Islington Safeguarding Adults Board has carried out a Safeguarding Adult Review to review the events in relation to Ms BB and Ms CC.

Ms BB died aged 91 years in hospital on 1 October 2015. Her cause of death was recorded as dehydration and infection secondary to a grade 4 pressure ulcer. She was admitted to hospital with Ms CC. Prior to this admission to hospital, Ms BB and Ms CC had been receiving 24 hour care following Ms BB’s discharge from hospital on 20 August 2015. The review looked at the period from May 2013 until the death of Ms BB in October 2015, with a focus on 5 distinct periods. The purpose of the review was to understand what happened, to learn from any missed opportunities and to also learn about the way organisations and staff locally worked together.

This Review focuses on the need for health and social care staff and the organisations they work for, to ensure there is good practice when working with risk and need in situations where somebody has complex health and social care needs. The importance of ensuring that the views and wishes of people with care and support needs and their families are heard when decisions are made is emphasised.

The report notes that Ms BB and Ms CC often declined support and treatment when professionals were concerned they lacked the mental capacity to make an informed decision. The report highlights an absence of holistic risk assessments, poor communication between professionals about how to manage this risk and a lack of focus on the balancing of choice and safety. This review also highlights a need to focus on improving the understanding of pressure ulcer prevention across all organisations both in the community and in hospital. Discharge from hospital, in particular where this involves an out of borough hospital, was identified as an area of concern. There is a need to focus on improving joint working between the community and hospitals when somebody is discharged.

The Safeguarding Adults Board is committed to ensuring this learning is acted on and that changes are made to practice as a result. Each organisation has an action plan to enable the key concerns identified in this report to be acted on. The aim is to ensure that adults who are in need of care and support are better safeguarded from significant harm in the future.