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DOI:

[10.1108/JAP-03-2017-0013](https://doi.org/10.1108/JAP-03-2017-0013)

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Citation for published version (APA):

Manthorpe, J., & Martineau, S. (2017). Home pressures: Failures of care and pressure ulcer problems in the community - The findings of serious case reviews. *Journal of Adult Protection*, 19(6), 345-356.
<https://doi.org/10.1108/JAP-03-2017-0013>

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Home pressures: Failures of care and pressure ulcer problems in the community – the findings of Serious Case Reviews

Journal:	<i>The Journal of Adult Protection</i>
Manuscript ID	JAP-03-2017-0013.R2
Manuscript Type:	Research Paper
Keywords:	Serious Case Reviews, pressure ulcers, community, enquiry, vulnerable adults, adult safeguarding

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Table 1: Serious Case Reviews / Safeguarding Adults Reviews included in initial analysis

Author, date	Name / Pseudonym: age, gender	Living situation as referred to in the SCR/SAR	Reported condition of person/adult at risk	Incident/s and circumstances relevant to call for a SCR/SAR; mention of pressure ulcers
Braye, S., 2016 (Overview and Executive summary)	Mr BC: 72	Sheltered housing	Complex health problems.	Death in a fire, which had started in his bed. History of occasional refusal of care. Bleeding bed sores were recorded once in year prior to death.
Birmingham SAB, 2012	Mr A2: 78	Own home till hospital and care home	Multiple health conditions.	Multiple safeguarding referrals including in respect of financial abuse, neglect and verbal abuse by a family member. Pressure ulcers of grade 4 at time of hospitalisation and subsequent death in care home
Coventry SAB, 2010	Mrs A: 91	Home till her death in hospital	Following a fall, she had been in receipt of domiciliary care.	Grade 4 pressure ulcers on heels and sacral area. Cause of death: sepsis
Coventry SAB, 2013	Mrs D: late 80s	Own home	Sustained a neck injury following a fall.	Pressure ulcer (grade 3) resulted from the neck collar for her injury. She died from septicaemia resulting from ulcer.
Coventry SAB, 2015	Mrs E: 66	Housing with care	Sustained injury following a fall.	On returning from hospital she developed multiple pressure ulcers, one at grade 3. Cause of death: pelvic abscess, sigmoid perforation, and fracture of the L1 vertebrae.
Cumbria SAB, 2009	Bill: 87	Lived with his daughter	2005-2009 admitted to hospital on seven separate occasions.	Nursing staff noted early stage sacral pressure sore when he was admitted to hospital. Died of pneumonia and obstructive pulmonary disease.
Essex SAB, 2012	MM (female): 89	Own home	Multiple health conditions. Found to lack capacity and admitted to hospital on best interests grounds.	Multiple pressure ulcers (including one of grade 4). She is classified as exhibiting self-neglect. Resistant to help from Adult Social Care.
Harrington, K, 2013	Mr. J.: 59	Care home and	Alzheimer’s disease and	Admitted to hospital with multiple cuts,

		own home	alcoholism.	bruises and possible pressure sores of varying ages (i.e. possibly stemming from when he lived at home); extremely dehydrated. He had multiple injuries to his brain.
Isle of Wight SAB, 2015	Mr W: 86	Own home, followed by nursing home and hospital	Had experienced multiple falls and concerns about health led to emergency placement in nursing home.	Died of septicaemia. Found to have multiple pressure ulcers, including at grade 3-4.
Lawson, J., 2013	J.T. (female): ?age	Care home with nursing	Suffered first stroke 1990. Range of health conditions.	Died of a stroke 2012. Reluctant to receive services. Concern about pressure ulcers date from when she lived at home.
Lawson, J., 2015	ZZ (female): 79	Own home	In receipt of home care package.	Found to have 13 pressure ulcers (nine at grade 4) on admission to hospital. Home care provider found to be in breach of regulations.
Nottinghamshire Safeguarding Adults Board, 2013	Adult E (female): 40	Own home	She had spina bifida, was paralysed from the waist down and used a wheelchair. History of hospital admissions for pressure ulcer care.	Cause of death: sepsis resulting from pressure ulcers.
Nottinghamshire Safeguarding Adults Board, 2011	Adult B (female): 80+	Care home and own home	Older person with history of falls; arthritis.	Severe pressure sores, which developed while she was at home. Coroner's verdict: death by natural causes, contributed to by neglect.
Tudor, P., 2012	Female: 40	At parents' home	Mental health problems including agoraphobia.	Died of dehydration and ulceration. Resisted interventions, but assessed as having capacity.
Winter, I., 2015	RC (male): 61	Supported accommodation	Moderate learning difficulty and bi-polar disorder.	Death as a result of a choking incident. Pressure ulcers listed as a concern.
Wood, T., 2011	Adult A (female): 59	Own home, with brother	Had a learning difficulty and type 2 diabetes.	In the care of her brother, who was found guilty of her manslaughter (gross negligence). Cause of death was hypothermia. She was found also to have

				what appeared to be pressure ulcers.
Wood, T., 2014	Adult D (male): 91	Own home, with son	Had a number of heart attacks. Assessed as having impaired capacity.	Cause of death: bronchopneumonia due to pressure sores and colorectal abscesses. Both he and his son resisted intervention.
Worcestershire SAB, 2010	A1 (male): 58	Own home	Mental health problems and chronic gastric problems.	Cause of death: pneumonia, paranoid schizophrenia and inanition. Pressure ulcers had been identified about a year prior.

Home pressures: Failures of care and pressure ulcer problems in the community – the findings of

Serious Case Reviews

Abstract

Purpose: Local Serious Case Reviews (now Safeguarding Adults Reviews) may be held in England when a vulnerable adult dies or is harmed or at risk of being so, and local agencies may not have responded to suspicions of abuse or neglect appropriately. This article presents findings from a documentary analysis of these Reviews to ascertain what recommendations are made about pressure ulcer prevention and treatment at home, setting these in the context of safeguarding, and assessing what lessons may be learned by considering them as a group. This analysis is presented at a time of increased interest of the risks of pressure ulcers among frail and very ill populations; and debates about the interface between neglect and safeguarding.

Design/Method: Identification of Serious Case Reviews from England where the person who died or who was harmed had been suffering from pressure ulcers or their synonyms in their home; termed home acquired pressure ulcers. Narrative and textual analysis of documents summarising the reports was undertaken to explore the Reviews' observations and recommendations. The main circumstances, recommendations and common themes were identified.

Findings: We located 18 relevant Serious Case Reviews (SCRs), one of which was a Case Summary and two Safeguarding Adults Reviews covering pressure ulcers that had been acquired or worsened when the individual was living at home. Most of these inquired into the individual's circumstances, their acceptance of care and support, the actions of others in their family or professionals, and the events leading up to the death or harm. Failures to have followed guidance were noted among professionals, and problems within wider health and care systems were identified. Recommendations include calls for greater training about pressure ulcers for home care workers, but also greater risk communication and

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3 better adherence to clinical guidelines. A small number of reports focus on neglect by family members,
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5 others on self-neglect, including some vulnerable adults' lack of capacity to care for themselves or to
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7 access help. In some SCRs the presence of a pressure ulcer is only mentioned circumstantially.
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11 **Research limitations/implications:** Serious Case Reviews vary in content, structure and accessibility,
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13 making it hard to compare their approach, findings and recommendations; in respect of home acquired
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15 pressure ulcers these may only be part of a series of health-related conditions. There are risks in
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17 drawing too many conclusions from SCRs since many are not published in full. However, this first
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19 analysis of these documents to take home acquired pressure ulcers as the focus and it offers potentially
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21 valuable insights into community health and social care activity, training requirements, and safeguarding
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23 practices.
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28 **Practical implications:** This analysis highlights the potential multitude of complex social and health
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30 situations that may give rise to pressure ulcers among people living at home. Several SCRs observe
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32 problems in wider communications with and between health and care providers. Nonetheless poor care
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34 quality and negligence are reported in some SCRs. Cases of self-neglect give rise to challenging practice
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36 situations. While practices and policies about poor quality care and safeguarding in the form of
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38 prevention of wilful neglect are emerging they often relate to hospital and care home settings.
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40 Preventing and treating pressure ulcers may be part of safeguarding in its broadest sense but raises the
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42 question of whether training, expertise and support on this subject or wider self-neglect and neglect by
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44 others are sufficiently robust for home care workers and community based professionals.
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49 **Research implications:** The value of this documentary analysis is that it draws on case examples and
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51 scrutiny at local level. Future research could consider the related findings of Safeguarding Adults
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53 Reviews as they emerge, similar documents from the rest of the United Kingdom (UK), and international
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55 perspectives.
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Originality/Value: The value of compiling a set of SCRs is that they lend themselves to analysis and comparison despite their variations and limitations. This analysis is the first to focus on home acquired pressure ulcers and to address wider relevant considerations related to safeguarding policy and practice.

Conclusions: Pressure ulcers feature in several SCRs either as contextual information about the vulnerable adults' health-status or as indications of poor care. The potential value of examining home acquired pressure ulcers as a key line of inquiry is that they are 'visible' in the system, with consensus about what they are, how to measure them and what is optimal care and treatment. In the new Care Act 2014 context they may still feature in safeguarding inquiries as symptoms of failings in systems or of personal culpability for poor care. Learning from them may be of interest to other parts of the UK.

Introduction

Approximately 700,000 people in the UK are affected by a pressure ulcer annually (Stop the Pressure 2013). As Keen and Gaudario (2014) note, '*Pressure ulcers are a cause of pain, embarrassment, loss of independence, poor quality of life, depression, social isolation and distress for those affected, as well as being potentially life-threatening.*' (p38). A recent systematic review of the cost of prevention and treatment of pressure ulcers (Demarré et al. 2015) points to the considerable health and societal costs of pressure ulcers, noting that while prevention is costly, the cost of treating a severe pressure ulcer is even higher.

This article reports the findings of an analysis of Adult Serious Case Reviews (SCRs) in England where pressure ulcers were noted as affecting the individual vulnerable adult while living at home or were discovered upon their move to a health or care facility and when safeguarding concerns emerged in retrospective examination of several of these cases. The term vulnerable adult is used as SCRs were conducted prior to the Care Act 2014, following which the term vulnerable adult has generally been replaced by the term 'adult at risk'. The Reviews' comments on the care and treatment offered to or

refused by the vulnerable adult and the associated professional communications, information and other responses are explored. Relevant recommendations are presented and discussed. While our focus is on pressure ulcers acquired at home, such problems arise in care homes and hospitals and much research concentrates on these settings. A previous analysis has been undertaken of SCRs covering pressure ulcers in care home settings (Manthorpe and Martineau 2017) in which we address the potential impact of new Department of Health guidance following the Care Act 2014 that dissuades the reporting of pressure ulcers as automatic safeguarding concerns.

Background

Definitions

A pressure ulcer is defined as ‘localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear’ (European Pressure Ulcer Advisory Panel 2009). In the UK the gradation of pressure ulcers is fourfold, using grades/categories 1-4, with 4 being the most severe (ibid). The National Institute for Health and Clinical Evidence (NICE 2014) recommends that practitioners consider using a validated scale to assess ulcer risk and support their clinical judgement, such as the Braden scale, Waterlow score, or Norton risk assessment scale. Its Guidance states ‘*Pressure ulcers represent a major burden of sickness and reduced quality of life for people and their carers. They can be debilitating for the patient, with the most vulnerable people being those aged over 75. Pressure ulcers can be serious and lead to life-threatening complications such as blood poisoning or gangrene*’ (NICE 2014, p6, see also NICE 2015).

Patient safety

As with SCRs and aspirations for Safeguarding Adults Reviews, patient safety theories have recommended that system inquiry rather than blame cultures may be more productive when untoward

incidents or harms are suspected or detected. However, a recent major study (the PURPOSE study, Nixon et al 2015) of pressure ulcer care and treatment observes greater recognition in health care circles of ‘... an unhelpful divide between those such as Francis [author of the high profile inquiry into events at Mid Staffordshire NHS Foundation Trust], who stress the importance of organisational and cultural explanations for adverse events, and the bulk of the academic literature, which continues to focus on errors made by individual clinicians’ (p247) (see Francis 2010). As part of that research, in a separately reported study, Pinkney et al. (2014) undertook a retrospective review of eight pressure ulcers that had been classified as severe. They interviewed staff, patients and family carers to find out how each ulcer had developed and reached the severe stage. Of particular relevance to this present article are that three patients had acquired a pressure ulcer at home; although one had spent time in respite care and in hospital (the ages of these 3 patients were 37, 65 and 89 years). Summarising the overall findings about the development of the pressure ulcers, Pinkney et al. (2014) observe:

‘The principal explanation is that severe pressure ulcers developed in organisational contexts where there were failures in the overall governance of services. Specifically, they were characterised by one or more of (1) clinicians failing to listen to the patients, or carers, observations about their risks or the quality of their treatment and care, (2) clinicians failing to recognise and respond to clear signs that a patient had a pressure ulcer or was at risk of developing one, and (3) services not being effectively coordinated. In four of the accounts it was possible to identify specific, or causal, precipitating events, but in each case these events occurred in organisational contexts where there were more general governance problems.’ (p5-6).

Interestingly, none of those cases reviewed had apparently led to safeguarding concerns.

Serious Case Reviews and Safeguarding Adults Reviews

In England a Safeguarding Adults Review (SAR) must be undertaken when a vulnerable adult dies or harmed, abuse or neglect is suspected under the Care Act 2014, and there have been apparent failings in multi-agency working. Prior to the Care Act there was discretion to undertake a Serious Case Review (SCR) in such circumstances. Details of SCRs have been collected and different facets examined, such as SCRs in supported housing (Parry 2014), self-neglect (Braye et al. 2015), learning disability services (Manthorpe and Martineau 2015), dementia care (Manthorpe and Martineau 2016a) and care homes (Manthorpe and Martineau 2016b). At the time of writing (early 2017) a small number of SARs have been published (among which Winter (2015) and Braye (2016) are briefly discussed in this present analysis). SCRs remain an important body of detailed investigation about the care and treatment of vulnerable people, although not all were published in full and they vary in depth, focus and approach. There has been no analysis of SCRs focussing on home acquired pressure ulcers.

The threshold debate

A final contextual element is the debate about whether pressure ulcers are germane to safeguarding and if so in what ways. As discussed in more detail in our earlier article on safeguarding and pressure ulcers in care homes (Manthorpe and Martineau 2017), the Department of Health (DH) emphasises that pressure sores should not be treated as safeguarding concerns other than in what is considered to be rare circumstances of neglect (Crawley 2016). This marks a change from previous policy and procedures stipulating that severe pressure ulcers grade 3-4 were to be referred to safeguarding. In England most local Safeguarding Adults Boards (SABs) have adapted their policies to follow the London guidelines (London ADASS 2015) that reflect DH policy. While there are dissenting views (see Valios 2014) about this, currently (2017) the London guidelines state that the threshold of severity formerly applied (grade 3-4) should not trigger a safeguarding enquiry unless circumstances suggest neglect (London ADASS

2015). This change affects the contemporary relevance of some of the recommendations made by the SCRs considered in this present article.

Methods

In this section we summarise the steps of this study which included: 1) identification of possible reports (SCRs and SARs), 2) content analysis of terms, 3) narrative review (noting salient context, findings, and recommendations) through to textual analysis. Previous analyses of Adult SCRs have uniformly observed that they are difficult to compare as they have different methodologies, different purposes, are not generally published in full and both the full reports (if available) or executive summaries vary in terms of whether they include details of the incident(s), provide any chronology of events or detail communication, and any expert (second) opinion or evidence. They may be single or multi-authored; and reports of their hearings or the materials considered are not available for scrutiny. With these limitations in mind we undertook a documentary analysis of all obtainable Adult SCRs and SARs undertaken in England before end 2016, searching for direct or indirect mentions of pressure ulcers, bed sores, or pressure sores (or other indications such as tissue or skin breakdown or terminology such as necrotic sores or sores) in the vulnerable adult who experienced harm or had been placed at risk. As part of our continuing gathering and analyses of these documents we had undertaken a previous analysis of SCRs and SARs mentioning pressure ulcers among care home residents as salient to their enquiries (Manthorpe and Martineau 2017) and we followed this approach. We compared our list with a catalogue of SCRs (Clay 2014) to check for missing reports covering up to that time period. As part of our narrative review we adapted categories adopted in our previous documentary analyses of Adult SCRs (Manthorpe and Martineau 2014, 2016a, 2016b, 2017). These elements or categories cover the SCR rationale, details of the individual concerned (sometimes referred to as a victim, but rarely in the cases of pressure ulcers) and of alleged abuse or poor practice, the setting and its contexts, practitioners and

other parties, its findings and recommendations. Reading and re-reading of the SCRs was undertaken in January 2017 to consider these intra (elements within the SCR report) and inter (comparisons between SCRs) organisational categories. While most people at risk of pressure ulcers are older people since these are more likely to be frail, have restricted mobility and are critically ill or close to end of life than other adults, we did not focus on this age group alone. In some SCRs, textual analysis revealed that age is not given but general terms such as ‘elderly’ or ‘older’ are sometimes employed. Most SCRs use initials for the person involved or pseudonyms; confusingly these are often the same. Few provide details of ethnicity (generally if the person is not White British) or sexuality. Authorship of SCRs is reported variably, some are published on behalf of the local SAB; others mention an author by name, generally where this is an independent reviewer.

Findings

We located 16 SCRs of interest and two SARs (see Table 1) including Harrington’s (2013) summary of the SCR concerning a Mr J, for although he was only briefly (2 months) in a care home, the multiple injuries and possible pressure sores of varying ages appear to have been acquired at home. We included Lawson’s (2012) SCR re JT since the main concerns about pressure ulcer care related to the home setting. While a minor pressure ulcer is mentioned in the SCR concerning ‘Bill’ (Cumbria Safeguarding Adults 2009) this was not explored in the SCR and we make no further comment on this. We located one SAR (Winter 2015) containing a brief mention of care practice in preventing pressure ulcers (eg applying cream following bathing), but since this Review focused on a fatal choking incident in a supported living facility it is not considered further. In another SAR’s overview report (Braye 2016) into the circumstances of the death of BC (a 72 year old man living in sheltered housing) the presence of bleeding bed sores was noted by the visiting GP, but not followed up further. The presence of sores was not mentioned in the executive summary (City & Hackney SAB 2016) of this complex case involving a person who was seen

to place himself at great risk while being a risk to others. In the SCR following the death of A1 (Worcestershire SAB 2010, para 3.5) District Nurses had visited A1 at home '*owing to pressure sores, which would have been unusual in a young and mobile man*' but no further mention of these was found in the SCR. A1 had used community and hospital services over several decades. One key finding therefore is that not all pressure ulcers are relevant to the safeguarding concerns raised.

Insert TABLE 1 about here

Findings

Professional practice

Some SCRs provide chronologies of the development of pressure ulcers at home that have reached such severity that they are implicated in the death of the person concerned. In such reviews, questions may be directly asked in the Terms of Reference at the start of the SCR. For example, the executive summary of the SCR published by Nottinghamshire SAB (2011) reports that one question posed, among others, asked '*Was high quality pressure area care given and was it delivered in accordance with best practice?*' (p4). In this case of Adult B, an 83 year old woman, severe pressure ulcers had developed while she was in her own home (she later moved to a care home). Her need for pressure care arising from nutritional problems was said not to have been fully appreciated by care providers. Following a two-month stay at home, she moved to a care home having experienced weight loss and 'severe pressure sores' (dying soon after), with a verdict of death by natural causes, contributed to by neglect. The District Nursing service that visited Adult B at home was considered to not have been sufficiently proactive in assessment and treatment planning, and to have provided poorly coordinated response to her tissue deterioration (p5). The SCR held that NICE guidelines had not been followed and that dressings used did not promote optimal wound healing (ibid). Its main *recommendation* was for a single robust assessment process and better cooperation between health and social care practitioners, with the view that an

overall care coordinator might have improved the assessment process and reduced the risks for Adult B. Those devising tissue viability care plans were *recommended* to follow best practice guidelines.

The SCR in the case of JT, Lawson (2012, p29) notes:

‘Pressure Ulcers presented a specific aspect of the risk to JT... it was known that JT was at risk of pressure ulcers but there was no clear assessment or action plan given to Care South (the home care provider). There should have been a clear partnership arrangement to manage this issue between carers, district nurses and others, including JT and MT (her partner)... assumptions were made that because Health were involved they would be taking necessary action. Because there was no formal plan these informal impressions were perpetuated.’

Lawson adds that the case of JT highlights the importance of statutory agencies getting information from front line carers (care workers) to inform their assessment, monitoring and review processes, but it also underlines the parallel responsibilities of front line care workers in raising alerts about concerns (p23). She acknowledges that JT, a stroke survivor, had been reluctant to accept care and treatment from visiting professionals (JT lived with her spouse MT). Furthermore, ‘Inadequacies in recording contributed to the inability to recognise the escalating risks.’ (p46). Lawson *recommended* that there be:

‘... clear expectations on making the links between pressure ulcer care and safeguarding adults for all staff across agencies. That these links are made clear in the local safeguarding adults policy and procedures and that this is integrated into practice through training and supervision. This area of practice will be monitored by the Safeguarding Adults Board’. (p49)

The SCR (Coventry SAB 2010 – this document refers to the Summary of the SCR) relating to the case of a Mrs A (aged 91 whose cause of death was recorded as sepsis) notes she had been admitted to hospital shortly before her death with grade 4 pressure ulcers on her heels and sacral area. Prior to this she had been receiving four visits a day from staff working for a home care agency. Its *recommendations* included:

- Pressure ulcer awareness raising for health and social work staff around risk assessment, multi-disciplinary care planning and management and new pressure ulcer protocol.
- Production of a pressure ulcer protocol for management of Grade 3 and 4 pressure ulcers within the health economy including risk assessment, treatment and referral to safeguarding.
- Development of a pressure ulcer risk assessment tool for use by non-professionally qualified staff e.g. agency care workers. (p7)

The SCR concerning the case of Mrs D (Coventry SAB 2013) found that this mother of 16 children died as the result of a grade 3 pressure ulcer which caused septicaemia or blood poisoning. The ulcer had not been treated at home or identified in hospital visits. Furthermore, it was not reported until two days before her death even though it was noticed by professionals several weeks previously. The SCR considered there had been ambiguities and lack of clarity in previous policy on pressure ulcers and *recommended that all agencies should 'ensure that staff understand their responsibilities in relation to Safeguarding Adults and that the preventative opportunities of Safeguarding referrals are fully recognised and utilised as a positive way of achieving effective joint working in the best interests of vulnerable adults'* (p5).

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Professional practice in treating pressure ulcers within stretched services was criticised in respect of a Mr W (Isle of Wight Council 2015) both when he was living at home and after his move to a care home. *‘Services were not unaware of Mr W’s needs nor were they unaware of aspects of his self-neglect or vulnerability, however they did not know what each other knew and therefore only acted upon what they knew’* (ibid 2015 p47). This SCR recommended high level attention to local safeguarding arrangements and quality of services, some of which related to communication and recording between district nursing, re-ablement (rehabilitation services), the GP and care home.

Deterioration and normalisation

The SCR into the case of Adult E (Nottinghamshire SAB 2013) declared that Adult E ‘did not ring any safeguarding bells’ (p8) as she was independent and seemed to be able to manage her own care and to have decision making capacity. While she had a history of pressure ulcers related to her paralysis, these seemed to have been addressed. District Nurses concentrated on catheter care and accepted Adult E’s statement that she was self-checking her skin was intact. Both they and hospital staff respected her decision to refuse to be examined, as part of respecting her dignity. The SCR concluded that ‘a climate of optimism’ had developed between services, including her GP and that while risk factors were known services lacked knowledge that formerly protective factors were no longer so strong. Among a series of *recommendations*, were the issuing of ‘guidance’ to health and social care staff about the risks that pressure ulcers might be the result of neglect or self-neglect, training, information sharing, enhanced liaison with carers, and, in respect of the decision to close the case of Adult E by adult services:

Workers and managers in “case holding services” need to be reminded that closing the file of someone identified as at high risk of potentially life threatening pressure ulcers or similar, and described as “fiercely independent”, should be subject to a risk focused reflective practice

supervision discussion, and the reasons for the decision to close their “case” to be fully recorded (p16).

In the SCR relating to a woman referred to as ZZ, Lawson (2015) reported that ZZ had been admitted to hospital with 13 pressure ulcers on her hands, feet, chest, sacrum and legs. Hospital staff graded nine ulcers at grade 4 (the most serious), noting that bones or tissue were visible in some. ZZ had been receiving daily social care visits funded by the local authority. The care workers stated that ZZ had refused to let them touch her to provide personal care. While ZZ had a visiting relative who did her shopping and money management, the review focussed on professional competence and co-ordination. Although ZZ was said to be refusing care, there were queries about how the severity of the pressure ulcers could have been disregarded and her capacity to make decisions about assistance accepted at face value. Wider system questions such as the nature of the local authority review of its client’s wellbeing were also raised. The SCR found clear risk factors in relation to pressure ulcers had not been heeded and *recommended*:

Awareness raising primarily across domiciliary care agencies in respect of the risk of pressure ulcers. To include:

- The need to identify early signs and symptoms
- How/ when to escalate concerns
- Who needs to be involved where there is a risk identified

This to be supported by commissioning and to form a key focus in contract monitoring.

Awareness of links between malnutrition and pressure ulcers to be promoted in addition. (p58)

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While only the Case Summary is available in respect of MM (Essex SAB 2012) it is reported as one of self-neglect. The SCR *recommended* that a multi-agency self-neglect policy be put in place and training provided about the Mental Capacity Act 2005. MM had refused care for her developing pressure ulcers and the assistance of community nurses more generally. She employed the services of the wife of a friend/neighbour to provide some care and this carer had contacted professionals to raise her concerns. At one time developing pressure ulcers had healed; prior to MM’s death, however, several pressure ulcers were developing and considered serious. The *recommendations* in the Case Summary do not pertain to pressure ulcer care specifically but more to the system response to someone who was refusing care when seriously unwell.

The SCR into the circumstances surrounding the safeguarding of A2 (Birmingham SAB 2015) found that on his final admission to hospital it was observed that ‘A2 *may have pressure sores as he has been lying in bed. The family [member] stated his dad was doubly incontinent. A2 has pressure sores on his leg which were dry. Possibly grade 4*’ (p6). However, this very complex chronology revealed many concerns over several years about A2’s welfare; mainly connected to doubts about the care he was receiving from his family. In this SCR the presence of pressure ulcers is not further pursued.

The presence of several pressure ulcers, together with other injuries, was noted when a Mr J was admitted to hospital from home but he had only been in this accommodation for a two week period, previously receiving substantial care in a home (Harrington 2013). The SCR observed that ‘When Mr J left residential care his health and home circumstances deteriorated very rapidly, with multiple indications that this might be linked to repeated abuse’ (p5) and *recommended* better professional and system understanding and capacity for dealing with adults presenting complex risks.

This theme of building relationships so that people will accept care and treatment relates to patients and care users in several different circumstances, ranging from Mr J (Harrington 2013) who had mental health and substance misuse problems as well as a substantial history of being abused and exploited and others such as Mrs E (Coventry 2015) who had been very independent and indeed care providers themselves: 'When dealing with pressure sores, professionals need to look for creative health is a theme solutions in negotiation with service users where standard service options are not acceptable' (p8). Mrs E had refused a single pressure relieving mattress as she wished to continue to share a bed with her husband who had dementia.

Family contexts

As with Mrs E, not all the adults at risk whose circumstances were described by the SCRs considered in this article lived alone. In some SCRs the role of co-resident family members came under particular scrutiny, as touched upon in the case of A2 (Birmingham SAB 2015) mentioned above. In the case of a woman, referred to as 'Female Subject died aged 40 years' (Tudor 2011), the SCR noted that she had spent her whole life living at home with her parents. She was reported to have died 'from dehydration, ulceration (Sepsis), breakdown of body tissue and other contributing factors' (1.1). This is a brief SCR covering the individual's many contacts with health services, both mental health and primary care. The SCR observed '*There could – and should – have been more professional curiosity from the GP and the District Nurse and Staff Nurse; notably what was the impact of the parents' respective health conditions on their ability to care for the subject.*' (Tudor 2011, 6.9). It recommended dissemination across all agencies working in adult safeguarding of the need to be alert to carers' abilities and influences on the adults for whom they are providing care.

In another SCR, Adult A was described as being *'largely hidden from view throughout her adult life. Her family circumstances, her mental health and her reclusive nature all combined to make her problems difficult to see, recognise and deal with'* (Wood 2011, p17). The SCR reported that her brother, also referred to as her carer, had been found *'criminally responsible for her death through gross negligence, part of which was failure to seek help for Adult A'*. 'On arrival at Accident and Emergency Department, she was found to have *'severe hypothermia and showed evidence of severe neglect and numerous soft tissue injuries. She was suffering from an infestation of lice and maggots were present. What appeared to be pressure sores were observed, indicating that she had been lying for some time in the position she was found. During examination it was seen that Adult A's feet were blue/black in colour indicating lack of circulation, subsequently identified as gangrene'* (Wood 2011, p5).

In a further SCR, Wood (2014) investigated the circumstances surrounding the death of Adult D who died aged 91 in hospital with cause of death being recorded as *'bronchopneumonia due to pressure sores and colorectal abscesses'* (p3). This review does not comment on the treatment of the pressure sores for the reason that his son (Adult E) did not permit services to access Adult A. Wood (2014) stated *'From that time (2011) till Adult D's death in January 2013 Adult E successfully prevented agencies from gaining adequate access to his father in order to assess him and deliver appropriate services to him'* (p17).

Discussion

This analysis identifies some failings of care and treatment of pressure ulcers. This is unsurprising since the rationale for a SRC is to investigate any failings in local agencies' working together to safeguard vulnerable adults. Other themes include not adhering to NICE guidance and delays in response. Relatives appear to have notified authorities in some cases about their concerns that pressure ulcers were not

being managed appropriately but in a small number of cases their care was at fault. Such observations chime with the findings of the PURPOSE study (Pinkney et al 2014). In a small number of localities there were policies and procedures at the time stating that some (severe) or all pressure ulcers should be reported as a safeguarding alert. We do not know how many were so reported but only a very small number of SCRs comment on occasions when these policies were not followed. More commonly the cases reveal the risks of pressure ulcers generally being high among very ill or disabled older people, and some other adults with profound or complex disabilities living at home. Several of the individuals considered by SCRs, had experienced pressure ulcers in the past that had healed; the SCRs mention these tangentially and focus on other aspects of care that went wrong.

The limitations of this paper are those noted above in respect of other SCR analyses in that the documents vary in size and depth rendering comparison difficult. There are risks in drawing too many conclusions from SCRs since many were not published in full and contexts have subsequently changed. We lack detail of how their recommendations have been received and if they have been adopted. However, this examination has helped to clarify that pressure ulcer risks are faced by many community dwelling adults and this situation is likely to be more common with the growing emphasis on rapid hospital discharge and on care at home at end of life. Among some of the cases considered their chronologies indicated the presence of pressure ulcers across the years. Our analysis confirms others' observations (Oliver et al 2014) that healthcare skills and support are not always available to vulnerable people who rely on family carers or social care staff to alert healthcare professionals about a possible need for clinical treatment (as in the case of ZZ: Lawson 2015). Training for social care staff was recommended in the case of ZZ (Lawson 2015) and Mrs A (Coventry SAB 2010), but self-neglect and refusals of care may require more than training. There were also cases where family care was so poor that pressure ulcers became some of the many problems experienced by the vulnerable adults

concerned, leading in some cases to prosecutions for wilful neglect. Examples are also given in the SCRs of other delays in response, poor care and negligence but also good practice.

As with our previous analysis of SCRs concerning pressure ulcers in care home residents (Manthorpe and Martineau 2017), this present analysis has also identified that the pressure ulcers and their grading system may be used as indicators or symbols of poor care if responses to them are sub-optimal. It may be that because a pressure ulcer is noticeable, may be shocking, and the severity of it can be recorded and categorised, it is a less subjective indicator than other manifestations of neglect or poor care quality which may be far less visible in the context of home environments particularly when the individual concerned is resisting care. Home care often presents several risks when professionals are visitors and their presence is time-limited and only accepted with consent. As alluded to, these SCRs do not generally report that the safeguarding alert was made unnecessarily but it would likely be naïve to expect them to do so since SCRs are necessarily commissioned where harm or risk of harm is serious enough to warrant such a review and in contexts where there is suspected to have been multi-agency failings in safeguarding. Post Care Act 2014 there may be fewer variations in local policies and procedures about the threshold for a safeguarding concern, but there may also be greater numbers of SARs since these are now on a statutory footing. In two of the cases considered by SCRs private care workers were apparently being employed to care for someone who was reported to be resistant to statutory services – their own responsibility under the law not to neglect the adult at risk might need to be explained, particularly if they are in receipt of Direct Payments or if a professional has assessed their skills in carrying out procedures such as catheter care.

Conclusion

The SCRs considered in this article reflect the diversity of health and care circumstances of vulnerable adults living at home but also their own agency in deciding to accept help and the complications ensuing

when the capacity to make such decisions appears to be uncertain. We have highlighted the risks of pressure ulcers among vulnerable or at risk adults and the recommendations about training for home care workers and their employers; but also recommendations that agreed protocols are followed by health professionals which would need auditing. But training to address failures to see signs of deterioration such as pressure ulcers will not be enough if such observations are not passed to healthcare professionals, if they are normalised, if protocols and policies are not adhered to and if systems of care provision such as reviews or case conferences are perfunctory. The analysis indicates that problems in prevention and treatment are not only attributable to home care staff but to the extent to which they are supported by healthcare professionals. Overarching problems will remain if the wider problems of the sector are not addressed especially those which make communication, information sharing, accountability and resource provision difficult. While authors of future SARs may wish to ask further questions about local pressure ulcer care, SABs may wish to take more proactive approaches by scrutinising auditing and patient experience and taking a system overview.

Acknowledgements and disclaimer

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