Learning Brief: Safeguarding Adult Review: Adult M

A Safeguarding Adults Review (SAR) is a legal duty under the Care Act 2014. The aim of a mandatory SAR is to learn from serious incidents and deaths of adults with care and support needs to prevent similar incidents from occurring. The focus of a SAR is to look at the practice of agencies involved with the person and the systems they have in place to see if any learning can be identified about the way we support adults with care and support needs. The SAR also highlights good practice. The purpose of a SAR is not to apportion blame on any individual practitioners or agencies.

The Rochdale Borough Safeguarding Adults Board (RBSAB) conducted this SAR in 2023-24 to identify learning from a case in which a lady referred to as Adult M sadly died in hospital following a further deterioration in her physical health.

Background:

Adult M was born in the UK of white British ethnicity and was 83 years old when she died. She had experienced some physical health issues in the latter part of her life being diagnosed with head and neck cancer in March 2013. During this time Adult M's three adult children supported her to remain in her own home which was her expressed wish. Following this diagnosis her care had been overseen by the nutrition and dietetics team. In 2019 she had a radiologically inserted gastrostomy tube resulting in her being made nil by mouth, all nutrition and hydration then being administered via this tube. Adult M was in receipt of CHC funding for carers to support her to remain in her own home and OT's provided adaptive equipment to meet her needs. In June 2022 Adult M began to show signs that the cancer might have spread which resulted in Adult M not being able to communicate orally. Adult M had been moved onto a palliative care pathway in the same month and had regular palliative care reviews which included pressure area care, gastrostomy tube management and oral care. In early November 2022 Adult M was admitted to hospital following an episode of diarrhoea and vomiting.

Summary of Adult M's care:

When Adult M was first admitted to hospital her community feeding regime was sent with her. The feeding regime was not documented correctly from admission on her electronic prescription for medicines administration record (EPMA), resulting in a daily 445ml deficit. Following stabilisation of her condition there were 3 options for hospital discharge. An intermediate care placement to increase her mobility prior to return home which would also allow CHC to source a new care provider, family had raised their concerns about the current care provider. Transfer to a palliative care bed which was felt inappropriate at this time and lastly transfer to a Nursing Home under a discharge to assess pathway.

Adult M's preferred option was to transfer to the intermediate care placement however for reasons unknown she later agreed to be discharged into a local Nursing Home. When the original discharge plan for the intermediate care placement was agreed with Adult M a Physiotherapist completed the discharge to assess trusted assessment which did not include information that the Transfer of Care Team at the hospital might have included when the discharge plan was then changed to the Nursing Home placement later in her hospital stay.

Adult Social Care were asked to source a nursing home placement by hospital staff, Rakewood House confirmed that they could meet Adult M's needs after receiving the discharge to assess trusted assessment document. On the day of the discharge from hospital Adult M was transferred with incorrect documentation about her feeding regime, this was picked up by the Dietician at the

hospital the following day. The Nursing Home manager was contacted and informed that the correct feeding regime would be sent in the post that day.

When the CHC nurse reviewed Adult M at the nursing home 12 days later she too identified the error in the feeding regime she also raised her concerns about 3 falls Adult M had experienced and the further clear decline in Adult M's physical health. Her daughter also shared the CHC nurses concerns that Adult M was not being given adequate fluid and nutrition daily. The Nursing Home staff stated that they had not received the revised feeding regime, nobody at the home contacted the hospital to report this the CHC nurse advised them to make this a priority that day. Over the following 24 hours Adult M had another fall and was returned to her bed, later that day she was found to be much less responsive, and an ambulance was called.

Adult M was readmitted to another hospital in the local area and was found to be dehydrated and in kidney failure. These concerns led to hospital staff completing 2 adult safeguarding referrals about potential neglect of Adult M during her stay in the Nursing Home. These were reviewed by ASC and following some initial enquiries with the Nursing Home and CHC staff the referrals were closed without requiring S42 enquiries being made. The referrers were not made aware of the outcome of their safeguarding referrals, neither was the CHC nurse who had been asked to provide some information. Despite active treatment in hospital Adult M's condition continued to decline, and she sadly died 17 days after readmission.

Findings from the hospital admission:

Some staff on the hospital ward did follow the community regime rather than the EMPA when administering feeds however this ongoing error in the prescription was not communicated effectively to allow it to be corrected during this inpatient episode.

Co-ordination of the hospital discharge was poor with the wrong feeding regime being sent with Adult M on her transfer to the nursing home. There was poor communication between the ward staff and the Transfer of Care Team over discharge planning.

Learning identified following the hospital admission:

The hospital has undertaken a serious incident investigation following the discharge of Adult M to the Nursing Home. Several actions have been identified as a result which include a review of dieticians checking feeding regimes are correct as part of discharge planning, and a review of how the Transfer of Care Team co-ordinate hospital discharges and communicate with CHC and ward staff.

The feeding regime was posted out to the nursing home but didn't appear to arrive. Agencies to agree a process that allows for e-mail transfer of information securely between hospitals and Care Homes that is GDPR compliant to prevent future delays in communication.

Where this is not possible staff should know how to password protect a document to allow it to be transferred.

Communication between hospital staff and Care Homes should be reviewed in relation to discharge planning arrangements.

Findings from the Nursing Home stay:

There was a lack of clear leadership and communication in the Nursing Home, the failure to follow up the lack of receipt of the correct feeding regime from the hospital should have been addressed in the first 24 hours following transfer.

Staff at the home appeared not to be familiar with the management of the gastrostomy tube and the requirement for water flushes pre and post feed.

Rakewood House was reviewed by CQC in October 2022 and was found to require improvement across all domains.

Learning from the Nursing Home stay:

NHS GM ICB (HMR) and Adult Social Care to provide assurance regarding how homes on the framework are quality assured and to identify if there are any other Nursing Homes that report staff requiring training in the management of enteral feeds.

Findings from the actions following safeguarding referrals being made:

ASC did not report back to the referrers what the outcome of their safeguarding referrals were.

Learning from the actions following the safeguarding referrals being made:

Staff will be reminded to follow policy and procedure in respect of part 12.10 which states 'if a decision is made not to proceed with a S42 enquiry the referrer must be informed of the decision on a timely way, and the reasons for it'

Good Practice:

Staff referred to the Abbott Nurse Team when there were issues with the feeding tube, these are specialist staff who provide education and support for carers with the management of feeding tubes.

Next Steps:

All agencies and professionals are encouraged to reflect on the findings and learning themes and discuss the implications for their service and future practice.

The RBSAB has an action plan to track the recommendations made and will seek both compliance and effectiveness responses from partner agencies to ensure that the learning is embedded.