LEARNING BRIEFING

Learning Lessons Review Martin

Teeswide Safeguarding Adults Board

1 Background

Martin was a 64 year old man who had a diagnosis of autism and a learning disability. His physical health deteriorated in 2020 as he was diagnosed with a benign brain tumor. Martin had lived in a supported living setting, supported by services across health and social care, however following a hospital admission in October 2020 Martin was then placed in a residential care setting. Martin was admitted to hospital from the care home in January 2021 and sadly passed away in February 2021 due to aspiration pneumonia.

Martin was one of 5 siblings and was supported by his brother and sister who raised concerns regarding the care provided to him prior to his death. This resulted in a safeguarding enquiry which was followed by a Learning Lessons Review (LLR). The LLR was completed by an independent reviewer on behalf of the Teeswide Safeguarding Adults Board. This briefing has been created to share the key aspects of learning that have been identified.

2 Theme 1: The Service Users Voice/ Communication with family

The review has found that there missed opportunities to listen to Martin about how he felt about his health, care and accommodation, who he preferred to deliver support and how he could be engaged in social interaction. It appeared that professionals had consulted with each other but had not placed Martin at the heart of their work by ensuring that they understood his wishes and feelings.

Martin's family also felt that there was a lack of communication. For example, they had not been made aware of the deterioration in his health whilst residing in the care home. Greater involvement from Martin's family could have supported professionals to understand and meet his needs more effectively.

3 Theme 2: Professional Curiosity

The review has also found that there was a lack of professional curiosity in relation to Martin's history and the deterioration in his health. For example a greater understanding of his nutritional needs, weight and his diet when at home would have improved the quality of care provided when he began to lose weight and to have a reduced appetite. There were also assumptions made about the interrelationship between his mood and lack of appetite which were not thoroughly explored.

4 Theme 3: Discharge Arrangements

Martin was placed in a residential care home following discharge from hospital. The discharge to the care home happened quickly, communication could have been improved and had the family's wishes been known then alternative arrangements could have been made. Had Martin's family been consulted they would have explained that the home chosen had painful memories for them as another relative had passed away there.

5 Theme 4: Mental Capacity Assessments

Throughout Martin's hospital stay and time in residential care there were missed opportunities to complete mental capacity assessments in relation to decisions about his care and accommodation. This would have helped professionals to understand whether decisions needed to be made in Martin's best interests and would have provided a legal framework for consultation with others e.g. Martin's family.

6 Theme 5: Impact of COVID 19 pandemic

Whilst professionals had been working in the pandemic for some months at the time of Martin's placement in the care home it is clear that the pandemic had a significant impact on the way in which professionals worked with Martin. Care home visits were restricted and therefore family were unable to go inside the care home. Professionals such as the social worker and GP did not visit face to face which made the assessment of his social and health needs more challenging.

7 What to do now and next

- Reflect on how the above themes link with your direct work with adults, families and other professionals
- Think about how you can adapt your practice based on this learning
- Discuss within your team meetings and consider any team learning and development needs
- Check www.tsab.org.uk for up to date policies, procedures and guidance, including the Professional Challenge Procedure.
- Implement any identified changes required into practice.

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