Adult B Safeguarding Adult Review Learning Brief
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Case Summary

Lancashire LSAB commissioned a Safeguarding Adult Review (SAR) following the death of Adult B. The LSAB agreed to conduct a SAR due to concerns about how agencies had worked together to safeguard Adult B and the suspicion that neglect may have been a contributory factor in Adult B's death.

Adult B was placed by Wigan Council in a care home initially for respite following a deterioration in Adult B's health and with a diagnosis of vascular dementia and Alzheimer's. Adult B lived in the care home for 18months. Adult B sadly passed away in hospital following two falls in the care home. Both falls occurred on the same day.

The SAR also includes themes and learning following the death of Adult B2 who also sadly died in the care home.

The review highlighted key themes which are listed below:

- Key factors in the deterioration of standards in the care home appeared to be the result of deficiencies in leadership, oversight and supervision of staff, an over reliance on agency staff and the unsatisfactory handling of complaints.
- Providers should ensure staff competency assessments are completed and monitored via supervision and direct observation of practice
- Providers should ensure care plans are accurate and up to date and reflect the service user's needs; the recording guidance here sets out good practice standards.
- Professionals who perceive a decline in standards need to exercise professional curiosity and ensure that concerns are shared with other relevant professionals – this was of seen to be of particular significance for GPs and specialist care services
- Commissioners of individual placements need to ensure they have effective systems in place for monitoring the standards of care provided which should include feedback from relatives.
- When safeguarding concerns are raised, particularly following an observation of practice by a professional, as in this case, then efforts should be made to speak to the person who observed the concern rather than close the alert with minimum enquiry
- Information sharing between the CQC and Commissioners did not take place on a timely basis as initial concerns were rated as "low" – this may have been a missed opportunity to engage support from the Radar group in a timely fashion
- Where a fall occurs as a result of neglect or an act of omission then a safeguarding alert should be raised and steps taken to update the risk assessment
- Providers should have an adequate falls policy in place and monitor its effectiveness. Awareness of the potential seriousness of falls, the steps to take to prevent falls and the circumstances in which a safeguarding referral following a fall is justified, need to be increased amongst providers and their staff, including staff in the MASH
- A lack of a confident grasp of the implications of the Mental Capacity Act indicated by this case suggest further action is necessary to increase practitioner knowledge in this area. Providers need to ensure consistent good practice in respect of mental capacity and deprivation of liberty safeguards (DoLS) and further action is necessary to increase practitioner knowledge in this area.
- Providers need to be more open to complaints and actively encourage them in order to foster an environment of continuous improvement. In doing so they should seek to engage with families wherever possible
- Both the Care Home placements of Adult B and Adult B2 had been commissioned from outside Lancashire though the Care Home was in Lancashire. It would be good practice to ensure concerns are shared across boundaries when placements are commissioned by a number of areas.

The full SAR report is published on the Lancashire Safeguarding Adult Board website here.