7 Minute Briefing Safeguarding Adults Review – Mrs E

ROYAL GREENWICH SAFEGUARDING ADULTS BOARD

1- Background

Mrs E was a 82 year old woman with a diagnosis of dementia who lived in a care home. Mrs E condition was worsening and so was given one to one care. Mrs E was left unattended and stsrted to choke, however there was confusion between staff and the nurse in charge as to whether Mrs E was choking or struggling to breath. The ambulance service mangaed to remove a bolus of food from Mrs E airways however on admittance to hospital she was found to have irriversible brain damage and passed away. The coronor held an inquest into the death of Mrs E and conluded an outcome of accidential death contributed to by negelct.

2. Why was this SAR undertaken?

Section 44 of the Care Act 2014 (and the Care and Support Statutory Guidance 2016) states that a SAR must be arranged when an adult in its area dies because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult

3. Findings and Recommendations

Need to improve Record keeping in the care home

Care providers need to ensure investigations are speedy and thorough

Risk feeding guidelines should be followed up after hospital discharge

4. Findings and Recommendations

Care providers to ensure pHR policies shupport recruitment and retention of staff with the right values to care for older people.

Training for staff on the purpose and effect of do not attempt resucitation orders (DNARs)

5. Actions to take

The CCG and RBG undertook a joint choking action plan which resulted in assurances being sought from all nursing homes in the borough.

A review of Speech and Language services was undertaken in the borough.

6. Questions to consider

Are care and support plans updated, clear and accessible?

Are risks to feeding and other risks clearly identified and accessible within the care plans?

Do you understand how to correctly implement a DNAR order?

7. Further Reading

For more informaion and to read the full report and executive summary please visit

www.greenwichsafeguardingadults.org.uk

If you have any further questions

please e-mail

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