Worcestershire Safeguarding Adults Board

SAR / SCR Learning Event

13th October 2016

Why are we here

RESPECT

REFLECT

and

LEARN

Working in health and social care – the reality

"working in health and social care gives people a real sense of personal achievement from knowing that their job is helping people and creating a caring society.

In a survey of those working in social care,

- 88% of people said they were happy with their jobs.
- 99% agreed that they like feeling they help people
- 96% felt that their work really makes a difference

Skills for Care, 2016

Discussion and Activity

- Research shows that people who feel valued and supported in their job are more likely to stay in that role.
- Re-enforcing and communicating the workplace values to workers will help to achieve this.
- What common values should care workers possess?
- What skills and knowledge should care workers have or work towards gaining?

What gets in the way ?

I hear countless success stories about how skilled and knowledgeable workers make a real difference to the lives of people who use health, care and support services.

But sometimes I also hear of poor practice because organisations and the people working for them do not have the right mix of skills, knowledge and values

Sharon Allen, Skills for Care 2016

Discussion and Activity

Discuss and feedback activity

Carers/families :

What barriers and obstacles do you experience?

Professionals and paid workers

What are the barriers and pressures that affect your practice?

What could you do differently to make a difference ?

WORCESTERSHIRE SAFEGUARDING ADULTS BOARD

SAR Report V4 Revised 01-04-16

Learning and Development from the Safeguarding Adult Review into the death of Michael Upward

Ian Winter CBE

13th October 2016

CONFIDENTIAL

Information & Advice to Service Users & Carers

Carers/individuals and families should have access to clear information about respite care: the criteria, options and booking process should be set out at the start.

Using electronic records

Organisations ensure that their records systems are holding correct and relevant information

Where old information is used it should be clearly marked as such

Reviews at Key Events

Where planned respite takes place any assessment or care plan should be reviewed to ensure that the most up to date information is available, this should be shared with the provider in good time so that it can be seen by the staff

Mental Capacity Assessment (MCA)

The application and use of the MCA should be reviewed recognising its use and its requirements are not just the responsibility of the County Council.

Current local guidance should be reviewed and where necessary revised to ensure wide understanding of its requirements

All providers should be supported and encouraged to review how they assess the capacity for individuals within the meaning of the Mental Capacity Act

A presumption of capacity should be questioned and tested and not simply be assumed

Use of supportive technology

The eligibility for any items that supports personal safety and managing risk should be clearly set out.

If removal is considered careful account should be taken of all known information and circumstances before action is taken.

Service User & Carer Assessments

Assessment is the cornerstone of good practice in Social Care and Health. The Care Act 2014 requires joined up assessments that are appropriate and proportionate. They should also be relevant and timely. Old information may still be relevant but it should be noted as such.

Care planning is more than the sum of collected information. It draws on the skill and analysis of professional social care and health staff. It is not just a commentary on the information given.

Carers' assessment is an integral part of supporting individuals. Carers now have a legal right to be assessed according to their own needs. All agencies, in the course of reviewing an individual's needs, should be aware of the needs of carers and the requirements of the Care Act 2014.

Best Practice

- Pre- Admission Visits: Be clear about the purpose and how the information gathered is to be used
- Information about individuals should be relevant and accessible to all staff
- Risks should be weighed-up for every individual
- There should be clear arrangements for staff to access individual's information at all times
- Where the home has unlocked doors there should be:
  - A comprehensive policy that is understood by all staff
  - A clear statement for each individual of risks including an analysis of their illness or condition and any likely indicators or behaviours as a result of the new environment.
- Specialist skills and knowledge. Care providers should demonstrate how staff skills are being developed relevant to the stated purpose and objective at the home. Commissioning could have a key role in supporting and evaluating this

Reporting a serious incident

Where a Serious Incident is reported to the police, or other emergency services, it is essential to provide all relevant information about the individual and the circumstances so that decisions can be made at the earliest time.

At the very least this should include names, addresses and telephone numbers of key family members and significant other people.

Providers should develop a simple front sheet on a file/record to help this.

Managing Risk: Predictability & Preventability

- Michael was suffering from a progressive long term condition
- Wandering or walking is a prevalent feature of people living with Alzheimer's
- New or stressful environments can increase the likelihood of wandering/walking
- This was the first occasion that Michael had been away from his family for respite care
- The local authority assessment made it clear that he was not able to fully understand his condition
- During the first day at the Care Home he had shown some distress about where his wife was and had attempted to leave the premises on a number of occasions.
- On the day that he walked out he had already been asking about his wife and where she was.

Managing Risk: Predictability & Preventability

What could have mitigated risk:

- Consideration of his needs in accordance with the Mental Capacity Act
- A fully updated and comprehensive assessment available to care home staff
- A risk management approach during the pre-admission visit to the Care Home
- A discussion about Michael's first day at the Care Home and the potential degree of risk that this demonstrated - triangulating information
- A fully developed process and practice for managing risk with unlocked doors
- Readily available information about any resident in the event of a serious incident or emergency.

Family Statement

Family Statement

This statement is produced on behalf of family members Guy and Mark Upward, sons of Ernest Michael Upward, and Penny Hill, his sister.

Michael was a much loved grandfather of 5, father to two sons and husband of Primrose to whom he had been married for 55 years. Michael was a well known resident of Pershore, having lived in the area for almost 25 years and was an active parishioner at Pershore Abbey.

At his funeral, some 400 people attended, many were friends and former work colleagues, others family and many people attended from the Pershore area. His premature death has left a large gap in the lives of many people, including his wife, his children, his grandchildren and his many friends. His passing has affected many people both emotionally, practically and financially.

Family Statement

Michael was never afflicted by any major physical ailments and lived a full and very active life, walking his dog most days around Pershore and spending time in his garden. However, over the last 5 years of his life, Michael's health deteriorated due to the onset of Alzheimer's in its latter stages causing incontinence and deep confusion at times, especially when out of his normal routine or local area.

It is utterly tragic that an 82 year old man with dementia was allowed to abscond from a place of care to wander and die of hypothermia in a ditch on his own.

The family of Michael is of the view that a combination of human and systemic failures led to Michael's death on 18th April 2015. Those failings have been investigated by both a formal coroner's inquest and the Safeguarding Adults Review, the findings of which must now be fully reviewed and all recommended actions taken to ensure that no individual or family has to go through the trauma that surrounded Michael death.

Family Statement

The human failures can be summarised as a lack of attention to detail; poor focus on personal responsibility and a disregard for agreed procedures. People are not perfect and mistakes and oversights are part of who we are. However, in the field of care and support for frail and vulnerable people, such mistakes have costly consequences so every effort must be made to minimise scope for error.

The systematic failures can be summarised as poor management, lack of leadership and a blindness to essential detail. Perhaps arrogance can be added to this, as it is possible for organisations to act in an arrogant manner when they fail to consider the need to question themselves and instead, believe their own hype rather than demand evidence of it.

Some very practical things struck us when faced with the evidence gathered through the SAR and Coroner's inquest.

Family Statement

Agreed procedures around assessments are there for a reason so why don't staff stick to them? If work pressures lead to corners being cut then staff must raise this with managers to ensure that they don't end up being held to account for serious problems later.

All procedures must be reviewed regularly – fully tested and subject to challenge, not given a cursory look over – and not just in the face of a disaster.

Staff notes are only worth keeping if they are up to date and accurate. Failure to reflect on information and consider its worth in the light of other information leads to problems, if not disasters.

Risks should be identified and action taken to mitigate risk, with plans assessed, agreed and implemented. Michael's pre-admission assessment was poor and failed to identify – or even consider – significant factors such as the impact of his separation from his wife.

Family Statement

An organisation that trains its staff then proudly highlights that staff are specialists in a specific area, must firstly confirm that its staff have taken on board the training. Learning has to be put into practice and management must ensure that this occurs before it states that staff are 'specialists'. One cannot assume that anyone has benefited from training or coaching until they have been seen in action proving they have learnt from whatever course they attended. Post-learning assessment is necessary before any statement of expertise can be made.

One unanswered question that we identified was why a member of staff in a care home is not given time on their first day back after 2 weeks leave to catch up, read relevant reports, talk to colleagues rather than be scheduled to conduct an assessment immediately on their return. Such poor planning leads to poor decisions and actions.

Family Statement

Management has a responsibility first and foremost to its clients not to its own systems or structures or reputation. Excellent service only comes with excellent resources. Compromise on the resources and the services suffer. If you want to deliver excellence, invest in it and develop the resources you dedicate to this excellence.

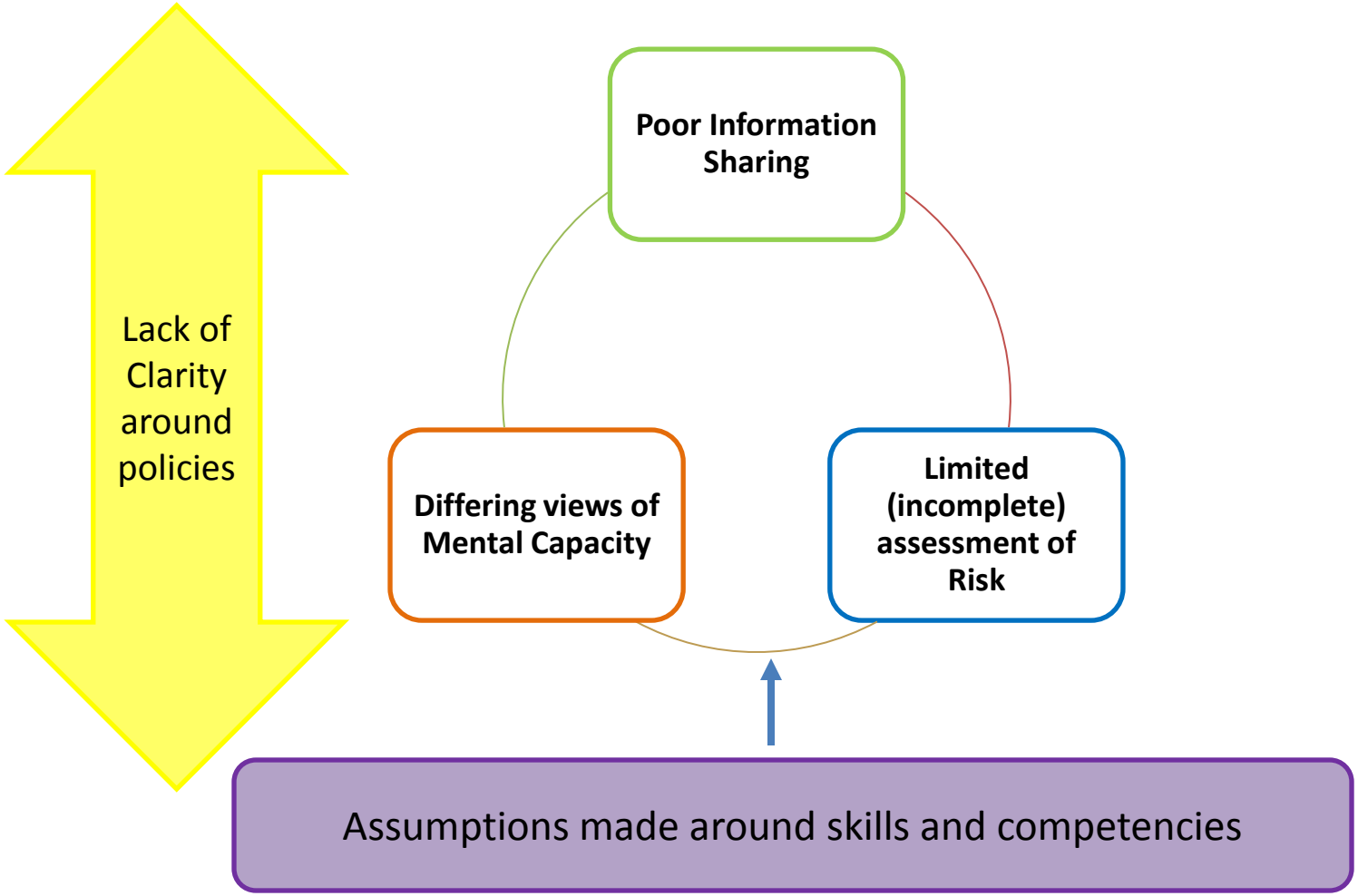
Managers and leaders set the culture of an organisation. If people in these positions of authority fail to develop staff and resources, allow mediocrity to creep in or accept behaviour that is below agreed standards, then the organisation has lost its way.

No-one deserves an ending that Michael experienced – wandering alone, confused, distressed, having no idea where he was going, incapable of making logical decisions, finally aimlessly making his way into a field and falling into a deep, water-filled ditch, unable to get out, getting colder and colder and colder until suffering the last hours of his life totally alone and helpless.

Family Statement

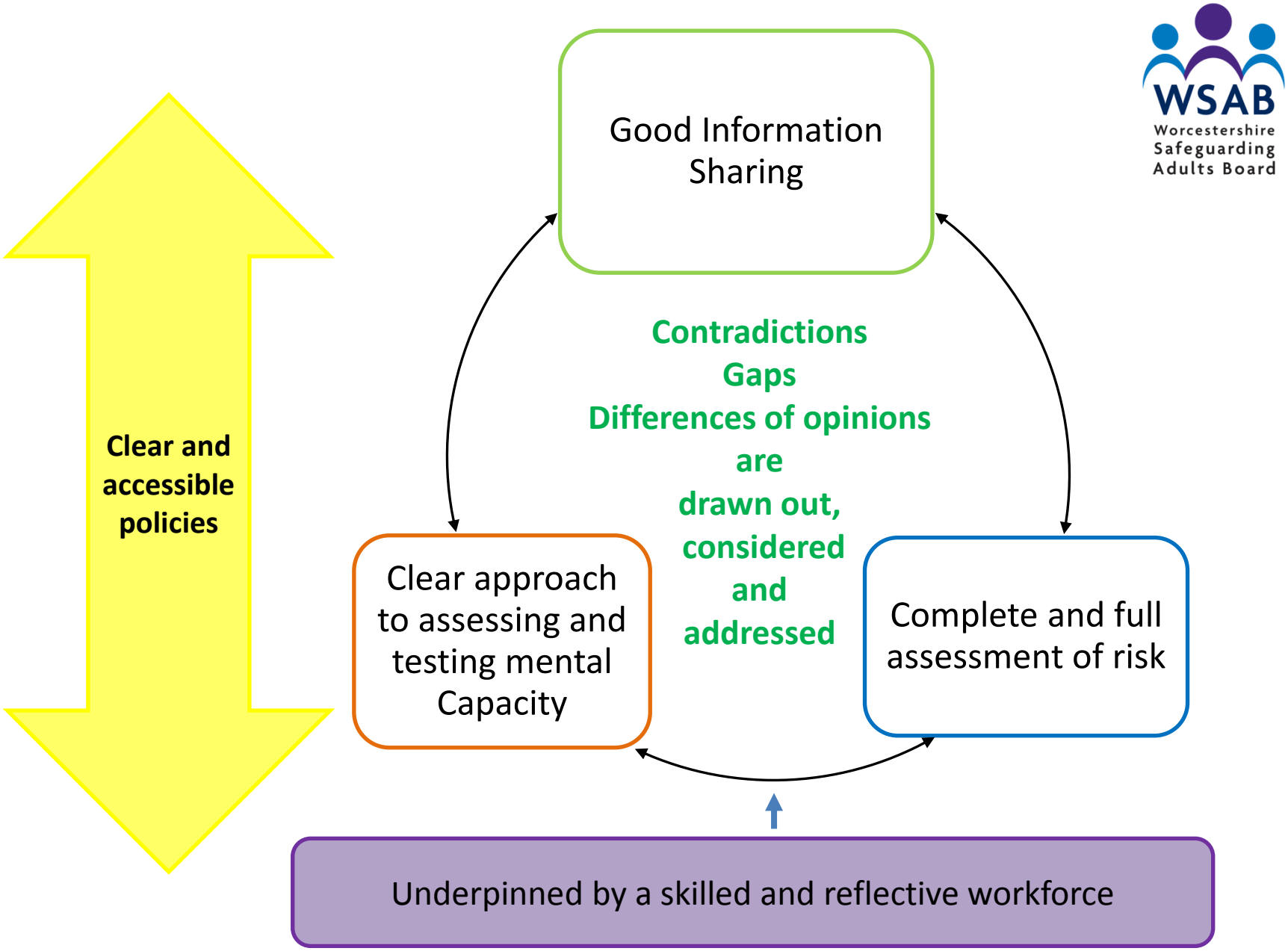
In the family's opinion Michael death was premature, avoidable and the result of poor practices on the part of two professional organisations. We sincerely hope that the multi-agency event in October 2016 focuses on lessons learned from this tragic death to ensure that no such incident is repeated and that care professionals live up to the expectations held by those in need of their support and their families.

Set of interrelated issues



Skills, Competencies and Experience

WSAB
Worcestershire Safeguarding Adults Board


Clear and accessible policies
Good Information Sharing
Contradictions
Gaps
Differences of opinions
are
drawn out,
considered
and
addressed
Clear approach to assessing and testing mental Capacity
Complete and full assessment of risk
Underpinned by a skilled and reflective workforce

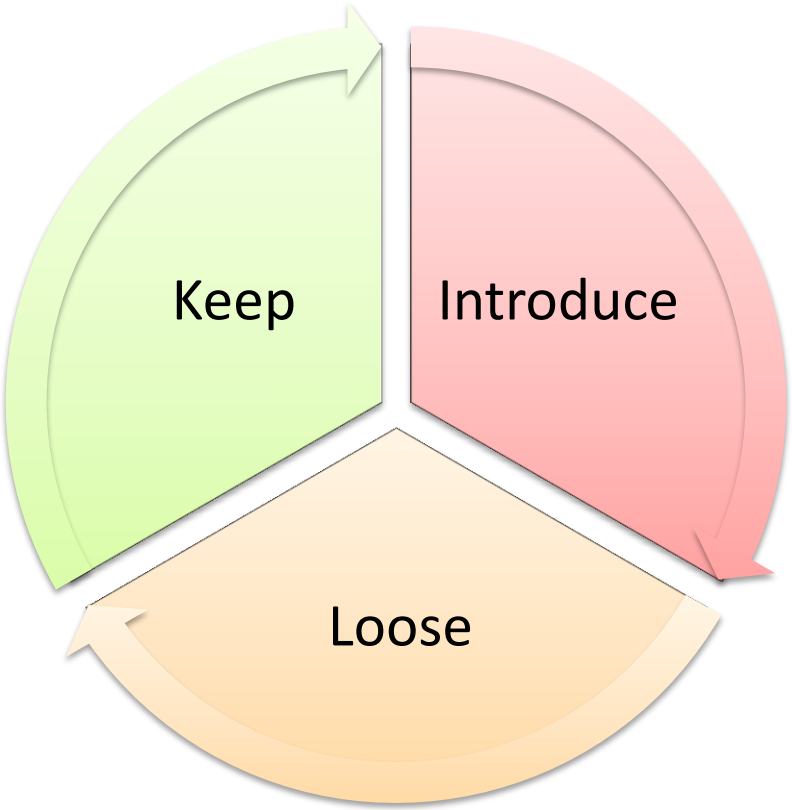
How can WE change the system?

- Workshop – 20 minutes

  - What could be done differently? (SYSTEMS)
    - What policies and process should be in place to support you to improve practice?
  - What could you do differently? (INDIVIDUALS)

Feedback

Planning the future
Doing things Differently



Feedback

WSAB
Worcestershire
Safeguarding
Adults Board

WSAB
Worcestershire
Safeguarding
Adults Board