7 Minute Briefing: George - for all Practitioners Working with Adults, Children and Families

The full report for this SAR is not yet published due to a criminal trial scheduled in early 2021

Visit www.walthamforest.gov.uk/strategicpartnerships for resources

Strategic Partnership Boards
SAFETY SAFEGUARDING WELLBEING

01 What is a Safeguarding Adults Review? (SAR)

A review that has to take place when an adult with care and support needs is seriously harmed or has died due to abuse and/or neglect and there is concerns about how agencies have worked together.

In Waltham Forest we take a Think Family approach and look at system level learning so we can understand how we need to change the system/s under which practitioners work to improve practice in the future

The purpose of a SAR is to look at **what happened / why / what action** will be taken to improve practice as a result of the review's findings.

02 What Happened?

George is a 93 year old man who lived in his own accommodation. He had several on-going health conditions including a colostomy bag following colon cancer. He was suspected to have dementia, awaiting an assessment. George received support from several agencies including home care and was known to various health services.

A friend helped George day-to-day and become an informal carer and raised concerns about George's ability to live independently. This friend sadly passed away in January 2018.

On the 4th of December George phoned the police thinking he may have been burgled. The police found him in a severely neglected condition and he was taken to hospital by ambulance. Since then he has moved to a 24 hour care home where he is now thriving.

03 First Finding

A lack of communication, coordination and escalation within and between agencies.

Communication is an essential aspect of care delivery for all health and social care professionals. George was known to community health services. A lack of escalation and coordination in relation to Georges changing health needs was apparent. References to changes to George's care and support needs that were not communicated to other professionals or agencies other that the informal carer David.

What needs to change? .

- Create a 'Team around the Person' Meeting with the individual and invite key agencies who may need to be involved, have a joint and open discussion about a support a plan.
- Ensure you are familiar with the escalation letter, and escalate any concerns or decisions you are not comfortable with.

04 Second Finding

Recognising and reporting Mental Capacity and Fluctuating Capacity was not evident.

Consent and the capacity to consent should be at the forefront of all health and social care intervention, with the same principles applying to a routine daily activity as to a major life changing event. It was reported by practitioners that George had capacity and consented to health and social care interventions. However, it was also identified that he also often presented as having diminished capacity particularly in the afternoon and evening, there was a lack of documentation and notes to evidence this.

What needs to change?

- Familiarisation with Mental Capacity assessments within your organisation;
- Ensuring Mental Capacity Assessments are carried out frequently and routinely;
- Recognition of fluctuating capacity and ensuring changes are recorded and communicated.

05 Third Finding

Practitioners to ensure the right care is in place when a person is admitted to hospital with care and support needs.

George had three unplanned hospital admissions and on each case his care package was resumed without change on his discharge. George had a lack of co-ordination for his care and support and risks between practitioners were not shared.

What needs to change?

- Ensure the communication between the discharge team and Adult Social Care is consistent;
- Referral to social care when in hospital so assessments can be carried out.

06 Fourth Finding

Practitioners to ensure Risk Assessments and Contingency Planning are carried out.

It is important for services to recognise and support informal carers. A carers assessment for George's friend took place, but no risk assessment was carried out. When George's friend was unable to continue his care there was a rapid deterioration of George's home condition and self-care.

What needs to change?

- Ensure robust risk assessments and contingency plans are carried out;
- Show professional curiosity to ensure an informal carer has all the support they also require.

07 What to do next?

- Familiarise yourself with 'A Guide to Thresholds and Practice for Working with People, Carers & Families in Waltham Forest'
- Watch the bitesize video guides on:
  - * Adult Threshold Guidance
  - * Professional curiosity
  - * Making Safeguarding Personal
- View the spotlight on Carers
- Review all the Strategic Partnerships resources to further your learning.
- Reflect on how the findings connect with areas of your direct practice with families or other practitioner:
  - * Think about what changes in practice you could make now to embed the learning
  - * Share this briefing in your next team meeting, with your manager/management team, in your next multi-agency meeting etc.
  - * Access the links and resources in this briefing.