7 Minute Briefing

Safeguarding Adults Review 'James'

Safeguarding Adults Review (SAR)

James was a 50 year-old man with a learning disability and autism, who died in 2021 as the result of a pulmonary embolism. The Coroner stated that James' death was due to natural causes, which may have been hastened by the effect of confusion around his prescribed medication due to a lack of collective communication between all those involved in his medication.

Sunderland Safeguarding Adults Board (SSAB) commissioned a discretionary Safeguarding Adults Review (SAR) using the SAR in Rapid Time model to identify systems learning - enabling understanding of the social and organisational drivers for current practice problems.

Background

James lived in the family home until he was 18 and then moved through a variety of residential placements in the Teesside area. From 2020 James expressed a strong desire to move to his own flat. He became increasingly frustrated at the time it was taking to find suitable accommodation (exacerbated by the Covid-19 pandemic and availability of suitable provision) and there was a significant and sustained deterioration in his presentation including frequent and significant staff assaults, and significant damage to property.

James moved from a placement provided by the Priory Group in the Borough of Redcar and Cleveland, to a placement provided by Swanton Care in Sunderland in August 2021. James was jointly funded by health (Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)) and the local authority (Redcar and Cleveland Borough Council), with TEWV acting as lead commissioner.

The Review

There was a 4 week transition period leading up to James' move to Sunderland with staff from Swanton Care shadowing those from the Priory Group, however this period was made difficult due to the Covid 19 pandemic and the distance between care homes (36 miles). As a result shadowing took place on seven days across the 4 weeks, and medication administration was not observed by Swanton Care staff. Furthermore, the transition plan

was unclear about who was responsible for what, and lacked a multi-disciplinary approach and neither James' old GP nor his new GP were involved in the plan or process.

During the transition period, James' medication was reviewed and changes were made. Swanton Care were provided with James' Medication Administration Record when he moved, which listed the medication he was prescribed and included:

Mental health medication

Risperidone – An antipsychotic medication used to treat the symptoms of some mental health conditions. In this case it was prescribed for aggressive/agitated behaviour.

Sertraline – An antidepressant medication known as a selective serotonin reuptake inhibitor (SSRI). It is used to treat depression, anxiety disorder, panic attacks and obsessive compulsive disorder. In this case it was prescribed for anxiety.

Pregabalin – An anticonvulsant medication used to treat epilepsy and anxiety. In this case it was prescribed for anxiety.

Promethazine – An antihistamine medication used to relive symptoms of allergies and known to have a sedative effect. In this case it was prescribed for restlessness and agitation.

Physical Health medication

Carbamazepine – An anticonvulsant medicine used to treat epilepsy.

Apixaban – An anticoagulant medication used to help prevent blood clots and reduce the risk of heart attack and stroke.

Atorvastatin – A lipid-regulating medicine, commonly known as a statin, used to lower cholesterol and prevent heart disease, including heart attacks and strokes.

Tamsulosin - An alpha-blocker used to treat enlarged prostate, and occasionally taken to treat kidney stones and prostatitis. Alpha blockers reduce blood pressure by relaxing blood vessels so blood can pass through them more easily.

James was registered with a new GP surgery nine days after he moved to Swanton Care, however as a person ceases to be registered with their old surgery once notification of re-registration is received, and medical records can take up to 28 days to transfer between old GP and new GP, this meant the new GP was not fully furnished with James' medical information - including medical history and medication - for 4 weeks. The electronic transfer of GP record failed in this instance and whilst a patient summary was sent to the new GP, this did not include medication details.

James' psychiatrist sent a letter to the new GP, which listed all of James' mental health medication, but not the medication prescribed for his physical health.

In September 2021 Swanton Care notified the new GP that James was missing the medications Apixaban, Atorvastatin. The surgery advised they had no record of this medication, and a few days later 'NOT NEEDED' was found handwritten on the prescription. On that basis Swanton Care informed the pharmacy that this medication was no longer required , therefore Apixaban, Atorvastatin and Tamsulosin were not administered to James for a two-month period prior to his death.

The review has questioned to what extent care providers and their staff understand the medication prescribed to the people they support i.e. what the medication is prescribed for, the effects of a missed dose, reduction or increase in dose or sudden cessation, the side effects of medication and when to seek medical assistance.

The review has also highlighted the added complexities to transitions when a person moves from one local authority to another.

Family Involvement

James' family were invited to be part of the review and contributed to the final version of the review report, they also chose the pseudonym James. They said that they understood the pressure that all of the people involved with James were under through the process of his move to Sunderland, his on-going care and his final days. The family acknowledged that it could be difficult at times for James to convey his thoughts, feelings and needs to staff in a positive way. The family felt that the people responsible for James' care in both Redcar and Sunderland were hardworking (and most likely overstretched), under pressure and facing conflicting demands. Despite this, the family felt that they did continue to care and never questioned the fact that professionals wanted to do their best for James and had his best interests at heart.

James' family felt that the review had answered the questions and responded to the themes they themselves had identified. They said the report has highlighted the system failures and they maintain some confidence that things will change. However, 'they wait to be convinced that lessons have been learnt, or more importantly, applied.'

Key Learning

Supporting People When Moving from One Home to Another and Responsibilities During Transitions

1. There should be guidance for the different professionals around transition planning for when a person moves from one placement to another. Any guidance should be specific to the role each professional/agency plays in the transition process
2. The above guidance should include the process for transferring information about an individual who is moving from one local authority area to another

3. Transition plans must include plans for ongoing health support and medication, with assurances of continuity and sufficient supplies of medication whilst transferring GPs, and providing a contingency in the event of delays acquiring medication from the new practice/pharmacy
4. Transitions plans should be multi-disciplinary with clarity around the roles, responsibilities and expectations of the professionals supporting the individual

Moving GP Surgery and Transfer if Medical Records for Complex/Vulnerable Patients

1. Social care accommodation providers to ensure that individuals who have moved to their provision are registered with a new GP on the day they move (or on the next working day) to minimise the risk of interruptions to the continuity of healthcare provision
2. Patient summaries should always include a list of prescribed medication and should reflect the 'state of play' from the day before registration ended
3. GP surgeries should be notified in advance when a vulnerable patient with complex needs will be moving to their practice, and to be encouraged to engage in the transition process
4. GP surgeries to consider gathering information in relation to vulnerabilities at point of registration

Seeking Clarification on Prescribed Medication

1. Professionals should have a clear understanding of the roles of psychiatry and general practice, and that the GP is the prescriber of medication
2. The lead partner/commissioner should be clear with everyone involved about how to escalate concerns, and who to contact to seek resolution to issues with prescribing. Social care accommodation providers should seek further clarity from the lead partner/commissioner about this when issues arise
3. Psychiatrists should be explicit in correspondence to patients and other professionals that the list of medications included in any correspondence may not reflect the full list of medication prescribed
4. Psychiatrists should be aware of all medication prescribed by using the Great North Care Record (GNCR) (including that for physical health) in case of contraindications

Verifying Medication Changes

1. Social care providers must verify any apparent changes to medication through formal written communication from the prescriber

2. GP practices to consider a system for alerting GPs when repeat medication for vulnerable patients is not ordered or collected
3. Raise the profile of Electronic Repeat Dispensing amongst social care accommodation providers
4. Social care accommodation providers to consider the use of Electronic Repeat Dispensing
5. Consideration to be given to proxy access to medical records for learning disability care homes

Understanding the Purpose of Medications, Side Effects and Consequences of Missed Doses and Overdose

1. Care providers should ensure that each client's care plan contains a list of prescribed medications which details what the medication is prescribed for, the effects of a missed dose, reduction or increase in dose or sudden cessation, the side effects of medication and when to seek medical assistance

Additional Recommendation

For the Integrated Care Board (ICB) to consider the totality of the recommendations made by this review, share with the Learning Disability GP lead and Safeguarding GP lead to consider the findings and recommendations, and report on how the learning and recommendations will be implemented/communicated out through primary care.