

1. What is a SAR?

A Safeguarding Adults Review (SAR) is a statutory requirement in legislation, Care Act 2014. Safeguarding Adults Boards have a responsibility to conduct SARs in instances where it is evident abuse and or neglect has occurred, and the person has died, with evidence of multi-agency working which could have been improved. SARs can also be initiated in instances where the person has not died, but serious harm has occurred.

The purpose of a SAR is to:

Identify improvements to be made to safeguard and promote the welfare of adults at risk.

Identify systemic issues, changes to policy and practice, and to identify areas of self-improvement.

It's also to determine what could have been done differently to prevent serious abuse, neglect or a death.

They are not conducted to hold individuals, organisations or agencies to account.

2. William

William was 81 years old and had been diagnosed with Alzheimer's disease. William required a long-term catheter. William had been married to his wife for more than 50 years together, they cherished holidays and valued time spent with their family. William's cognitive abilities declined, and his mobility became increasingly limited, his wife stepped into the role of his primary carer. In May 2020, at the height of the Covid-19 pandemic, William moved into a nursing home. During his time there, William's health continued to deteriorate, this decline ultimately resulted in his admission to hospital in December 2020. When William was admitted to hospital, he was suffering from a severe acute kidney injury, malnutrition, and serious injuries thought to have been caused by the catheter. A safeguarding enquiry found there were concerns in how William's care and support was delivered, including how his health was monitored and how medical needs were responded to. William sadly passed away in hospital in January 2021. His passing was deeply felt by his family, who had advocated for his well-being throughout his illness.



3. Safeguarding enquiries

S.42 (Care Act, 2014) sets out the purpose of safeguarding enquiries which are to establish the facts, ensure the safety and well-being of the adult at risk by assessing their needs and wishes, and decide what action is required to protect them from harm.

When adults lack capacity to articulate their needs and concerns there needs to be greater emphasis on information gathering from all relevant sources, including family, to clarify what happened and to put an effective safeguarding plans in place.

There is a need to consider whether concerns should be reported to the police. Sections 20 and 21 of the Criminal Justice and Courts Act (2015) highlights that it is an offence for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that other individual

Safeguarding enquiries involving commissioned care providers should involve the Local Authority Quality assurance team and NHS Cheshire & Merseyside ICB where nursing care is being provided.

Information and outcomes should also be shared with the CQC.

7. Resources

Mental Capacity Act (2005) Code of Practice

[mental-capacity-act-code-of-practice-2005](#)

Making Safeguarding Personal

[LGA-making-safeguarding-personal](#)

Management of the complications of long term indwelling catheters

[management of the complications of long-term indwelling catheters](#)

6. Quality Assurance

Liverpool City Council's Adult Social Care Quality Assurance and Contracts Team (QAASU) monitor, and support services commissioned by Liverpool City Council (LCC) to ensure compliance with the quality and performance standards outlined in the service specification and CQC regulations but also support the Council's duties under the Care Act 2014 in relation to market oversight, sustainability and shaping.

As a direct result of the learning from William's death, additional checks were added to the tools used by the Quality Assurance Managers when visiting care homes. Checks that continence care training for staff had taken place and that continence passports were being used for individuals with continence needs were added.

5. Catheter Care

William suffered from 6 UTI's in a month and was found to have urethral erosion (hypospadias) which was considered to be of a result of poor catheter care.

A catheter passport could have improved William's experience. This is a document containing essential information for the care of a urinary catheter, including personal details, catheter type, and instructions for its maintenance and management to prevent infections. The passport includes sections for both the patient and healthcare professionals to ensure consistent care across different settings and to facilitate communication between caregivers, patients, and medical teams.

A catheter passport improves communication, promotes consistency of care, and aims to lower the incidence of catheter-associated urinary tract infections (CAUTIs) and improve overall health and quality of life for the patient.

4. Mental Capacity and decision making.

William lacked capacity to make decisions in relation to his care and treatment. He had appointed his daughter as his attorney to make decisions about his health and personal welfare (Health and Welfare LPA)

Lasting Power of Attorney (LPA) should be formally recorded within adults notes in both health and social care settings. This makes sure that professionals are aware when there is an attorney in place who has been appointed by the person to make decisions for them should they lose the capacity to make those decisions themselves.