Adult C Safeguarding Adult Review Learning Brief
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Case Summary

Lancashire LSAB commissioned a Safeguarding Adult Review (SAR) following the death of Adult C (John*). John resided in Care Home 1 and died of natural causes contributed to by injuries sustained as a result of an altercation with another resident (David*) of the Care Home. Both residents had vascular dementia. The review considered the 13 months prior to the incident.

Throughout the period under review, John remained in Care Home 1 with no transitions between Care Homes.

However throughout the timeframe, David had a number of transitions and resided in three different care homes as well as spending two and a half months in Hospital Settings. Whilst residing in all three care homes, David had a number of incidents of aggression towards fellow residents and staff members. David had been a resident of Care Home 1 for 10 weeks when he assaulted John. Care Home 1 had already served notice recognising they couldn't meet David's needs. The full report is published on the Lancashire Safeguarding Adult Board's website here.

The review highlighted key themes which are listed below:

- Commissioners and Providers to ensure that record keeping is robust to ensure that, when required, evidence for support e.g. 1:1 funding is available.
- Practitioners should ensure that there is a consistent use of the Mental Capacity Act and DOLs when patients with dementia refuse prescribed or advised treatments and interventions. Public health have identified that perspective vaccinations for vulnerable groups is a key priority.
- Practitioners should always request all information to ensure that pre-admission assessments are complete and thorough. An incomplete pre-admission assessment can lead to an unsafe transition from one care home to another and residents can be placed in Care Homes unable to meet their needs.
- Following a Safeguarding alert, practitioners should always consider a strategy discussion with relevant professionals; strategy meetings should be arranged where appropriate. This will provide practitioners with the opportunity to discuss decisions from MASH and Safeguarding professionals.

Good Practice Highlighted:

Good practice was identified by the reviewer of the Safeguarding Adult Review, the Safeguarding Adult Review panel, professionals at the practitioner learning event and the family of John.

- The RIT team completed a risk assessment on the same day as they received the referral. Additionally, the coroner reported that the RIT team had done everything they could to support the patient and care home.
- Dementia Care Mapping is an established approach to achieving person centred care for people with dementia. Staff take the perspective of the person with dementia in assessing the quality of care that's being provided, it allows staff to engage in critical reflection in order to improve the quality of care for people living with Dementia, and also to educate staff. Professionals in this review used Dementia Care Mapping to form part of their assessments and to plan care.

**Names have been changed to maintain anonymity*