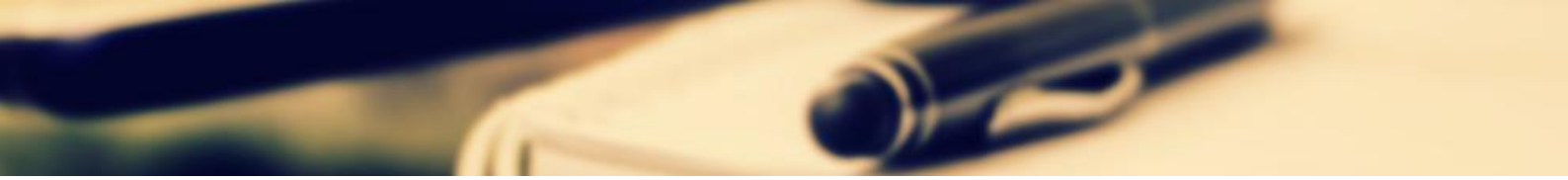


JOSEPH

What were the circumstances that led to this Rapid SAR

Joseph was a 79 year old male. He had multiple health conditions which left him extremely frail as he advanced in years. He was having an increasing number of falls, and there were concerns regarding fluctuating mental capacity, resulting in him refusing appropriate care on occasions. Despite being initially reluctant, Joseph had a package of home care for some time. As his needs increased, he moved into residential care 20 months prior to his passing.

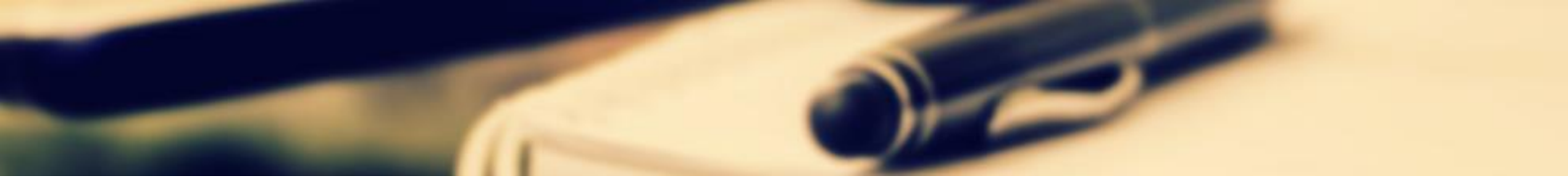
Following a further hospital stay 8 months prior to his death, Joseph moved to a care home nearer to his home to be closer to family. During his stay within this residential care placement Joseph received the services of multiple teams to address his physical health needs as well as services from the GP practice.

Following a further fall at the residential home, Joseph was admitted to hospital and died the following day from aspiration pneumonia. An inquest was held, and the coroner issued Regulation 28: Report to Prevent Future Deaths[1]. Following an organisational abuse enquiry into the care at The Nursing Home, which was partially upheld, a recommendation was that a SAR Referral to be made.

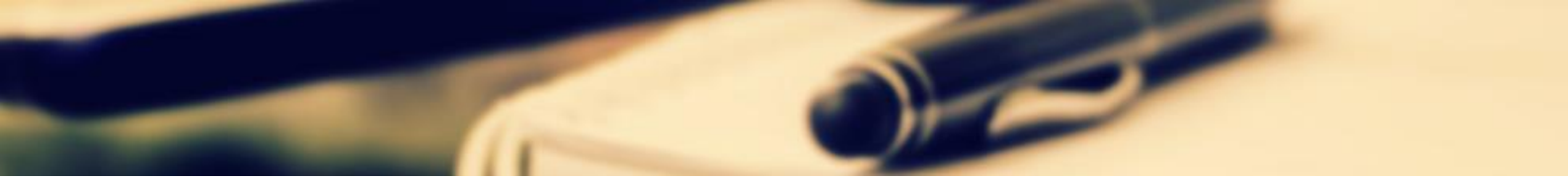
What should you do?

- Ensure effective communication with other agencies - think of the team around the person
- Where there are concerns regarding cognitive decline - seek onward referrals for clarity; consider mental capacity
- Understand the history of the person; there may be clues to presenting behaviour
- Use shared care records where available
- Raise concerns with care home management appropriate; make onward referrals to quality assurance teams and safeguarding when necessary.
- Ensure the Guidance for Fast Track for CHC Funding is understood and used when a person's health may be rapidly deteriorating, and end of life *may* be approaching
- Record outcomes of ALL meetings

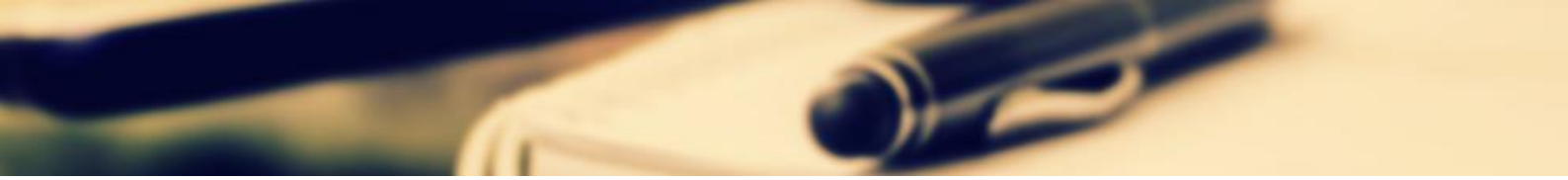
[1] https://www.legislation.gov.uk/ukpga/2009/25/contents



Learning identified	What will help?
Understanding the person; improving communication • Information that is available regarding care home residents' history is useful and made available to visiting professionals. • More support is needed for care home residents to understand the role of an advanced nurse practitioner. • Systems are needed to ensure that there are ways for visiting professionals to understand the history of the person they are working with. • People in receipt of services would benefit from communication barriers for professionals using IT systems to be resolved. This may include ensuring that all staff are up to date with current shared systems.	Discuss with peers and in team meetings how you find out about the people you are working with. Ask Care Homes if they provide 'all about me style passports' for visiting professionals. If they don't suggest that they do. Link to NHS example of on Health Passports Link to Alzheimer's Health Passport Link to Dorset Easy Read Health Passport Consider if the aging population understand new roles that support people, how can you help and support them to understand your role? For example at each contact with the person, clearly explain your role as part of your introduction. Understand how to access and use systems that are available for sharing of records.
Assurance of quality of care in care homes • When concerns come to light from whatever source regarding care delivered in care homes, the care home manager and where necessary the Care Home management company should be notified. • Where concerns are not responded to or the concern is such that it constitutes a safeguarding issue, alerts should be raised with safeguarding and the Quality Assurance Teams within the local authority and, in the case of a nursing home, with the ICB quality assurance team. • Concerns regarding quality of care should also be raised with the CQC. • Accountability for nursing care in a home registered for nursing care	Discuss any concerns with care home managers in the first Instance. Know how to raise concerns with Quality Assurance Teams in the Integrated Care Board (Nursing Homes), Local Authority (homes without nursing), as well as CQC. Revisit Adult Safeguarding procedures for raising concerns and escalation. If someone is at immediate risk of harm or abuse, contact Adult Front door./duty team Link to WSAB information on reporting a safeguarding Concerns Understand who the accountable manager is within a nursing/residential home.



Learning identified	What will help?
should be clarified where there is no registered manager and there is no other person in a senior nursing position.	
Discharge to assess and other placements/funding for care. • All professionals involved in the care of a person with multiple care needs and a terminal diagnosis should have an overview as to whether end of life may be approaching. • Whilst fast track applications are required to be made by an appropriate clinician, the views of those who know the person best, including the person and their family and carers may be consulted. • The Fast Track Process and guidance needs to be understood by those who are likely to be caring for people who are approaching end of life.	Discuss with your peers and teams what this means to you and your team. Ensure you are familiar with the guidance and challenge where you are concerned the spirit of the guidance is not being applied in the way that it should.
Quality of recording and reviewing Multi-Disciplinary Team (MDT) meetings • MDT meetings are an effective way to share information and collaborate on assessment findings and care planning. • Effective MDTs need to be recorded to allow robust information sharing and follow up.	Ensure the outcomes/actions of all meetings are recorded as this provides good evidence of decision making and agreed care planning etc. Remember it may be difficult to evidence decisions in the future- including who was present etc
Mental Capacity and Cognitive impairment. • Where there are concerns regarding a person's cognitive ability, it is necessary to understand the reasons behind that concern in order that appropriate diagnostic, support services and treatment (if of treatable cause) can be provided. • The recording of mental capacity assessments provides rationale for the reason a practitioner states or	Ensure that appropriate support and onward referrals are undertaken where a person has a low mini mental state score. Notify GP is decline in cognitive ability is thought to be physical health related. Reflect on and revisit with your team your understanding of professional curiosity, the Mental Capacity Act and in particular the decisions specific elements.



Learning identified	What will help?
concludes that person has capacity. This is particularly important where cognitive impairment is being questioned. • Mental Capacity assessments are decision specific and are not an overall statement regarding a person's presentation and decision-making ability.	Can your recording clarify and justify your statement 'has capacity'?