Diogelu Gwent
Gwent Safeguarding

7 Minute Briefing

Title: GwASB 2/2019 Adult Practice Review

Summary of Learning Themes:

- Ensure assessments, monitoring & review of individual's needs and risks are consistent with the care actually provided.
- Evaluate the care actually provided corresponds to the care contracted for.
- Consider and balance the care provided on trust with the need to assure compliance with care regulations
- Ensure the training of care staff corresponds to the needs of the individual being cared for, accounts for any specific risks identified and is evaluated on inspection.
- The Police response to an un-explained death is revised to include notification to a public protection supervisor and in their absence to the Duty Detective Sergeant

See full practice review for full recommendations

Introduction

A concise Adult Practice Review was commissioned by the chair of the Gwent Wide Adult Safeguarding Board following the death of a 67 year old gentleman hereafter known as A. He was described by people who knew him as a lovely person with an infectious laugh, a character and "you knew when he was in the room". He relied on the care of others for all his care needs. He had a learning disability and several other long-term conditions. He lived in his supported living placement since 2010 with one to one care support.

Background

In 2015 A was referred for an assessment around his ability to eat and drink safely and an Eating and Drinking Plan was produced. A's needs around eating and drinking comprised having his food cut up, close support and supervision, verbal prompts and consistent staffing arrangements. Within the supported living placement as time passed this close support appears to have been replaced by less strict, but un-described, monitoring arrangements. In March 2017, a choking episode occurred at a local supermarket restaurant; A was checked out by his GP but the incident went un-reported by the care provider to either the commissioner or regulatory body. A risk assessment identified the probability of his choking as low due to the presumed supervision at mealtimes and the severity as catastrophic if he did choke. A had a further choking incident in December 2017 that resulted in his death.

Key Learning – Sudden Deaths in Care Environments

PPU Detective Sergeants, and in their absence the duty Detective Sergeants, should be notified of any deaths in care homes, to make an assessment of whether a Detective resource is required. Attending Police Officers are to be aware of the existence of care plans and should make reference to it in the report to coroner form.

Key Learning – Assessing Risk

There was good evidence in assessments and risk assessments that the choking risk was known and well understood. The Eating and Drinking Plan was detailed and simply written and appeared to have been widely shared. The WARRN risk assessment assessed the risk of choking as unlikely but catastrophic if it occurred. There was limited evidence of the understanding of his mental capacity and his ability to evaluate the consequences of his wishes.

Key Learning – Ensuring Care is Provided

Although the system of reviews by social care and health professionals, contract monitoring by the local authority, regulatory visits by the Regulator and feedback from family members provides a degree of assurance of the quality of care provided, the current system relies on a degree of trust that contracted care providers will provide quality and safe levels of care, informed by care and risk management plans.

The responsibility for providing A with safe levels of care within the supported living placement lay with the domiciliary care provider.

There did not appear to be a professional curiosity to identify whether care arrangements were being followed, whether the provider's stated practice changed the identified risks and whether overall it was a good enough care environment for A.

Key Learning – Care Plans & Management of Risk

The care and support plan that supported the commissioning of A's care in his supported living placement identified his need for help with nutrition and fluid in-take. The Eating and Drinking Plan was clear on how this should be done. This was supported by advice and guidance from the Speech and Language Therapist.

The care provider's service delivery plan contains this advice but adds the phrase that staff should supervise "wherever possible". There is no evidence to suggest this plan was seen by the commissioner of the service or by other professionals. The care provider's staff fed back to a multi-agency review that they were not providing close support due to A's preferences. There is no indication that this was challenged or triggered a review of A's care needs.

You can access the full APR report from www.gwentsafeguarding.org.uk