospital, but Nancy declined. Nancy was spoken to by a GP over the telephone the following day because of being made aware that Nancy was suffering from constipation, appropriate medication was prescribed, there was also a discussion about Nancy's management with her daughter.

10.18 On the 9th of October Nancy's daughter contacted the social worker again to request further information about why the referral to the ICRAS had been refused. She expressed her concern that her mother's health was rapidly declining. On the same day a call was made to NHS 111 by Nancy's son stating what his mother had been in pain for six hours due to a wound to her sacrum, the advice was to transfer Nancy to a walk-in-centre for assessment. Within an hour of the previous call NHS 111 were contacted by one of the care staff to state that Nancy was having spasms in her body, was in significant pain, appeared to have a slight temperature, was clammy to the touch and needed assistance with a pressure ulcer to her sacrum. The call was assessed and referred for the DN service to attend.

10.19 One and a half hours later a further call to NHS 111 was made by a carer to report Nancy was still in pain. An assessment was made with the outcome being that the information would be passed electronically to the GP out of hours service. Later the same evening Nancy's husband rang NHS 111 to report they had not heard from the Out of Hours GP; family were advised there was a delay and worsening advice was given.

10.20 Nancy was reviewed by NWAS late on the 9th of October following which she was transferred via ambulance to RLUH arriving in the early hours of the 10th of October. On admission she was found to have raised markers on blood results indicating an infection, her pressure ulcer was reviewed and found to be a grade 4 full thickness wound. She was commenced on IV antibiotics and IV fluids, and a referral was made to the TVN at the hospital. Nancy was taken to an operating theatre to have her wound debrided on the 12th of October which revealed a large cavity in the sacral region which exposed the sacral bone. Despite active treatment Nancy's health continued to deteriorate and she sadly died on the 26th of October of sepsis from her infected pressure ulcer.

11.0 Findings following this key episode of care and treatment

11.1 Staff Factors

11.1.1 Nancy was discharged from hospital on the 28th of September 2022, an initial assessment was undertaken by the DN service the following day. During this visit Nancy had

her Waterlow score[10] assessed as being 14 indicating a risk of pressure damage. No pressure ulcer prevention plan was documented or discussed with her and there was no evidence to support that Nancy had been given a patient information leaflet about the risk of pressure ulcers.

11.1.2 The wound to Nancy's sacrum had no wound assessment documentation recorded initially, and there was therefore no review documented when a deterioration was noted to the pressure ulcer. The initial visit was allocated on the information provided in the referral. This delegation of task was appropriate in response to the clinical need at that time to respond to a moisture lesion or a grade 2 pressure ulcer care. Pressure ulcer and wound competencies are additional training modules to enhance existing knowledge and skills that any nurse would gain throughout their training programme or work experience.

11.1.3 There was documentation in Nancy's records by the DNs to support that they observed localised signs of a wound infection, this was not escalated to senior staff members of their team or Nancy's GP, neither was the wound swabbed for microbiology screening to rule out an infection, all of which would have been expected practice. A Datix® incident form was not completed by the staff when there was a significant deterioration to the wound as would also have been expected.

11.1.4 On the 2nd of October 2022 the wound was incorrectly categorised as a deep tissue injury, however the intervention from the caseload holder was consistent with pressure management for an ungradable pressure ulcer, and a pressure ulcer care plan was commenced. The caseload holder initiated the request for an airflow mattress and instructed the carers not to use the bedpan. There was however no referral to the TVN for support in the management of the wound. Digital photography of Nancy's wound was obtained although there were no patient identifiers linked to the images or documentation of a date and time the images were taken.

11.1.5 Equipment to record clinical observations was not used by the DNs and their Trust policy was not followed when there was documentation to suggest clinical signs of a localised wound infection.

11.1.6 There was no care plan documented by the DNs relating to pain management, the ongoing monitoring of this or a request to the GP to review Nancy's analgesia despite being aware that Nancy was in considerable pain and the current prescription was not sufficient.

11.1.7 The carers felt they were able to meet aspects of Nancy's care plan such as supporting her with hygiene needs and repositioning on the hospital bed using the wedges supplied but raising their concerns with the DNs and ASC did not result in any mitigating actions being taken, or consideration of requesting an MDT or discussion at the DN safety huddles.

11.1.8 On the 9th of October the GP could have requested a call to the out of hours GP service for a home visit and for a prescription for pain relief. DNs did not communicate directly with

[10] A Waterlow score is a risk assessment outcome of the likelihood of risk of pressure ulcers, the total score ranges are from 0 to 25

Nancy's GP practice, they had been providing advice to the family members to contact the GP themselves for a pain review.

11.2 Team Factors

11.2.1 MCFT uses an Escalation Management System (EMS) which collates scores of between 1-6 regarding staffing, skill mix, flow, response and non-direct patient care and environmental factors. A score of 1-2 would indicate that a team does not require any assistance to facilitate service delivery. During the period of Nancy's care the DN service was recording an EMS score of 2. Minimum staffing levels were reduced due to maternity leave and staff sickness.

11.2.2 This reflected a loss of capacity was across both registered and non-registered staff within the team, there was also no full-time team leader, cover was provided by someone working 2 days per week. There was no secondment post to cover maternity leave.

11.2.3 There is a lack of evidence to support that the continence team responded to the telephone messages left by the carers. Practice at that time was to record telephone messages to the team in a book for actioning, the book for this period cannot be located.

11.2.4 There was some miscommunication between the carers over how frequently the DNs would be visiting Nancy to manage her sacral wound following the referral to their service. The DNs themselves were aware that the carers were commissioned to visit four times a day.

11.3 Care and Service Delivery Factors

11.3.1 The EMS score was within safe parameters although the tool does not take into consideration for unplanned calls, documentation, or double up visits. Although the DN team raised concerns over the EMS and weighting tool.

11.3.2 There was a holistic assessment of Nancy's care needs during her care at home by the DNs. From the 2nd of October 2022 there were notable interventions, it was after this that there were gaps identified in the approach to the reassessment of Nancy's care needs.

11.3.3 There was a lack of robust clinical documentation to support the rationale for the wound dressings.

11.3.4 There was a lack of evidence to support that Nancy was routinely discussed at DN safety huddles, Nancy's care would have met the criteria for discussion.

11.3.5 MCFT guidance, policies and procedures relating to wound care, NEWS 2[11], pressure ulcer and pain management were not correctly followed by staff to support the care of Nancy.

11.3.6 There was a lack of ownership in reporting concerns to Nancy's GP, this responsibility was passed to the family of Nancy to undertake. The rationale for this was that the DN's did not have access to a professional's telephone number or e-mail and would have to go through the main GP telephone number resulting in time pressures. There was no access to use an

[11] NEWS2 is a National Early Warning Score updated in 2017 that determines the degree of illness of a patient and prompts critical care intervention based on the outcome of the risk score

electronic referral system for Nancy's GP surgery. Tasking within the GP EMIS system did not support this function at the time of Nancy's care.

11.3.7 Care staff felt that the incontinence pads and net knickers provided by the hospital were unsuitable in meeting Nancy's needs. Moisture such as urine can cause the skin to become macerated, which means it blisters and breaks down more easily. This weakens the skin's barrier making it more susceptible to pressure and friction. Urine also contains toxic chemicals that can damage the skin cells[12]. The referral to the continence team and request for an alternative product was sent by the DN team but not until the 3rd of October.

11.3.8 The care agency also felt that they should have requested written confirmation from the OT about the change in the care plan for Nancy following her discharge from Whiston Hospital to evidence to the DNs why they could not use the hoist to relieve the pressure on Nancy's sacrum.

11.3.9 When the ICRAS referral was rejected on the basis that Nancy had no identified enablement goals this would have been an opportunity for ASC to request an MDT meeting to discuss how her care needs were going to be managed in the community from this point onwards. In January 2025 the LSAB partners agreed a Resolving Professional Difference and Escalation Policy which will now provide guidance for professionals in resolving such situations in future.

12.0 Responses to the Adult Safeguarding Concerns

12.1 On 29th of September 2022 a Liverpool social worker raised a safeguarding concern relating to Nancy's discharge from hospital including concerns that had been raised by Nancy's daughter over how this had been undertaken. Whiston Hospital is situated within the boundary of Knowsley Local Authority, this concern was shared with them to allow them to decide on what action should be taken as a result. Contact was made with Nancy's daughter on the same day, and it was recorded that there were concerns about a skin tear to her sacrum but that the DN's were managing this.

12.2 The social worker escalated their concerns to their management team on the 4th of October to discuss potential options as it was clear the commissioned package of care was not meeting Nancy's needs. As a result of this escalation the ICRAS team were contacted to see if Nancy could be transferred to an intermediate care bed, but this was rejected by MCFT overseeing the ICRAS on the 6th of October due to Nancy being bedbound with no enablement goals being identified.

12.3 On the 3rd of October 2022 Liverpool ASC received an e-mail from Whiston Hospital safeguarding team noting the allegations related to the discharge process, they did not consider this first safeguarding concern by Nancy's daughter a safeguarding matter as there was no evidence of neglect of Nancy, Knowsley ASC were informed that the Patient Advice and Liaison (PALS) team would manage the concerns.

[12] www.nhs.uk

12.4 A DN shared a second safeguarding concern with a social worker at Liverpool ASC on the 3rd of October 2022 regarding the support from the hospital OT service provision in Nancy's own home, with concern that the pressure ulcer was deteriorating at home.

12.5 On the 4th of October Nancy's daughter also contacted Liverpool ASC to report that her mother was not doing well and was becoming more vulnerable the longer she was left. The social worker explained that she had shared the safeguarding concern reported to them with Knowsley for them to investigate. The possibility of Nancy being offered a rehabilitation bed was also discussed.

12.6 This second safeguarding concern was progressed on Wednesday the 5th of October with an initial enquiry plan documented as being:

- Check that Nancy was safe and well and all her needs were being met
- Refer to Careline
- Establish Nancy's wishes
- Share the concerns with Whiston Hospital Safeguarding Lead
- Await the outcome of the safeguarding investigation report

12.7 There was no documented evidence to support that Nancy's wishes had been established or that she was safe and well and all her needs were being met as part of the initial enquiry plan prior to her readmission to hospital.

12.8 It was appropriate for the social worker to comment that Knowsley were looking into the safeguarding concerns relating to the hospital discharge and that her daughter's further concerns about how this was planned would be reviewed by Knowsley as both were about the discharge planned at Whiston hospital. Nancy's daughter explained to the social worker that her mother was deteriorating further now back at home, consideration should have been given to holding an urgent MDT to review equipment provision and how the pressure ulcer was being managed. It was inappropriate to await the outcome of the safeguarding investigation report by Knowsley, Nancy was deteriorating further at home, her care package was not meeting her needs.

12.9 It was on the 10th of October Liverpool ASC were made aware that Nancy had been readmitted to hospital. Following the death of Nancy the safeguarding enquiry managed by Liverpool ASC was kept open to consider transferrable risk to others and what actions needed to be taken to mitigate those risks as far as possible. As part of the enquiry learning from both NWAS and MCFT as a result of their SI investigation was shared. The enquiry was also open pending the outcome of the coroner's inquest.

12.10 On receipt of the safeguarding referral on the 29 of September, Knowsley ASC contacted Nancy’s daughter and advised her that the concerns were a matter for Liverpool ASC to respond to, and to consider requesting that Nancy was to be readmitted to hospital if her care needs could not be managed at her home. The referral was shared with Whiston hospital who responded that this was not a safeguarding concern but that the issues raised would be dealt with by the Trust via their PALS route. The safeguarding referral was therefore not progressed to a s42 safeguarding enquiry by Knowsley with Liverpool ASC being made aware.

13.0 Findings from the management of the adult safeguarding concerns by Liverpool ASC and Knowsley ASC

13.1 Staff factors

13.1.1 The Liverpool social worker appropriately raised a safeguarding concern following the information shared by Nancy's daughter the day after her discharge home from hospital. As identified earlier Whiston Hospital sits within Knowsley Local Authority and so was appropriately forwarded to them for action as would be expected practice to allow the correct authority to make enquiries.

13.1.2 Knowsley ASC took no further action relating to the safeguarding concern following notification that the hospital was managing this via the PALS process. This prevented further consideration by Knowsley ASC of the failings in this discharge were part of a wider picture of concern relating to adequately plan for discharge of people with care and support needs from the Trust.

13.1.3 There was no review of the care and support plan commissioned by Liverpool ASC to establish whether an MDT approach would be appropriate and would provide an agreed risk management plan and identify any need for escalation following the moisture lesion becoming an open wound to Nancy's sacrum.

13.2 Team factors

13.2.1 No team factors identified because of the review.

13.3 Care and Service Delivery Factors

13.3.1 There was no direct communication with the care provider by Liverpool ASC following concerns shared by Nancy's daughter about the additional problems in the care package not meeting Nancy's needs in her own home. ASC should have requested an urgent MDT meeting to assess the risks to Nancy given the acknowledgement that the current care plan was not meeting her needs despite the support of the DNs, and against the background of not being accepted by the ICRAS team.

13.3.2 A formal review of the care and support plan for Nancy which indicated that the support plan required change would have involved a visit to Nancy in her home to review her needs which was not undertaken only telephone contact was made.

13.3.3 The S42 enquiry following the death of Nancy took longer to conclude than would have been normal practice because the outcome of the coroner's inquest was awaited. The focus of the safeguarding enquiries mirrored the concerns raised at the inquest in respect of the hospital discharge and the management of the pressure ulcer by the DN service. Learning for several agencies was identified as a result of the safeguarding enquiry.

13.3.5 As part of the safeguarding enquiry undertaken by ASC information provided by MCFT and MWLTH was shared with HMC without the prior consultation with the Trusts. ASC had a responsibility to share this information with the coroner, good practice would have been to

share and discuss the contents of the enquiry report with all agencies involved prior to finalising and sharing the report with the coroner.

14. Good Practice

14.1 Independent Community Care Provider

14.1 The carers provided by this agency were proactive in checking that a referral had been made to the continence team due to their concerns about the products being supplied not being adequate to meet Nancy's incontinence.

14.2 The carers raised frequent concerns with the DNs and social worker about the deterioration in the wound to Nancy's sacrum. On the 9th of October they correctly identified that Nancy was displaying evidence of infection, noting that she has a slight temperature, and her skin was clammy to touch. They informed their managers and sought the consent of Nancy to call 111.

14.3 The carers regularly spoke with both Nancy and her daughter to communicate their concerns and steps they had taken to escalate these.

14.2 Mersey and West Lancashire Teaching Hospital NHS Trust

14.2.1 There was effective use of the intentional rounding tool used to make physical checks on Nancy on the ward by the nursing staff. All appropriate preventative measures to maintain Nancy's safety were used.

14.2.2 Discussions with Nancy relating to her hospital discharge were person centred and respectful of her decision-making capacity.

14.2.3 Therapy staff at the Trust made significant efforts to procure a suitable chair after Nancy's discharge, and physically went to the equipment store to hire a chair rather than Nancy's family having to purchase a chair themselves that would meet their mother's needs. The request for the chair was expediated to the necessary panel for agreement to avoid a delay.

14.2.4 The last contact with therapy staff was on the 30th of September, good practice was evidenced via the frequent telephone contact with Nancy's family to arrange visits and update them on specialist equipment. No concerns were raised by Nancy or her family during these conversations.

14.3 NWAS

14.3.1 At the last contact with Nancy and her family the attending crew assessed Nancy's capacity to understand the concerns for her health and discussed these with her family and a daughter via telephone who was not present at Nancy's home address.

14.4 Mersey Care NHS Foundation Trust

14.4.1 A thorough holistic assessment on both the 2nd and 3rd of October 2022 by the caseload holder resulted in instigating referrals to the community OT and Physiotherapy team and changes in equipment use.

15.0 Agency Learning already Implemented

15.1 Independent Community Care Provider

15.1.1 The care provider now requests a copy of the moving and handling plan if one is applicable to people they will be caring for.

15.2 Integrated Care Board (ICB) Knowsley Place

15.2.1 The designated adult safeguarding lead has provided the bypass number for all GP practices across Liverpool, and this has been shared with Mersey Care leads for the community services so that they do not have to wait in a call queue with the general public to speak to primary care staff.

15.3 Mersey Care NHS Foundation Trust

15.3.1 The Trust completed a Serious Incident (SI) investigation report following the death of Nancy, from this report an action plan was developed, and actions taken forward for completion because of the learning identified. From July 2023 all the actions are noted to be complete with ongoing monitoring of the overarching pressure ulcer reduction plan the responsibility of Place Performance process. Communication and escalation improvements being picked up under the Patient Safety Incident Response Framework[13] (PSIRF). Staffing and the use of the EMS weighting tool is an ongoing workstream as part of the Trusts safer staffing review.

15.3.2 The Trust has also held a learning event for staff following the learning from the attendance at the coroner's inquest into the death of Nancy. The learning was shared with the team and extended to all team leaders in Liverpool Place and to senior clinical nurses across the division. This was facilitated by the Assistant Director of Nursing at the Trust supported by staff from their Quality Team. Staff attending the PLE who had participated in this event reported that they found it to be of value.

15.4 Mersey and West Lancashire Teaching Hospital NHS Trust

15.4.1 The Head of Therapy Services undertook a review of the care and discharge planning of Nancy following notification of her death. This concluded that although there was no environmental visit undertaken by therapy staff prior to Nancy's discharge had there been this would not have identified the difficulties on transferring her from the ambulance stretcher onto her chair as Nancy and equipment would not have been present. An environmental visit is carried out if concerns are highlighted with regards to space for equipment required for discharge and/or space for moving a patient for transfers or care provision. This visit would be carried out by the therapy staff, in extreme circumstances this would be carried out before

[13] PSRIF sets out the NHS's approach to developing and maintaining effective systems and processes for the purpose of learning and improving patient safety https://www.england.nhs.uk

any equipment is ordered to review if discharge home is even possible with essential equipment for care.

15.4.2 The majority of environmental visits are carried with equipment in place, so that the therapy staff can review the space/concerns and reorganise the environment with the family to ensure that the patient can be discharged home safely and effectively. As the patient does not come home on the environmental visit, carrying out one would not have discovered the concern in positioning Nancy comfortably in her chair.

15.4.3 The review did result in a 6 heading 10-point action plan following the identification of improvements required to existing practice and procedures. Much of this action plan was completed within the timeframes set. There remains one action that requires ongoing work to embed fully due to the scope of the change required.

15.4.4 The hospital discharge team are now aware of the correct e-mail address to use to refer to the continence team following the death of Nancy.

16.0 Conclusions

16.1 Care and Treatment at Whiston Hospital

16.1.1 The inpatient care at the hospital met the standard expected in respect of initial risk assessments, evaluation of these over the weeks Nancy was in hospital, in appropriate care planning and equipment provision to manage her risk of developing pressure ulcers. It has been noted earlier that the evaluation of the moisture lesion could have been evidenced more frequently and that the nursing staff did appear to incorrectly categorise the moisture lesion on one occasion as a grade 2 pressure ulcer until this was corrected by the TVN. There was little evidence to support that Nancy had been given a patient information leaflet in respect of pressure ulcer prevention as part of her nursing care. The standard of nursing care afforded Nancy identified some missed opportunities but does not suggest a concern regarding a wider system failing.

16.1.2 The discharge planning process at the hospital fell short of what the Trust would have wanted to achieve and was identified by HMC as one of the 'gross failings' in their narrative verdict.

16.1.3 There was good practice evidenced of Nancy being engaged in discussions with her about different discharge options. There was no reason to question her cognitive ability to engage in these discussions and her initial decision to be transferred into a rehabilitation placement was acknowledged. When she later changed her mind in favour of a return home and community rehabilitation it was not evidenced that the risks to her of less intensive therapy support were discussed. Following discharge Nancy was not seen by any community therapy staff, the contact timeframes are based on the level of priority identified within the referral to the service.

16.1.4 As previously identified there was no environmental visit by therapy staff prior to Nancy's discharge home. There is no evidence to suggest that had an environmental visit been

undertaken that this would have identified the problems encountered in transferring Nancy comfortably into her chair.

16.1.5 There was inadequate communication between the nursing, therapy staff and social worker in relation to what was known when the Transfer of Care Document was completed and used to commission the package of care at home. The impact of the intentional rounding overnight in managing Nancy's moisture lesion and reduction in further skin breakdown was not understood by the social worker. This resulted in a package of care which was insufficient to meet Nancy's needs. The moving and handling assessment was not updated and there was only verbal communication between the therapy staff and the carers over the change in plan to care for Nancy only on her bed until further equipment could be provided.

16.1.6 At the PLE there was discussion about the role of the discharge co-ordinator and the nursing staff when planning Nancy's discharge. There is no evidence to support that social worker spoke directly to the nursing staff on the ward who could have informed them that Nancy was receiving care overnight identified as part of the intentional rounding arrangements to manage her incontinence and to limit further damage to her skin. As a result the Transfer of Care Document did not identify the additional nursing care Nancy was receiving overnight primarily to manage her continence.

16.1 7 There was also discussion at the PLE about whether Nancy's discharge was 'complex' and that without a formal definition agreed by agencies this was a subjective matter based on personal views. Hospital staff felt that the discharge of Nancy was not complex, there was a care package in place for her return home that would meet her needs, appropriate equipment had been ordered, and her family her happy to support their mother returning home. Community staff felt that this was a 'complex' discharge as Nancy had a high level of need that as the days passed following her discharge was increasing, the lack of care overnight was problematic and the ICRAS referral being declined left Nancy at significant risk.

16.1.8 The need to hold discharge planning meetings/MDTs was something else that was raised at the PLE. There was a difference of opinion amongst practitioners about whether a discharge planning meeting should have been held for Nancy prior to discharge which involved a social worker and a representative from the community DN service if they would be required to support the person on their return home. As this was not viewed by hospital staff as a complex discharge for the reasons previously stated their view was that this was not required, an MDT could have taken place in the community once the problems managing Nancy's needs became apparent. Other practitioners felt that a discharge planning meeting should have been held once Nancy was documented as 'medically fit for discharge' to allow the community teams to be sighted on what the Transfer of Care document had identified.

16.1.9 Practitioners shared that practice was different across Liverpool with some health and social care teams willing to accept invites from the hospital to discharge planning meetings, whilst others indicated that they didn't have the capacity to attend these and would prefer to hold a meeting after discharge. Different approaches across Liverpool do not lend themselves to an easy solution to the problem identified.

16.1.10 The existing practice of sending the hospital discharge summary to the patient's GP and giving a copy to the patient was also flagged at the PLE as problematic in that the DN's do not receive a copy of this directly and rely on the patient being able to share their copy, or the DN's requesting this from the GP surgery once it is uploaded onto the patient's electronic record.

16.1.11 As HMC concluded at the inquest *"gross failings which amounted to neglect"* were found to have occurred in the planning for discharge home. The Trust has acknowledged where things could have been done differently, the LSAB should take a level of assurance that the Trust reviewed their care of Nancy soon after her death, has already taken steps to address some of the findings of their review and that monitoring of these is ongoing.

16.2 Care and Treatment at home

16.2.1 MCFT have acknowledged that the care and treatment of Nancy in her own home was below the standard they would expect to achieve, and which HMC identified as the second *"gross failing amounting to neglect"* at the inquest.

16.2.2 The Trust completed a SI investigation following the death of Nancy which concluded there were significant issues over the care and treatment provided to Nancy by their DN service.

16.2.3 There was a lack of senior leadership within the team at the time they were caring for Nancy due to a staff vacancy. There was a failure to escalate concerns to managers within the team and to discuss the management of Nancy at the DN huddles which would have been appropriate.

16.2.4 The report found that MCFT policies and procedures were not followed, and that staff had not attended the required training, which had they done so would have supported them in caring for Nancy.

16.2.5 There was a failure to request a GP review of the medication to manage Nancy's pain, the lack of functionality in the EMIS system was seen as a barrier by some in the DN team.

16.2.6 There was no consideration by the DNs to request an MDT meeting to discuss their concerns about their ability to manage Nancy in her own home, and whether remaining in her own home and the risks this was presenting was her decision. On the second visit by the DN service multiple referrals to support Nancy in the community were made instead. Following escalation on the 3rd of October 2022 a safeguarding concern was made as an alternative option to requesting an urgent MDT.

16.2.7 At the PLE the GP representative shared that the practice was unaware of the difficulties in managing Nancy's care at home. They were not alerted to the DN's concerns and the ANP from the practice does not appear to have alerted any GP to concerns about Nancy's care package not being able to meet her needs following Nancy's refusal to be readmitted to hospital on the 6th of October.

16.2.8 Difficulties in speaking to GPs was discussed at the PLE by the DNs it was acknowledged that there was a system for health staff to communicate electronically with a GP surgery to

make referrals, some staff felt that having a dedicated telephone line for health staff to ring and speak to a GP would be beneficial rather than them having to use the telephone number used by the public. Discussion by the practitioners again reflected that at some GP surgeries there is a direct dial number for professionals to use, whilst at others there isn't. Different approaches across Liverpool once again highlight the need for a more consistent approach if at all possible and clear communication across the various community health and social care teams about which service is available in the area they cover. The ICB panel member has confirmed as above that a solution to this issue is now in place, dedicated telephone numbers are now available for practitioners to use.

16.2.9 The care staff did frequently raise their concerns with the DNs over the pain Nancy was experiencing and the deterioration in the appearance of her pressure ulcer. However, this did not result in any appropriate action being taken. No request by care staff for an MDT meeting was made to discuss the care and treatment of Nancy. At the PLE the Care Provider manager reflected that their staff would request and MDT via their manager, which would be communicated to the social worker allocated to the oversight of Nancy's care package to organise.

16.3 Safeguarding Adult Responses

16.3.1 Appropriate action was taken by LCC ASC in referring the initial safeguarding concern to Knowsley ASC to investigate. The hospital safeguarding team indicated that they would address this referral via their PALS service as a care concern as in their view this did not meet the safeguarding threshold. At the point at which the Liverpool social worker developed concerns as to the way in which health and care services were being provided to Nancy now that she was back in her own home there should have been an MDT held, at which Nancy and her family and all partners providing care and equipment could discuss and consider next steps. The last safeguarding referral relating to Nancy's care at home was not raised until after her death.

16.3.2 The safeguarding concern recorded on LCC ASC system relating to the care of Nancy at home was managed according to LSAB's policy and procedures. It remained open until the conclusion of the inquest into the death of Nancy.

16.3.3 The social worker did escalate their concerns over the care package provided to Nancy to their line manager. Following this escalation a referral to the ICRAS team was advised. The referral was subsequently declined by the service as Nancy was bedbound and had no enablement goals were identified. There was no further action taken or escalation by ASC as a result of the referral being declined by the ICRAS team. This was a missed opportunity to convene an urgent MDT meeting as the risk was still present and required discussion with partners about what other options were available and to establish what Nancy would consent to.

16.3.4 The safeguarding concern managed by LCC ASC remained open awaiting the outcome of the coroner's inquest and enquires responded to by Whiston hospital, MCFT, Care Provider and NWAS, learning was identified as a result.

16.3.5 The safeguarding concern that was passed by LCC to Knowsley ASC following the concerns raised by the DN's relating to the discharge from Whiston Hospital of Nancy was dealt with by the Trust via its PALS because the Trust felt this was not a safeguarding issue as a result of an unsafe discharge. It is not clear if the Trust shared their response to the concern with Knowsley ASC to allow the closure of the safeguarding episode on the database used by the Local Authority.

16.3.6 Since December 2023 there has been a Standard Operational Procedure (SOP) agreement between Knowsley ASC and NHS health providers setting out what the requirements are from health partners once a S42 enquiry is sent to them for investigation and action. This SOP would require health providers to share information on how they were managing the request as above and require them to provide the outcome of the issues raised if via another route to allow the Local Authority to consider closure of the safeguarding episode.

Learning Outcomes from SAR 'Nancy'

Learning 1: The Therapy Team at Whiston Hospital completed a review of their management of Nancy's discharge and produced an action plan as a result of their findings.
Question 1 – How will the LSAB and KSAB be assured that the learning from this review is complete and embedded to support safer discharges in future? ***(Single Agency)***
Learning 2: There was ineffective communication between the social worker and health staff relating to Nancys needs on discharge from hospital which resulted in a care package being commissioned that was not able to meet her needs at home.
Question 2 – Were the errors in communication around Nancy's needs a 'one off' event? How will the LSAB be assured that staff share/obtain information about patient needs effectively when discharge planning? ***(Health and Adult Social Care)***
Learning 3: The referral to the DN service made by the hospital staff did not include information about the equipment provided for Nancy, her wound management, location and severity. DN's are not copied into hospital discharge letters, they rely on a copy given to the patient being available or when received by the GP.
Question 3 – Should there be agreed guidelines on when a hospital MDT discharge planning meeting is required? ***(Health)***
Learning 4: It was not possible for Nancy to be cared for at home using the airflow mattress and bed rails that had been used in hospital due to the commissioning arrangements of equipment stores not allowing airflow mattresses with bed rails to be used in the community where Nancy lived. Whilst it is acknowledged that a static mattress was adequate for a person with up to a grade 2 pressure ulcer to be nursed on, when the wound became 'black' the static mattress was inadequate.
Question 4: Is there an opportunity to review equipment provision in the community to allow people to be discharged home with the same equipment they have been nursed on in hospital when back in their own homes? ***(Health)***

Learning 5: Mersey Care NHS Foundation Trust undertook a Serious Investigation Report following the concerns identified in the care of Nancy which resulted in an action plan being developed.
Question 5: How will the Trust provide assurance to the LSAB that all the actions from this SI are complete, and the learning is embedded? ***(Single Agency)***
Learning 6: The Continence Team rely on a notebook to transcribe all telephone messages left for them which allows them to action these. The notebook documenting the message left for the service in this SAR could not be located as part of establishing a 'fact'.
Question 6: Is there a more robust way using available technology to make this process more reliable? ***(Single Agency)***
Learning 7: No agency involved in the care of Nancy in the community following her discharge from Whiston Hospital called an urgent MDT meeting to discuss if there was any further action or support that could have been taken or requested when it was clear that her care needs could not be met by the support she was receiving at that time. There was ineffective escalation following ICRAS declining the referral for reablement.
Question 7: What more can agencies do to encourage practitioners to take responsibility for convening an MDT when there are multiple agencies involved in supporting someone's care but the risk to the person's health and wellbeing is increasing? How can escalation be improved when risk to an individual of a poor outcome is increasing? ***(Multi-Agency)***
Learning 8: Practitioners need to understand where the responsibility lies for investigating a safeguarding concern. Regardless of where the person was ordinarily resident or who the worker's Local Authority was if the alleged abuse/neglect occurred in their area they should proceed with the safeguarding enquiry. If there is disagreement on who should progress the enquiry there should be an appropriate use of the escalation process if agreement can't be reached.
Question 8: How will LSAB and KSAB be assured that safeguarding concerns are accepted and managed by the correct Local Authority and escalation process is being used when required? ***(Adult Social Care)***