ADULT PRACTICE REVIEW – NWSAB1/2017 - SUMMARY

Background:

Adult A was a resident of North Wales and lived in their own home with an adult son who was a registered carer. Based on Adult A`s complex health /social care needs, Adult A was in receipt of direct payments for up to 43 hours a week (managed by the son who also and acted as second carer). Adult A was deemed not to have capacity, was bedbound and appears to have been dependent on carers for all health and social care needs.

There were significant contacts over the years between the family and statutory services (in particular, District Nurses, Social Workers, Occupational Therapists, Specialist Nurses and General Practitioner). There had, over the years been numerous safeguarding reports raised in relation to the domiciliary set up and, at times agency's ability to access the property (in particular District Nursing services). Within the time period reviewed (August 2016 – March 2017), four adult at risk reports were submitted to the host Authority's Safeguarding team by the District Nursing staff which highlighted anecdotal concerns in relation to suitability of the son to care for Adult A. Over the last 12months prior to Adult As death, all agencies note there was significant deterioration in health resulting in a joint package of care under Direct Payments and NHS Continuing Health Care funding. Despite the concerns raised by agencies, Adult A`s health and care needs were not formally reviewed by an MDT.

Adult A was transferred from home to a secondary care unit in England on the 7th March 2017 following multi-agency concerns in relation to the clinical presentation and sadly passed away in hospital on the 28th March 2017. It is important to note that there is no evidence that Adult A`s death was attributable to a direct result of abuse or harm.

Recommendations:

Recommendation 1a: To develop multi-agency guidance for managing challenging families and carers.

Recommendation 1b: To review their training in relation to conflict management techniques for front line staff and supervisors (front line approach to defusing challenging situations with families and carers).

Recommendation 2: To ensure practitioners and independent contractors have received training to ensure that they are aware of the principles of the Mental Capacity Act (including awareness of the code of practices for best interest meetings, power of attorney, court appointed deputies, and general powers within the Act itself)

Recommendation 3: Safeguarding strategy discussions should as a minimum include detail of agency risk assessment and protection plans where there have been significant concerns raised about an adult at risk (these plans should clearly note how agencies plan to mitigate risks).

Recommendation 4: 4a - To have clear process in place for the review of direct payments offered to long term complex cases. This process should clearly detail the review and management of direct payments when there is an increased need of additional hours.

4b - As part of direct payment programme, develop a screening process of the main carer's suitability to care for complex clients where there are significant health care needs (including evidence that full consideration is offered for cases of carer breakdown and how this manifests).

Recommendation 5: 5a – To agree on a process for reviewing joint packages of care to ensure those who have increased needs /complexities are formally reviewed by an MDT – including where appropriate completion of Decision support tool. This process should clearly identify the lead agency (care coordinator).

5b -For episodes where frequent concerns are raised, as a minimum a professionals meeting should be held to identify options for the MDT.

Recommendation 6: To develop a clear process for formal management and clinical Supervision of their staff, ensuring they`re supported in escalating concerns and reduce risk of burn out with complex cases. Where there are concerns that staff are not confident in their approach to safeguarding complex cases the corporate safeguarding team should support bespoke training /offer peer support and supervision.

Recommendation 7: - To identify a lead officer to ensure full implementation of the failed access policy for community services across the region.