WSAB
Worcestershire
Safeguarding
Adults Board

Briefing for Worcestershire Safeguarding Adults Board:

Lessons Learnt from the Death of "Alan".

Safeguarding Adult Reviews

The purpose of a Safeguarding Adult Review (SAR) is to gain, as far as is possible, a common understanding of the events that led to death or significant adverse incident(s), to identify if partner agencies, individually and collectively, could have worked more effectively and to suggest how practice could be improved. A SAR is about learning, not blaming, and aims to improve future practice.

Lessons Learnt from the Death of "Alan".

Alan was aged 68 at the time of his death. He had lived with his wife in the western part of the County. He was an active man who was still driving his car until a few months before his death. He had a son and two daughters. In the latter part of his life, Alan had care and support needs which were met by his wife and family with the support, as required, of primary and psychiatric care services.

In February 2016, the onset of dementia, related to the Parkinson's disease, was diagnosed and the depression confirmed, for which medication was prescribed. In late March 2016, Alan was admitted to acute hospital, for physical and psychiatric assessment. It was determined that he was fit for discharge within the first week, but he remained in the hospital for a period of 10 weeks for various reasons which are detailed in the SAR. On 9th June 2016. Alan was admitted to a specialist care home on a "Discharge to Assess" (DTA) basis

Alan was admitted to (a different) acute hospital on 6th July 2016 in an unconscious state and found to be suffering from a chest infection and septicaemia. It was also found that he had pressure injuries to his heels and bruising to his ankles. Alan died 5 days later.

Download the full report:
www.worcestershire.gov.uk/downloads/file/9784/safeguarding_adult_review_-_alan

Learning Points

1. Timely Discharge:

(i) Alan's stay in the first acute hospital, from March to June 2106, was far too long.

- Timely Discharge is essential to not expose the patient to the risk of hospital acquired infections or to the known adverse impact an acute hospital environment can have upon the mobility and well-being of patients with severe cognitive impairment.
- Ensure all process are followed to ensure timely discharges from hospital.

2. Consider Tissue Viability as part of the care planning process:

(ii) On admission to the second acute hospital, Alan was found to have three pressure injuries to his ankles and an ulcerated penis, but these conditions had not been seen nor recorded by the care home.

- Where skin integrity is compromised: all providers must ensure that the use of body mapping is adopted to record the progress of healing/deterioration.
- Seek additional support from the Tissue Viability Specialist Team where necessary.
- Evidence within the care plan the use of risk assessment in selecting specialist pressure relieving equipment.

3. Transfer:

- When a transfer is required, the transfer information must provide full details of tissue status. This must be identified preferably using a body map and photographs as appropriate.

4. Carers

- Are you aware of the expectations the person you are caring for and their families have, is denial of the care outcome evidenced by those you are caring for? Is the likely outcome you foresee the same as those you are caring for?
- If not what action have you considered to address this situation?
- All agencies should ensure that the needs of Carers can be identified within holistic assessments.
- All agencies should ensure that there is effective and timely record keeping of all care and support requirements. The desired outcome must be clearly identified.

5. Raising Concerns/Whistleblowing

- NHS providers should raise staff awareness of the benefits of an early offer of support from Patient Advisory Liaison Services if/when concerns or conflict arise between patients/relatives/NHS staff.
- All services should ensure that service users and their carers/families are made aware of their organisations complaints and compliments process; and their 'whistleblowing policy'.

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