Martha Safeguarding Adult Review 6 Step Briefing

The Background

- Martha was an 89-year-old lady who lived in Southampton throughout her life. As a result of bombings during World War 2, her family moved within Southampton to the road where Martha met her future husband, to whom she would be happily married for 62 years.
- In May 2020, Martha suffered a closed fracture of her left ankle. She was discharged from hospital to a care home with nursing for a 5–6-week episode of respite care, with an air cast boot on the fractured ankle.
- In July 2020 the boot was removed, and Martha was found to have developed pressure ulcers. In the following months, Martha's condition deteriorated, and rehabilitation of the ankle was unsuccessful. She was later admitted to hospital where she died of to an infected pressure sore and dehydration.
- Before her admission to hospital, Martha had been living independently at home with minimal care support.

The Incident

- The Care Home investigated and concluded that there were failures in the care of this resident and that Martha's pressure ulcers were preventable - staff were treating the boot as a Plaster of Paris cast rather than a removable medical device.
- The incident was investigated under a Section 42 enquiry and led to the Care Home putting improvement measures in place.

Safeguarding Concerns

- On admission to the Care Home, Martha's diabetes was stable and her nutritional intake was reported to be quite good up until the end of September 2020, when she became unwell. Martha did not have a big appetite and needed to be reminded to take fluids.
- External professionals visiting the Care Home seemingly did not enquire about the air cast boot.
- The hospital discharge notification did not state that Martha had been fitted with the device.

The Review

This Safeguarding Adult Review (SAR) concerns the effectiveness of inter-agency practice in relation to engagement and care of an 89-year-old woman. The Southampton Safeguarding Adults Board Case Review Group recommended that this case met the criteria for a Statutory SAR and this was agreed by the Southampton Safeguarding Adults Board (SSAB). The timeframe for the period under review was 23rd May 2020 to 27th November 2020.

Findings

- Standard practice for discharge would be for the ward to complete an onward care report, but in this case Martha's air cast boot was fitted after the report had been sent. This information was not gathered and reviewed efficiently, leading to misconceptions about the air cast boot.
- The Physiotherapist gave Martha information, verbally, about the treatment of her foot and how to use the air cast boot. A leaflet should also have been given to Martha which could then have been given to the Care Home. It is acknowledged that discharge practice has since changed, but Care Homes continue to receive admissions with no discharge paperwork and medication.
- Generally, there can be misconceptions about Care Homes by the acute health sector in terms of what can be done for individuals following discharge. Acute settings need to ensure that the appropriate referrals are in place before discharge as, otherwise, Care Home staff need to refer for additional services or equipment through the GP. This can result in individuals being placed on waiting lists for services or, as in Martha's case, gaps existing in the sharing of information regarding the treatment plan.
- Martha needed to have rehabilitation whilst at the Home, however, staff were unable to commence exercises without having had instruction from a physiotherapist and had to await any equipment needed. This caused delays.
- At the Care Home, the GP is contacted twice a week, with additional calls if needed, and there are visits by Practice Nurses to give vaccinations. Some residents continue to use their own GP which causes added bureaucracy to whose who may wish to receive seamless care.
- Practitioners also identified the human factor of making assumptions about other professionals and care plans as a factor in this case, as the systems in place in the hospital, Care Home and community services did not provide an adequate safety net for any one professional's misconceptions around the air cast boot.

Good Practice

Despite the tragic outcome for Martha, there is some evidence of effective practice, especially in the context of the crisis period of the pandemic:

- Martha was known to Physiotherapy, who continued to visit her at the home – allowing them to assess the changes in Martha's demeanour
- Good access to community services by the Care Home, meaning staff had access to specialist support. An inclusive approach was evident from the NHS community services
- Outpatients Clinic staff recognised Martha needed to be seen, and communicated with the GP when they could not reach the Care Home
- Upon discovering Martha's foot had been inappropriately cared for, professionals recognised the safeguarding risks and worked together to investigate and prevent any further individuals being at risk of harm

Useful links for Best Practice

- Martha Full Report and Recommendations
- Overview | Pressure ulcers | Quality standards | NICE
- Overview | Pressure ulcers: prevention and management | Guidance | NICE
- 4LSAB Multi-Agency Safeguarding Adults Escalation Policy
- Care Act factsheets - GOV.UK (www.gov.uk)