Safeguarding Adults Review
7 Minute Learning Summary

West of Berkshire
Safeguarding Adults Board
Reading, West Berkshire & Wokingham

Ben, moved to a Nursing Home in August 2014, after a stay in hospital. Ben had a diagnosis of Vascular Dementia and multiple co-morbidities. Ben lacked capacity to consent to the care and support provided to him, a Best Interests Meeting decided that it would be in Ben's best interests to move into a Nursing Home.

A Nursing Home had been identified by the Local Authority. Ben's family however expressed concerns about the cleanliness of the home, and requested that a placement be made closer to his family. As Ben had been in hospital for over 3 months it was decided at a further Best Interests Meeting that it was it was in Ben's best interests to move into the Nursing Home on an interim basis pending a six week review. The six week review concluded that the placement appeared to be working well for Ben and Ben's case was transferred over for a 12 month review.

Ben was admitted to hospital in July 2015, and the hospital immediately raised a safeguarding concern under the category of Suspected Acts of Omission and Neglect by the Nursing Home. As Ben was noted to have 12 pressure ulcers and bruises over his body. The police were also notified. As a result of this safeguarding concern the Nursing Home was investigated under the Provider Concerns Framework and a police investigation was opened.

Ben did not return to the Nursing Home and passed away in August 2015. It was noted that Ben had several pressure ulcers at the time of his death. A criminal prosecution against the provider did not take place, due to lack of evidence. The Care Quality Commission (CQC) considered action under their regulatory powers but concluded there was not enough evidence to progress.

The Care Quality Commission, Thames Valley Police, Clinical Commissioning Group, GP, District Nurses, Podiatry, Tissue Viability Nurses, Royal Berkshire Hospital, Wokingham Borough Council, South Central Ambulance and a independent Nursing Home. All supported Ben during the period of review and contributed to this SAR.

Lessons

- **The Nursing Home had no pressure care prevention plan in place for Ben, despite Bens needs resulting in him being at high risk of pressure damage. This was not identified as an issue at the six week review.**
- **The Mental Capacity Act was adhered to throughout Adult Social Care's involvement with Ben. Best Interest Meetings were held in regards to decisions regarding Ben's care and support.**
- **A Deprivation of Liberty (DoLs) assessment took place following an application by the Nursing Home, which was in line with policies and procedures.**
- **Concerns raised about the Nursing Home by Ben's family by the Best Interests Assessor were not shared with the commissioning Local Authority.**
- **There was no safeguarding concern raised by a Nurse who visited Ben and noted that Ben had unexplained bruising. An assumption was made that the bruising was due to a general decline in Ben's health.**
- **There were delays in supporting Ben with his pressure care needs due to confusion around the referral process.**
- **Once initiated the Provider Concerns Framework was a success and a cross agency coordinated response supported the Nursing Home to improve.**
- **Previous safeguarding concerns raised about other residents at the Nursing Home, did not lead to further investigation, which may have identified the failings in the home sooner.**
- **The workforce within the Safeguarding Adults Board Partnership are not clear on the Safeguarding Adults Review process or the functions of the Safeguarding Adults Board.**

Ben's daughters View

"It is important to me that lessons are learnt from my father's case so this doesn't happen to anyone else. Professionals should ensure that they take responsibility for referring and follow up the outcome of that referral, when pathways relevant to their role are not/or no longer appropriate."

Thankyou for taking the time to read this practice note. If you would like to provide any feedback or have any questions regarding the Board please contact: Lynne.Mason@Reading.gov.uk
The full SAR report for Ben can be found here: http://www.sabberkshirewest.co.uk/practitioners/safeguarding-adults-reviews/

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7-minute Learning Summary

Safeguarding Adults Review Ben

Provider Concerns

Under the Care Act Local Authorities (LA) are required to meet the care and support needs of service users, in the event of provider concerns.

It is important that feedback regarding the quality of service provision is provided to the LA in order for the LA to have information on how that provider is performing and potential support the LA to take preventative action prior to the provider failing. If a provider fails it is likely to have a detrimental impact on its service users as well as impacting on the resources of the partnership, due to the level of work that is required when a provider fails.

Please contact the LA Commissioning Team for information on how to provide feedback on service provision.

Pressure Ulcer Prevention?

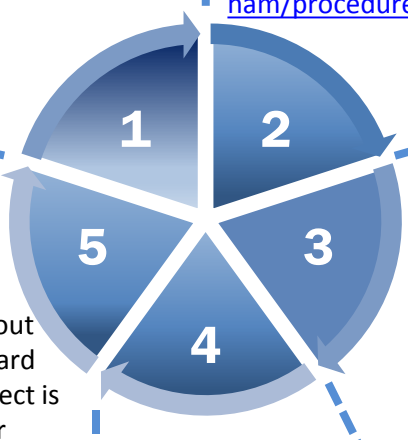
Anyone can get a pressure ulcer but the following can make them more likely:

- Being over 70
- Obesity
- Incontinence
- Poor diet
- Medical conditions that effect the blood supply, make skin more fragile or effect movement.

For people receiving personal care support in the community, in hospital, or in a care home the provider should be aware of the risk of developing pressure ulcers. They should have completed a risk assessment and implemented a prevention plan if appropriate.

Copies of risk assessments, plans and evidence that they are being followed should be viewed when reviewing a persons care. Providers should be challenged if this information is not available and if appropriate reported to the Local Authority.

If a provider fails to support a vulnerable person to manage the risks around developing pressure ulcers this may be a Safeguarding Concern. The Pressure Ulcer Pathway provides further information on this: https://www.berkshiresafeguardingadults.co.uk/wokingham/procedures/?procId=1454



What are Safeguarding Adults Reviews?

The SAB has a legal duty to carry out a Safeguarding Adults Review (SAR) when there is reasonable cause for concern about how agencies worked together to safeguard an adult who has died, and abuse or neglect is suspected to be a factor in their death; or when an adult has not died but suffered serious abuse or neglect.

The aim is for all agencies to learn lessons about the way they safeguard adults at risk and prevent such tragedies happening in the future. The West of Berkshire Safeguarding Adults Board has a Safeguarding Adults Review Panel that oversees this work.

Lessons learnt from SAR's are used by the SAB to set its key priorities.

For a SAR to be considered by the SAR Panel a notification needs to be made, notifications can be accepted from anyone including members of the public.

There are opportunities for practitioners to observe SAR Panels, for practitioners to better understand the process, in order to reduce the anxieties that are sometimes felt, when asked to contribute to a SAR. If you would like to be considered to observe a SAR Panel, please contact Lynne.Mason@reading.gov.uk

The SAB has a dedicated SAR section on its website, which includes information on submitting SAR notifications along with published SARS.
http://www.sabberkshirewest.co.uk/practitioners/safeguarding-adults-reviews/

Safeguarding and Prosecution

It is not uncommon for a Safeguarding Enquiry to be substantiated despite no criminal prosecution following. The is due to the Safeguarding process aligning with the civil thresholds (*balance of probability*) whilst criminal prosecutions consider a threshold of *beyond reasonable doubt.*

Where a pattern of safeguarding and/or care quality concerns is identified, and there are concerns with the way in which the provider is dealing with these concerns the provider concerns procedure will be initiated. As in the case of Ben.

The process can be viewed here: https://www.berkshiresafeguardingadults.co.uk/wokingham/procedures?procId=1448

What is the Safeguarding Adults Board (SAB)?

The West of Berkshire Safeguarding Adults Board covers the three local authority areas of Reading, West Berkshire and Wokingham.

The main objective of the Board, as set out by the Care Act 2014, is to gain assurance that local safeguarding arrangements help and protect adults with care and support needs who are at risk of or experiencing abuse.

The Board aims to make sure that all of the organisations involved have effective safeguarding policies and procedures and work together in the best way possible to protect adults at risk. The three core duties of the Board are to:

- Publish an annual strategic plan;
- Publish an annual report;
- And Conduct Safeguarding Adults Reviews of serious cases in specific circumstances

The Board has a dedicated website:
http://www.sabberkshirewest.co.uk/