1 Background

A Concise Adult Practice Review was commissioned by Gwent Safeguarding Board in accordance with the Social Services and Wellbeing (Wales) Act 2014 Guidance for Multi Agency Adult Practice Reviews

Adult A was found deceased during the morning by two carers who were conducting a home visit. Adult A was found in an unnatural position with her arm caught in the bed rail.

Due to a report of a sudden death, the Police attended the scene, and a referral was submitted to the Local Authority by the care agency. Adult A's family raised concerns to Police around the suitability of equipment, which they stated they had reported previously to Social Services.

Diogelu Gwent Gwent Safeguarding

7 Minute Briefing

Concise Adult Practice Review

2 Background

Following a number of enquiries, a multi-agency strategy meeting was arranged. It transpired that the equipment documented on the Occupation Therapists (OT) WCCIS notes, was different to what was supplied to Adult A.

It was the opinion of the OT attending the strategy meeting that the equipment in the photograph was different from what they had requested. It was similar but not what the OT expected to see in the photograph. It is possible that had the equipment been as requested, Adult A would not have been able to get her arm trapped/caught. The equipment would have had a solid partition and not open rails. Adult A only had use of her left arm, and this was the arm, which caught in the bed rail equipment.

3 Identified Themes

- **Assessments:** There appeared to be a lack of ownership from all agencies both statutory and independent services and it was not clear whose responsibility it was to coordinate, communicate and holistically assess the changing needs of Adult A.
- **Information sharing & Silo working between individuals/professionals/agencies.:** Different methods of record keeping were confusing and did not aid communication and the sharing of key messages.
- **Differing Terminology** can be a barrier in effective communication and information sharing. For any agency attempting to understand each other's abbreviations, caution should be taken to ensure that the correct interpretation is used and not assumed.

4 Identified Themes

- **Roles & Responsibilities:** In Adult Social Care, the care plan is not managed by one person. Some professionals are involved for short periods of time so it can be difficult to identify a lead person responsible for the care plan.
- **Impact of COVID:** The pandemic had a detrimental impact on services. There appears to have been a reliance from all statutory agencies on the carers to manage Adult A's needs.
- **Training & referrals:** It is unclear if independent carers are given the training and resources needed to understand the holistic, longer-term indicators of deteriorating health and wellbeing A referral would have been required to request another assessment, and this did not occur.
- **Voice of the service user:** There is a sense that there is too much focus on equipment and process as opposed to hearing what Adult A and her family were asking for and what mattered to them.

5 Learning and Actions

- **Communication book/ virtual log:** Where different mechanisms of recording exist, consideration should be given to keeping a communication book/ virtual log that all agencies and families can access to ensure timely information is shared.
- **Roles and responsibilities** in relation to falls and indicators of deteriorating wellbeing when working with people in the community, should be clearly understood
- **Escalation of key incidents** Commissioners should consider the escalation of key incidents from external providers to case managers is part of the core contract requirements. There should also be assurance of escalation and communication processes in the community with all agencies taking ownership. These processes must evidence that they include the partner agencies, the family and the person at risk.

6 Learning and Actions

- **Care coordinating.** When a multi-agency package of care is in place consideration should be given to appointing a key person/Lead professional who is responsible for coordinating the care.
- **COVID:** Agencies and Local Authorities to contribute to the regional and national review of COVID responses and to be cognisant of the recommendations when published.
- **Disruption of Service provision:** All agencies to consider reviewing their communication to external partners, service users and their families when service provision is being affected by external factors (health pandemics, severe weather etc).
- **Voice of the Service User:** All agencies to be reminded that families and citizen should be included in conversations and communications about their developing care needs.

7 Positive Practice

- **District Nurses -** Visiting regularly and consistently and were completing care plans during their visits. Appropriate diagnosis of moisture lesion by an experienced Sister. Consent was regularly gained from Adult A prior to checking areas/wounds, completing observations. They communicated with the family. Body map / skin checked each visit. Notes stayed with Adult A in her home for others to access.
- **Review & Assessment**– Following a report of confusion in July 2019 the Social Worker arranged a timely review. The CPN and Social Worker undertook a Capacity Assessment. A letter with Care and Support Plan and Review was sent to the family. Annual reviews arrangements are confirmed, and the care package continues 4 times a day. There were lockdown contingency plans made between Adult Services and the family.

To access the full report please visit the Gwent Safeguarding Board website and search for adult practice reviews using the identifier GWASB 2-2020
www.gwentsafeguarding.org.uk