Practitioner Learning Brief Safeguarding Adults Review (SAR): SONIA

September - December 2016

In September 2016, Sonia's leg ulcers were being treated at home by District Nurses, who expressed concerns over her property being unclean (dog faeces and urine). The Duty Team and Care Provider were made aware, but no review took place.

District Nurses' visits continued, however requests for the home to be cleaned were not fulfilled.

A Mental Capacity Assessment was completed in November; the outcome was that Sonia had capacity but also a learning disability (not a formal diagnosis). Care provision was also withdrawn at this time due to internal capacity issues; a care and support needs review was carried out with Sonia and her brother. The review found that they supported each other in some areas, but that Sonia also required equipment, adaptation, and support as she was also struggling to maintain a habitable home environment and her personal hygiene. It was recorded that an OT (occupational therapist) assessment for both Sonia and her brother would be of benefit, and care packages were commissioned from a new provider (interim provider covered this support until January 2017).

In December a further review took place, and it was established that Sonia wasn't accessing the community, and her brother was meeting some of her needs. Her care package was reduced from 14 to 3.5 hours (rationale not documented) and a functional referral to OT was also made at this time.

August - September 2017

In August, Sonia was discharged from the mobility service (re-refer once works in the house were complete and wheelchair provided). Around this time, Sonia reported possible financial abuse by an informal carer/friend (a safeguarding referral was raised by care provider).

In September, a joint visit took place regarding the financial abuse and Sonia's brother took over management of her finances. Conversations were also still ongoing regarding the adaptions to Sonia's house (delayed by the need to know the exact measurements). From mid-September, Sonia reported feeling increasingly unwell, which led to antibiotics being issued by the GP, however this was not until 3 days later as it hadn't been marked as urgent. Sonia's health unfortunately deteriorated further some days later and she was taken to hospital by ambulance, where she died the following day.

Background

- 60-year-old female, described as a sociable woman who enjoyed the company of others.
- Worked at a hospital for several years, however left in the 1980s due to an incident in which she was attacked, resulting in her experiencing anxiety out in the community (relied on her mother to be with her).
- Lived with her brother following the death of her mother in 2006 (father died in 1996) and both had care plans (Sonia from 2006 and her brother from 2011 following a stroke).
- Became housebound (and stopped using the upstairs of the house) following a fall and lengthy hospital admission in 2015 (however expressed a wish to be able to go out and walk the dog).

January - June 2017

New care provision began in January and, following an EPUT home visit in February, a referral was made for a mobility assessment (to widen a doorway in the home). In March Sonia had ulcers, oedema and bandages which limited her physically, and a fear of falls leading to anxiety; hence a wheelchair was required, and wider doorways for access.

In April, a telephone review was carried out by Social Care with Sonia; she was happy with her care package and hadn't noticed the reduction in hours (due to support, including kitchen tasks, from her brothers' carers during their visits). Input into the review from the care provision confirmed that Sonia and her brother helped each other with some personal care needs, however these needs were not met to a high standard, so a 'tea call' was recommended. It was also noted that Sonia had a dog that frequently had accidents inside the house which she couldn't clean up as she didn't appear to mobilise, so they suggested a joint review of both Sonia and her brother be carried out with social workers; however, this had already taken place (around this time, Sonia and her brothers cases were transferred from Working Age Adult (WAA) Team South to WAA Mid team, and a telephone call took place between teams).

Throughout May and June, contact was maintained with Sonia regarding her mobility, nurses continued to visit to attend Sonia's leg ulcers and attempts to progress the door widening obtain a wheelchair were made.

6 services working with Sonia at the same time in 2016 and 2017.

10 A reduction of 10.5 hours in Sonia's care package took place in 2016.

1 Only 1 safeguarding concern raised for alleged financial abuse.

4 areas for improvement that were identified:

1. Identified learning to be shared through joint learning events and training programmes, to link with internal programmes of individual organisations, draw on work already ongoing and learn from each other.

2. Assurance that the links already developed between practitioners across borders, and the impact of this that is being felt, continues to develop, and improve.

3. Review the systematic factors that can impede practitioners from using their professional curiosity and identify what could be done to overcome barriers.

4. Review how multi-agency work operates and whether practitioners understand which teams/partners to access? Are they empowered to engage with colleagues to share information, develop joint understandings and achieve consensus about a situation before exploring and agreeing solutions.

Good Practice:

Several incidents of good practice were recognised throughout the SAR report, where practitioners:

- Documented their assessments, which were completed and reviewed regularly (NELFT Integrated Community Team).
- Established effective communication with Sonia through the expert development of a therapeutic relationship (EPUT Learning Disability Team).
- Acted promptly and proactively in response to the safeguarding concern in August 2017 (EPUT Learning Disability Occupational Therapist). A concern had already been raised and so they did not raise another one (although they could have done), but they did chase ECC ASC Safeguarding and kept in contact with the care provider who had raised the concern until the situation had progressed.
- Worked proactively to progress the adaptations needed by Sonia to enable her to move about her home comfortably and leave her home at all. This involved working with other services including the housing provider (EPUT Learning Disability Occupational Therapist).

The SAR Panel noted that some of the above examples of 'good practice' could be seen as 'standard' or expected practice. Nevertheless, they are worthy of noting.

Essex Safeguarding Adults Board