Bexley Safeguarding Adults Board

7-minute Learning Summary

SAR – Mr K

1. Rationale for Safeguarding Adult Review (SAR):

The BSAB regularly carries out SARs. They are extensive pieces of work, that look in details at cases when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. This SAR was carried out so that the agencies involved in providing services to Mr K could learn lessons and improve practice.

Agencies looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight.

The overall aim of a SAR is to improve services because of that learning. **What do you do?** Make sure you embed the learning and can evidence to the BSAB especially if you work for an agency that was involved in this SAR.

The full report can be found here –

http://www.safeguardingadultsinbexley.com/wp-content/uploads/Mr-K-Executive-Summary-and-Findings-for-Publication-June-2017.pdf

2. What happened in the case of Mr K?

In July 2015, the Bexley Safeguarding Adults Board (BSAB) received a Safeguarding Adults Review (SAR) notification from the Bexley Clinical Commissioning Group (CCG) relating to the death of a Bexley resident potentially due to self-neglect. A post mortem was carried out and the cause of death was given as:

1a. Heart Failure
1b. Brown Atrophy of heart
2. Severe electrolyte disturbance with malnutrition

A decision was been taken not to publish this report in the best interest of the family.

3. BSAB Recommended Professional Learning:

1. Vulnerable Adults identified by Practitioners having a history of self-neglect should have self-neglect embedded in their profiles and shared as appropriate with all key practitioners involved in their case.

2. Risk assessments should be considered to ensure unsafe risks are recorded and shared as appropriate with key practitioners in their case including asking service-users' families and carers for information about risk and include it in that person's risk profile as well as ensuring access to appropriate advice and support is available.

3. All relevant staff should be competent to manage safeguarding adult referrals including self-neglect and challenging behaviours when working with hard to reach groups.

The Assessment and Treatment Care Pathway should be followed to ensure a patient-centred planning meeting is carried out within three-weeks if none has been carried out within the previous six-weeks.

4. BSAB Recommended Professional Learning cont….

5. All In-Patients mental capacity to be considered at the point of contact as to their ability to consent at that time to the proposed actions/action plan/care plan; and being continuously reviewed throughout their stay keeping in mind that mental capacity is time and decision specific.

6. When a patient is subject to an emergency admission and is unknown by the unit or community team, a comprehensive assessment of the family or carer's knowledge and experience of the patient should be undertaken.

7. Clinical teams should ensure that families and carers are fully engaged in the planning and delivery of care and understand the Referral Pathways for Safeguarding Adults when considering mental health, mental capacity and self-neglect concerns.

8. Organisations should ensure collaborative working across Adult Social Care, Children's Social Care and Community Based Health services (including GPs, District Nurse, and Physiotherapists), agreeing Joint Referral Pathways and Information Sharing Protocols.

9. A process for escalating refusal for health or social care services, when there is a concern.

6. Useful link

https://www.safeguardingadultsinbexley.com/protecting-adults/safeguarding-adult-review-learning-2/#

5. Since the SAR concluded:

- The Board held a SAR Workshop on the 15th December 2016, to analyse and create a baseline in order to respond locally to the findings from the Reviewers.
- The Review Team involved throughout the SAR convened twice since December 2016 to evaluate and create a workplan on the learning.
- The Board linked with the Bexley Safeguarding Children's Board to share practice lessons and work together to shape the workplan.
- The Independent Chair planned a workshop for frontline workers involved in the SAR to go through the lessons.
- The Review of the workplan was to be carried out through the SAR Sub Group, Chaired by Healthwatch with a direct report back to the Board and Independent Chairperson at any time.

A Learning Event Conference was held in September 2017 – all slides and action plans can be found on the BSAB website

www.safeguardingadultsinbexley.com