Diogelu Gwent
Gwent Safeguarding

7 Minute Briefing

Title: Adult Practice Review GWASB 1 2017 – Resident A 2019

Summary of Recommendations:

- Care Homes should have clear and appropriate policies and procedures
- Responsible Individuals must ensure the 'Clinical Lead' is suitably registered and experienced
- Sufficient staffing should be in place and risk assessments completed where there are gaps, those risk assessments to be made available to CIW, LA's and CHC Commissioners
- Gwent Safeguarding Board to consider good practice exemplars across the sector
- Training for DoLS
- Safe recruitment processes
- Clarity for families to raise concerns and complaints
- Improved communication with families to support their rights

See full practice review for full recommendations

Introduction

A concise Adult Practice Review was commissioned by the chair of the Gwent Wide Adult Safeguarding following the death of an 82 year old woman known as A. This lady was a wife, a mother, a grandmother and a great grandmother, A, along with her husband, was the centre of her family and community. She was greatly loved and respected. A mad the best "welsh cakes". A had been married to her husband for 50 years. A was diagnosed with Alzheimer's and had other health conditions. During hospitalization following a fall at her home the family were advised that her care could no longer be managed safely at home and she was admitted to a care home on the 3rd March, 2015.

Background

Between the 3rd March and 13th April 2015 A experienced 9 falls and despite varying levels of mobility and pain it was not until 23rd April 2015 that a GP saw her and arranged an x-ray - she had fractured her neck of femur. An Adult Safeguarding investigation concluded Neglect was not found on basis of probability. The incidence of falls continued.

In January 2016 A experienced two falls in 24 hours. Following her first fall she was seen in A&E, clinical signs did not indicate a CT scan of the head was needed. A returned to the care home, where it was noted that her speech and movement was "different". Following the second fall an intracranial bleed was identified and A was documented as being "not for intervention". A passed away on the 16th January 2016 surrounded by her loved ones.

Key Learning – *Loss of Dignity – Empowering Family*

Within 3 weeks of entering the care home A had lost her false teeth, Photographs show the deterioration in her presentation and wellbeing with no services to address significant weight loss, chiropody needs or hairdressing. Particularly for the family A being sent to hospital in a nightgown with no underwear, an incontinence pad tucked between her legs was distressing and humiliation for her, should dementia not have robbed her of her understanding. A's husband and family have some good memories, however these are overshadowed by their feeling of frustration at the care their loved one received and their lack of inclusion. Complaints were made but the family were not equipped with knowledge to understand their rights and A's rights, to access the Safeguarding Processes and who had responsibility for her care. The family's experience of inclusion and care from hospital staff in A's final days only highlighted to them the poor experiences elsewhere.

Key Learning – *Sharing of information*

Whilst there was some evidence of clear meaningful recording/case notes by the care home staff, the lack of a consistent framework for recording information and sharing information with family and professionals led to a lack of a narrative in relation to A's life and care needs within the care home. This resulted in poor handover processes, GP's and CHC not being made aware of the number of falls A had and so medical risks were not fully assessed.

Key Learning - *Professional Responsibility*

No one was responsible for the collation and management of information which would give a narrative, nor understand developing health needs, or management of risk. This was identified from staff on a daily basis, lack of management response to staff issues, and failure of professionals to raise issue i.e. use of "stair gates" to restrict peoples liberty and ensure DoLS was in place.

Key Learning - *Policy and Risk Management*

The homes "Falls" Policy was not robust nor consistently related to best practice. Procedures for undertaking clinical observations post fall were limited, and without clarification in relation to what constituted a "fall, slip, trip, unwitnessed fall, lowering self to ground/floor" it was again difficult to understand A's experiences and to manage Risk. Whilst policies were introduced in 2016 training and compliance are key issues.

You can access the full APR report from Gwent Wides Safeguarding Adult Board Website.