7 minute briefing

James

James

James was an 80-year-old single man, from a white Irish background. Prior to his retirement he had worked for British Telecom. James lived alone in a council property. He was living independently with no need for any care and support services. During his childhood he had Polio. This impacted in his mobility, and he used callipers. He had no children and had a nephew and niece. His nephew shared that James was independent however found personal care difficult and required support with shopping. His nephew said that James had isolated himself due to Covid-19 and following the death of his sister.

James was admitted to Croydon University Hospital (CUH) on 29 December 2021 following a fall at home.

While in hospital, he was referred to the Older Adult Psychiatric Liaison Service (SLaM) who identified low mood and suicidal ideation within the context of the recent bereavements of his last two siblings. During the admission he was treated for community acquired pneumonia, hospital acquired pneumonia and Covid 19. He was started on the antidepressant mirtazapine.

A best interest meeting was arranged on 20th April 2022 by Croydon Council Adult Social Care which James's nephew and niece attended. The outcome was that James should return home based on the decision-maker however, family and other professionals strongly disagreed with this decision.

James was referred to the Older Adults Community Home Treatment Team (HTT) and assessed and accepted on 25/04/22 due to his suicidal ideation. Discharge on the 23/03/22 was postponed and was finally discharged to home on the 10/5/22 with double handed care support and 4 x daily visits.

There was limited multiagency communication regarding medication arrangements, care agency details and the district nurse plan. There were several problems at home including no hot water or heating and care workers being either unable or unwilling to give medication.

On 18/05/2022 a member of staff of the HTT called the London Ambulance Service due to their concerns over James presenting as physically deteriorated and unresponsive. He was taken back to hospital where he was diagnosed with a right sided pneumonia. James sadly passed away on 20/05/2022.

Review Methodology

The Safeguarding Adult Review sub group agreed that the James request met the criteria for a Safeguarding Adult Review and the methodology discussed. Individual Management Reviews (IMRs) were requested from SLaM, Police, Adult Social Care, GP and Croydon University Hospital. The IMRs had demonstrated thorough reviews had been carried out by each agency which had led to clear actions being identified, it was agreed that a 'critiqued chronology' method was appropriate.

Croydon Safeguarding Adults Board

www. croydonsab.co.uk

csab@croydon.gov.uk

Areas for Consideration

- Management of high risk cases in the community so senior managers are made aware of the significant and increasing risk.
- Medication administration issues and prescription and the need for immediate escalation.
- Approaches to long term planning with regards to mental health and self neglect.
- Communication with family members and family members not recorded on systems.
- Minutes of Best Interest Meetings were brief and lacked detail with the need to fully reflect discussions regarding risks and concerns.
- Where a person lacks mental capacity in respect of a hospital stay and treatment, ward doctors and nurses should consider Deprivation of Liberty Safeguard (DoLs) and make an application where required.

Good Practice

- An assessment of care and support needs was completed in a timely manner with a plan to review in two weeks with the required onward referrals made.
- Mental Capacity Assessment completed by hospital based social worker and signed off by team manager.
- There was evidence of good multi-professional working and communication between services with James, his nephew and niece involved with the Best Interest Meeting.
- James wasn't discharged with a blister pack however, this didn't affect his care as the district nurses attended and administered until this was available for the care workers to use.

Recommendations

1. Ensure that risks are recognised, that this leads to incident reporting and/or escalation processes being followed so senior managers, safeguarding lead and, where needed, the GP are made aware of these issues. This includes: issues relating to medication and prescription issues, and significant deterioration of physical health.

2. Where a person lacks mental capacity regarding hospital stay, care and treatment the ward doctors/nurses should consider Deprivation of Liberty Safeguards and make application where required.

3. To ensure that discharge planning is communicated across all agencies that need to be informed, and that records are made of that communication.

4. To ensure that best interest decisions made under Section 4 the Mental Capacity Act 2005 meet the requirements of the Act and the MCA Code of Practice. Where there is a dispute over what is in a person's best interests then this must be responded to in line with the expectations set out in pages 88—91 of the Mental Capacity Act Code of Practice.

5. To ensure that records are kept in line with expectations. In particular

    - That the names and details of family members names are fully recorded.

    - Minutes of best interest meetings should include sufficient detail to explain how decisions were reached and the rationale for them.