Learning from OSAB SARs: Miriam

Background Information

- Miriam lived within the same community for over sixty years and was an active member of the church community.
- Following a stay in hospital, Miriam moved into a residential care home for a period of rehabilitation before returning home.
- After settling in well, the home reported heightened anxiety and a deterioration in Miriam's cognition.
- Different medications were prescribed by the GP and psychiatrist to address this, some of which had sedative effects. It was then decided that Miriam needed to move to a nursing home.
- The move was delayed, during which time the GP admitted her to hospital as her 'alert, verbal, pain, unresponsive' (AVPU) level was reduced, possibly due to her medication.
- Over the next month, Miriam was discharged to a nursing home but returned to hospital for palliative care. Miriam was 89 when she died.
- The Coroner stated that Miriam's death was exacerbated by high levels of sedation and immobility in the months prior to her death which worsened her underlying frailty.

Communication between GP and Consultant

- Due to the deterioration in her health, multiple professionals became involved in Miriam's care within a short period of time.
- The GP and consultant were responsible for planning her medical care and prescribing her medication and the care home were responsible for administering the medication.
- Miriam was administered a damaging dosage of medication which was not noticed at the time due to poor communication between the GP, consultant, and the care home.
- This is despite the care home records and despite concerns raised by Miriam's family that she was unresponsive.
- This over medication resulted in the deterioration of Miriam's health and mobility.
- Guidance from the National Institute for Health and Care Excellence (NICE): Managing Medicines in Care Homes recommends that GPs should work with other professionals to identify a named health professional who is responsible for medication Reviews of care home residents.

Learning for Teams

- Reflect on the findings and share ideas with the OSAB Business Unit that might help to embed the learning and improve practice.
- How can you support your service to think about how you recognise and manage escalating need? Can we improve how we routinely share information about changes to single-agency care plans?
- Working in the interests of the person being cared for, reflect on ways to work with a family where the relationship between them and professionals has broken down.
- Please help share the identified learning by reading and sharing the Review Report.

Safeguarding

- Before her death several concerns were raised by Miriam's family. There was some confusion about the concern relating to the quality of care provided rather than meeting the criteria for a safeguarding investigation. The review found that safeguarding investigations can feel complicated and frustrating to family members. OSAB have produced a safeguarding leaflet for families to explain the process and how decisions can be appealed.
- The review found that care home staff need to feel able to challenge poor practice through clear and independent whistle blowing procedures.

Miriam's Voice

- There was little evidence of Miriam's voice in her care plan or an understanding of her feelings or wishes.
- Resident's care should focus on what works best for the resident, not the care home and the home and the resident's family should work in partnership.
- There was no evidence that the GP, care home, consultant, and Miriam/her family ever came together to review her care plan or medication.
- Was Miriam happy with her care? How did she feel? How did the medication make her feel?
- Best practice includes setting up regular three-monthly meetings with all relevant contacts to aid ongoing communications and ensure that the voice of the individual has been listened to by all involved and reflected within their care plans.
- The review found that, in the absence of Miriam being able to communicate her own wishes and feelings, those of the people closest to her should have been sought.
- Family observations should be listened to as a key information giver and not dismissed.

Effective Care Planning

- Professionals were asked to document their visits, observations and findings in the care home notes, but they had their own records which they completed instead.
- As a result, it was left to staff in the care home to update the care record.
- Changes in medication were notified by the consultant to the GP and care home, but the GP did not notify the consultant of any subsequent changes they then agreed with the care home.
- The review highlights the need for a single overarching care plan to prevent any confusion or conflict in the prescribing of medication and that care notes completed by staff on behalf of another, must be confirmed by the attending professional.
- Robust mechanism are also needed to ensure primary care keep secondary care updated of changes to a person's care and medication.

Escalating Needs

- Miriam's social worker was from a neighbouring local authority as her care was funded by a different council.
- Cross-border working added an extra layer of communication into the decision making resulting in delays assessing Miriam's changing needs and finding an alternative nursing home.
- Confusion over who was the lead professional meant there was no central point of co-ordination or regular review of Miriam's changing needs.
- Oldham Safeguarding Adults Board have provided guidance about the roles and responsibilities of the Lead Professional which is available on the website.
- The review also recommends that the care home or social worker act as an advocate to ensure a timely response to escalating needs and where there are delays from the commissioning authority, additional support should be sought from the Care Home Quality Assurance and Commissioning Team.

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