Practitioner Learning Brief

Safeguarding Adult Review (SAR): William

Essex Safeguarding Adults Board

May

William felt unwell and called 999. He was clinically assessed by phone and received advice from the duty doctor

June

William attended his GP surgery on 11th June and was prescribed antibiotics for a urinary tract infection. Two days later he called 999 as he was unwell and was advised to contact his GP for support. Two days later his GP called 999 and William was admitted to hospital with possible sepsis. On 18th June William reported to his GP that he was unwell, three days later a GP visited and referred William for a 2-week cancer appointment. The following week his GP changed William's anti-depressant medication as his mood had worsened.

July

On 1st July William fell and neighbours called an ambulance and his wound was dressed by the crew. The following day the GP surgery care co-ordinator nurse visited. On 3rd July William called 999 with abdominal pain and was referred to his GP for support. The nurse visited again the following day and referred William to Adult Social Care. On 6th July *the* care co-ordinator nurse visited William to change a dressing and referred him to the community nurses.

August

William attended his GP Surgery on 3rd August for a knee injection. Two weeks later the GP increased William's anti-depressant dosage as he was increasingly depressed, and prescribed antibiotics for a toe infection. On 22nd August William called his GP as he continued to feel unwell and a home visit was booked. The following day he called 999 but the ambulance service did not respond. A few days later his neighbour called 999 as William had a fall. He was taken to hospital but discharged himself. Two days later he called 999, due to increased memory loss and was readmitted to hospital.

5 times William shared that he wanted to kill himself

14 times William had contact with his GP

10 times an ambulance was called

9 times William had contact with a nurse

4 times William had a hospital stay

Background

- 83 years old
- multiple long-term physical health problems
- history of depression
- lived alone
- no immediate family
- dependent on neighbours and friends

October

William returned home on 1st October after wanting to leave the care home and was visited by a nurse 3 days later to change his dressings. The community nurse visited William again the following week and discovered that he was not using his pressure cushion and noted that he found it uncomfortable and too high. The following day, William called 999 but abandoned the call. An ambulance crew attended and found William had fallen and been helped up by his neighbour. He was not injured. On 12th October the Social Worker called an ambulance due to William taking an overdose and he was taken into hospital. Four days later he died in hospital.

September

On 8th September William was discharged from hospital. Three days later an out of hours GP visited as he was struggling to cope. On 18th September William's ex-neighbour contacted the GP due to William having a swollen ankle. The GP visited 3 days later. On 24th September the community nurse visited William for the first time before he went for a short stay at a nearby care home.

What areas for improvement were identified?

- Having effective systems and high-quality professional practice in recording and sharing information on people's needs and risks.
- Developing professional skills, confidence and professional curiosity in assessing and reviewing risk
- Greater professional understanding of the impact of loss and ageing on individuals.
- Improving access to mental health and wellbeing services and physical health support services.
- Ensuring that the means of self-harm or suicide are removed when risk is identified, including safer prescribing.
- Improving the sharing of information between hospital and community services, and between domiciliary and home care services.

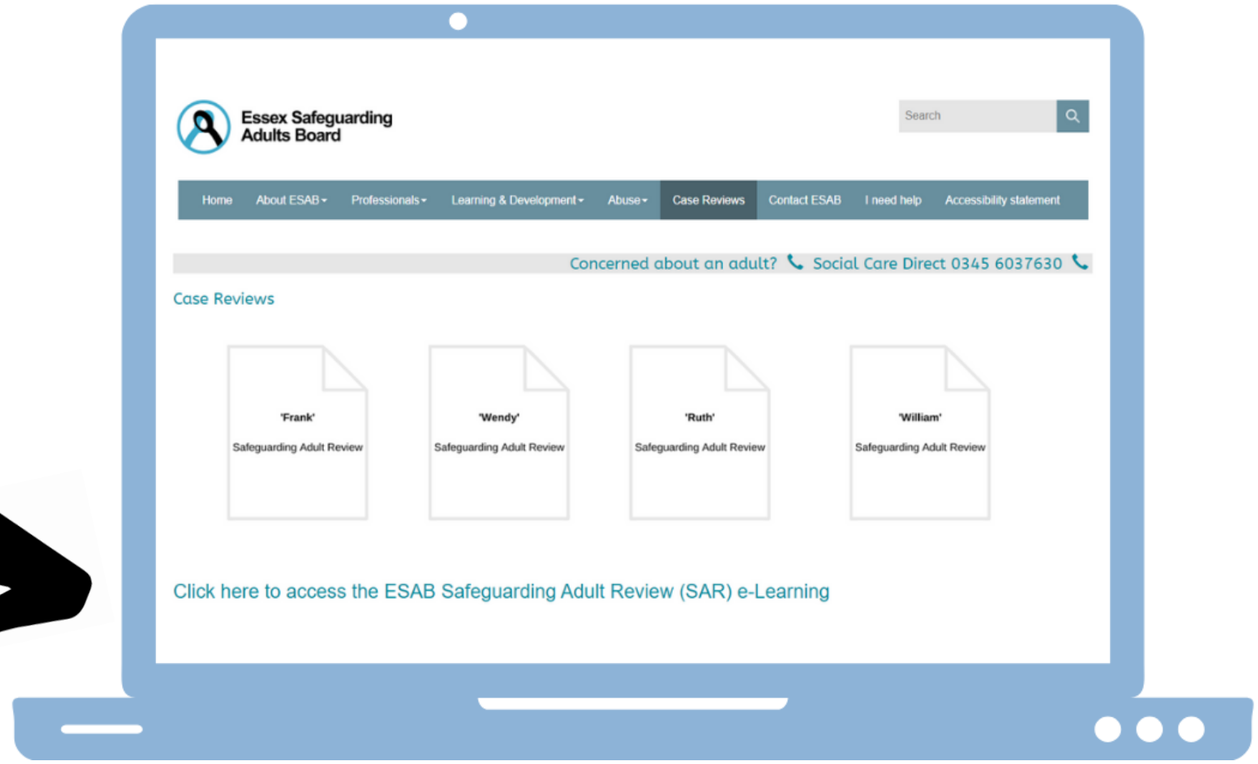
Sharing Information

- The hospital Trust's investigation for this review found that upon William's discharge, the hospital did not share information with community health and care services regarding his low moods and expressed wish to die or refer him to community mental health services.
- The domiciliary care agency expressed their main concern that the Individual Support Plan provided by Adult Social Care did not include mental health issues. This meant the agency was unaware of the extent of William's depression and his disclosures about wanting to die, and so they could not monitor his mental health effectively.

What good practice was identified?

- Even though William declined, his GP referred him for further investigations for cancer.
- GP increased the dosage of his anti-depressants, which William reported helped his mood.
- Adult Social Care increased William's care package following the agency's concerns that it was not sufficient
- Care given to William was consistent with his care support plan
- William was hard of hearing and refused to have a hearing aid, so staff spoke loudly to him.
- The carers undertook extra tasks for William such as taking out bins, hoovering the carpet and cleaning the toilet and bathroom, for which William was very appreciative. William's bed was moved downstairs so he could live on one floor, he used a frame and could not manage stairs.
- The ambulance service contacted the community nursing service to advise that William's carers were arriving late and so might not be meeting his needs.

click here to view the full SAR



Recommendations include;

1. **Ensuring that a person's mental health and wellbeing forms part of any assessment and consequent care planning. To include the priority of prompt information sharing to all organisations providing a service or care to the individual, to guarantee that everyone involved are aware of a person's needs and risks.**
2. **Ensuring continuity of primary care services during transition periods in order for an adequate stock of the person's medication to be in place and access to advice and support from their original GP whilst re-registration takes place.**
3. **Ensuring all clinicians who visit patients in the community are aware of the importance of investigating potential self-harm, including taking baseline observations, establishing the extent of the self-harm, actively exploring with the patient their risk of further harm and removing the means of self-harm wherever possible.**