North Lincolnshire Safeguarding Adults Board (SAB)

Safeguarding Adults Review (SAR) Adult A - learning briefing

January 2021

What is a SAR?

The SAB as part of its statutory duty, is required to carry out a SAR under the following circumstances:

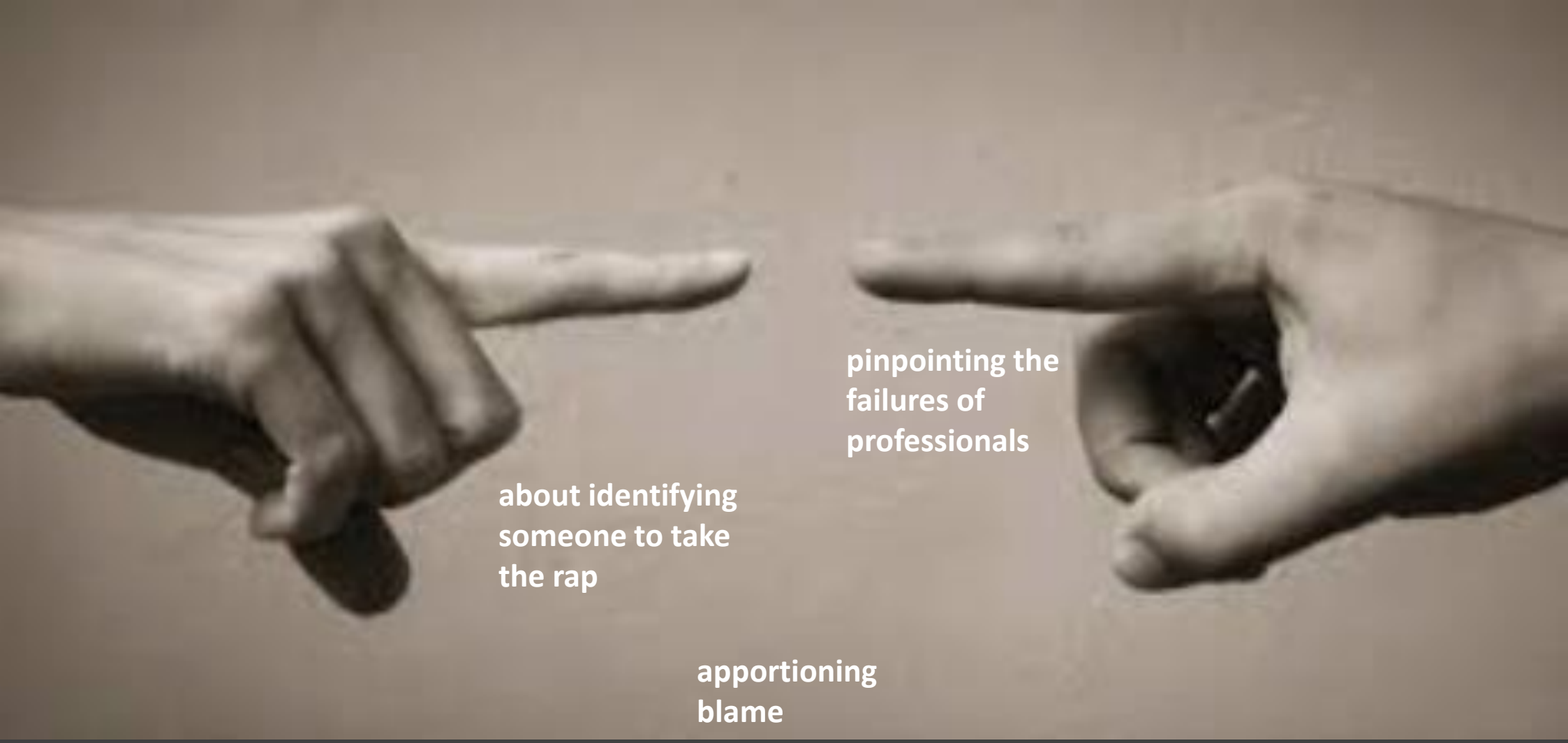
- When an adult who has care and support needs, in the area dies as a result of abuse or neglect (whether known or suspected) and there is a concern that partner agencies could have worked more effectively to protect the adult.
- When an adult who has care and support needs has not died, but the SAB knows or suspects the adult has experienced serious abuse or neglect.
- SABs are also free to arrange a SAR in any other situations involving an adult in its area with care and support needs.

Care Act 2014

What is a SAR?

- The aim of a SAR is to **promote effective learning and improvement**.

- SARs should be used to explore **examples of good practice**, as well as those areas that were not so good. SARs should **identify learning** which can be **applied to future cases**.


pinpointing the failures of professionals
about identifying someone to take the rap
apportioning blame

A SAR is not

Adult A

Adult A was an 87-year-old gentleman who suffered from Alzheimer's disease. Adult A also had prostate disease and type 2 diabetes.

Adult A had been cared for at home by his family until June 2018 when he was admitted to a care home by his family due to a deterioration in his Alzheimer's presentation. Adult A's placement was self-funded.

Adult A was taken to hospital twice in July 2018 following falls. On the second occasion, medical staff were concerned by multiple bruises and raised a safeguarding concern.

On the second admission Adult A was diagnosed with multiple secondaries from a cancer of an unknown primary source and died as a result of this seven weeks later.

A referral for a SAR was sent to SAB, following concerns raised about how the section 42 enquiry was conducted.

The Review

The purpose of this SAR was not to investigate the cause of the bruising but to provide learning and recommendations regarding how agencies worked together to undertake the safeguarding section 42 enquiry.

Adult A's family chose to take part in the review and their views are reflected within the SAR report. Family members provided a helpful background as to the person Adult A was.

The SAB chose a review methodology which engaged frontline practitioners and their line managers. Agencies were asked to review their own involvement and provide a report of their findings and learning. Practitioners and managers took part in learning and reflection workshops to review all of the material and identify key themes and learning.

The Learning

The SAR identified several learning points in relation to three key areas within the review.

- Transition from home to care home.
- Managing falls, and behaviours in dementia.
- The safeguarding system

Transition from home to care home learning points

- Recent deterioration in a person living with dementia may continue when moving to a care home, with an increase in deterioration on move to a care home that may or may not settle after a few weeks. Assessment should consider this.
- The distress of a person living with dementia moving to alternative full-time care may be minimised by a gradual transition process.
- A person centred ‘passport’ and life story can support a person to be understood by carers and visiting professionals.
- Families may benefit from professionals proactively supporting them in managing care home choice and transition.

Managing falls, and behaviors in dementia learning points

- Co-ordination of care, particularly for adults who have limited cognition and communication ability ensures early recognition of care delivery issues and concerns.
- Use of existing roles to coordinate care and communication provide evidence of effective responses to issues and concerns.
- Those who have LPA for health and welfare must be regularly consulted on all aspects of care decisions and concerns.

The safeguarding system learning points

- Making enquiries regarding physical injuries requires specialist guidance and input.
- Collaboration between Local Safeguarding Adult Boards to produce joint multi agency procedures may be helpful to organisations who cover several areas.
- Body maps provide evidence of bruises from falls and other accidents. This is particularly helpful in a person who is not able to communicate.
- Making Safeguarding Personal provides clarity on person centred safeguarding processes that include the person and their representatives throughout safeguarding processes.

The safeguarding system learning points

- Those with LPA for Health and Welfare must always be consulted and included in health and welfare decisions.
- Clarity regarding outcomes for different procedures being followed avoids confusion and helps maintain focus.
- ‘Causing others to make enquiries’ when more appropriate ensures effective use of expertise.
- Single agency procedures are more effective when congruent with multi agency procedures.
- Multi agency safeguarding procedures need to be easy to access, navigate and follow.
- Professional challenge and escalation play a key role in safeguarding procedures and practice to ensure effective and robust section 42 enquiries.

“The GP practice staff always responded in a timely manner to requests for family and care home for advice, support and consultation”

“The care home consulted and asked for support from various professionals”

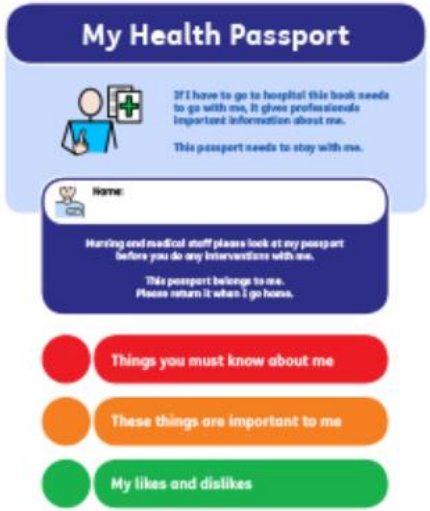
“The social care needs assessments and carer’s assessment, prior to admission to the care home were good”

“Care delivered to Adult A in hospital was of a good standard and the fast track for NHS continuing health care funding ensured a prompt transfer to a suitable nursing home for end of life care”

Adult A’s family had high praise and thanks for some professionals within the agencies concerned for how they undertook their roles and supported them as a family during this difficult time.

Key points for learning and reflection

- Pre-admission assessments to a care home should consider, and plan for, the needs and potential deterioration of someone living with dementia.



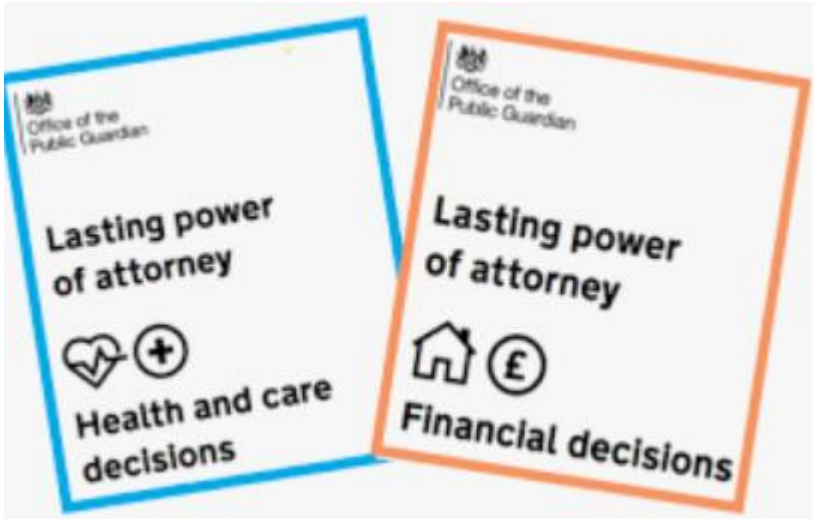
- Best practise is to proactively offer advice, support and discussion to enable a person and their family to choose a care home and how this might affect them, even if they are going to fund their own care, and ensure care is coordinated effectively across the system.

Care home checklist

ageUK

Things to look out for and questions to ask

Key points for learning and reflection



- All staff who provide care must regularly consult and involve family members and/or those that hold LPA for health and welfare.

- All organisation's safeguarding policies and procedures must refer to multi agency procedures, provide clarity regarding advocacy, 'causing others to make enquiries' and be available to all staff.

Sharing the learning

Thank you for taking the time to read this learning briefing.

This briefing has pulled together the key learning points and messages arising from the Adult A SAR. We ask that you take the time to reflect on these issues and consider, together with your team how you can challenge your own thinking and practice.

This briefing will be disseminated to all partner organisations, and we will also ensure its content is included within or informs our safeguarding training.

To support with the learning points seven learning briefings have been developed to be shared with the workforce across North Lincolnshire, they can be accessed at: http://www.northlincssab.co.uk/professionals/north-lincolnshire-safeguarding-adults-review-adult-a/