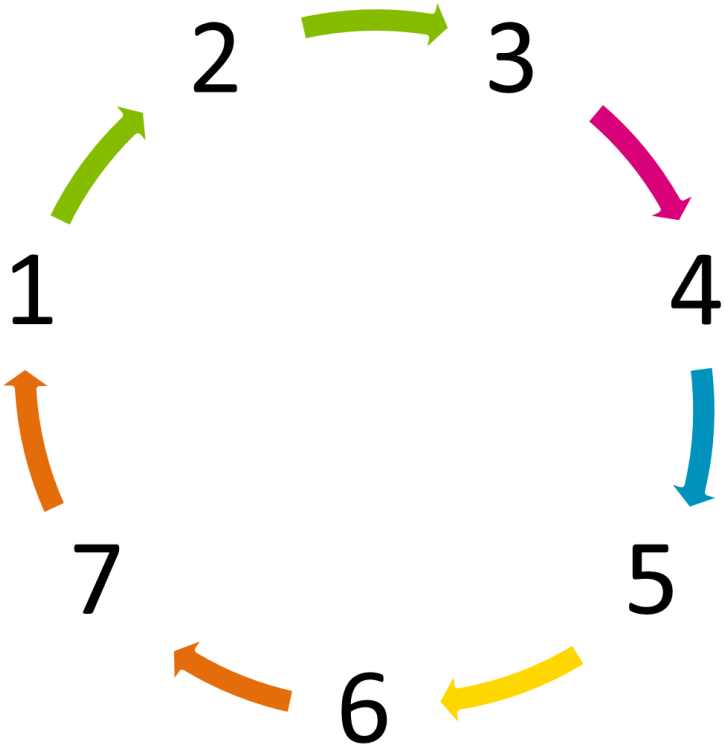



# 7 Minute Briefing: David

## *Safeguarding Adult Review (SAR): David*

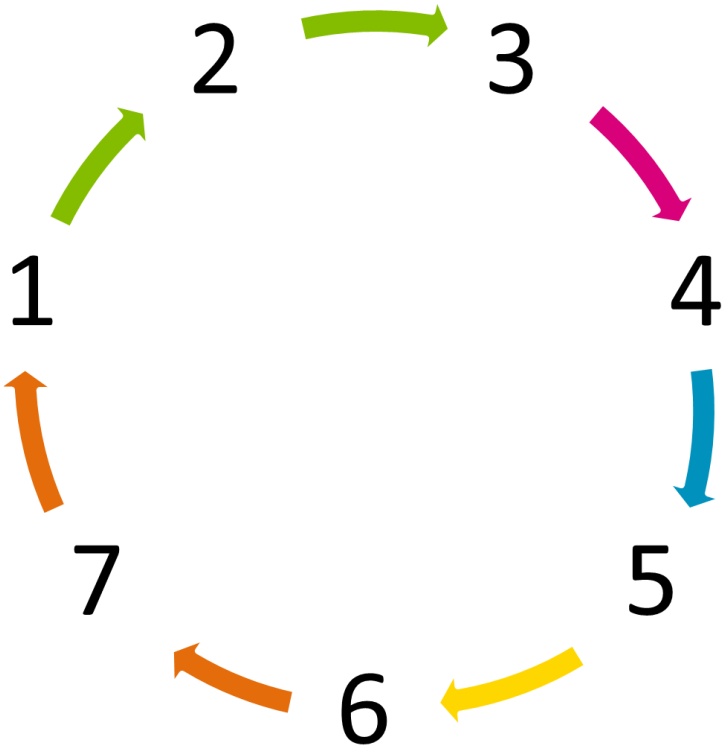
Wigan Safeguarding Adults Board

***Methodology***

The Adult's Independent Chair is consulted on the methodology utilised in any given SAR, and mandates the approach.

The WSAB used a 'Systems Learning' approach in the review of David. This is a model that was introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011. This approach sets out to study the whole system and look closely at what influenced professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice in a more in depth way. The process seeks to be a collaborative process with professionals being actively involved in the review from the outset. The approach promotes reflective thinking as a system to identify the causal factors that influenced practice for which improvements can be made upon.

## Background




***Background***

David was an elderly man who was living with a number of chronic physical conditions, including Ischemic Heart Disease, asthma and COPD. David died in hospital in 2019 of natural causes following a

rapid deterioration in his physical health and his ability to care for himself in his own home. This impacted on his wellbeing.

*The main themes within the case are:*

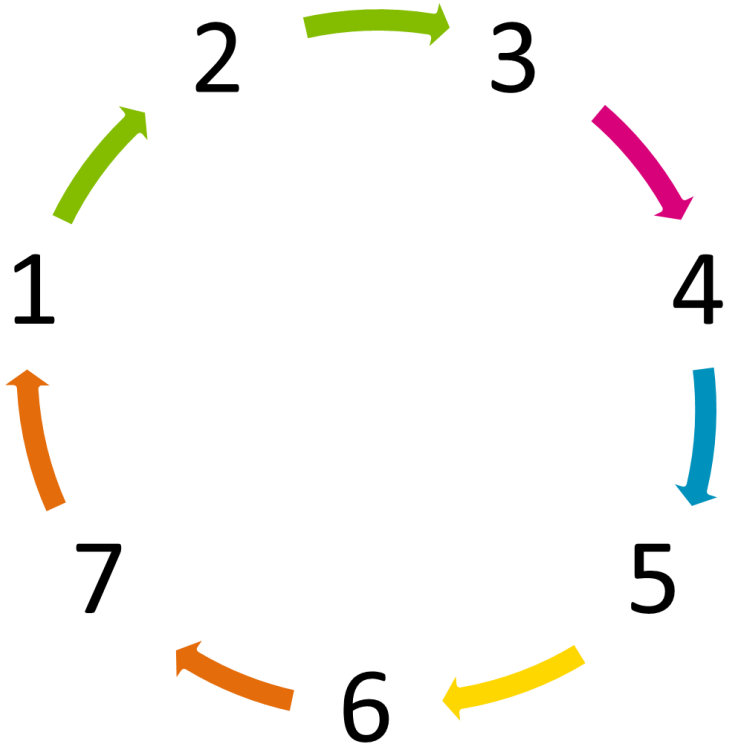
- Informal carers
- Self-neglect
- Pressure Ulcers

*The main learning themes from the review are captured within Key Lines of Enquiry and in this case include:*

1. Informal carers
2. Self-neglect
3. Safeguarding processes

Learning points were identified through the case review, highlighting areas of learning and improvement.

## 1. Informal Carers




***Informal Carers***

- **Assumptions were made regarding David's carer; her relationship with David and her understanding of the role and responsibilities:** Whilst David had support from a friend, it was not clearly understood to what degree this was a carers relationship. A carers assessment was offered but declined. David referred to the friend as partner, whilst the friend viewed the relationship as a friendship where she assisted with shopping and other low-level tasks. They did not live together. As David's ability to care for himself decreased, his care needs were not being met, resulting in crisis responses.

The initial supported self assessment in February 2018 involved David and his friend/carer, and made reference to the support that she provided to him. This resulted in an assessment of all needs being met and subsequently no package of care was commissioned at this time. Despite David's friend/carer being identified as a carer by adult social care, she was not recorded on the case management system as such. This resulted in the absence of safeguards against change in circumstance, of both David and the friend/carer, for example, notifications of periods of unavailability of the carer, such as holidays.

In February 2019, an urgent support plan request was triggered by David's friend/carer requesting support, reporting that she was struggling to cope. The package of care commissioned to support David at this time was based on a telephone conversation between a social care officer and David who reported positive levels of support from his carer, however this information was not confirmed with the friend/carer. It was apparent during the case review that David over-reported the levels of care being received. The package of care provided was based on face value of what the friend/carer suggested at her point of contact, and did not reflect the wider needs of David (3-visits weekly). There was a missed opportunity at this point to offer a carers assessment again, and to establish what support was, or was not in place.

Within the first 6 visits, the home care providers delivering the package of care reported concerns regarding the welfare of David and were supporting him above the commissioned package. At this point (2-weeks into the commissioned support), a safeguarding response was initiated when David was admitted to hospital due to pressure sores. It was at this point that Adult Social Care became aware of the friend/carer being abroad on holiday. David was discharged from hospital with an increased package of care (3-visits daily). The 6-week initial review of this package of care did not take place due to a rapid deterioration in David which resulted in his further admission to hospital where he subsequently died.

*Making a difference:*

**Informal carers' input defines the package of care in place, therefore the informal carers role should be fully understood by all parties and supported in their role:**

*> Quality assurance of the carers assessment and resulting care plans, the conversation leading to it and how it is recorded on systems is needed to take account of the following key issues:*

*- The conversation offering a carers assessment should promote the importance of it as a supportive tool*

*- The care plan should reference the conversations taken place with the carer regarding their understanding of the caring role, the expectations of this role, and outline a process to follow if circumstances change*

*- Informal carers should be recorded as such on the case management system*

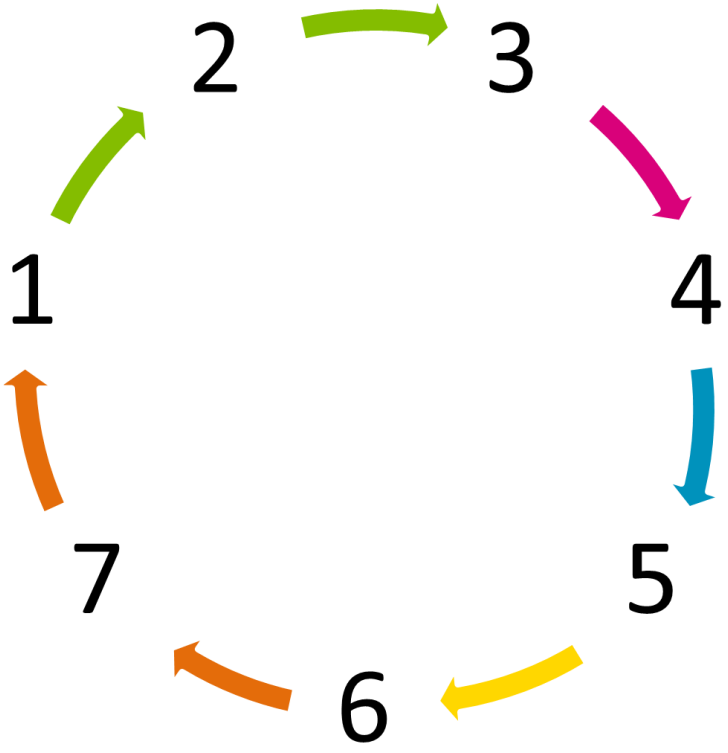
*- If carers assessment declined, evidence that professional curiosity is applied to ascertain why and whether information relating to support and signposting (Carers Centre) has been provided.*

*- Ensure a carers assessment is re-offered at review of Social Care Assessment if not previously accepted*

*> Adult Social Care to develop a Quality Assurance framework and to include a focus on ensuring the quality of urgent and desktop assessment and support plans. Monitoring and oversight to be included as part of the Adult Social Care Assurance Framework, within the Achieving Excellence Board*

*> Adult Social Care to establish a risk stratification approach to undertaking care plan assessments and reviews and embed within practice.*

## 2. Self-Neglect




***Self-Neglect***

- **David had low levels of engagement in terms of accepting help, or conversations regarding this**

Home care providers reported perceived non-engagement regarding personal care which was not recognised as self-neglect, in part due to over reliance and assumptions on the friend/carer.

Experienced formal carers were able to engage David by employing a range of different tactics.

- **Self-neglect and deteriorating health issues**

The self-neglect presented when David's health starting rapidly declining. It is unclear what degree was self-neglect, and what degree was resultant from unmet health needs.

- **Self-neglect and capacity**

David was considered to have capacity but there wasn't a full mental capacity assessment to confirm this in relation to his detrimental decisions relating to his health.

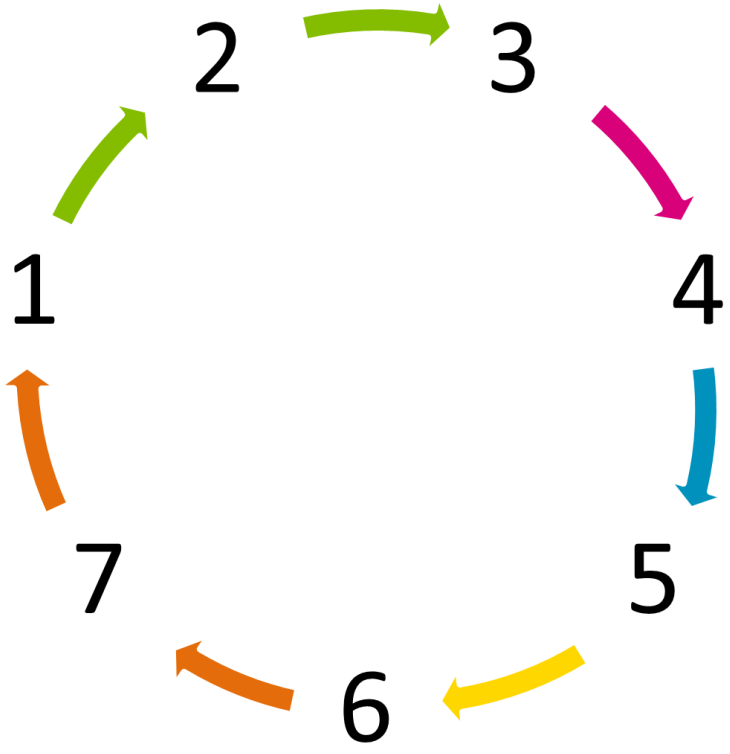
*Making a Difference:*

*> The Self-Neglect Pathway has been developed locally to support the risk management of self-neglect cases when required and there is a workforce development programme across the partnership to raise awareness in the identification and response to self-neglect.*

*> There is an ongoing programme of training in relation to mental capacity assessment as well as reference within a self-neglect context within local self-neglect training.*

*> Engagement approaches that are known to enable professionals in the support of an individual in their care needs should be documented within their care plan and shared with all practitioners delivering care and support to the individual*

## 3. Safeguarding Processes




**Safeguarding Processes**

- **Missed opportunities to raise a safeguarding concern**

An admission to hospital in December 2017 triggered an Adult Social Care referral for assessment (NWAS). During the 2-month wait for the assessment, a contact was received by Adult Social Care from the Community Link Worker Team who had ongoing concerns for David. The contact was chasing the allocation of a social worker for assessment of David's needs. The Community Link Worker Team were involved as a result of David's GP referral, following a phone call from David in January 2018 reporting that he was lonely. It did not appear that this was considered by Adult Social Care during the assessment of need.

Within the 2-weeks of the commissioned package of care starting in February 2018, the home care providers reported concerns regarding the welfare of David and were supporting him above the commissioned package. There was a missed opportunity to respond under safeguarding as this was not logged on the case management system appropriately.

In December 2018 the chemist flagged that David had not accessed his prescription for 5 weeks, stating this to be a safeguarding issue, however this was not formally raised as a safeguarding alert by either the GP or chemist.

There were multiple points within this case where key information was held within case notes that are not as easy to access and resulted in some information being overlooked. This included known communication barriers, which would have indicated a face-to-face visit opposed to a telephone call.

- **Notification of Discharge**

The care plan on discharge from the first hospital admission in March 2019 included delivery of Pressure Ulcer care via District Nurses attending David's home, however the District Nurse's were not notified of his discharge. This oversight occurred due to the Duty Team case managing David through the safeguarding pathway and implementing the urgent support plan. As such, the discharge did not follow the usual pathway via the Hospital Discharge Team. Also, as a result of this, David was not seen by Adult Social Care. Furthermore, David was discharged home without the relevant discharge papers.

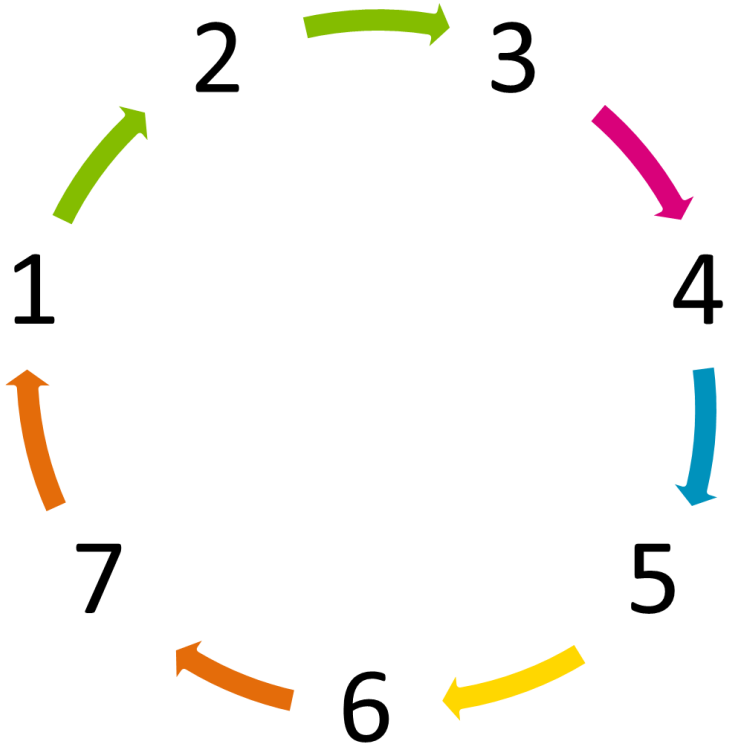
*Making a difference:*

*> Transfer of Care Hub Social Worker to retain all cases for 6 weeks and until first care plan review and before hand over to Adult Social Care Locality Teams*

*> Clarify the safeguarding referral pathways within primary care regarding missed prescription medication collection notifications from pharmacies*

*> Utilise the Safeguarding Tier Model and training to establish mechanisms between care providers and Adult Social care that ensure that safeguarding issues relating to both non-compliance or care plans that need reviewing urgently are responded to*

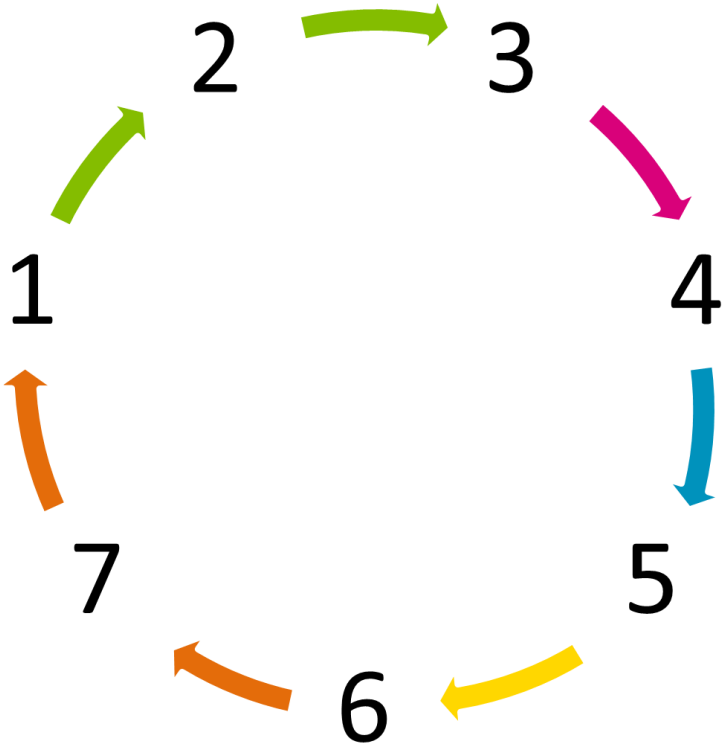
## 5. Good Practice




**Good Practice**

**The Home Care Provider displayed good practice when they were unable to access David's property on a planned visit;** they triggered an escalation process despite this not being a part of David's care plan due to their ongoing concerns for his welfare and the level of commissioned support.

## Practitioner questions to consider



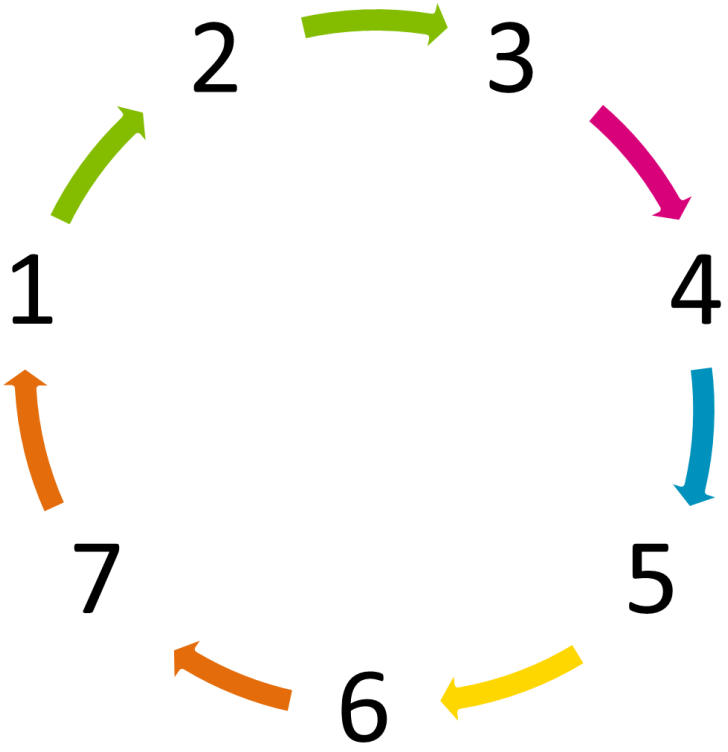

1. ***Have you established the carers understanding of responsibilities and expectations by undertaking a carers assessment?***

2. ***Have you considered the wider context of the individuals needs across health and social care, taking account of expected risks?***

3. ***Is your organisation aware of up-to-date next of kin and contact details?***

4. ***Are you aware of other agencies involved in care plans for the individual, and the extent of their involvement - without assuming levels of care provision?***

## Want to learn more?




**Carers Centre:**

Wigan and Leigh Carers Centre (wlcccarers.com)

**Self-Neglect / Perceived Non-Engagement:**

Understanding non engagement with services (wigansafeguardingadults.org)

**Evidence Led Practice:**

Matching interventions and people: A decision-making tool (scie.org.uk)

NHS England » Ageing well and supporting people living with frailty

NHS England » Healthy ageing and caring

supporting-adult-carers-quick-guide.pdf (scie.org.uk)

Overview | Supporting adult carers | Quality standards | NICE

**WSAB Training:**

WSAB Training Brochure 2021 (wigan.gov.uk)