October 2023

MRS. WEBSTER, 2019

LEARNING FROM SARs

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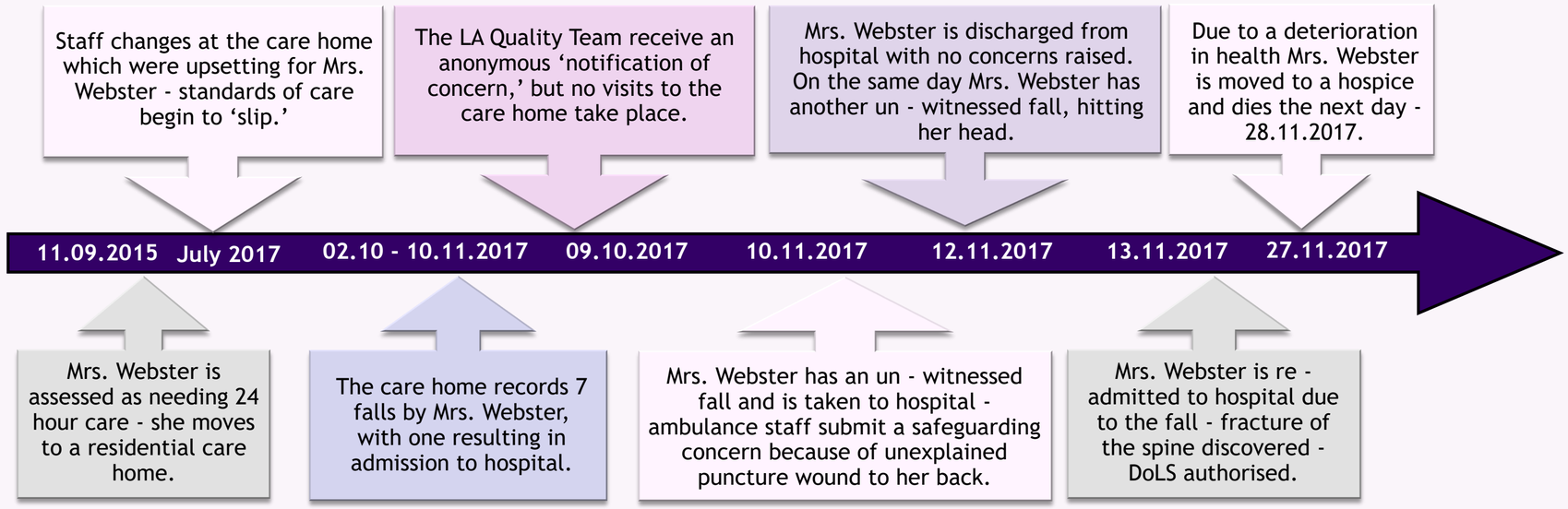
BACKGROUND:

Mrs. Webster was the mother of 2 daughters, who described her as ‘a very independent person: a homemaker, creative in crafts like knitting, she spoke her mind - a Yorkshire woman!’

Mrs. Webster was a widow, living independently until she was 80. She could be sociable but preferred her own company, or that of people she knew well.

Mrs. Webster died from natural causes as a result of bronchopneumonia, likely exacerbated by lack of mobility due to the neck collar worn, aged 86.

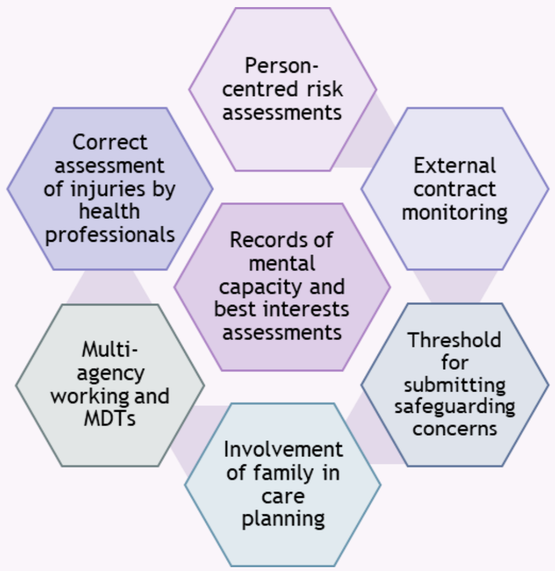
SIGNIFICANT EVENTS IN MRS. WEBSTER’S LIFE:



*KEY ISSUES:

- There was a lack of person - centred care and risk assessments to explore the reasons behind Mrs. Webster’s falls.
- There was a lack of multi - disciplinary meetings.
- The LA did not fulfil their requirement to carry out person - centred case reviews, and there was only one contact from adult social care during the two years Mrs. Webster lived at the care home.
- There were no safeguarding concerns raised by staff despite Mrs. Webster having 34 falls from 1st January to 10th November 2017.
- There were missed opportunities of more formal family involvement.
- There is little evidence of recorded mental capacity assessments and best interests assessments to support Mrs. Webster’s decision making.
- Hospital staff failed to identify the significant injury to Mrs. Webster’s spine.

KEY LEARNING:



POSITIVE FINDINGS:

Mrs. Webster enjoyed her stay at the care home during the first year, being involved in activities organised by a specialist staff member, and also having privacy in her en - suite room.

During 2017, Mrs. Webster was referred for additional support to:

- Dietetics – for assessment and support with nutritional needs.
- District / Community Nursing – for holistic assessment of her physical health needs.
- Falls Service – for assessment of falls risks and advice and intervention to reduce the risk of further falls.
- Community Mental Health Team (CMHT) – for assessment of her mental health.

ARE WE PREPARED IN NORTH LINCOLNSHIRE?

- Are you confident that your service provides person - centred care and risk - management?
- Do you have effective mechanisms in place to ensure that the person’s voice is heard and recorded clearly?
- Do you actively involve family members, carers, advocates etc. in care planning?
- Are you aware of the local safeguarding thresholds? Do you know how to use the safeguarding threshold document and risk matrix?
- Are you confident is assessing mental capacity and making decisions in person’s best interests?
- Do you participate in multi - agency / multi - disciplinary work?

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ADDITIONAL INFORMATION

*KEY ISSUES:

Person - centred care:

- Risk assessments should have been undertaken with Mrs. Webster and her family to fully explore the reasons for her falls, and to prevent the impact of further falls.
- Whilst the residential care home sought advice from the GP and specialist health referrals were made, no one arranged multi - disciplinary meetings.
- Using a 'making safeguarding personal' approach to assessing Mrs. Webster's changing needs may have resulted in a more balanced assessment of her needs and her wishes.

Oversight of direct care:

- The LA didn't fulfil their requirement to carry out person - centred case reviews in the residential placement.
- There was only one contact from adult social care during the two years Mrs. Webster lived at the care home.
- Care homes are subject to scrutiny from a number of organisations such as commissioning / contract / quality monitoring and the Care Quality Commission (CQC). Mrs. Webster's care / placement was reviewed by the LA on 6th April 2016, where it was reported that she was happy and that the residential care home was meeting her needs.

Raising safeguarding concerns:

- There were no safeguarding concerns raised by staff despite Mrs. Webster having 34 falls from 1st January to 10th November 2017.
- Whilst the residential care home notified adverse incidents about Mrs. Webster's falls to CQC, these were not identified as requiring a S42 safeguarding enquiry until mid - November 2017. If these had been notified earlier, the safeguarding concerns might have been identified at an earlier stage.

*KEY ISSUES: (CONT'D)

Involvement of family in multi - disciplinary meetings:

- The report identified missed opportunities of more formal family involvement, such as involving the family in multi - disciplinary meetings following A&E attendance.
- Following Mrs. Webster's return to hospital and the discovery of the seriousness of her spinal injury, her family were more involved in the meetings, but they expressed concerns over the lack of communication about the reasons the injury wasn't detected. They also felt not listened to.

Mental Capacity Act assessments:

- There is very little evidence that any agency recorded mental capacity assessments and subsequent best interest assessments to support Mrs. Webster's decision making and that of professionals involved with her.
- There is little recording despite the number of examples where she was distressed / non - compliant when health / care / safety interventions were necessary.
- Mrs. Webster's daughter had lasting power of attorney for her mother's health and welfare, and she should have been involved in any best interest decision when her mother was assessed as lacking capacity to make her own decisions.

Failure to identify spinal fracture:

- The hospital staff failed to identify the spinal fracture and didn't forward the relevant scan.
- Because of this error Mrs. Webster was moved without a fully informed risk assessment. The second hospital, therefore, made decisions about treatment and transport back to the residential care home without knowing about crucial information.

RECOMMENDATIONS:

- The LA senior managers to provide assurance that their actions to manage the identified shortages in assessment and review teams are effective.
- The LA Quality Team to provide assurance that mechanisms are in place to ensure person - centred care and risk management.
- The LA senior commissioning managers to provide assurance that all care providers are afforded the same level of sufficient scrutiny.
- The hospital to provide assurance that action plan is introduced and monitored to avoid similar errors.
- All SAB partners to provide assurance that the person's voice is heard and recorded appropriately.
- All SAB partners to review training provision and practice regarding mental capacity assessments and best interests decision making.
- Where care providers have concerns about their ability to meet the person's needs, these should be referred to the LA for an urgent care reviews, and responded to in a timely manner.
- The LA commissioning teams to ensure that care providers deliver person - centred care based on the person's needs and preferences, and ensure that communication with residents is heard and recorded.
- All partners should consider re - instating the Countywide Falls Ambulance Service given the evidence of good outcomes.

FURTHER RESOURCES

SAR full report - MRS. Webster SAR008_MrsWebster_OverviewReport_Oct2019_FINAL_ (northamptonshiresab.org.uk)

SAR executive summary - Mrs. Webster SAR008_MrsWebster_ExecSummary_Oct2019_FINAL_ (northamptonshiresab.org.uk)

SAR learning briefing - Mrs. Webster Learning Briefing_SAR008_v1_Dec019 (northamptonshiresab.org.uk)

NLSAB enhanced safeguarding threshold document and risk matrix - Risk-Matrix-and-Thresholds-2022.pdf (northlincssab.co.uk)

Free mental capacity online learning - Understanding mental capacity - OpenLearn - Open University

NLSAB 7 - minute briefing 'making safeguarding personal' - 7-Minute-Briefing-MSP-FINAL-1.pdf (northlincssab.co.uk)

NLSAB safeguarding adults in care homes resources - North Lincs SAB | News and Updates - North Lincs SAB

NLSAB how to report abuse and neglect - North Lincs SAB | Reporting a Concern - North Lincs SAB

NLSAB 7 - minute briefing 'record keeping' - 7-MB-Record-Keeping-FINAL.pdf (northlincssab.co.uk)

NLSAB 'lasting power of attorney' learning briefing - Layout 1 (northlincssab.co.uk)