7 Minute Briefing

Adult Practice Review

APR4/2017

Background

A Concise Adult Practice Review was commissioned by C&V RSB in accordance with the Social Services and Wellbeing (Wales) Act 2014 Guidance for Multi Agency Adult Practice Reviews

The subject of the review was a 59 yrs. old woman (Adult C), found deceased at her home. The cause of death was recorded as Ischaemic Heart Disease
Coronary Artery Atherosclerosis &
Infected Venous Leg ulcers of the lower limbs.

This 7-minute briefing will summarise the key learning from this review.

Context

During the timeline of the review Adult C was known to two agencies consisting of seven service providers. Adult C was known to suffer from limited mobility, was housebound and had financial difficulties. She lived with her adult son who presented with his own unmet needs.

The relationship between Adult C and her son was acrimonious. A neighbour had raised concern in respect of Adult Cs wellbeing on a number of occasions to the police and on one occasion to the local authority.

Engagement between Adult C and services was challenging characterised by missed appointments and failure to engage with services to meet her health and financial needs. Furthermore it was not clear to professionals if it was Adult c or her son making decisions in respect of services needed.

Context (continued)

Adults C's Home conditions were described as "squalid" and Adult C often presented as "unkempt". Whilst there was never any criminal neglect established in Adult C's case there was evidence of self-neglect.

Professionals trying to work with Adult C at the time documented many concerns that would indicate that Adult C was an Adult at risk however no referral was made by those professionals to Adult Services, nor did they seek advice from their safeguarding leads in respect to the concern.

Organisational Learning

There were five key areas of organisational learning points identified within the review.

These are set out below:

- Information Sharing and Multi Agency Working
- Engagement with Services
- Self-Neglect
- Capacity and Consent
- Adult at Risk Threshold for Referral

Recommendations for improving systems and Practice

- The review made six recommendations related to the five key arears of organisational learning these are set out as follows:
- Organisations need to establish effective mechanisms for information sharing both internally and externally to their service
- Professionals need to fully understand the definition of an adult at risk and be aware of their duty to report under the SSWBA (2014)
- Professionals need to consider the potential influence of carers and significant others on individuals decision making

Recommendations continued

- Practitioners need to ensure that the views of the vulnerable individual are clearly stated within documentation and that they evidence understanding of risk
- The regional board should give consideration to the development of a Self-neglect policy
- Practitioners need to recognise the importance of safeguarding supervision particularly for complex presentations

Learning opportunity

Reflect on the case discussed and think of how this situation could have presented in your work with vulnerable individuals?

Ask are there any similarities in cases you have worked or situations you have encountered?

What would you have done in a similar situation when working with vulnerable individuals? And what are the barriers to practice in your organisation?

Identify key support for yourself in your team.