Adult I Safeguarding Adult Review Learning Brief
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The name 'May' has been chosen as a pseudonym for Adult I

Case Summary

May was a 71 year female who died suddenly at home, post mortem results indicated the cause of death to be sepsis, with evidence of pressure ulcers and acute on chronic cholecystitis. May lived alone, she was extremely overweight with a BMI of 51.8, with multiple health problems and limited mobility; this resulted in her receiving support 5 times a day from 2 Homecare Provider agencies. She also had input from District Nursing services, GP and had spent time as a hospital inpatient. May exhibited some hoarding behaviours and had a degree of learning difficulties, although agencies did not doubt her capacity to make decisions. May had periods of low mood and anxiety and was at high risk of Pressure Ulcers due to her very limited mobility. Regular district nursing visits occurred to address May's health needs and reablement support was provided to try to improve her mobility, though she was not always concordant with interventions. Despite May's complex health needs, her death was not expected. The review highlighted key themes and areas of learning which are explained below. The full SAR report can be found on the LSAB website.

Key themes and learning points

Service user voice and family involvement – The review suggested that agencies understanding of May's circumstances, including her history and her family's involvement in her life was limited. There was opportunity for greater professional curiosity in relation to May's behaviours; particularly with regards to the potential exploration of self-neglect and the impact that this had on her health. Lancashire LSAB have recently launched a Self-Neglect framework which practitioners should familiarise themselves with.

Case Management – In situations where a number of agencies are providing care and support to an individual with complex needs, agencies must work together and ensure frequent and close communication at all times. Effective case management and regular multi-disciplinary meetings are crucial in order for the high quality, targeted care to be provided in a coordinated way.

Person centred assessment of need – May's health needs were complex and agencies were providing care to address these predominately in a task focused manner. There were missed opportunities for May to be assessed holistically, taking into account her physical, emotional, social and mental. An assessment which put May at the centre of the intervention rather than dictating specific tasks to be undertaken by specific agencies is likely to have had a greater impact on May's health and wellbeing. Pro-active information sharing to support such an approach would have ensured that May's needs were visible to all agencies enabling to respond in a coordinated way. Lancashire LSAB have launched a guide for practitioners for Making Safeguarding Personal which aims to develop a person-centred approach to safeguarding.

Capacity to consent to interventions – The review found that agencies working with May I did not doubt her mental capacity. There were however times when May was non-concordant with advice and interventions offered. Professionals should fully consider and record the potential reasons for non-compliance with the support and guidance offered. Depression, anxiety and poor pain management should be acknowledged and explored as potential reasons why individuals refuse or avoid support.

The home care system – Agencies commissioning care should be satisfied that Home care agencies have sufficient resources and skill levels to support people with high needs and complex behaviours. Care agencies need to be able to identify serious risks and be sufficiently competent to escalate concerns.