Islington Safeguarding Adults Board

'EE'

7-minute briefing

Background

1

EE was in his 60's and had multiple and complex health needs. EE's neighbour started helping him with odd jobs and over time took on more of EE's care. Eventually the neighbour moved in to give EE 24-hour live-in care. Social services gave EE a direct payments budget to help towards the cost of paying for this care.

When EE's care needs increased and his informal carer appeared not to be coping, agency carers were sent in to support EE. But these arrangements never lasted because EE and his informal carer refused or cancelled the services.

EE and his informal carer frequently refused to engage with other professionals too.

2

EE had a history of developing pressure ulcers. In December 2019, EE was admitted to hospital in a neglected state with multiple pressure ulcers. With treatment he made a full recovery but died shortly afterwards from an unrelated cause.

After EE's death, his home was found to be in a very neglected state too.

3

This case did not meet the thresholds and criteria for a full safeguarding adults review.

A multi-agency reflective workshop was held instead to ensure that lessons are learnt and learning embedded.

Learning Points

4

EE's sibling raised concerns about the informal carer's ability to cope. The sibling's concerns were not given sufficient weight.

Several times the informal carer wanted to end his role, but the family increased his pay in response. Every time the informal carer was persuade to stay, professionals wrongly assumed the informal carer would cope. The financial inducements should have been a 'red flag'. A carer's assessment would have identified the difficulties at an earlier stage.

Does your service think holistically about a carer's own history, needs and wishes and how these might affect their ability to sustain care?

5

EE's informal carer was given brief training on pressure ulcer care. However, there were no follow-up checks to ensure the pressure ulcer care was being done properly and no follow-up support offered. In addition, the other professionals were not informed that EE had been discharged from the district nursing service and that the informal carer would be taking over pressure ulcer care.

Does your service routinely notify other services when discharging a patient/service user?

Does your service make follow-up checks after delivering training to informal carers?

6

EE had fluctuating mental capacity due to his physical health and alcohol misuse. He was assessed as having mental capacity to refuse additional care and support but practitioners failed to consider whether the Mental Health Act applied. They could have considered using a multi-disciplinary approach. Just because someone is assessed as having capacity about a specific issue, does not mean services can abandon a high risk situation.

Where someone is refusing care or treatment, does your service consider the full range of legal options?

What is the legal literacy level of your staff? Do they know when to escalate to a multi-disciplinary team approach?

7

Both EE and his informal carer had complex interactions with services. They engaged erratically and often not at all.

The outcome for EE could have been better if risk assessments about the informal carer continuing to care for EE had been timely and detailed.

There was a lack of holistic thinking about the case.

Does your service monitor disengagers?

Does your service think holistically and explore the reasons why someone is not engaging?

Does your service carry out detailed and timely risk assessments when a service user/patient repeatedly disengages?