STOCKPORT SAFEGUARDING ADULTS BOARD

01 Background

GA was 70 years old at the time of his death. He died as a result of gastrointestinal bleed. He had a number of chronic health issues and also a history of mental ill health.

GA was admitted to Stepping Hill Hospital (SHH) on three occasions and subsequently GA died on his last admission. Throughout the final admission GA had developed issues relating to eating food, non-concordance with care, investigations and treatments.

Medics considered GA to be low in mood and he was referred to mental health for a review. There was evidence that there was a difference of opinion between the medical team and the mental health team around GA's capacity, diagnosis and treatment.

02 The Incident

GA had recurrent cycle of admissions and discharges within a short period. On all admissions mental health support was requested by the medical team and actioned. However, there was ongoing evidence that there was conflicting opinions in the treatment plans, his capacity and a lack of joined up working between both medical and mental health trusts.

03 The Review

A review was commissioned based on a recommendation from the SAR panel.

It was decided the case had met the criteria for a Multi- Agency Safeguarding Adult Review, but the decision was made to conduct a single agency health review to look at lessons learned.

04 Concerns

A lack of a coordinated response specifically around information sharing, lack or professional challenge and escalation.

There was no evidence to show if GA was asked the reasons why he was non-concordant with medical advice, weight loss advice and investigations.

Professionals didn't work together to understand GA's capacity around decision making.

Record keeping issues, multiple clinicians, poor communication and a lack of coordinated holistic approach to care.

Concerns around the practical application of MCA and evidence of decision making.

05 Learning Points

Effective record keeping and the need for coordinated response within teams for sharing information.

Face to face meetings with Multi Agency partners to ensure a shared holistic care approach.

Professionals need to ensure a sound understanding of the application of MCA including best interests and DoLS.

A formal assessment of capacity is undertaken when a person's behaviours cause concern which may negatively impact on their health.

If professionals are in doubt of any issues relating to MCA, or risks to an individual involving complex health needs, seek early advice from the safeguarding team.

06 Recommendations

Recording and timely sharing of information between clinicians from other agencies/organisations.

A clear escalation policy that includes what to do when there are differing views on the best response and the process to resolve such conflicts.

Professionals seek early safeguarding advice with complex cases that include non-concordance with care and MCA issues.

There needs to be a consistent process for assessing capacity which should be agreed by the relevant teams involved in care management.

Acute Trust and MH Trust to audit the effectiveness of the MCA training and the use of formal assessments in the health records.

Acute Trust to review their quality of applications of Deprivation of Liberty Safeguards (DoLS), and training.

MH Trust and Acute Trust should consider a record-keeping audit to review communication and care planning in the cases that they co-ordinate together.

07 Actions

Good information sharing to be reinforced through dissemination of learning from this review

Development of a shared care flag on EPR/record keeping systems to identify patients who are under the care of both health providers.

Both Trusts to agree Memorandum Of Understanding in accordance with national standards – 'treat as one' and Parity of Esteem.

Increase awareness in the understanding and practical application of the Mental Capacity Act (2005)

STOCKPORT METROPOLITAN BOROUGH COUNCIL

Safeguarding Adults in Stockport