Learning Report - Neil

The circumstances that led to this Safeguarding Adults Review (SAR)

Neil was a 78 year old man who died in 2016. The Coroner stated that Neil had died due to an accident and that neglect contributed to his death A Safeguarding Adult Review was completed in April 2017. This review focused on the period from the 1st January to the date of Neil's death in January 2016

Neil lived in his own home and was described as a relatively private person. He had three sons, two of whom lived locally and provided support. Until the period of this review his health needs had been minimal. He had type 2 diabetes, suffered a minor stroke in 2014. From January until mid-July 2015 Neil received several services from Primary Care, including diabetic podiatry assistance. In January, there had been some concerns about weight loss and in March 2015 which were resolved following the removal of a colonic polyp.

From mid-July to November 2015 Neil's needs increased, he had a number of low level falls and began to display confused behaviour which led to calls to the out-of-hours GP service and other primary care services alongside attendance at the Minor Injuries Unit. In November 2015, following a series of episodes where Neil presented as very confused about his situation the Family agreed for Neil to spend some time in a respite dementia unit at a relatively local residential care home. During this time the relevant assessments were undertaken, including a Mental Capacity Assessment. Initially he settled in well and his family notices a gradual improvement in him.

However after a month his behaviour began to become more challenging, both verbally and physically abusive to members of staff and other residents. He was seen to enter other residents' rooms, without permission and was generally very agitated. Neil was visited by health professionals on six occasions during his stay, to review his declining mental state and adjust medication. He was referred for an urgent CT scan in relation to his continuing cognitive and behavioural decline and a Deprivation of Liberty Safeguards (DoLS) authorisation was applied for.

On the 13th December Neil was admitted to hospital following an assault by another resident. The hospital raised a formal Safeguarding Alert with the Local Authority and the Patient Safety Lead at the hospital advised that Neil should not return to the care home until further investigations could be undertaken. During his stay he continued to cognitively decline and on 21st December he had an unwitnessed fall from his bed.

Following continual assessments Neil was discharged to different residential Nursing home on 4th January however his health declined rapidly following his admittance and on 6th January the Registered Nurse on duty observed that his circulation appeared compromised with no cardiac output. A colleague commenced CPR whilst the Registered Nurse rang for paramedic assistance; however they were unable to resuscitate him. The coroner confirmed that the medical cause of death was pneumonia and the verdict was that Neil had "died as the result of an accident, to which neglect contributed."

Learning identified:	What will help?
Care needs to be coordinated. There was a lot of activity in working with Neil, but this activity lacked oversight.	If there are more than two professionals/agencies involved with a service user, a lead professional or care coordinator should be in place.
Delay was evident in Neil's case.	DOLS[1] assessments need to be undertaken in a timely way and BIDs[2] need to be shared widely.
Communication between professionals and with family members needs to improve.	All professionals involved need to ensure that family members are aware who is involved in their relative's care, what their responsibilities are, what their role is, and their contact details.
Up to date information should always be available when a person transfers from one placement to another.	Ensure copies of historic information, plus updated assessments, notes, and all relevant information is transferred with a patient in all cases.
Some medication can increase the risk of falls.	Practitioners need to be aware of these medications and assess the risk and benefits. Good practice was evident in this with support being given to Neil to organise and dispose of unrequired medication.
Neil's dentures were lost when he was undergoing surgery.	The little things are important to ensure good quality care.
If it is established that a resident with care and support needs is assaulted by another resident in any setting, all of the agencies who are aware of this should raise a safeguarding alert.	Do not assume someone else will do something, take responsibility.
Pain management is a priority.	Appropriate pain assessment procedures must be used, particularly when someone who has dementia may be in pain following a fall or surgery. If prior to transfer it has not been possible to administer analgesia, this should be recorded and shared on the handover.
Noisy and busy hospital environments can be detrimental to a person with dementia.	If hospital admission is necessary, risk assessment should consider the impact of the environment against the risk of lack of supervision in a single room.
Staffing levels did not allow the expected care and supervision of the patient.	The appropriate escalation process should be used, and family members should be informed if staffing is inadequate.
GP records take time to be transferred when a patient moves to a new address.	Be aware that GPs may not hold all of the patient's history following a move.

[1] Deprivation of Liberty Safeguards (Mental Capacity Act 2005)

[2] Best Interests Decisions (Mental Capacity Act 2005)