Learning Lessons Practice Briefing Note

Mr J Case Debrief, April 2016

From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this briefing sheet. It is one way by which we are supporting multi-agency professionals working with adults at risk, or families, to learn from practice.

This briefing sheet pulls together key messages arising from local case reviews, formal and informal.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults. This document includes a feedback sheet to capture how you have used this learning.

The practice briefing will also be disseminated to training providers to ensure content is included within or informs safeguarding adults training.

What is a Safeguarding Adults Review?

The SSAB, as part of its Learning and Improvement Policy, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

SABs are also free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

'Mr J' Case Review Debrief, April 2016

In this case, a SAR was not commissioned, but the principles were applied to an internally-convened debrief session involving key professionals involved in the case. The key messages contained in this briefing sheet reflect the learning to emerge from this event following the death of an elderly, terminally-ill gentleman, Mr J. It highlights concerns around the effectiveness of safeguarding and hospital discharge procedures, challenges of working with resistant families / individuals, and dealing with issues of self-neglect.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

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Follow us on twitter https://twitter.com/SomersetSAB

Key considerations for practice arising from the debrief

Working with people who self-neglect

'The hospital raised concern because they felt Mr J was self-neglecting but could not determine his capacity as he refused to engage with staff and threatened to self-discharge if staff continued to try and engage with him'

Self-neglect is challenging for practitioners, due to:

- its varied presentation, influenced by a complex mix of personal, mental, physical, social and environmental factors
- the high risks it poses, both to the individual and sometimes to others
- the possibility that adult social care intervention is not welcomed by the individual, making engagement difficult
- the challenges of assessing mental capacity
- ethical dilemmas between respecting autonomy and fulfilling a duty of care
- care management systems that prioritise short- term, task-focused involvement rather than long-term relationships with service users
- the need for coordinated interventions from a range of agencies.

'Professionals must be aware that, whilst we use the term 'self-neglect' to recognise specific types of behaviour, many individuals won't regard their behaviour in that way and may consider such behaviour as the only way of exercising agency and asserting their sense of self'

Practice with people who self-neglect is more effective where practitioners:

- build rapport and trust - showing respect, empathy, persistence and continuity
- seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience
- work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes
- keep constantly in view the question of the individual's mental capacity to make self-care decisions
- communicate about risks and options with honesty and openness, particularly where coercive action is a possibility
- ensure options for intervention are rooted in sound understanding of legal powers and duties
- think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks
- work proactively to engage and coordinate agencies with specialist expertise to contribute towards shared goals.

Effective practice is best supported when:

- strategic responsibility for self-neglect is clearly located within a shared inter-agency governance arrangement such as the SAB
- agencies share definitions and understandings of self-neglect
- inter-agency coordination and shared risk- management is facilitated by clear referral routes, communication and decision-making systems
- longer-term supportive, relationship-based involvement is accepted as a pattern of work
- training and supervision challenge and support practitioners to engage with the ethical challenges, legal options and skills involved in self-neglect practice

Source: RIPFA Practice Tool, Working With People Who Self Neglect

Working with hard to engage or resistant families

'The family were also very resistant to Mr J leaving his home, and there was a history of non-compliance and mistrust of services'

- Working with families who are hard to engage is a commonly recognised feature in safeguarding. A key feature in many case reviews, relating to both children and adults, has been the lack of persistence of workers to engage the family in the offer of support as well as the lack of co-operation and/or hostile attitude of some family members. When there are wellbeing or protection issues, a failure to engage with the family may have serious implications and non-intervention is not an option.
- It is important to intervene early if more serious problems are to be avoided later in life. One of the major barriers to service delivery is that vulnerability increases the likelihood of refusing the offer of services. The more vulnerable families who do engage are also more likely to disengage before positive outcomes are met and sustained.
- Effectively engaging families can be split into three key stages: the process of first motivating or attracting a family to engage with the service for the first time; enabling the family to recognise the benefits and goals of the service; and building a relationship between the practitioner and family members, sufficiently engaging them to begin delivering meaningful and beneficial support
- Some practitioners find it difficult to engage. They may not have the necessary skills to address defensiveness / anxieties expressed by families. They may misunderstand the practical or emotional difficulties impacting on people's ability to engage, or find it difficult to spare the time to build meaningful, trusting relationships with family members. Sometimes the professionals' frame of reference (values, beliefs, attitudes) will differ to those of the family and lead to value clashes and judgements. There is also often pressure from services to engage and make changes within a situation quickly.
- Effective engagement is crucial to work with all families but especially with families with multiple or complex needs, particularly since many of these families have a history of non-engagement and often have actively disengaged or rejected previous support for a range of reasons. This can include previous negative experiences of agencies, not understanding professionals' concerns, a dislike or fear of authority figures, not wanting to have their privacy invaded, a chaotic lifestyle, or fear of oppressive judgements.
- Difficult to engage behaviour can manifest itself in a variety of ways – ambivalence, confrontation, avoidance, refusal, or disguised compliance (whereby they adopt an appearance of co-operation to minimise agency intervention).
- Strategies and approaches to support engagement include:
  Working in partnership with the family: *active involvement; shared decision-making; honesty; clear communication; negotiation*
  Practitioner qualities and skills: *non-judgemental attitude; respect; active listening; enabling change; problem-solving; exploring; using persistent, proactive and assertive approaches to engage the family; at all times remaining person-centred; starting with and building on families strengths.*

Further reading:

Home Office: Controlling or Coercive Behaviour in an intimate or family relationship, December 2015

SCIE Guidance: Gaining access to an adult suspected to be at risk of neglect or abuse, 2014

Safe Discharge from hospital

'A Best Interest meeting concerning all professionals and family should have taken place, and discussions around the need for an application to the Court of Protection around medical treatment or discharge arrangements given the safeguarding concerns'

- Poor hospital discharges are a cause of issues in safeguarding, with failure of communication between health and social care being the principle contributing factor to an unsafe discharge. There can be significant human and financial costs of getting discharge wrong.
- Hospital discharge should be a planned event, with hospitals starting to plan discharge soon after admission, and ensuring they work with other agencies, such as social services and the Police, to promote patient safety.
- Discharge from hospital can only happen when a clinician has decided a person is medically fit for discharge; however this does not mean that the person is now 'well' or has no medical conditions.
- In addition, Health & Social Services must be satisfied that the discharge would be safe, which means that there is an appropriate care and support plan in place. This aspect is sometimes missed out.
- Before discharge, health and social care assessments should be undertaken to identify the individual's needs and whether they will require further care and support after discharge.
- If a relative or friend is to provide care upon their discharge, then the relative/friend will be entitled to a carer's assessment.
- If it is decided that an individual lacks the capacity to make a decision about their needs, and if no one has been appointed to act on their behalf, Health and Social Services must act in the person's "best interests". This should involve a Best Interest meeting in which family / close friends are invited to attend.
- When an individual does not have any family or close friends, Health and Social Services have a duty to appoint an Independent Mental Capacity Advocate (IMCA) to act in the person's best interests.
- Ensure contingency plans are in place, especially where it is expected that the accepted discharge plan is likely to fail or put the patient at significant risk from self neglect.

If a patient insists on self-discharge from hospital against clinical advice:

- Ascertain whether the patient is capable of making the decision through a capacity assessment. Ensure the person understands the information relevant to this decision, can retain this information, use or weigh up the relavant information, and can communicate the decision.
- If the patient is unable to do any one of the aspects outlined above, the person lacks capacity and must be prevented from leaving hospital. Staff should use persuasion, calming and de-escalation techniques.

We recommend further reading:
http://www.39essex.com/docs/newsletters/capacityassessmentsguide31mar14.pdf

Safeguarding

'Mr J was subject to a safeguarding investigation and involvement in the weeks leading up to his death; however, there had been numerous alerts dating back some 18 months of a similar nature which had not resulted in a safeguarding response being offered'

- Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's well-being is promoted.
- A vulnerable adult is described as a person aged 18 years and over who is in receipt of or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be able to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. Mr J met the above criteria and therefore should have received a safeguarding service at an earlier opportunity.
- Workers across a wide range of organisations, including those in children's services, need to be vigilant about adult safeguarding concerns in all walks of life. Findings from serious case reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, the death or serious harm might have been prevented.
- Staff should be vigilant to patterns of incidents or activity that might indicate potential or actual risks which require action to ensure they can be proactively addressed and future risks or incidents prevented.
- Care Act guidance requires each Local Authority to arrange for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent/support them.

Carers and safeguarding

'It is important to recognise when risk increases for the carer as well as the cared for'

- Carers can have a range of roles regarding safeguarding – they can be partners, the person who raises the concern or themselves be vulnerable to harm and abuse; or can be abusers themselves.
- Risk can increase in relation to carers either unintentionally or intentionally harming or neglecting the adult they support when the carer has unmet or unrecognised needs of their own; are themselves vulnerable; have little insight or understanding of the vulnerable person's condition or needs; is unwilling to change his or her lifestyle; feel socially isolated or stigmatised, or are themselves being abused by the vulnerable person they care for.
- Timely and careful assessment is critical. Assessment of both the carer and the adult they care for must include consideration of the wellbeing of both people. A carer's assessment is an important opportunity to explore the individual's circumstances and consider whether it would be possible to provide more information or support to prevent abuse or neglect from occurring (e.g. providing training to the carer about the condition the adult they care for has, or supporting them to care more safely).
- The assessment must include consideration of the carer's ability and capacity to meet the needs of the person, identifying, recording and addressing any potential risks or gaps which may put the person needing support at risk or render him/her more vulnerable.

Are you worried about the safety or welfare of a vulnerable adult in Somerset, or do you provide care for an adult and think you qualify for assistance? Contact Adult Social Care on **0300 123 2224** or email **adults@somerset.gov.uk**
In an emergency call the Police via 999

SOMERSET SAFEGUARDING ADULTS BOARD

Learning Lessons - Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

Your name	
Agency	
Date	

This briefing was cascaded to: (e.g. all district nurses; duty social workers etc.)
This briefing was used in: (e.g. supervision with X number of staff; team meeting; development event etc.)
Action taken as a result of the learning:
Other feedback / discussion points