ADULT PRACTICE REVIEW – APR3/2016 - SUMMARY

Background:

Adult A was placed in an out of county specialist dementia residential home in February 2013 by Authority A. The residential home was in Authority B's area. Before Adult A's death 3 months later, Adult A sustained three falls at the home which led to an admission to hospital early May 2013. Sadly, Adult A never recovered from the injuries from her last fall and passed away in hospital a few days following admission, the cause of death was recorded by the Coroner was a Pulmonary Embolism, Deep Vein Thrombosis and a Fractured Left Pubic Ramus.

Areas considered during the review were:

- Authority A's involvement in the case and whether or not this was sufficient and appropriate.
- The development of an appropriate care package/plan and the scrutiny of such a package/plan and follow up of actions.
- Any confusion with the ownership of the case.
- The operation of the POVA process, and the communication between agencies (in particular the sharing of information across agencies) in the POVA process. The communication with the family as part of the POVA process.
- Identify whether a safeguarding referral was considered at any point in the month prior to Adult A's death, and if not then why?

Recommendations:

Record Keeping: The care home's record keeping should be improved to provide detailed information concerning the circumstances of a fall. It is recommended that information be recorded about who participated in the communication, what issues were discussed, what actions were agreed and who would be responsible for those actions when communication with family.

POVA process: Whilst the SSWB Act 2014 now places a 'duty to report' on agencies, prior to the Act's implementation in April 2016, agencies were expected to consider safeguarding referrals and to record their rational for not submitting referrals. Legislation has surpassed this recommendation it is hoped that if the same situation arose in the future, agencies would report their concerns immediately.

Format of Strategy Meeting minutes be improved to make them easier to read, and actions from the Strategy Meetings should reflect the decisions made within the meeting. The rational for decision made or conclusions reached in Strategy Meetings is not limited to the 'options' within the POVA Procedures and more detail is provided in the narrative together with reasons/rationale.

It is recommended that all Local Authorities involved in an Adult Safeguarding process attend Strategy Meetings, take responsibility for relevant actions and are part of the decision making process.

Individual/General Protection Plan section is completed to accurately record the general protection plans put in place, even if the individual concerned has passed away.

Communication: Families are supported to obtain information under the relevant access request processes. It is recommended that a leaflet explaining the Adult Safeguarding process be produced, and that a Communication Agreement be created with the Service User and / or their family to agree who will be their lead professional point of contact, the agreed frequency and method of communication.

Guidance be developed to assist providers and commissioners to support the communication between Care Homes and families when difficulties and differences of opinion arise.