LEARNING BRIEFING

Case 4/21
Adult H

Teeswide Safeguarding Adults Board

1 Background

Adult H was a 69 year old man who was diagnosed with dementia in 2017. He also had type II diabetes and cellulitis to his legs.

Adult H was supported by his brother who provided a high level of support and in 2019 home care services were provided to support Adult H's brother in his caring role.

Adult H was noted to be self-neglecting when at home and home care staff found it difficult to engage him in personal care support, particularly bathing. He would also sleep in his chair.

In the early stages of the COVID-19 pandemic, it was becoming more difficult to support Adult H at home and increasing concerns were raised by his brother due to self-neglect and the deterioration in the condition of his legs.

Adult H was admitted to residential care in May 2020. In August 2020 a safeguarding enquiry had commenced due to self-neglect and in September 2020 Adult H sadly passed away in hospital.

Following his death, Adult H's case was heard by the Coroner and the TSAB Safeguarding Adults Review Sub-Group. This learning briefing has been created to share the key aspects of learning that have been identified.

2 Theme 1: Learning from working within COVID-19 restrictions

Whilst acknowledged that work with Adult H took place early in the pandemic when professionals were adapting to changes in practice, the lack of face to face contact had a significant impact on Adult H.

Risk assessments must be undertaken which balance the risk of staff and residents contracting COVID-19 with the need to accurately assess and safeguard an adult at risk.

In this case, face to face assessments from Adult H's social worker, the Intensive Care Home Liaison Team and his GP would have helped to ensure that he had the appropriate level of care and support and that the care home were supported to meet his needs.

Unfortunately COVID-19 restrictions on family visits meant that Adult H's brother was unable to enter the home. One of the lessons learnt was to look at ways of involving family more effectively when visiting cannot take place.

3 Theme 2: Communication and involvement with family members

The most significant omissions in care expressed by Adult H's family was communication. They were not informed of key events in Adult H's life, for example a fall that he had in the care home or that he was developing pressure sores.

Using the expertise of family members is key. Adult H's brother was able to provide valuable history and an insight into ways in which professionals could engage with Adult H to achieve the best outcomes.

4 Theme 3: Assessing Needs

Lessons have been learnt in relation to the completion of pre-admission assessments for care homes, ensuring that a full picture is obtained from the adult, their family and all professionals involved. The need for body maps to be completed on a regular basis has also been identified.

When supporting with wound care, such as dressing Adult H's legs, it is also important for nurses to be professionally curious and to assess whether the adult has wound care needs on other areas of their body.

The assessment process for moving residents when a care home identifies that they are finding it difficult to meet the person's needs has also been reviewed. There have been lessons learnt from the delay in completing the NHS Continuing Healthcare assessment and the funding approval process for nursing care.

5 Theme 4: Understanding Self-Neglect, Dementia and the Mental Capacity Act

It is important that we understand the link between self-neglect and dementia. Adult H was resistive to intervention from care staff and community nurses and could become aggressive at times. However self-neglect needs to be seen in the context of a diagnosis of dementia and the progression of this disease.

Adult H had sores to his groin, breast, buttocks and heel. It is important to consider the risk of pressure damage when an adult with dementia does not allow carers to assist with personal care. Professionals should also consider underlying health reasons which could lead to changes in behaviour for example considering the impact of pain and the difficulty that adults with dementia may have in expressing pain.

Assessment of mental capacity for people with dementia who self-neglect is a key piece of learning in Adult H's case. It is important that assessments reflect changes in the person's needs and situation and that assessments consider executive capacity. Assessors should also be wary of making judgements that refusal of care and refusal to engage with services is an unwise decision.

Being aware of the safeguarding threshold for raising a safeguarding concern is also important as there were missed opportunities to make an earlier referral into safeguarding for Adult H. This would have supported the creation of a person-centred, multi-agency plan to help the care home to meet Adult H's needs.

6 What to do now

- 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

7 What to do next...

Check out this information and share with your team:

- Safeguarding E-Learning (including Self-Neglect and Dementia Awareness) https://www.tsab.org.uk/training/
- Self-Neglect Training Workbook https://www.tsab.org.uk/training-resources/
- Safeguarding Training Courses and Events https://www.tsab.org.uk/events-key-dates/

Check www.tsab.org.uk for up to date, policies, procedures and guidance including:

- Inter-Agency Safeguarding Adults Policy and Procedure
- Decision Support Guidance
- Self-Neglect and Hoarding Policy and Guidance
- Mental Capacity Act and Deprivation of Liberty Safeguards Policy
- Mental Capacity Act Guidance
- Multi-Disciplinary Team Guidance
- Safeguarding Information for Carers—https://www.tsab.org.uk/key-information/carers/

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