Safeguarding Adults Review Publication: Nancy

A Safeguarding Adult Review commissioned by Bolton Safeguarding Adults Board (BSAB) has been published today.

It considers the case of Nancy, an 82-year-old female, who had been receiving a care package from care providers and the Older Adults Community Mental Health Team.

Unfortunately, due to a breakdown in communication, the care providers discontinued the care package, unbeknown to both the family and professionals involved.

This resulted in Nancy being left without care for a number of days.

Tragically, Nancy passed away following a month-long hospital stay.

The review made ten recommendations that include:

- When changes are required to a home care package, a checklist / dialogue with home care bookings team to ensure the care manager, relevant professionals and where appropriate, family members, are notified.
- BSAB to convene a working group, within six months of the publication of this report to consider the development of a universal care log which would be signed by agencies following a home visit.
- BSAB to lead on a targeted audit of the updated Home Care Bookings processes when care packages are to cease, or changes are required. This will happen within six months of this report publication.
- As part of our Care Act duties, practitioners need to ensure Carers assessments are considered as part of standard operating procedure. This will build on and embed strengths and assets-based working. Adult Social Care to ensure their case recording systems record the active consideration of carers assessments so that this can be routinely monitored via case file audits.
- When a care provider, family member or social worker / community assessment officer / CPN provides concerns that the current support package is not meeting an individual's needs, a request would be made to the Social Worker (or allocated worker) to undertake an urgent review. This will take place within 28 days and form a re-assessment of the individual's needs.
- The BSAB needs assurance that Care Act Assessments and Carers Assessments are undertaken in a timely manner resulting in an outcome focussed care plan, reviewed at least every twelve months, which responds to changing needs. The plan will be shared with all professionals and the family, in line with current protocols.
- There needs to be consideration of Decisional or Executive capacity – as part of the safety planning and assessments - to enable risks to be effectively managed. There needs to be clear evidence of the person's voice, wishes and feelings in line with Care Act duties - Making Safeguarding Personal
- The BSAB need to ensure a multi-agency training programme on discriminatory abuse is available across the safeguarding adult workforce.
- BSAB partners will ensure that the learning from this review is shared with practitioners and the learning is embedded in front line practice.
- The BSAB will ensure that the above recommendations are implemented within six months of the publication of this report and progress is formally reported back to the BSAB, its subgroups and Nancy's family for scrutiny purposes.

Neil Smith, Independent Chair of the Bolton Safeguarding Adults Board said:

“This is an incredibly sad case, and our thoughts remain with the family of Nancy at this difficult time.

The purpose of a Safeguarding Adults Review is to identify what agencies could have done differently and what lessons can be learned to prevent similar cases in the future.

While this report does highlight examples of good practice, it also makes key recommendations for improvements around continuity of care, more detailed record keeping, better communication between partners and ensuring families are included as part of care planning.

Agencies do not wait for a SAR to be published to put changes in place, and work has already begun to implement recommendations identified via their internal review processes.

Immediate actions were undertaken to prevent a recurrence of this case.

Each Safeguarding Adult Review has an accountable action plan associated with it which is monitored by the BSAB to embed learning and reduce the risk of repeat incidents or causes of harm.

The BSAB have assured the family that we will report back to them in six months’ time to demonstrably provide assurance of the impact of the actions from this review.”

Rachel Tanner, Bolton Council’s Director of Adult Services, said:

“Everyone at Bolton Council was deeply saddened to hear of the passing of Nancy.

We once again offer our condolences to the family and thank them for their participation in the review.

A number of key lessons have been learned from this case and new measures are already in place to address the issues that have been raised.

We note the findings and recommendations of this Safeguarding Adults Review and we will continue to work with partners to improve standards.”

ENDS

Notes to editors:

The Care Act 2014 makes a safeguarding adults board a statutory requirement.

The purpose of the board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area; and that they are effective, person-centred, and outcome focused.

For more information about the Bolton Safeguarding Adults Board, and to read a full copy of the report, visit: Information for safeguarding professionals – Bolton Council.

Safeguarding Adult Reviews (‘SARs’) were established on a statutory basis under Section 44 of the Care Act 2014.

The purpose of a SAR is to review multi-agency practice, so that it may provide invaluable insights to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. A SAR is not an inquiry into how an adult at risk has died or was seriously harmed or re-investigating a case. These are matters for coroners and criminal courts, respectively, to determine as appropriate. It is not to apportion blame to any individual or organisation.