Shropshire Partners in Care
The Care Workforce Development Partnership

Safeguarding Adults Forum

January 31st 2018

NHS Telford and Wrekin Clinical Commissioning Group
a co-operative council
Telford & Wrekin Council
NHS Shropshire Clinical Commissioning Group
Shropshire Council

Agenda

Introduction from safeguarding adults forum organisers *(Karen Littleford)*

Introduction to the Forum & Agreements *(Karen Littleford)*

Learning from the analysis of the 27 London Safeguarding Adults Review's *(Paul Cooper)*

Update on Safeguarding Adults Board Websites & Phone Numbers *(Karen Littleford)*

Good capacity assessments: how to and how *not* to do an assessment of capacity *(Marion Kelly)*

Record Keeping (Themes and Trends Across our Patch) *(Kathy George)*

NICE - Sepsis: Risk stratification tools *(Kathy George)*

‘Making Waves’ for Dignity.

Staff from the Social Care and Health sector in Shropshire and Telford and Wrekin attending a Safeguarding Adults Forum organised by Shropshire Partners in Care, Shropshire and Telford and Wrekin Clinical Commissioning Groups and Local Authorities prepared to mark National Dignity Action Day (February 1st 2018) by ‘Making Waves’ for Dignity.

Kathy George, Telford and Wrekin CCG said “We want to encourage everyone to participate and celebrate dignity by joining in with us by creating a wave as a signal of our support” so we did!

Click the link to watch the video on twitter
https://twitter.com/SPICnews/status/958717771298328576

Introduction to the Forum & Agreements

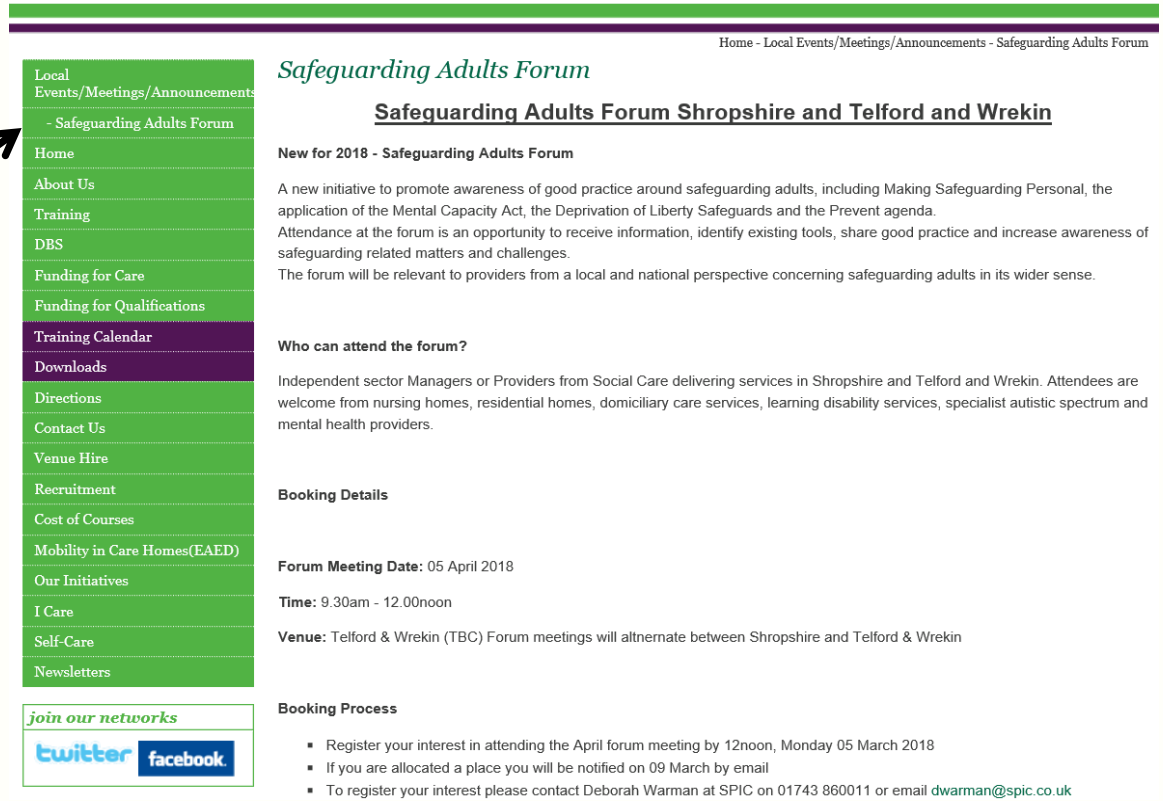
Karen Littleford,
Safeguarding Adults Lead,
Shropshire Partners in Care

The purpose of the Safeguarding Adults Forum is to promote awareness of good practice concerning safeguarding adults, including the application of the Mental Capacity Act, the Deprivation of Liberty Safeguards and the Prevent agenda
(SA Forum ToR, 2018)

Engagement with the Forum

Communication outside of forum meetings:

Visit the SPiC website to access signposting Materials



SPiC Website -
http://www.spic.co.uk/

Safeguarding Adults Forum page
http://www.spic.co.uk/local-events/safeguarding-adults-forum

Forum Questions

Karen Littleford, Shropshire Partners in Care
klittleford@spic.co.uk
01743 860011

Shropshire Partners in Care
The Care Workforce Development Partnership

Learning from SARS: A Report for the London Safeguarding Adults Board

Paul Cooper

Head of Adult Safeguarding

Shropshire Clinical Commissioning Group

Link to Report

http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf

LEARNING FROM SARS:
A REPORT FOR THE LONDON SAFEGUARDING ADULTS BOARD

SUZY BRAYE AND MICHAEL PRESTON-SHOOT
18th July 2017

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Safeguarding Adults Boards must arrange a SAR when:

- An adult in its area dies of abuse or neglect, whether known or suspected **AND**
- There is concern how the SAB or member agencies or those with relevant functions worked together to protect the adult

- An adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Care Act S44.1-3

Safeguarding Adults Boards "free to arrange" a SAR when:

- The SAB feels it would provide useful learning from "near misses"
- Situations where the arrangements worked especially well.
- Any other circumstances of the SAB's choosing

SAR Requirements - the SAB must:

- Publish each SAR's Terms of Reference 14.166
- "Determine locally" the modus of SAR 14.170
- Complete within 6 months 14.173
- Consider publication of the report 14.179
- Publish findings & actions in Annual Report 14.177

Summary of London Report

- Looked at 27 SARS from 30 London Boroughs
- From April 2015 to April 2017
- Ethnicity in majority not included
- **50% SARS were of people in residential care. 58% in Hull Review**
- **Organisational Abuse** – highest category [9]
- Self neglect – 2nd highest category [7]
- In 75% of the cases the adult died

"**Organisational abuse** is the mistreatment, abuse or neglect of an adult by a regime or individuals in a setting or service where the adult lives or that they use. Such abuse violates the person's dignity. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

A number of inquiries into care in residential settings have highlighted that organisational abuse is most likely to occur when staff:

- receive little support from management;
- are inadequately trained;
- are poorly supervised and poorly supported in their work;
- receive inadequate guidance;

Or where there is:

- Unnecessary or inappropriate rules and regulations;
- Lack of stimulation or the development of individual interests;
- Inappropriate staff behaviour, such as the development of factions, misuse of drugs or alcohol, failure to respond to leadership;
- Restriction of external contacts or opportunities to socialise."

http://www.keepingadultssafeinshropshire.org.uk/media/1008/west-mids-adult-safeguarding-information.pdf

Methodology Used

- Chronology and IMR [9]
- SCIE systems model [6]
- Hybrid or custom built [12]
- Period under review ranged 2 weeks to several years
- When adult still alive [0] were involved
- For those deceased 50% involved family
- Other 50% declined

Major Findings

- When discoverable only 2 completed within recommended 6 months
- Length of report varied from 2 to 98 pages
- Number of recommendations varied from 3 to 39
- Only 8 published
- 21 reports involved issues of capacity
- MCA most frequent learning area for direct practice

Four Learning Domains from the Review

- Quality of direct practice by workers
- Agency factors that affect practitioners
- Inter professional and inter agency practice
- SAB's governance role

Quality of Direct Practice by Workers

- **Missing or poor capacity assessments**
- Absence of Best Interest decision process
- Poor risk assessment – escalating risks
- **Making Safeguarding (MSP) failings from both ends**
- Poor involvement of family
- No curiosity about and context of behaviours
- Lack of assertive engagement
- Focus upon relationship

Agency Factors that Affect Practitioners

- Records: case records not clear or missing; technology shortcomings
- Safeguarding literacy
- Lack of management oversight and challenge
- Resources
- Supervision biased towards targets not needs
- Organisational policy
- Legal literacy
- Culture
- Market features/contracts/placement monitoring

Inter Professional and Inter Agency Practice

- Parallel working with no coordination or MDTs
- Information not shared - practice and policy
- Lack of single system information sharing
- Service thresholds impede referrals
- No whole “think family” working
- Safeguarding policy and referral scrutiny
- Legal literacy lack of knowledge of powers within MDT

What Care Homes Did Do Well

- Personalised care - positive choices to remain in care home during final phase of life
- Care Home staff had best knowledge of the person
- Example of a care home working closely with a surgery to introduce named GP scheme

Practice improvements required [1]

- Lack of personalised care –preferences
- Policy to restrict who could raise a concern
- Processes to manage assaults
- Lack of challenge to other professionals
- Poor info given to care homes
- Lack of advocacy when patient has no family
- Institutional responses

Practice improvements required [2]

- Lack of supervision
- Information exchange at transfer/referral (necrosis)
- LD patient passports not shared
- Safeguarding Literacy [16 SARS]
- 2 Care Homes very defensive during SAR
- Lack of nutritional log - detect deterioration
- Infection control

Recommendations [1]

- MCA use and knowledge
- Pressure ulcer management protocols and training
- Improve information to homes on admission
- Personal handling and lifting training
- Care plan audits
- IPC inspection and audits

Recommendations [2]

- Assaults from other residents → safeguarding

(please refer to local safeguarding adults guidance on this issue)

Shropshire Telford and Wrekin

- Better support for assaulted staff
- Training on sexuality and consent
- Sufficient discharge medication
- Documented handovers
- GPs and community staff to write in notes
- Better access to Health Action Plans (LD)
- Implement Night checks schedule

Local Implications- What Do We Want To Do Next????

- Do any of the issues strike a chord?
- Would any of the recommendations apply to your service?
- How could learning from SARS improve your service
- What themes and trends analysis takes place in your service

Learning from SAR's - New for March 2018

https://www.scie.org.uk/safeguarding/adults/reviews/library/

Update on Safeguarding Adults Board Websites & Phone Numbers (Shropshire)

Karen Littleford

Safeguarding Adults Lead

Shropshire Partners in Care

Keeping Adults Safe in Shropshire Board

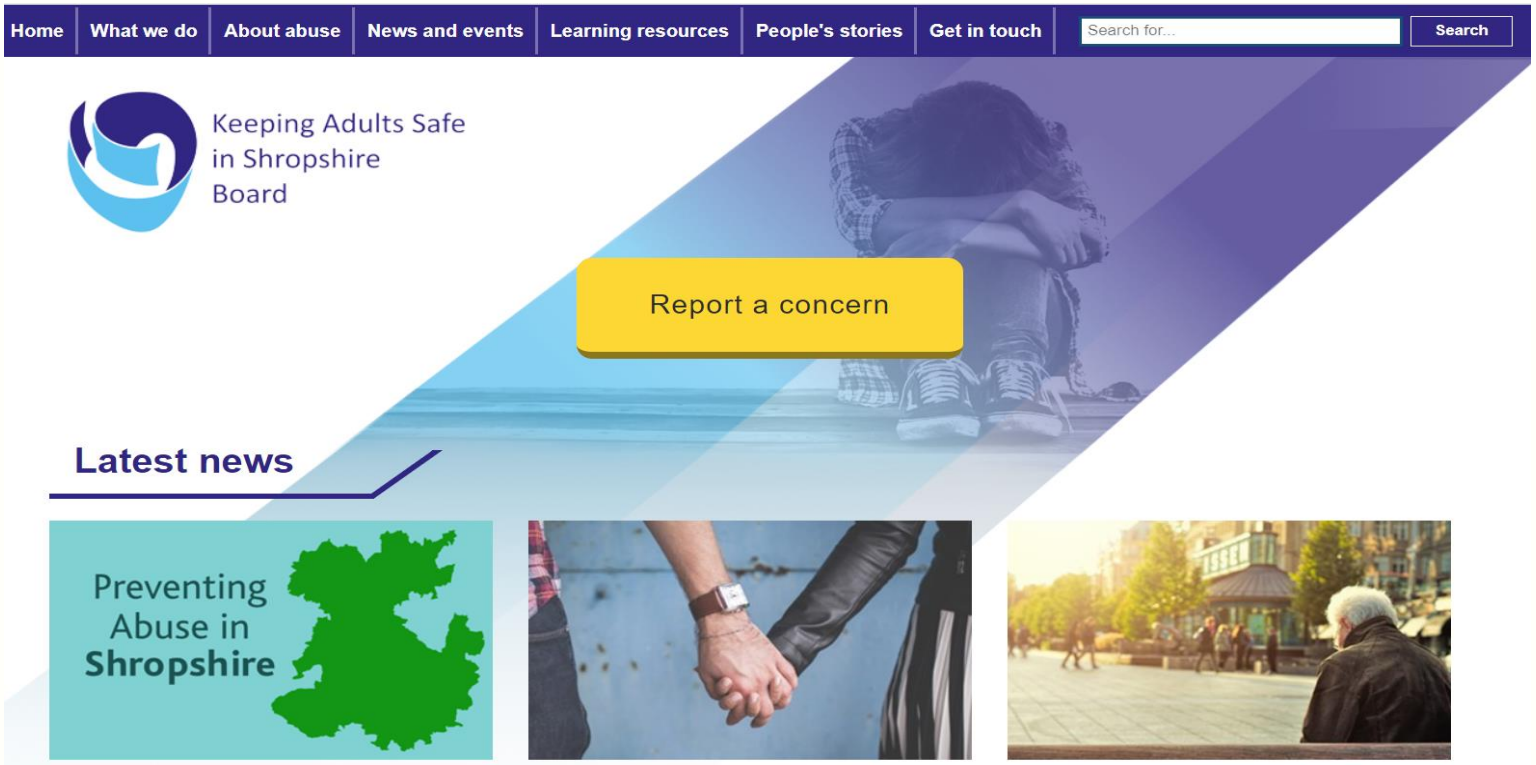
Telford & Wrekin Safeguarding Adults Board

Keeping Adults Safe in Shropshire Board

Access

Search ‘Keeping Adults Safe in Shropshire Board’

http://www.keepingadultssafeinshropshire.org.uk/

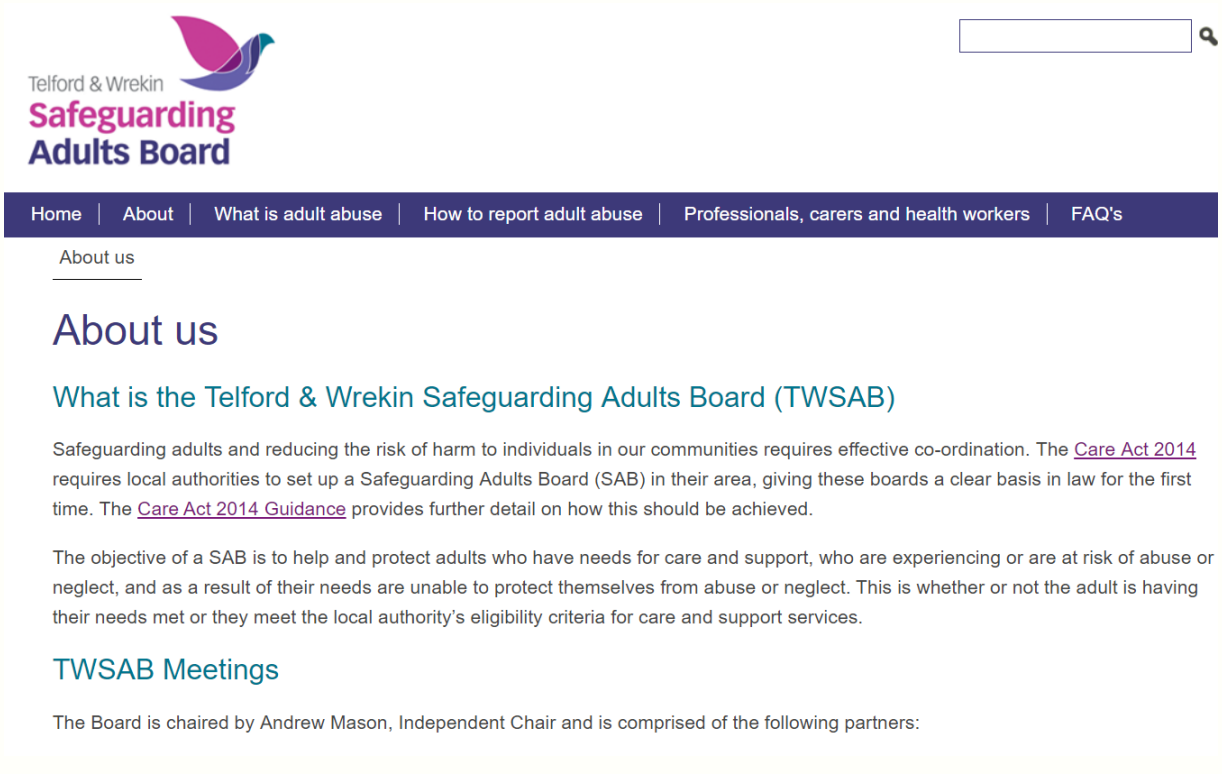


Telford & Wrekin Safeguarding Adults Board

Access

Search ‘Telford Safeguarding Adults Board’

http://www.telfordsafeguardingadultsboard.org/sab/about



Reporting a Safeguarding Adults Concern

Shropshire (new number)

First Point of Contact

0345 6789044

Telford and Wrekin

Family Connect

01952 385385 - select option 3

Good capacity assessments: how to and how *not* to do an assessment of capacity

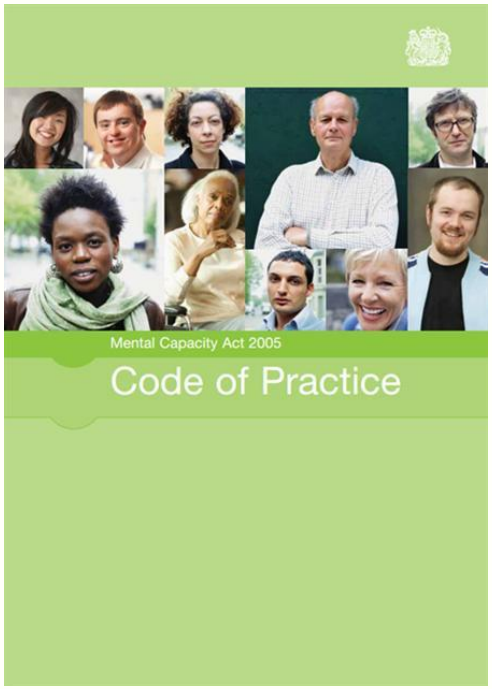
Marion Kelly

Trainer and Development Officer
Shropshire Partners in Care

Good capacity assessments: how to and how *not* to do an assessment of capacity

A good example of a mental capacity assessment was provided to forum members.

A less robust example of a mental capacity assessment was provided for comparison.



Shropshire Council

Telford & Wrekin Council

NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

Shropshire Multi-Agency Mental Capacity Act Guidance

The Shrewsbury and Telford Hospital NHS Trust

Shropshire Community Health NHS Trust

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

POhWER advocacy, making your voice heard

Shropshire Partners n Care The Care Workforce Development Partnership

Shropshire Council

Shropshire Mental Capacity Assessment Tool

This document is to be used when a formal two stage assessment of capacity needs to be made (e.g. a new care plan, a move into residential care, consent to treatment or discharge from hospital)

Name: **Address:**	**Date of Birth:** **Care First No:**

Stage One
Diagnosis that there is an impairment of or disturbance in the functioning of the mind or brain? (Without this diagnosis a person cannot lack capacity).

Decision to be made:

Stage Two
Functional assessment of capacity to make the recorded specific decision only. Tested in the following four areas, a failure in any area constitutes a lack of capacity for the specific decision.

a. Record how you have tested whether the person can understand the information, the questions used, how you presented the information and your conclusion.

b. Record how you tested whether the person could retain the information and your conclusion.

c. Record how you tested whether the person could use and weigh the information and your conclusion.

d. Record your findings about whether the person can communicate the decision?

e. Conclusion (including any further input needed). Record the outcome of the assessment.

Completed by:

Shropshire Partners in Care
The Care Workforce Development Partnership

Record Keeping

Themes and Trends Across our Patch

Kathy George

Named Nurse, Adult Safeguarding

Telford and Wrekin CCG

Record Keeping

- Care Quality Commission

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17

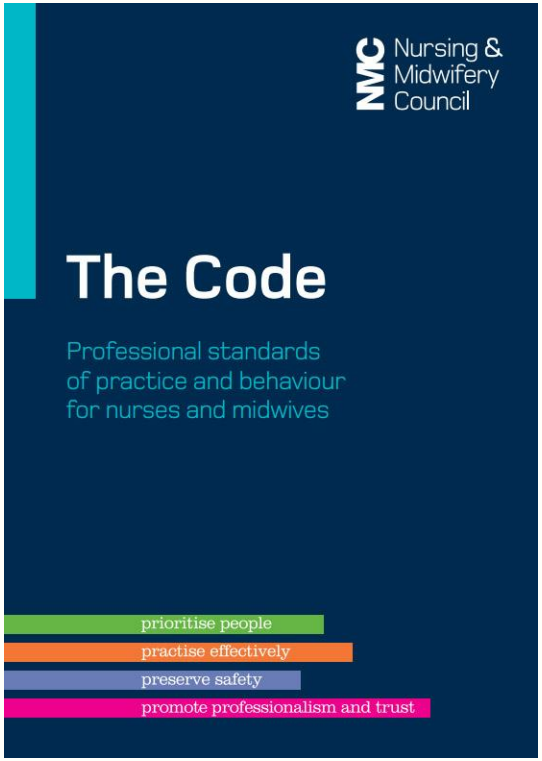
Regulation 17(2)(c)

- 17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

- **Records relating to the care and treatment of each person using the service must be kept and be fit for purpose. Fit for purpose means they must:**
- **Be complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information, as far as is reasonable. This includes results of diagnostic tests, correspondence and changes to care plans following medical advice.**
- **Include an accurate record of all decisions taken in relation to care and treatment and make reference to discussions with people who use the service, their carers and those lawfully acting on their behalf. This includes consent records and advance decisions to refuse treatment. Consent records include when consent changes, why the person changed consent and alternatives offered.**

- Be accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe. This applies both internally and externally to other organisations.
- Be created, amended, stored and destroyed in line with current legislation and nationally recognised guidance.
- Be kept secure at all times and only accessed, amended, or securely destroyed by authorised people.
- Both paper and electronic records can be held securely providing they meet the requirements of the Data Protection Act 1998.
- Decisions made on behalf of a person who lacks capacity must be recorded and provide evidence that these have been taken in line with the requirements of the Mental Capacity Act 2005 or, where relevant, the Mental Health Act 1983, and their associated Codes of Practice.

Nursing and Midwifery Council (NMC)



https://www.nmc.org.uk/standards/code/

The Code – Professional Standards

- **3**. Make sure that people's physical, social and psychological needs are assessed and responded to
- **8**. Work cooperatively
- **10**. Keep clear and accurate records relevant to your practice
- **13**. Recognise and work within the limits of your competence

NICE - Sepsis: Risk stratification tools

Kathy George

Named Nurse Adult Safeguarding
Telford and Wrekin CCG

Recognising a Deteriorating Condition

Think Sepsis -

National Institute for Health and Care Excellence (NICE)

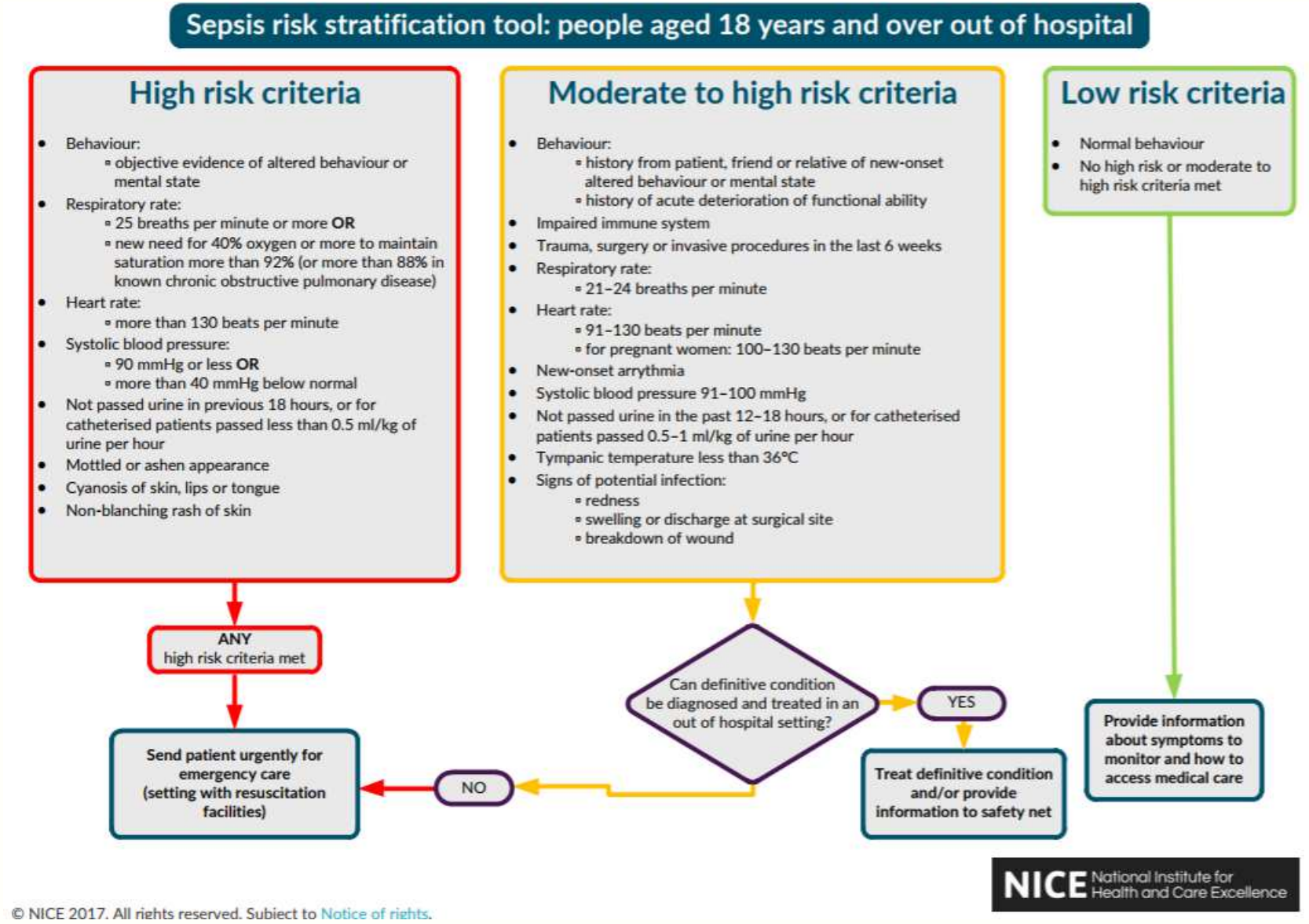
Sepsis: Risk Stratification Tools

Sepsis Risk Stratification Tool:

People aged 18 years and over out of hospital

Link

www.nice.org.uk/guidance/ng51/resources/algorithms-and-risk-stratification-tables-compiled-version-2551488301 (Page 10)



What Do We Need to Consider ?

Observe, Record and Report

- Behaviour
- Respiratory Rate
- Heart Rate
- Blood pressure
- Urine output
- Appearance - skin, cyanosis swelling, wound discharge etc.

Safeguarding Adults Forum Evaluation

Future Dates:

5th April - 9:30-12noon (Telford & Wrekin venue)

18th July - 9:30 – 12noon (Shropshire venue)

19th December - 9:30-12noon (Telford & Wrekin venue)

Keeping Adults Safe in Shropshire Board

Telford & Wrekin Safeguarding Adults Board

Save the date – 14th June 2018

Joint Safeguarding Adults Boards Prevention Event to mark World Elder Abuse Awareness Day (WEAAD).

We are pleased to announce Professor Michael Preston-Shoot will be speaking about working with adults who self-neglect and Mental Capacity (learning from Safeguarding Adults Reviews).

Thursday 14 June 2018 from 9:30am – 1:30pm at **Oakengates Theatre @ The Place**, Limes Road, Oakengates, Telford, TF2 6EP.

World Elder Abuse Awareness Day is commemorated each year in June to highlight the often silent suffering of older people. People across the world will voice their opposition to the abuse and neglect of older people. The joint Safeguarding Adults Boards in Shropshire and Telford and Wrekin event will focus on preventing the abuse of all adults with care and support needs.

This is a free event, co-ordinated and run jointly by the **Keeping Adults Safe in Shropshire Board (KASiSB) and Telford & Wrekin Safeguarding Adults Board** (TWSAB). Booking Essential further information on how to reserve your place will follow shortly.