From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this briefing sheet. It is one way by which we are supporting multi-agency professionals working with adults at risk, or families to learn from practice.

This briefing sheet pulls together key messages arising from local case reviews.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults.

This document includes a feedback sheet to capture how you have used this learning.

The practice briefing will also be disseminated to training providers to ensure content is included within, or informs, safeguarding adults training.

What is a Safeguarding Adults Review?

The SSAB, as part of its Learning and Improvement Policy, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

Mrs L - Learning Review

In this case, a SAR was not commissioned, but similar principles were applied to a Practitioner Debrief and Learning event held with the individuals and organisations involved in Mrs L's care and support that considered information relevant to this case. The key messages contained in this briefing reflect the learning to emerge from this.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Does my organisation have robust policies and processes in place to support the management of medication and transfers between care homes?
- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Key features of Mrs L's Case

- A referral was received by the Somerset Safeguarding Adults Board (SSAB) following Mrs L experiencing a significant deterioration in her health that was linked to her not receiving a prescribed medication following the transfer between two care homes. She sadly died some months later.
- Mrs L was in her late seventies, and the incident occurred when a controlled medicine which she was prescribed was not included with her other medication when she moved from a care home in Somerset to one in another area of the South West.
- The move was due to it being determined that Mrs L needed the support of a specialist provider, and in the period prior to the transfer she was being supported by an external agency which was working alongside care home staff. Professionals considered this to only be a short-term solution to support Mrs L's care while an alternative care provider was identified.
- At least one care home in Somerset was considered, but was not pursued after discussion with her family.
- Mrs L's family felt that the reasons for the transfer were not fully explained to them at the time. There was approximately a 4-month period between the need for a new care home being identified, and the move taking place. However, this encompassed periods of relatively low activity, followed by intense activity once the potential new care home was identified and a Best Interests meeting had been convened.
- Following the move there was a delay in Mrs L being registered with a new General Practitioner (GP), having been deregistered from her Somerset GP. This resulted in a delay in her being prescribed replacement medication.

Key considerations for practice arising from the review

Communicating about changes

- In Mrs L's case the move took place relatively quickly after a Best Interests meeting had been convened, with the intention of reducing her anxieties. This may have created the perception that it was being rushed in the absence of clear communication about the process with her family and likely timescales once there was an option for a Best Interests meeting to consider.
- When considering a change of placement such as this, it is important to ensure that there is appropriate and clear communication about why a change is needed, the proposals and decision-making process with the adult and those who are important to them/involved in decision making.
- This should include giving the adult and those who are important to them/involved in decision making appropriate time to absorb information, and then checking to ensure that those who are not health and social care professionals understand the points at which processes may slow down/speed up, and why. This should be done in a timely way to ensure that nobody feels surprised when this happens, and to also provide the adult and those who are important to them/involved in decision making, with opportunities to consider options and ask questions.

Pre-admission checks

- When someone is moving between care homes, information must always be shared, ideally electronically, by the outgoing care home with the new one under their duty of care to the adult and recorded. This should aways be as early as possible once the arrangements for someone to move to a care home have been agreed in order to allow appropriate planning to take place.
- All care homes should use pre-admission checklists to support staff in ensuring that essential information is gathered about the adult.
- The information provided to care homes in advance of admission must provide a realistic presentation of an adults needs, regardless of whether someone is being admitted to a care home for a first time or, as in Mrs L's case, is moving between two care homes.
- Care homes should be mindful of those times where a new admission may present more risk, for example immediately before a public holiday, and put appropriate mitigations and contingency plans in place for if something goes wrong.
- Both care homes should exchange contact details to be used on the day of the transfer in the event of a problem occurring.

Medication Policy

- All care homes should have a Medication Policy that includes how information about an adult's medications, and the medications themselves, must be recorded and shared if they are moving to a different care home.
- The policy should include information about how any unused medications should be disposed of.

Checking medication prior to a transfer between care homes

- The transfer of any adult, their belongings and medication between two care homes must be seen as a **shared responsibility** by both care homes.
- Prior to the transfer taking place the outgoing care home should check to ensure that there is sufficient medication remaining to cover the time needed to register with a new GP, and agree arrangements to obtain any additional supplies with the new care home if necessary.
- The outgoing care home must share a list detailing an adult's medication in advance of all transfers. This must be no later than 24 hours before the transfer is due to take place.
- Both care homes must be working with the same information about medication. If there is any change to an adult's medication after details of it have been shared then a replacement list of their medication should be issued immediately.
- On the transfer taking place, the outgoing care home must physically check all medication against the list before the adult leaves the care home, with adequate time allowed so that this is not rushed. Where, as in Mrs L's case, a controlled medication is involved, this check must not take place until it has been retrieved from where it is stored securely.

- On the adult arriving at the new care home the medication must be physically checked for a second time against the list that has been provided before it is put away.
- If the outgoing care home finds any medication that has been left, or the new care home identifies any that is missing, then they must notify the other care home immediately. If a controlled medicine is found to be missing then, if following checks, this remains the case then the police should be notified.

Registering with a new GP

- While changes to GP registration are instantaneous, and therefore cannot be undertaken in advance, Care Homes must ensure that they have the information required to complete the adult's registration with a new GP before an admission takes place. The adult must then be registered with their new GP on either the same or, if the admission is after it has closed for the day, the next working day for the GP Practice following the admission.
- All care homes should ensure that they have an NHS email address to enable secure communication with GPs.
- Where, as in Mrs L's case, an adult requires a medication urgently after a transfer has taken place this should be made clear to the new GP as this should enable them to request the details be disclosed by their previous GP under the duty of care element of the Caldicott Principles.

Further information

- Somerset Safeguarding Adults Board: Safeguarding and Medicines Management: Guidance for Providers

Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

Your name	
Organisation	
Date	
This briefing was cascaded to: (e.g. all district nurses; duty social workers etc.)	
This briefing was used in: (e.g. supervision with X number of staff; team meeting; development event etc.)	
Action taken as a result of the learning:	
Other feedback / discussion points	