Case R - Safeguarding Adult Review Recommendations

Recommendation 1:
Guidance to be in place on the commissioning of services, particularly in relation to out of area placements.

Recommendation 2:
Service providers should have regard to a "Prevention of falls" policy to ensure residents have a Risk Assessment and management of falls care plan. This should include the referral route to the Falls Prevention Service and appropriate reference to Mental Capacity Issues and Best Interest decisions.

Recommendation 3:
All staff should be aware of the legal framework in which they are providing care and treatment. This should include knowledge about the MHS, the MCA and DoLS. Confirmation of an individual's legal status should be well documented and included in individual care plans.

Recommendation 4:
Staff to understand the different legal frameworks for managing financial affairs, and to understand the Powers of the Attorney, when a Lasting Power of Attorney is registered, for both financial and welfare.

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Recommendation 5:
All service providers to ensure staff have received appropriate safeguarding training at a level commensurate to their role.

Recommendation 6:
All service providers to ensure they document all parties involved with an individual's care and ensure communication channels are maintained in line with safe sharing of information

Recommendation 7:
The production of practice guidance by HSAB to be issued to agencies to use in supporting best practice on verification and recording of Last Power of Attorney records held by Adults representatives .

Recommendation 8:
HSAB to commission the development of a Mental Capacity Assessment / Best Interests Assessment Toolkit to be used by individual practitioners to support them to work to the expected standard (links to MCA Competency Framework).

Recommendation 9:
HSAB to work with partner agencies to promote the importance and development of anticipatory care planning approach for adults who lack capacity, are at high risk of falling and living with long term progressive illness.

01 Background

Elderly Male
Living on Welsh/English Border
Assessed as requiring Elderly Mentally Ill Registered Nursing Care
Placed out of County (Cross Border Funding Arrangements)

02 Safeguarding Concerns

- Safeguarding Concern raised regarding multiple falls
- Subject to Section 117 Aftercare under Mental Health Act
- Safeguarding Alert raised by Wye Valley Trust regarding the lack of reviews being completed

07 Implementing Change

Each agency contributing to a case review is required to produce an action plan to ensure they meet the recommendations made for their agency which identifies how they will be progressed and what is expected to change as a result.

Progress on these actions are monitored and reported to the Joint Case Review subgroup of Herefordshire Safeguarding Adult Board.

03 Themes

- No evidence of formal Risk Assessments
- Confusion regarding Cross Border funding arrangements
- Lack of clarity and knowledge of Power of Attorney legislation
- Lack of understanding of the Mental Capacity Act 2005 /Mental Health Act 1983/07

06 Recommendations

The agency reports included recommendations which have largely been completed by the conclusion of the SAR.

The recommendations for Herefordshire Safeguarding Adults Board are listed in full overleaf.

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05 Overall Finding

Information relating to the funding of PR's care, which would have given focus and outlined the responsibilities to provide a regular and thorough review of PR's physical, psychological and social care needs, were not included in any care planning of any party involved.

04 findings

- Missed opportunities to undertake a thorough review of PR's needs
- Missed opportunity for service providers & agencies to involve Falls Prevention Service
- Missed opportunity to gain clarification of legal status