7 Minute Briefing

Adult Practice Review. APR 01/2021

Background

STEP 01

Adult A was conveyed to hospital in June 2021 following a 999-call made by her daughter that Adult A had fallen out of bed two months previously and had been on the floor since and was now delirious and not eating.

Upon admission to hospital Adult A was covered in urine and faeces with full thickness infected pressure sores to her sacrum, buttocks, spine, lower back, hips, and heels. She was only able to respond to pain and could not be fully examined as she was too unwell to roll. Adult A died the following day.

Context

STEP 02

Adult A was a 77-year-old woman who was born and raised in Cardiff together with her brother and sister. Adult A was married aged 21 and had 2 daughters Adult A and her husband divorced when their children were still in school. Adult A's youngest daughter has a learning disability.

Adult A was described as a private and independent woman who did not want people including family visiting her home or telephoning the family home. She did not like loud noises and would take steps to reduce this such as covering the door knocker with a tea towel.

It was known to professionals that mobility issues and alcohol dependence were factors for Adult A and concerns were raised that Adult A made decisions on behalf of all the family. She could be rude and verbally aggressive to her daughters, both of whom resolutely obeyed her directions.
Adult A was not in receipt of care and support and declined this when it was offered.

Adult A's brother died in January 2019, and it is believed she did not leave the family home after this with an exception of a hospital admission in 2020 when Adult A had a fall and remained on the floor for several weeks which resulted in pressure damage. During this admission Adult A described herself as the Carer for her daughters. Upon discharge into the Community in Oct 2020, there was discussion between professionals about the alcohol consumption of Adult A and evidence of her drinking spirits in the morning. District Nurses appropriately offered advice and support in relation to this which was declined.

A further fall occurred around April 2021, and she gave specific instructions to her daughters not to call an ambulance. In June 2021, her daughter made a call to WAST which led to the hospital admission for Adult A where she subsequently passed away the following day.

At the time of her death, her daughters were in their fifties. Her oldest daughter was believed to have had mental health issues but is not open to any Mental Health Services. Her younger daughter has a learning disability and is in receipt of a care and support package from Adult Social Services

Organisational Learning

STEP 03

The following key areas of organisational learning were identified within the review:

- Working with and supporting those who self-neglect
- Professionals' understanding and application of the Mental Capacity Act
- Professionals' understanding of internal and multi-agency Safeguarding processes and the importance of recording Safeguarding outcomes
- Information sharing and the (perceived) barrier of GDPR
- The importance of a whole family approach to fully understand context and risks
- The impact of covid on professionals and the risk of vicarious trauma
- The importance of person-centred approaches with people who self neglect

Recommendations for Improving Systems and Practice

STEP 04

Recommendation: All Cardiff and Vale Safeguarding Board agencies should provide evidence to the Board of their plans around implementation of the self-neglect toolkit to enhance practitioner awareness of self-neglect and embedding of the tool kit.

Recommendation: The Cardiff and Vale Safeguarding Board should review how the establishment of the self-neglect toolkit and associated self-neglect and hoarding panels has improved the approach to self-neglect in the region.

Recommendation: The Cardiff and Vale UHB should provide training to District Nurses on their responsibilities around MCA assessments to increase confidence and understanding and develop an escalation route for staff to access support and guidance if concerns around mental capacity are identified.

Recommendation: Cardiff and Vale UHB should ensure that training for District Nurses covers internal and multi-agency safeguarding processes in relation to making safeguarding reports and recording outcomes, to provide clarity on the distinction between the two processes but also how and when they interlink.

Recommendation: Cardiff and Vale UHB should ensure that Safeguarding outcomes are recorded on Health systems so that all Heath professionals (including GPs) are aware of decisions made and action required.

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Recommendations for improving systems and Practice continued

STEP 05

Recommendation: Flags/alerts/markers should be used across Board agency systems to identify individuals who are at risk from self-neglect to improve informed inter and intra-agency decision making where there are concerns regarding known or emerging risk factors.

Recommendation: Association markers or links between family members on agency records should be used to support a holistic understanding of how each family member's individual needs can impact upon others within the household/family. This will help to encourage information sharing within and between agencies when subtle risk factors are identified regarding adults/families.

Recommendation: The Reviewers are aware that a recently published APR (APR 02/2020) within the region also identified the risk of vicarious trauma to professionals in situations involving self-neglect. It is therefore recommended that in conjunction with the learning arising from this review, the actions arising from APR 02/2020, are progressed as a priority

Self Neglect Toolkit

STEP 06

The below is the link to the Adult Neglect toolkit from the CVSB website

CV-RSB-Adult-Neglect-Toolkit-Final.pdf

CVSB website

STEP 07

The website has now been upgraded and contains the report and guidance on the themes identified within this review

Cardiff and Vale Safeguarding Board

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