Safeguarding Adult Review (SAR) Gladys

Undertaken in 2017 using the Significant Incident Review process

Gladys was an 86-year-old with mixed Alzheimers disease and vascular dementia. She was placed in a care home, initially as an emergency as her husband was not coping but after less than two days back at home she returned to the same care home on a permanent basis. Between her admission and subsequent hospitalisation thirty days later she fell twelve times. Following the series of falls and a visit from the GP Gladys was admitted to hospital where she was found to have several previously undiagnosed injuries including a bleed on the brain which were believed to have been caused by the falls. At this point she was placed on end of life care pathway and died seventeen days later. The Coroner returned a verdict of accidental death following a succession of falls.

Theme	Learning
Communication	The biggest area for learning within this case has been regarding communication and it is possible to see the system issues that contributed to the communication failures many of which have led to recommendations.
	Treatment plans including medication and any subsequent changes must be communicated to those who provide daily care for a patient and electronic records must be updated.
	When attending health practitioners arrive at the Care Home it is important that they are able to be given accurate information about the reason for the attendance and all relevant recent history and medication. CCGs lead the development of an effective and succinct information sharing pathway for health professionals to use when visiting care homes for the purposes of assessing residents and providing advice and treatment. Models such as the SBAR tool should be considered.
Emergency Care situations and weekend and Bank Holiday arrangements	It is important for all assessing practitioners who respond to emergency care situations to be aware of the arrangements when approaching or during weekends and bank holidays and providers who have staff who are in a role of assessing and placing people in appropriate care settings are aware of the process for weekends, evenings and bank holidays.
	Where staff are required to undertake an assessment It is important that barriers to completion are addressed in order that patients/clients receive the assessments that provide evidence of the level of need and care required. Where assessment has been identified as being required, reasons for not undertaking

Completing assessments including carer's assessments and recording decision making	that assessment should be recorded as evidence of robust decision making.
	Where carers are offered any social care assessment, either to support their caring role or as a suspected victim of abuse by the person they care for, the rationale for not undertaking this should be recorded. Caring roles do not cease when the person being cared for goes into residential placement. Duties under the Care Act 2014 require that suspected victims of abuse are spoken to and that their wishes and feelings are recorded with regard to any ongoing safeguarding investigation and protection plan. Assessments, including financial and carer's assessments must be robustly recorded and shared appropriately. A rationale for not undertaking full assessments should also be recorded.
Homely Remedies	It is important that care homes which provide homely remedies ensure regular review of their contents in line with NICE guidance. Associated policies should stipulate that each resident's needs in respect of treatment with homely remedies is discussed with their GP. Medication polices are reviewed as part of the regulatory visits by CQC and Local Authority contract compliance reviews.
Unwitnessed falls, head injuries and monitoring	All unwitnessed falls should be treated as potential head injuries and require a period of monitoring for evidence of such injuries. In patients/residents with cognitive impairment where there have been unwitnessed falls, head Injury should be considered as a possible cause of agitation.
	Commissioners should ensure there are Head Injury policies and procedures in place across care settings in the locality that meet NICE Guidance.
Self-funded clients	Under The Care Act requirements, self-funded clients must still receive a robust assessment of care and support needs where the family make an approach for support. Financial and carer's assessments must be Care Act (2014) compliant and robustly recorded and shared appropriately. The rationale for not undertaking full assessments should also be recorded.
	It is important that families are made aware of the Local Authority eligibility criteria, the arrangements and possible charges for self-funding the care of their family member. The Care Act recognises the need to offer of financial assessment and families should be signposted to independent financial advice. An information leaflet for families should be produced with the details of eligibility criteria, what self-funding means and signposting to independent financial advice.

Attendance at Safeguarding Strategy discussion meetings when a criminal investigation is ongoing	Where there are possible criminal investigations ongoing, although the Local Authority maintain lead responsibility for the safeguarding process, it is important that conversations take place and that the police are able to ask for family members to be excluded for part of the meeting.
	The police should be made aware of who is attending the meeting and have the ability to challenge where a person potentially implicated is due to attend. This will require the Chair to be clear about the people and roles of those attendees. The Chair should agree with the police representative in advance of the meeting anyone who should not be included.
	It is important that staff who attend meetings are aware of their role within it and whether it is appropriate for them to attend.

Conclusions

Gladys came to the attention of Mental Health services late in 2015. Her deteriorating cognitive ability and behaviour associated with her diagnosis of dementia led to a crisis in December 2015 leading to her death at the end of January 2016.

This review has focussed on a very short time during which there was much activity. It is important that the learning that this case highlights is shared across the partner agencies and care providers in the locality. That said, it is also important to recognise that dementia is a terminal illness, and whilst the disease progression will be different for all those with the condition, the falls that Gladys suffered were at the stage of her dementia that falls prevention strategies were largely not possible.

Initially Gladys was placed on a unit that is not set up to manage residents with dementia but the lack of pre-admission assessment did not provide the Care Home with the relevant. diagnosis and information about her care needs. Even when Gladys became a permanent resident her needs were not comprehensively assessed in order that a robust falls prevention care plan could be formulated.

What should have happened was a more robust response to her falls and recognising the impact on her of repeated falls and the associated head injury risk of unwitnessed falls.

The biggest area for learning within this case has been regarding communication and it is possible to see the system issues that contributed to the communication failures many of which have led to recommendations:

- Memory medication had been agreed but never received by Gladys. It is not clear in records that there was a clear view that it was no longer indicated.
- The GP did not update the electronic system to identify a medication change.
- Adult Social Care system for self-funded clients did not have Care Act changes embedded and managers encouraged closure of cases for such clients.

- Community Matrons did not have a good history from Care Home staff of the falls.
- Care Home staff did not feel that they could challenge qualified nurses.
- There was confusion related to what assessments had been carried out and by whom and what they related to.
- The family were not robustly encouraged to be involved in decision making related to health and well-being.

Recommendations

1. That the lessons learned within this review are shared across all commissioners of care provision in the locality

2. That providers who have staff who are in a role of assessing and placing people in appropriate care settings are aware of the process for weekends, evenings and bank holidays

3. That the CCGs lead the development of an effective and succinct information sharing pathway for health professionals to use when visiting care homes for the purposes of assessing residents and providing advice and treatment. Models such at the SBAR tool should be considered.

4. That the NHS Foundation Trust ensures:

a. that the Community Matron service is operating within the sphere of responsibility and that where an X-ray is required, that the request is passed to the relevant medical clinician for approval

b. That barriers to the completion of holistic assessments by the community matrons are addressed and that, if they are a requirement, these are always completed and flagged as incomplete until done.

5. That commissioners ensure there are Head Injury policies and procedures in place across care settings in the locality that meet NICE Guidance

6. It is recommended that :

a. Assessments, including financial and carer's assessments, and advocacy arrangements are Care Act (2014) compliant and are robustly recorded and shared appropriately. Rationale for not undertaking full assessments should also be recorded

b. An information leaflet for families should be produced with the details of what eligibility criteria is, what self-funding means and signposting to independent financial advice

7. That the appropriate sub group of DSAPB updates the multi-agency safeguarding adult procedures to strengthen the guidance on the following :

- Agreement with police in advance of a strategy meeting anyone who should not be included.
- Excluding family members from part of the meeting, if relevant, to allow for professional conversations.
- Chair of meetings being made aware of who is attending, role and purpose
- To ensure all multi-agency procedures reinforce the importance of all relevant and historical information to be considered (including information from multiple referrals) for safeguarding meetings and decision making.