Safeguarding Adult Review (SAR) about HM

Background

HM was a 91-year-old woman with a diagnosis of dementia and a number of significant health problems. She lived with her daughter in a 2-bedroomed sheltered accommodation property. As the main informal carer, her daughter provided support with cleaning, finances, shopping and emotional support, but did not provide any direct personal care. HM's care plan included 4 visits a day from 2 carers each time to provide personal care. This was provided by Personal Assistants, employed by daughter using the Direct Payments for care costs she requested. HM was believed to lack capacity to take decisions about her needs for care and support but did not have the services of an external advocate, or appear to be included in assessment of her capacity. HM was identified as showing signs of short-term memory loss described as advanced in January 2015 and severe in April 2015.

Key finding

Direct payments. When direct payments are in place, professionals and organsations must acknowledge their duty of care to ensure needs are being met and any potential safeguarding risks monitored. Personal Assistants should keep verifiable records, including timesheets.

Further reading

If you would like more information on the SAR about HM, please refer to the published executive summary.

To receive information about the Havering SAB's multi-agency training programme

safeguardingpartnerships @havering.gov.uk

Background

In early 2015, HM was admitted to hospital for several short periods but continued to receive care when she was at home. In May 2015, the hoist at the property was assessed by an Occupational Therapist from Adult Social Care as in need need of repair, but the replacement was refused by HM's daughter, so the hoist was never repaired or replaced. At the end of December 2016, after concerns raised by HM's granddaughter, a District Nurse (DN) visited and subsequently made a safeguarding referral to the local authority, having found HM to have 11 pressure ulcers at the advanced stage of grade 4. HM was urgently admitted to a hospice, where she died in early January 2017. The Coroner's report indicated that the pressure ulcers had contributed to HM's death. No concerns had been raised, or medical assistance sought, prior to the DN's visit.

Review

Following the inquest into HM's death, the Havering Safeguarding Adults Board (SAB) commissioned a SAR as key statutory criteria had been met, including concerns about how relevant agencies had worked together to safeguard HM. The SAR was undertaken by an Independent Reviewer and involved a number of agencies represented on the Havering SAB. The review reported in September 2018. The report identified several professional and practice-related improvements to multi-agency systems.

Key finding

Safeguarding concerns, especially when arising in complex situations where preventative measures may be necessary, require multi-agency responses. Different organisational views of safeguarding definitions and understanding about when safeguarding duties apply in accordance with the Care Act need to be acknowledged and addressed. Safeguarding templates need to be intuitive to use, offer prompts where necessary and contain clear wording on key concepts such as capacity and consent to ensure ease of use and application. Care Act duties in relation to carer's assessments – and distinctions between assessments, reviews, re-assessments and criteria for safeguarding – should be clearly communicated to assist collaborative partnership working.

Havering Safeguarding Adults Board

Key finding

Risk, information sharing and professional curiosity. Individual risks to HM were considered in isolation and risk assessments were limited and static. No collaborative multi-agency approaches or information sharing was evidenced. All agencies must improve their holistic risk assessment and risk management, including re-assessment at important points of change such as HM's daughter refusing the replacement hoist. Robust information sharing protocols should recognise the required balance between capacity, informed consent, public and vital interests. Changes to policy and and procedures must be disseminated effectively and referral pathways streamlined to focus on outcomes. Practitioners should be actively curious about risk, caregiving abilities, relationships with Personal Assistants and the dynamic nature of health and care needs requiring ongoing review and re-assessment. Workforce development strategies should include promoting a positive culture of professional curiosity, with a key focus on person-centred approaches.

Key findings

Practice matters (recognising the connection between neglect and capacity). To comply with the Mental Capacity Act, formal assessments must be undertaken and include evidence of how the individual has been involved or observed. People with care and support needs must be offered advocacy to ensure their views, wishes and feelings are represented and to ensure interventions are person-centred. Regardless of a person's capacity, where potential conflicts of interests arise, appropriate advocacy should be obtained. Understanding how neglect and capacity are connected requires inter-agency working and flexible case management. Multi-agency training on these issues would improve recognition and response.

Personal Assistants and Carers would benefit from mandatory training such as provided by the Care Certificate. Training should include pressure area care.

7-minute briefing