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# Safeguarding Adult Review Mrs. Joyce Taylor

(not her real name)

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## Rationale for Safeguarding Adults Review (SAR)

The Calderdale Safeguarding Adults Board (CSAB) regularly carries out Safeguarding Adult Reviews (SAR). They are extensive pieces of work, that look in detail at cases when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. They are intended to ensure that we learn from cases. In this case the person didn't die or experience serious abuse, however the CSAB decided to conduct a SAR because it was believed it provided significant learning opportunities about the safeguarding process in Calderdale.

## What happened?

Mrs Taylor is 70 years old and a resident at a Care Home. She has a diagnosis of Alzheimer's Dementia and requires support 24 hours a day. Mrs Taylor experienced an unwitnessed incident at the care home which was believed to have been a fall. The care home did not inform the family of the event. The family discovered extensive bruising to Mrs Taylor's body and were upset and concerned. The family were advised by a Local Authority representative to report the incident to the police. A number of questions have been raised throughout the review as to whether the police involvement was proportionate in this case.

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## Learning Point - Safeguarding system

This case highlighted a tendency to over refer a 'concern' (risk averse). There was insufficient evidence to suspect a crime had been committed and reporting the incident to police increased anxieties for all. There is a need to:

- Ensure that there is a more consistent understanding of when to raise safeguarding concerns.
- Recognise 'Out of Hours' response considers immediate protection arrangements.
- People raising safeguarding concerns are informed of decisions made and how to challenge.
- The right people are invited to safeguarding strategy meetings and case conferences.
- There are opportunities to reflect on safeguarding cases.

## Learning Point - Responding to Falls

There are many different falls policies in Calderdale and this causes confusion for practitioners. The SAB will standardise and produce one specific overarching Falls Protocol which advises safeguarding or other action to be taken in different circumstances and evidence requirements

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## Learning Point - Record Keeping

The quality of record keeping in this case was poor. The rationale for decisions was absent. This SAR has highlighted the need for all professionals to consistently show analysis of information and record the rationale and relevant evidence for decisions made and this should be communicated to partner agencies.

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## Learning Point - Mental Capacity Assessment

There was delay in assessing Mrs Taylor's ability to contribute to the resulting enquiry, due to a belief that she lacked capacity. Where there are doubts about someone's mental capacity to make decisions about their safeguarding needs, a capacity assessment must take place. The review also identified that Mrs Taylor's husband had been making decisions on her behalf whilst a resident in the care home about her medication. Whilst it is appropriate for families to be involved in Best Interest decisions, they should not unduly influence decisions about the care provided. See <http://www.ncpqsw.com/download/8433/>

All providers should make sure they have a robust system to ensure they see and record evidence of the Lasting Power of Attorney (LPA) at entry to services, and the level of influence and decision making is discussed and agreed.

## Making Safeguarding Personal

The need to improve the person centred approach to care and safeguarding has been highlighted in this case. "Making Safeguarding Personal" is about the presumption of patient led decisions about their care and safeguarding needs.

## Learning Point - Safeguarding Process

The police seized records which created a risk for Mrs Taylor's continuing care in the care home. It is essential that copies of records are always left with care homes.



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