WSAB
Worcestershire Safeguarding Adults Board

Learning Briefing

Regarding the learning from the death of Dorothy

Produced by Karen Rees, Independent Reviewer

What were the circumstances that led to this SAR?

- Dorothy was a 77-year-old lady who had severe dementia and her daughter had found it increasingly difficult to ensure she had the support she required to continue living at home.
- After 5 weeks in hospital, Dorothy was placed in the Care Home.
- Following an altercation with another resident Dorothy fell and was taken to Hospital.
- During the journey to hospital Dorothy deteriorated and died 10 days later in hospital.
- A safeguarding alert was raised regarding the incident.
- Concerns were raised regarding the suitability of the care home to manage residents with challenging behaviours.
- Dorothy was CHC funded (under Covid discharge scheme), and the other resident was self-funded. Both had only recently moved to the care home following completed assessments.

REMEMBER: LEARNING CAN OCCUR FROM GOOD PRACTICE

COMMUNICATE and COLLABORATE

Learning was identified in the following areas

- Assessment and Placement of the two people
- Resident on Resident Abuse or Harm
- Caring for Carers

Learning identified	What will help?
Assessment and Placement	Ensure that if you refer to the Emergency Duty Team that you are aware of actions expected and risks of wating until next working day. Ensure that you are clear on the risks of domestic abuse in older people whatever the triggers for violence may be. Assess the here and now risks. Check agreed admission restrictions if you are involved in finding a care home for a person. Challenge your use of labels in recording- are you identifying what you mean by the label e.g. challenging behaviour? Are you evidencing how history informs your current assessment? Have you checked who else is, or has worked with the person? Keep the family up to date and involved with your assessment and progress on finding a suitable care home and how this will be funded. If you are placing out of county check placement with host authority. Ensure you access regular supervision inline with your organisation's policy.
Resident on Resident Abuse and Harm	In your work with care homes, understand and support if appropriate the check the system for recording and managing resident on resident harm. See Mitchell, D. Sheikh, S. & Luff, R. (2021) **Resident-to-resident harm in care homes and other residential settings: a scoping review** by the Social Care Institute for Excellencehttps://www.scie.org.uk/safeguarding/evidence/resident-to-resident-harm
Caring for Carers	Seek to understand family history in order to offer the best support for carers. Offer in depth explanations of available support especially when carers refuse an assessment. Revisit carer support at every opportunity and consider rationale for refusal of support. https://www.carersworcs.org.uk/ Challenge yourself to be int he soes of the carer as a way of understanding needs. Challenge yourself to support self-funding people in the same way as you would those who are partially or fully funded in all aspects of care and support.
Case Study	Reflect on this case within team meetings and reflective sessions. Use in Training where appropriate. Consider what good practice looks like? What works? What were the barriers? What can you do?

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