SAFEGUARDING ADULT REVIEW

RN

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1.0 Introduction

1.1 RN was a single white British man who was 48 years old at the time of his death. He had several chronic health conditions which most likely contributed to his premature death and he was in receipt of services from several agencies offering support with health issues and daily living.

1.2 He displayed patterns of behaviour which would now be recognised as symptomatic of self-neglect, although at the time these may have been construed as "lifestyle choices" rather than requiring multi-agency action under self-neglect procedures.

1.3 Engaging him constructively in planned help proved to be difficult and he was often reluctant to make the most of the help that was on offer. The reasons for his ambivalence towards accepting help is not properly understood and there was no coordinated attempt to address these concerns at the time.

1.4 As a result of the frequent difficulties experienced in working with RN, the fact that he was not seen for several days did not initially raise any anxieties. However, it was eventually 15 days before concerns were escalated and RN was discovered deceased in his flat. It was apparent that he had been dead for some time.

2.0 Adult Safeguarding Process

2.1 The Care Act 2014 places a statutory duty on Safeguarding Adults Boards (SAB) to undertake safeguarding adult reviews in circumstances where an adult has died or sustained serious abuse or neglect and there are concerns about how agencies worked together.[1]

2.2 The fundamental purpose of a Safeguarding Adults Review is that it seeks to determine what could have been done differently that could have prevented harm or death taking place and to learn the lessons to prevent a similar incident happening in the future.

2.3 The decision to undertake this review was taken by Worcestershire Adult Safeguarding Board was taken in 2015. However, formal commencement of the review was delayed until the completion of a Police investigation.

2.4 This Review process began in May 2016 with the aim of presenting the final version to the Worcestershire Adult Safeguarding Board in December 2016.

3.0 Methodology

3.1 Terms of reference for this review were drawn up by the Worcestershire Safeguarding Adults Board (see appendix 1). These required that all of the agencies involved commission an Independent Management Report (IMR) which critically reviewed the practice of their own individual agency, and included a chronology of their involvement based on agency records.

[1] Care Act 2014 section 44

3.2 The Review process is a systemic enquiry into the actions and decisions taken by the relevant agencies and review those decisions in the context of the real working conditions which existed at the time.

3.3 Research has shown that methodologies that engage practitioners in reviews are more likely to achieve learning and changes in practice, therefore the participation of frontline staff is extremely valuable, and improves the quality of the overall review and the commitment to taking the lessons back into practice.

3.4 Reports have been provided by the following agencies:

- Worcestershire County Council - Directorate of Adult Services
- Worcestershire Health and Care NHS Trust
- NHS Redditch and Bromsgrove Clinical Commissioning Group
- Care Force Ltd
- Bromsgrove District Housing Trust
- Worcestershire Acute Hospitals NHS Trust
- Warwickshire and West Mercia Police

3.5 Frontline staff and their managers/supervisors attended a practice seminar where they reviewed a first draft of this report, discussed and shared observations on the challenges of working with this case, both as providers of services and members of a multiagency network. Their candour and willingness to participate is much appreciated.

3.6 Family members were invited to participate and some close relatives have been interviewed and read a draft of this report. They have provided helpful information about RN and comments on support services. Their views and opinions have been included in the report at different points where appropriate. Their hope is that professionals can learn from the experience of working with RN and similar cases do not occur in the future.

3.7 The Overview Report is devised from these three sources of information; the IMR's, the practice seminar and views and observations of the family. Additional guidance, advice and quality assurance has been provided by a dedicated Case Review Panel, which has worked with the Overview report author to ensure the report is balanced, references relevant guidance and legislation, and makes useful and constructive recommendations.

4.0 Background Information

4.1 RN was a white British male who had lived in Worcestershire all his life. He had family living in the area who had supported him in different ways over the years. He had previously worked in a local manufacturing industry, although he was unemployed due to ill health in the period subject to this review. Various health

problems complicated his life; the most serious and long-standing of which was alcohol dependency; throughout most of his adult life he could be described as a heavy drinker and he became increasingly alcohol dependent as he got older.

4.2 RN's dependency upon alcohol caused rifts in the family, and those close to him became frustrated with his lack of motivation to address his problems with alcohol. He became isolated and at times estranged from his family. His isolation was compounded by his unwillingness to accept help from agencies who tried to work with him and support him in the community.

4.3 RN had mobility problems as a result of a leg fracture in 2010 which did not heal correctly. Because of this, his mobility was restricted and at times he was in significant pain, which in turn led to greater consumption of alcohol to ease his symptoms. There was a referral to Occupational Therapy Team in 2013 who were able to offer him some advice on transfers within the home and aids and adaptations. However, he did not take advantage of the range of help and support that was available. The referral to the Occupational Therapy service made no mention of alcohol issues at this time, although RN's dependence was known to his GP and Housing provider.

4.4 RN was diagnosed with throat cancer in September 2014. He received radiotherapy and suffered some side effects as a result. The side-effects were exacerbated by his general poor state of health and alcohol intake.

4.5 During the period under review, RN resided in local Housing Trust accommodation although he also spent time living with his parents. His mother died in February 2015 and RN was unable to attend her funeral because of his own ill health. This in turn led to a further decline in his health, partly as a result of drinking more heavily, but also through low mood and self-neglect.

4.6 Some of the professionals who worked with him describe him as intelligent, sociable and polite on first meeting. He had previously played chess at a competitive level in the County and was a keen cyclist. He spoke of having a range of interests that he wanted help in pursuing, although he was less capable in following them up than he first appeared. However, this perception was not universally shared, and professionals from health agencies tended to report different observations which focussed on his frailty and personal and material neglect.

4.7 It should be noted that the events discussed in this Review span the implementation of the Care Act in April 2015. Several of the procedures within Health and Social Care changed during this time, therefore the processes described may be different from how agencies would respond if the same events were to occur today.

5.0 Key Events

(a) Diagnosis of cancer September 2014

5.1 RN was diagnosed with throat cancer in September 2014 following a GP appointment in July for difficulty in swallowing - this was the only face-to-face consultation with the GP during the period under review. A specialist assessment was fast tracked because of the GP's concerns. RN underwent a course of chemo/radiotherapy over a six-week period.

5.2 RN's cancer was successfully treated although the treatment had serious side-effects which were exacerbated by RN's general poor state of health at the onset. Attempts were made to engage RN with a dietician who prescribed supplements to build him up. The situation was worsened by his failure to attend follow-up appointments after the treatment and he also refused to see the district nurse.

5.3 The Community Nursing Team also received a referral to dress RN's neck due to skin damage caused by the radiotherapy. The Community Staff Nurse who undertook the initial assessment and care planning visit on 30th November described RN as appearing "thin, unwell and dirty, no furniture, no carpets, drinking and smoking". It is also documented that the flat was cluttered and dirty. This visit took place at the weekend and RN was not on the normal GP caseload for the Nurse undertaking the assessment. It maybe for this reason that no further care planning took place to explore the issue of self-neglect during this episode of care.

5.4 The Community Nursing Environmental Risk Assessment Form was revised November 2014. The revised document asked specific questions around the environment, and includes 'whether anyone in the house has a drug or alcohol problem'. However, this document was aimed at assessing and action planning in relation to risks to staff, and did not include action planning in relation to the patient.

5.5 RN cooperated with the daily visits to change his dressing for several days before refusing treatment and subsequently being discharged from the Community Nursing Team caseload on 8th December, at this point he was referred back to his GP.

(b) Hospital Admission 17th February – 16th March 2015

5.6 RN was admitted to hospital following a fall at home, the result of excessive alcohol consumption. This admission was soon after his mother's funeral, which he had been too ill to attend. Family members have commented that the loss of his mother, through a similar illness to his own and his inability to attend her funeral had a significant traumatic impact on RN and he binged on alcohol as a result.

5.7 On admission he was found to have numerous pressure ulcers which prompted a referral to the Council Safeguarding Team (this was the correct procedure before the implementation of the Care Act). A Mental Capacity Assessment was prompted by the discovery of the pressure damage and his continued refusal of treatment for this during his stay in Hospital. The Assessment established that RN had the mental capacity to make decisions about his care needs and had deliberately chosen not to seek treatment from his GP. Family members and the GP surgery confirmed the opinion that the pressure ulcers were a result of self-neglect and he was not in receipt of support from any other agency. Both the GP and family members confirmed that they were unaware of the existence of the pressure ulcers and that RN had neither sought treatment or complained about them.

5.8 The outcome of the safeguarding process was that RN agreed to accept ongoing support from the Tissue Viability Nurse, Occupational Therapist and Physiotherapists. The necessary referrals were made to introduce these services once RN had returned home. At this point the Safeguarding referral was "closed

down" although in hindsight it has been recognised that it would have been prudent to keep it open for a short time after discharge to ensure that the plans were viable and addressed RN's care needs.

5.9 RN's general health had improved in hospital; with no alcohol, regular meals and limited cigarettes he gained 9 kg in weight. RN had a Personal Assessment from a Hospital Social worker on 11th March. He had refused the offer of rehabilitation services, but to enable him to return home safely he agreed to accept an interim Social Care package, which comprised three daily visits from a Care Agency to support him with washing, dressing, assistance with meals, medication and keeping his flat tidy. In addition, a referral to the District Nursing Service was made to assist with dressing his pressure ulcers.

5.10 The care and treatment provided by the Hospital was thorough and addressed many of RN's presenting health needs which had responded positively to treatment. It was clear that some of the choices he had made had prolonged or worsened the severity of his pain and suffering and at various points the Hospital considered whether RN was making conscious and deliberate choices to avoid improving his health. It was clear that he established clear parameters about how far he would go in modifying his behaviour and while he had recorded his brother as his next of kin he also withheld consent from the Hospital in discussing his care and treatment with him.

5.11 RN was discharged home on 16th March; a Care Agency willing to undertake the support had been identified, discharge information was sent to the GP with a request to follow-up in one week's time for a blood test and monitoring of the pressure ulcers, the usual practice would be for there to be a follow up telephone call from the ward to the surgery and it has not been possible to confirm that this occurred on this occasion.

5.12 A referral was also made to Worcestershire Connect services to address some of his social needs, such as hobbies and clubs, help with welfare benefits, keeping his flat tidy and possibly bereavement support. For future reference, it should be noted that Connect do not provide welfare benefits advice and several weeks went by before the correct source of benefits advice was identified.

5.13 Social work responsibility transferred to the area Social Work Team by electronic transfer to await allocation of a Social Worker. This was customary practice for new cases that were safe with a package of interim care in place. It should also be noted that RN was one of a 150 pending cases at this time. This volume was not unusual and is illustrative of the rapid turnover in work for an area Social Work Team.

(c) Initial Care Plan 17th March – 23rd April 2015

5.14 Within a week of RN returning home problems with his planned package of support became apparent. The Care Agency first raised concerns with the Area Social Work Team about their inability to access RN's flat four days after his return home on 20th March. They were concerned about the condition of the property (described as "terrible"), his refusal of personal care support and sometimes denying them access to his flat. This frustration in RN's attitude to accepting help was reflected in

contact from a relative who also expressed their disappointment that RN was not accepting help from family members.

5.15 The Care Agency reiterated their concerns about the package to Social Care on 17th April; RN was still refusing support and often refusing them entry or asking them to leave after five minutes. In the light of this the Care Agency wanted to end their support because RN was refusing their support and they did not feel they could meet his needs. A social work visit was arranged for six days later – 23rd April, when a new Needs assessment was completed. It was agreed that the three daily calls would reduce to one lunchtime 30-minute call. The purpose of this visit was to prepare a hot meal, check RN had taken his medication and undertake any cleaning required.

5.16 The Needs Assessment recorded the opinion that RN was "anti-establishment but appears self-caring in all areas so does not need support with personal care". RN's focus was on his benefits and he diverted concern away from his personal care or the state of his flat. This seems to have been a pattern of behaviour that occurred repeatedly when he was being assessed.

5.17 With regard to the involvement of Connect, RN agreed to Connect workers visiting him and an assessment was completed on 4th April. He agreed to accept support regarding social activities, transport and benefits, but was not interested in stopping smoking or reducing his alcohol intake. This appeared to be a positive start; RN seemed motivated to accept some help, although there were clear limitations to this. He also shared his anger towards his GP and health services generally, who he believed had let him down regarding an operation on his leg. However, as with many of the attempts to support RN, the positive start was not maintained. A Connect Support Worker telephoned RN six times between 21st April and 5th June and was able to speak to him on five occasions. He was polite, but firm that he did not want the worker to visit.

5.18 In the month following RN's discharge from hospital he was separately assessed by three different agencies; the Care Agency, Social Care and Connect. There are some noticeable differences in these assessments; Social Care and Connect seemed to take at face value that RN could manage self-care and cleaning adequately and the focus was on providing social support. This view was at odds with the opinion of the Care Agency and the District Nursing service which had both described the conditions in the flat as "filthy and terrible". However, it is difficult to establish with any objectivity what the reality was regarding the material conditions; such as whether RN had adequate bedding, cleaning materials or access to a washing machine.

5.19 The extent to which alcohol was a problem is also described differently by different agencies, his use of alcohol is partly explained as self-medication for pain relief for his leg, his "alcohol dependency" could cause him to be "fed up", but it is not linked in the assessments to the state of his accommodation, his poor self-care and malnutrition. There is no reference to the long-standing nature of his alcohol problems although this information had been documented by the GP, Hospital, Community Health and Housing Authority.

5.20 The Social Care Needs Assessment undertaken with RN, was not shared between agencies or with RN himself. Neither did it prompt that level of reappraisal of how to meet RN's needs that the Care Agency felt it warranted.

5.21 A multi-agency meeting would have been very useful at this point to resolve some of the ambiguity in the parallel assessments, challenge RN about the amount of support he would realistically engage with and make plans for managing the on-going risk. The Care Agency deferred to Social Care in this respect in the belief that they held more information than they actually did.

5.22 The Social Care policy at the time was that following the social work assessment, another Social Worker/Social Work Assistant would undertake the support plan, this system is no longer in place and service users now only work with one Community Social Worker. The process in place in 2015 had inevitable delay built into it; the social work assessment was completed on 23rd April, but the visit to undertake the support plan did not take place until 11th May.

(d) Reduction of services 2nd May – 15th June 2015

5.23 The reduction in the number of visits from the Care Agency was a reasonable and pragmatic decision based on:

- the assessment that RN had the mental capacity to understand the decision and the potential consequences of it,
- the demonstrable failure to engage him constructively in three daily visits and
- his apparent willingness to accept help from Connect services.

5.24 However, there was a flaw in the agreed plan; whilst a lunchtime visit seemed a reasonable suggestion it would seem that RN was often out during the day, which further reduced the opportunity to work with him. He would also tell staff from the Care Agency that he did not either want or need their support.

5.25 The Social Care support plan completed during a home visit on the 11th May seems an accurate assessment of RN's needs at that time. It highlights his alcohol dependency, neglect of personal care, nutrition and worries over his benefits. The task for the Care Agency is clearly described as "*to prepare a meal, leave a flask of tea, prompt to complete personal care tasks, monitor medication has been taken or call GP".* RN also mentioned the pressure ulcer on his hip and gives his permission for the Social Work Assistant to contact the District Nurse. Unfortunately, due to a problem with the electronic diary system used by the District Nursing service the request was directed to a member of staff on annual leave and was not picked up for two weeks (27th May) by which time RN refused a visit from the District Nurse and also refused to contact his GP for advice regarding the pain.

5.26 The Support Plan was not shared with either the Care Agency or RN, which would have been good practice. Given the number of failed attempts to engage RN in services to support him and improve the quality of his life, it would have been useful to consider calling a multiagency meeting to share information and devise a shared approach.

5.27 By this time - mid-May - a pattern of RN agreeing to plans then subsequently disengaging was well established, and to some extent, probably expected. The Social Work Assistant also attempted to assist RN with welfare benefits and liaised with the Department for Work and Pensions and DIAL.

5.28 On 2nd June the Care Agency contacted Social Care and stated they felt RN's flat was unsafe for their staff to work in and would withdraw from the care package until the property has been cleaned up. This specifically referred to the state of the bathroom which was dirty and insanitary. A company was found to undertake the work although there was a delay in them gaining access to the flat to quote for the job.

5.29 The concern over the physical condition of the flat, the information from the Care Agency that RN was frequently not eating the food provided and his reluctance for his GP to be informed could have been the catalyst to call a multi-agency meeting or prompt a discussion with the safeguarding team due to the concerns about self-neglect.

5.30 On 4th June the Social Work Assistant spoke to RN on the telephone and he told her that he 'is not good today but I do not need a doctor'. The Social Work Assistant was sufficiently concerned to ring the GP informing him that RN was unwell, not eating the food the Care Agency prepare and living in dirty conditions. The GP recorded this contact as "for information" and would not have prompted a visit as this was expressly against RN's stated wishes.

5.31 The 4th June was RN's birthday, this was also his last contact with members of his family; there was an exchange of text messages to wish him Happy Birthday

5.32 The Connect Services' final contact with RN took place on the 5th June in similar vein; he reported feeling unwell complaining of pain in his head, neck, back and legs, but he refused to contact the GP or allow the Connect Support Worker to do so on his behalf. The Connect worker sent an alert via the electronic recording system about RN's health concerns to the Social Work Assistant.

5.33 The last contact anyone had with RN occurred on 15th June 2015; the cleaning company gained access to the flat at the third attempt and quoted for a deep clean for the bathroom. The Social Work Assistant left a message on RN's phone the following day.

5.34 The Care Agency continued to make daily calls, but were unable to gain access. Unlike previous occasions the agency did not contact Social Care on the assumption that they were already aware of RN's current condition.

5.35 While other agencies were aware of the long-standing issues regarding contact with RN, and access to his flat, it was an unusual course of action for the Care Agency with planned daily contact not to escalate these concerns after so many failed visits. The correct course of action was debated at the time within the Care Agency and in hindsight they recognise that they should have passed on these concerns sooner. This lack of action left RN as the service user, the individual staff and the Agency itself in a vulnerable position. However, it is important to also understand the decision in its context; they had formally raised concerns about the difficulty of

working with RN on five previous occasions and they did not see any significant improvement in the engagement of RN following these referrals.

5.36 The dominant view was that RN was exercising his right to make unwise decisions about his own care and there had never been a discussion with Social Care about what would be the appropriate trigger point to escalate concerns.

5.37 Eventually it was concern from RN's brother who contacted the Social Work Team on 30th June to say he had not been able to contact RN since his birthday on 4th June that prompted Social Care liaise with the Care Agency who confirmed they had not been able to gain entry to the flat for a number of days. The Social Work Assistant made a home visit and with the assistance of the Housing association gained access to the property. RN was found deceased in his flat and it was apparent that he had been dead for some time.

6.0 Practice Issues

a) Alcohol Dependency

6.1 RN's history of alcohol abuse was a serious and long standing problem; his GP records state that in April 2010 he was "utterly uninterested in stopping" drinking alcohol and had minimal motivation when it was suggested that he should refer himself to local alcohol services also in 2010. In all the GP practice gave RN advice on his alcohol consumption on eleven different occasions between 2009 and his death.

6.2 The Housing Trust were also aware of the history of alcoholism when he obtained the tenancy of his flat. Similarly, the Police records show a history of drink related issues and offences going back over 18 years.

6.3 The relevance of this historical information may be debatable, however, it is clear that his alcohol dependency was long-standing and significant, and predated the injury to his leg - which seems on occasion to have been a rationalisation for his use of alcohol. RN's alcohol dependency had consequences for his relationships with virtually all his family as well as his own physical and mental health. The assessments undertaken by Social Care were dependant on self-reporting and observations made during home visits; the fact that habitual drinkers underestimate their consumption is widely recognised[2] and a more accurate assessment could have been made after consultation with the GP or Housing Provider.

6.4 Given his lack of motivation to change it may well be that it was not possible to have an effective intervention with him. However, he was highly unlikely to ever self-refer or respond to information in a leaflet. His problems with alcohol were more serious and long-standing than the assessments seem to recognise. It is significant that while several professionals observed RN drinking alcohol, no one reported seeing him drunk or passed on their concerns about his use of alcohol. As a habitual drinker, his tolerance level had built up over the years and masked the extent of his drinking.

b) Self-Neglect

6.5 The research on self-neglect[3] emphasises the importance of building relationships in enabling people to commit to and engage with the process of change. It was apparent that RN could be resistant and it would take time to build trust, and unfortunately the management of his case did not allow for a trusting working relationship to develop.

6.6 It is accepted in most of the IMR's, that self-neglect was not so widely recognised as a safeguarding issue in 2015. Yet it is quite clear that professionals recognised some aspects of RN's illness and his struggle with daily living and did not see his inability to care for himself as a "lifestyle choice". However, the way self-neglect is conceptualised still tends to lead professionals towards making an either/or decision; if a person has mental capacity then by definition they can choose their lifestyle and are making a conscious choice. In the case of RN, with a history of nearly three decades of alcohol abuse, living with a chronic and painful disabling injury, the options of improving his situation may have felt severely constrained and not an exercise in freedom of choice.

6.7 It became apparent in this review that describing material neglect and dirty living conditions is a subjective process and there was a noticeable disparity in how different professionals describe the same conditions. Value judgements apart, it should be possible to adopt an

[2] Drinkers can underestimate alcohol habits DoH 2013

[3] Self-neglect and adult safeguarding: findings from research SCIE 2015

agreed baseline standard for objectively describing material conditions and their impact on the person living in them.

6.8 Designating a pattern of behaviour as a safeguarding issue does not in itself make an individual safe. However, the WSAB self-neglect – process does require a multiagency perspective and brings individuals and agencies together to share their concerns. There are several occasions in the period under review where assessments were not shared when it would have been helpful to do so. Also, assumptions were made about contact with RN, when the reality was that all agencies were facing the same difficulty, and no agency, individual or family member were any more successful than anyone else in maintaining a relationship with RN.

6.9 Perhaps most importantly the self-neglect process would have necessitated a multi-agency meeting and identified a Lead Professional to coordinate and oversee the management of concerns. This is a finding is similar to other local and national Safeguarding Adult Reviews.

c) Assessment of Mental Capacity

6.10 The assessment of mental capacity is the responsibility of all agencies, and all agencies have policies and training programmes in place to train staff in their responsibilities under the Act.

6.11 RN's mental capacity was formally assessed on one occasion; as an in-patient on 19th February immediately after the Safeguarding referral was made with specific regard to his capacity to make decisions about his care. The assessment concluded that RN had the capacity to make decisions regarding his care needs.

6.12 There are a number of reasons why mental capacity was assumed in RN's case and not formally assessed. Firstly, there was an assumption that due to his age and relatively independent life, he must have mental capacity. Secondly the extent of his alcohol consumption was unknown or underestimated by most services in day to day contact with him. Underpinning this was his general presentation as a person who knew the consequences of his actions, and was making his own choice about the degree of help he wanted.

6.13 All the available evidence is that RN retained mental capacity, however there is a learning point for agencies regarding the failure to record the assumption of capacity and the reasons for this. In view of his rejection of support it would have been prudent for all agencies to address this in their record keeping.

d) Safeguarding

6.14 A Safeguarding Referral was initially raised in hospital in February following the discovery of a number of pressure ulcers. The cause of the pressure ulcers was recognised as being the result of self-neglect and failure to seek treatment in the community. The subsequent protection plan addressed his immediate needs and also made reference to the need for further care in the community on discharge.

6.15 This Review has found a lack of continuity in the follow-up between in-patient and community services where there have been safeguarding issues. One possible solution would be to keep safeguarding referrals, where there is a need for ongoing care and support, open for a period of time to ensure that referrals are followed up and the plan is viable. RN seemingly took the "line of least resistance" when he was confronted by the support plan, in the sense he agreed to accept services in principle but did not cooperate, or abide by these agreements following his discharge from hospital.

6.16 Identification of RN as being higher risk and more vulnerable was not recorded explicitly by the GP surgery and this may have been a missed opportunity. Practice staff would have

benefitted from being made aware of the information from other agencies and organisations. This information would enable fuller understanding of RN's needs, risks and vulnerability which may have enabled the practice to develop a coherent plan which would potentially help understand the risks to RN.

6.17 RN's expressed very negative opinions towards his GP and the District Nursing Service and shared these with Social Care, although it seems health professionals were unaware of this hostility. Given his views it was highly unlikely that he would engage constructively with them. The GP surgery took no proactive action to feed back their inability to engage RN.

6.18 A further safeguarding referral was unlikely to come from any one single agency because the ones who were actively involved with RN did not have the historical context, and the agencies who did possess the previous case history were not in current contact with him. However, the degree of self-neglect demonstrated by RN was on the threshold of becoming a safeguarding issue.

6.19 The current guidance on self-neglect includes the following guidance:

"Bray et al (2015) state that for definitional purposes self-neglect,

> "Includes people, either with or without mental capacity, who demonstrate:
>
> • lack of self-care – neglect of personal hygiene, nutrition, hydration and/or health, thereby endangering safety and wellbeing, and/or
>
> • lack of care of one's environment – squalor and hoarding, and/or
>
> • refusal of services that would mitigate risk of harm."[4]

6.20 At the very least a multiagency meeting could have been convened, which would have given the opportunity to discuss the reality of his home situation and the effectiveness of the existing plan in addressing his needs.

e) Relationship between Service User and Professionals

6.21 Prior to the period under review RN had limited contact with any agency. He was described by his GP practice as a "low profile" patient. If and when he needed treatment, he was more likely to use out of hours' services rather than his GP.

6.22 RN expressed hostility and suspicion towards health professionals, and in particular his GP surgery whom he seemed to hold responsible for (in his opinion) the unsuccessful treatment of the injury to his leg in 2013. He also kept District Nursing Staff at arm's length and only reluctantly accepted help from them for a short time.

6.23 "Acceptable" help for RN centred around medical intervention for his leg fracture and throat cancer; RN had made his views quite clear about his self-neglect and his alcohol issues. It is the nature of work with "hard to reach" individuals that professionals essentially make a compromise; and accept there are areas that a person won't engage with in order to preserve a working relationship in the hope that an opportunity to address these concerns will occur at some point in the future.

6.24 RN's relationship with non-medical professionals and carers were slightly better, although the degree to which he would cooperate, or even allow people into his flat, varied considerably. As part of this Review professionals and family members have reflected on RN's attitude towards accepting help, and despite the frustrations of seeing someone whose quality of life could be improved reject the help on offer, they reluctantly accept that RN did this in full knowledge of the likely consequences. This may have been driven by a

[4] Worcestershire Adult Safeguarding Board Multi-Agency Self Neglect Guidance p5

misplaced fear of the consequences for his independence or embarrassment at the physical conditions he lived in.

6.25 It may perhaps have been implicit in some of the assessments, but an overt recognition that RN was “hard to reach” may have prompted a different approach earlier on. It would have been appropriate for the social work staff holding the case on a duty basis to escalate their concerns to their manager when it became apparent that RN was not accepting help and the material conditions were significantly worse than expected.

7.0 Summary

7.1 In common with many Safeguarding Adult Reviews, this one raises questions regarding assessments, joint planning, sharing of information and uncertainty about escalation processes.

7.2 Efforts were focused on superficially addressing RN's physical health and care needs - which were essentially the only one's RN would allow agencies to help him with. There was a range of potential support which he declined.

7.3 The central unaddressed concern was his alcohol dependency; this was a long-standing illness which he expressly did not want to be helped with. It is well known that alcohol dependency has serious social consequences as well as affecting physical and mental health.

7.4 The background information regarding his alcohol use was relevant because it painted a picture of an individual who had long-standing problems which were in evidence before agencies became involved. He also showed a tendency to ignore advice about his health, and lacked motivation to change aspects of his lifestyle, which would have made daily living easier and possibly also extended his life.

7.5 With regard to assessments, the link between RN's health problems and his living conditions was known by his GP at the time of his treatment for cancer in 2014. The material conditions within his flat were confirmed by the District Nurses who attempted to dress his wounds in December 2014, and partly acknowledged by RN himself when he was admitted as an in-patient in February 2015. Whilst in hospital he admitted that he was having problems with his flat and would accept help. However, this soon proved not to be the case and the pattern of RN refusing entry to carers became established.

7.6 Although his care needs were reassessed by different agencies, the link between his health needs and his home environment seems to have been lost following his discharge from Hospital in March 2015 and essentially a "bargaining" took place between RN and Social Care where he accepted the minimum amount of help to allay professional's concern, although in reality, he did not comply with these arrangements either.

7.7 A holistic assessment would have been the precursor of effective joint planning, and there is little evidence of joint planning, with regard to RN. This is not to say that information was not shared; but the situation arises when events are merely "reported" but their meaning and significance is not recognised. In this case, for example, the number of failed attempts by the Care Agency to gain access was the clearest indication that the support plan was not working. Eventually the number of failed visits was only logged by the company and the concerns not passed on to Social Care.

7.8 This in turn raises the question of sharing information at a very basic level. There seems to have been an assumption that Social Care were engaged to a much greater degree. While they played a key role in further assessment of RN, and Connect also offered some support (not taken up), their contact with him was extremely limited and there was little involvement beyond the statutory assessments. RN had effectively declined offers of help from Occupational Therapists, Dieticians and District Nurses, leaving only the Care Agency supported by Social Care.

7.9 In this case it is possible that concerns were not escalated because the expectations of RN's adherence to the plan were minimal and the best that would have been hoped for was early warning of imminent deterioration. This may be seen as being unduly pessimistic, but by the end of May there was 10 weeks' evidence of failure of the care plan, lack of engagement in any of the services offered and a deterioration in the home conditions to the extent a deep clean was requested on health and safety grounds in order for the Care Agency to remain involved.

7.10 In a case such as this the existing Multi-Agency Escalation Procedure does not seem

particularly relevant because it has a focus on professional disagreements between agencies. In this case all agencies were struggling individually with the same problems of engagement of their service user and needed to share information and concerns.

7.11 In the context of a plan which had never properly worked it may have seemed that the situation had not deteriorated, but was progressing as well as could be expected.

8.0 Recommendations

Multi-Agency Recommendations

1. WSAB should review the current Self-Neglect Policy to emphasise:
    a) the role of a lead professional (currently referred to as a “key person”) in coordinating the multi-agency response and ensuring there is communication between agencies,
    b) all agencies should share information when an appointment has been missed or postponed where there are concerns about self-neglect,
    c) a multi-agency adoption of objective descriptors of material and personal conditions that depict the individuals living conditions and the effect on themselves and others.

2. The revised Self-Neglect Policy will be reissued and publicised to all agencies working with vulnerable adults in Worcestershire.

9.0 Appendix 1 – Terms of Reference

1. Introduction:

1.1 On 30th June 2015 RN's brother contacted the Area Social Work Team to advise that he had been unable to contact his brother. RN was found deceased in his flat. The care agency had not seen RN for some time prior to his death. The family advised that the last entry in the care record was 15.6.15, the correct time of death has not been established.

1.2. The information provided indicated that RN was a very private man who did not readily share information with his family or professionals. It appeared that RN had been neglecting his self-care and home environment and had been refusing to accept care and treatment.

2. Supporting Framework:

2.1. The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

2.2. Section 44, Safeguarding Adult Reviews**:**

(i) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(ii) Condition 1 is met if:

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

2.3. This Safeguarding Adult Review is being held in accordance with the Worcestershire Safeguarding Adults Board Safeguarding Adults Review Protocol

criteria **1**. This states that "*the Worcestershire Safeguarding Adults Board must arrange for there to be a Review if the statutory criteria prescribed in section 44 of the Care Act 2014 are met. Statutory Guidance on these criteria is provided in Chapter 14 of the Care and Support Statutory Guidance, at paragraphs 14.133 and 14.134. Therefore, the Board **must** undertake a Safeguarding Adults Review under the following circumstances;*

> *when an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) dies and the Worcestershire Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knows about or suspected the abuse or neglect before the adult died)."*

3. Methodology:

3.1. This Safeguarding Adults Review will primarily use an investigative, systems focused and Individual Management Review (IMR) approach. This will ensure a full analysis of detailed chronology to show comprehensive overview and alignment of actions.

3.2. This will ensure that practical and meaningful engagement of key front line staff and managers will take place on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.3. This is more likely to embed learning into practice and support cultural change where required.

4. Scope of Safeguarding Adult Review:

4.1. Adult: RN Date of Birth: 4th June 1967
Date of Death: 30th June 2015

4.2. Timeframe

The scope of the SAR will be from 1st September 2014 to 30th June 2015

4.3. In addition, agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of this adult.

5. Agency Reports:

5.1. Agency Reports will be commissioned from:

- Worcestershire County Council
- Worcestershire Health and Care Trust
- Redditch and Bromsgrove Clinical Commissioning Group (GPs)
- Care Force
- Bromsgrove District Housing Trust
- Worcestershire Acute Hospitals NHS Trust

- West Mercia Police
- 3RExtreme (short report)

5.2. Agencies will be expected to complete a chronology and IMR. Please see a template and guidance attached. It is essential that the IMR does not hold raw information but instead is an analysis of agencies actions, systems and processes in regards the areas for consideration listed below. Agencies should note that IMRs may be requested by the Coroner and / or RN's family.

6. Analysis

When analysing the actions taken by an agency IMR authors are requested to consider the six principles of adult safeguarding[5] and also to address the following specific questions:

1. Determine whether the policies, procedures and practice expectations of the agencies were followed during the review period.
2. Are there any parallel processes; search as criminal investigations, civil actions or employment/disciplinary hearings, which affect this review?
3. How did the agencies seek to engage RN with their services?
4. The quality and effectiveness of services provided to RN; to what extent do agencies consider they understood and were able to respond to his needs?
5. Does the way RN was responded to highlight any gaps or deficits in service provision?
6. Within the review dates, specific episodes where agencies had direct contact with RN should be considered for deeper analysis under the following broad headings:
    a. How did the professionals working with RN understand and fulfil their responsibilities in relation to:
        i. Patient/Service user confidentiality,
        ii. Safeguarding responsibility,
        iii. Duty of care,
        iv. Professional boundaries?

5 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197402/Statement_of_Gov_Policy.pdf

b. The quality and effectiveness of information sharing and planning between agencies.
c. The level of awareness of safeguarding in adult and community services, in particular is training adequate and supervision and management oversight adequate?

7. Areas for consideration:

1. How the agencies held Making Safeguarding Personal[6] at the centre of all the services provided to RN Specifically, how these needs were assessed and the plans for addressing those needs.
2. What evidence is there that DoLS and MCA were considered – were managers involved in these discussions?
3. How do agencies ensure that key groups have completed MCA DoLS training and how do they assure that this is embedded in day to day practises?
4. Did agencies consider the issue of self-neglect, what action did they take in regards to escalation when concerns were raised. (the Self-Neglect Policy[7] was not in place at the time under review)
5. How did agencies work with others that were involved with RN? Was there evidence of multi-agency planning and liaison?
6. What role did the Occupational Therapist play within the Safeguarding context, how did they link in with other agencies?
7. How were concerns relating to living conditions and welfare responded to?
8. Had appropriate action been taken to maximise RN's finances?
9. What attention was paid to dietary and nutritional needs by health agencies?
10. What support was offered and what action was taken in regards to RN's use of alcohol?
11. What policies do agencies have in place relating to recording, how is this evidenced and how does these feed in to the risk assessment process?
12. Were the decisions around Fair Access to Care Services (FACS)[8] correct?
13. Were the safeguarding concerns around RN's pressure ulcers understood and managed appropriately?

[6] http://www.worcestershire.gov.uk/wsab

[7] http://www.worcestershire.gov.uk/downloads/file/6609/wsab_self_neglect_guidance

[8] http://www.scie.org.uk/publications/guides/guide33/

14. How did agencies engage with the family?

15. What continuity was there in regards to RN's care?

16. What action was taken when it became apparent that care needs not being able to be met?

17. Was malnutrition and alcoholism considered within RN's hospital discharge?

18. Did the use of Discharge Home to Access / Patient Flow processes impact on proper discharge planning and address social needs as well as medical ones?

    a. Who was managing pressure ulcers?
    b. Was information around pressures ulcers shared?
    c. Was the decision to reduce the care package appropriate?
    d. Was the care plan specific in regards to what was required and how to escalate issues around self-neglect?
    e. What information was shared with the care agency?

8. Engagement with the individual/family

8.1. While the primary purpose of the Safeguarding Adult Review is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in and across agencies and services, it is imperative that the views of the individual/family are included in this.

8.2. Firstly, this is in recognition of the impact of RN's experience/death. In doing so it ensures that this enshrines the principles and practice of Making Safeguarding Personal, a core value signed up to by all agencies working as part of the Worcestershire Safeguarding Adults Board.

8.3. Worcestershire Safeguarding Adults Board are responsible for informing the family that an Independent Reviewer has been appointed.

8.4 All IMRs are to include details of any family engagement that has taken place or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the SAR.

9. Media Reporting

9.1 In the event of media interest all agencies are to use a statement approved and provided by WSAB.

10. Publishing

10.1 It should be noted by all agencies that the SAR report will be published once complete.

11. Timetable for Safeguarding Adult Review

Item	Date
Scoping Meeting to agree on Panel members, terms of reference, methodology etc. Letter to IMR agencies to identify authors and secure documents	4th February 2016
First introduction and discussion with the family	May
Panel Meeting	20th June 2016
Authors' briefing	14th July 2016
Completion date for IMRs	5th September 2016
First draft of Report circulated to learning event attendees	15th September 2016
Learning event for practitioners and panel members	22nd September 2016 (Venue TBC)
Final draft of report completed and 2nd meeting with family to consider final draft and suggest amendments. Any amendments made to final draft following meeting with family	September
Panel meeting to approve final draft of the report and draft multi-agency action plan. Any amendments made to final draft following panel meeting	October
Safeguarding Adults Review Sub Group meets to consider final draft report and multi-agency action plan circulated to Worcestershire Safeguarding Adults Board members.	October
Final draft report and multi-agency action plan circulated to Worcestershire Safeguarding Adults Board members.	5th December 2016
Worcestershire Safeguarding Adults Board meets to consider final report and multi-agency action plan and consider dissemination of learning, publication etc.	12th December 2016

Appendix 2 – Single Agency Action Plans

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
1	The Integrated Safeguarding Committee (ISC) within WHCT develop actions in relation how all staff assess and support patients who are known to have an alcohol dependency.	The ISC consider this recommendation at the ISC meeting 1st September 2016	Minutes of ISC meeting	Specific actions identified	1/9/16	1/9/16	**Completed**		WHCT
2	The Guidance for Management of Self Neglect Policy is reviewed and includes advice when caring for patients who may be considered to misuse alcohol.	Guidance for Management of Self-Neglect in Adults reviewed.	Policy development	Additional guidance is available to support practice for staff working with patients who are known to have an alcohol dependency, aimed at providing best possible care to this patient group.	1/1/17		**In Progress**	Policy has been revised and consultation completed. Just awaiting final approval processes	WHCT
3	The Medical Director writes a briefing for staff to be circulated within the 2-minute update reminding staff of possible complications of alcohol misuse and how this may contribute to self-neglect	Briefing written	2 Minute Update Circulated	Briefing written	5/12/16	11/11/16	**Completed**	Email sent out to staff (see sheet 3)	WHCT

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
4	The organisation undertakes a 'dip audit' of referrals to Community Nursing teams to give assurance that significant delays in response to receipt of referral is not a wider spread issue.	Community Nursing Audit to be undertaken	Audit report	WHCT can be assured that patients are not at risk due to failures within the organisation to respond to referrals in a timely way.	5/11/16	5/11/16	**Completed**	Dip audit completed and triangulated with lack of complaints and positive feedback from users	WHCT
5	Staff are empowered to challenge poor quality referrals / referrals with inadequate information.	The ISC consider this recommendation at the ISC meeting 1st September 2016	Minutes of ISC meeting	Specific actions identified	1/9/16	1/9/16	**Completed**		WHCT
6	The teams involved review their referral processes ensuring they are assured that sufficient information is received within any referral to undertake the assessment requested.	Quality leads review referral processes with teams.	Locality Quality meeting minutes	Assessments are based on adequate information and if not included in original referral is sourced elsewhere - either the patient or by follow-up with the original referrer	1/1/17		**Not Started**		WHCT
7	A dip audit is undertaken to provide assurance that Referral information received is sufficient to support best practice.	Dip audit of referrals to DN and OT teams	Audit report	Assurance can be provided that Referral information received is sufficient to meet service needs to provide best possible care for patients	5/12/16		**Not Started**		WHCT

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
8	Social work and Connect staff to be reminded to send Assessments & Support Plans to Service-users and Providers in a timely manner	Communication to all relevant staff	E-mail and Minuted discussion at Team Meetings	Improved communication about assessment, care needs and risks for service-user and Provider	30/10/16		**Overdue**		WCC
9	Social work and Connect staff to be reminded to read through previous case notes and episodes on Frameworki, paying particular attention to any Safeguarding issues, when allocated a new case	Communication to all relevant staff which will also reference the recording standards.	E-mail and Minuted discussion at Team Meetings	Ensuring staff take into account relevant history, particularly over any previous safeguarding issues	30/10/16		**Overdue**		Wcc
10	Ensure Connect staff have adequate Frameworki training and are aware and able to create new Support Plans, not just add on to previous out-of-date Support Plans	Connect Manager checks individual staff have had adequate Frameworki training and are able to create new support plans.	Individual Supervision and training if needed	Ensure staff can create appropriate up-to-date support plans with clear outcomes	31/12/16		**Not Started**		WCC
11	Link to current Worcestershire Self-Neglect Policy sent to all social care and Connect staff	Practice Development Groups to be established, with	E-mail and Minuted discussion at Team Meetings	All staff are aware of the Worcestershire Self-Neglect Policy and know how to escalate concerns	30/10/16		**Overdue**		WCC

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
		the first session to be on self-neglect							
12	Actions from Protection Plan on all Safeguarding episodes need to be clearly recorded as completed on Frameworki	Add to guidance on closure summaries.	E-mail and Minuted discussion at Team Meetings	All staff involved in Safeguarding work ensure that agreed Protection Plan is implemented and evidenced as such	30/10/16		**Overdue**		WCC
13	Any assessments or safeguarding episodes involving Self-neglect, completed by Hospital staff, should not be ended in Hospital, but workflow passed to Locality Social Work Teams to monitor, review and complete if the service-user returns home.	Practice Development Groups to be established, with the first session to be on self-neglect. Standard operating procedures to be developed for the hospital teams.	E-mail and Minuted discussion at Team Meetings	All Hospital social work staff are aware that self-neglect issues but must be followed up in the community if service-user returns home, and not ended by hospital staff	30/10/16		**Overdue**		WCC
14	Connect Information Leaflet sent to all social care staff as a reminder of what they can and cannot do	Connect Information Leaflet to be reviewed.	E-mail and Minuted discussion at Team Meetings	Social Care staff are aware of the services that Connect can offer	30/10/16		**Overdue**		WCC

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
		Leaflet to be disseminated to staff.							
15	All WCC Social Care Managers reminded to allocate any cases where there are Safeguarding or Self-neglect concerns to qualified social work staff only.	Communications to all social care managers	E-mail and Managers supervision	Managers allocate safeguarding and self-neglect cases to appropriately experienced and qualified staff	30/10/16		**Overdue**		WCC
16	Managers ensure staff have done up-to-date training on Assessment Skills/Safeguarding/MCA/DoLs and this is recorded	On-going Individual Social Work and Managers Induction and Professional Development Spreadsheet developed for	Spreadsheet created, updated, and monitored for all staff	All staff receive appropriate training and it is clearly recorded on their individual Spreadsheet	30/10/16		**Overdue**		WCC
17	Learning from IMR to be disseminated to practice staff.	GP Practice to include learning from IMR for discussion in one of their practice's Multidisciplinary meetings.	Practice informs CCGs that this has been discussed and is included in the Practice MDT Meeting	To strengthen processes and practice	31/12/16		**Not Started**		CCG

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
			Minutes.						
18	Process for routine GP notification of adult Did Not Attend (DNA) appointments not robust	GP notification of DNA appointments will be in accordance with an agreed standard	Patient records	Agreed process will be followed	31/12/16		**Not Started**	02.11.2016 - this action has been sent to clinical informatics Jas Cartwright to ascertain if this can be actioned from the Trust Oasis system for any appointments recorded as a DNA -response awaited	WAHT
19	GP's to take all reasonable actions to ensure post discharge recommendations are implemented.	Every discharge letter is reviewed by a GP alongside the patients record and actions implemented	Patient records						
20	Quality Policy reviewed QMS -QMS01	Reviewed	Ensure compliant with current legislation	Ensure suitable	1/8/16	1/8/16	**Completed**		Care Force Ltd

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
21	Access to Premises Policy reviewed HR - 16 - 0002	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
22	The Failure to gain access and missing person reporting form generated. Admin – 7 – 0033.	Generated and implemented/issued	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
23	Failure to gain entry & missing person Log generated Admin - 7 – 2 - 0050.	Generated and implemented/issued	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
24	**All Care Force policies to be reviewed and amended to include the Care Bill 2014**		Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
25	General Safe guarding policy statement reviewed HR -16-0034	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
26	POVA Protection of Vulnerable Adults Reporting policy & Procedures HR -16 - 0048	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
27	MEETING Needs Procedure Reviewed HR -16- 0053	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
28	Missing Person policy reviewed HR -16- 0054	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
29	Policy & Procedure on the Mental Capacity Act 2005 & Deprivation of Liberty Safeguards reviewed HR -16- 0061	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
30	RECORD Keeping Policy reviewed HR -16- 0070	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
31	Recording System Policy reviewed HR - 16 - 0072	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
32	Risk assessment policy reviewed HR -16 - 0078	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
33	Safe guarding of Service users from Abuse Policy Reviewed HR -16 - 0080	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
34	Whistle blowing and Referrals Policy Reviewed HR -16 - 0090	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
35	Failure to gain access policy Reviewed HR -16 - 0095	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
36	Late and Missed calls policy & procedure reviewed HR -16 - 0096	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
37	People Planner automatic response to missed calls was not fully operational.	Electronic Monitoring System (EMS). Will be activated week commencing 27th July 2015	Reviewed monitoring logs	Ensure ALL staff are applying booking on/off protocols	31/7/15	31/7/15	**Completed**	New system being rolled out initial issue with mobile app now rectified	Care Force Ltd

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
38	People Planner feedback portal to be tested and implemented (This is a real-time communication tool that staff can communicated with the office, it supports the written communication Monitoring forms)	Roll out usage with all staff	Portal visited throughout the day	Now fully operational	1/7/16	1/7/16	**Completed**	New system being rolled out initial issue with mobile app now rectified	Care Force Ltd
39	**Care Force to appoint a Quality reviewing officer.**	Quality reviewing officer to be appointed.	Victoria Parker (Front line Carer appointed)	To improve quality and to monitor performances	1/3/16	1/3/16	**Completed**	Commitment from the Directors to promote Quality and accountability	Care Force Ltd
40	**All office based employees** to attend an operational meeting to discuss the failure to gain entry and missing person protocols	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
41	**All office based employees** to receive the Failure to gain access and Missing persons' policies	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
42	**All office based employees** to be made aware of the Failure to gain access and missing person reporting form and the requirement for Community employees to be prompted to complete this form when an issue is reported	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
43	**All office based employees** to be made aware of the requirement for office-based employees to complete the failure to gain entry and missing person log and report concerns immediately to the Registered Manager.	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
44	**All office based employees** to be aware of the WCC Adult protection team 0845 607 2000 during office hours and the emergency duty team 01905 768020 for out of hours	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
45	**All office based employees** to be aware of the Multi agency reporting protocols	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
46	**All office based employees** to be aware of the Mental Capacity act and Deprivation of Liberties Safeguarding	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
47	**Team Leaders** to attend an operational meeting to discuss the failure to gain entry and missing person protocols	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
48	**Team Leaders** to receive the Failure to gain access and missing person policies	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
49	**Team leaders** to be aware of the Multi agency reporting protocols	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
50	**Team Leaders** to be made aware of the Failure to gain access and missing person reporting form and the requirement for Community employees to be prompted to complete this form when an issue is reported (best practice will be for the TL to complete a	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
	form to support the frontline Health Care Worker by detailing and comments or actions they have made)								
51	**Team leaders** to be aware of the WCC Adult protection team 0845 607 2000 during office hours and the emergency duty team 01905 768020 for out of hours	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
52	Team Leaders to be aware of the Mental Capacity act and Deprivation of Liberties Safeguarding	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
53	Front line Carers to attend an operational meeting to discuss the failure to gain entry and missing person protocols	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
54	Front line Carers to receive the Failure to gain access and missing person policies	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
55	Front line Carers to be aware of the Multi agency reporting protocols	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
56	Front line Carers **to** be made aware of the Failure to gain access and missing person reporting form and the requirement for Community employees to be prompted to complete this form when an issue is reported (best practice will be for the TL to complete a form to support the frontline Health Care Worker by detailing and comments or actions they have made)	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
57	Front line Carers to be aware of the WCC Adult protection team 0845 607 2000 during office hours and the emergency duty team 01905 768020 for out of hours	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
58	**Front line Carers** to be aware of the Mental Capacity act and Deprivation of Liberties Safeguarding	Company meeting planned	Register completed	Staff aware of policies/protocols	20/07/2015	20/07/2015	**Completed**	General discussions found staff were aware of the policies and protocols	Care Force Ltd
59	Development & Training policy reviewed HR - 16-0020	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
60	Health & safety Policy reviewed HR - 16 - 0038	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
61	All staff to attend refresher training	Reviewed and correct			5/9/16	5/9/16	**Completed**		Care Force Ltd
62	Health & Safety policy reviewed HR -16-0038	Reviewed and correct	Reviewed all relevant Policies	Amended where appropiate.ie Made reference to the Care Bill 2014	1/8/16	1/8/16	**Completed**	Found Policy still referred to the old CQC safety standard	Care Force Ltd
63	All Staff issued with "Skills for Care “Codes of conduct	Discussed in company meeting and training replaced if required	Register completed	Staff aware of codes	20/07/2015	20/07/2015	**Completed**	Staff aware and the need to apply	Care Force Ltd

	Recommendations	Key Actions	Evidence	Key Outcome	Target date	Date Completed	Status	Comment	Agency
64	All Staff issued with the "Six Cs"	Discussed in company meeting and training replaced if required	Register completed	Staff aware of the six Cs	20/07/2015	20/07/2015	**Completed**	Staff aware and the need to apply	Care Force Ltd
65	John Hollingsworth &Michelle Coates to attend WCC Mental capacity act & DOLS training	To develop Knowledge	Certificates	Improve and apply best practice/Duty of Care/Duty of Candour	04/07/2016	04/07/2016	**Completed**	Half Day course	Care Force Ltd
66	John Hollingsworth &Michelle Coates to attend WCC Mental capacity act & DOLS training	To develop Knowledge	Certificates	Improve and apply best practice/Duty of Care/Duty of Candour	09/01/2017		**In Progress**	Book in on two-day course to build upon the knowledge gained on the 4/7/16	Care Force Ltd
67	All office notice boards to have up to date guidance for staff relating to Safeguarding /Whistle blowing	Ongoing	Notice board viewed		Ongoing	Ongoing		To share knowledge	Care Force Ltd
68	Safe guarding questions check on interview process	Reviewed Document	Document visited	No amendment required	20/7/15	20/7/15	**Completed**	Interviewers aware of protocols and apply them	Care Force Ltd