Appendix 1

Safeguarding Adults at Risk – briefing note in response to CSSIW Performance Review of Denbighshire in relation to Safeguarding Adults.

1. Lack of involvement of the individual or their carers in the safeguarding process.

Summary of findings of safeguarding audits for 2016 -17 indicate there has been an improvement in this area with evidence of arrangements for feedback to the adult at risk and / or their family recorded in Strategy Meeting minutes and casenotes. There has also been improvement in recording the capacity and consent of individuals in relation to the safeguarding process.

2. Care providers being asked to investigate themselves without oversight.

The Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse indicates that terms of reference for a non-criminal investigation should be considered by those present at the strategy meeting, which includes who the investigating agency or agencies will be.

Care providers, whether they be within the independent sector, third sector, health or local authority are often asked to identify an investigator from within their organisations. The 'oversight' is provided via the terms of reference agreed by those present at the strategy meeting, and also when the investigation report / feedback is discussed at a further strategy meeting.

Capacity within an organisation to carry out such investigations are often an issue. If it's deemed that a single agency investigation is appropriate, very often it is agreed that the case coordinator or contracts officer is also involved in the investigation.

There are times when an independent investigator is deemed necessary – this is often due to the complex or contentious nature of the allegations.

3. Minutes being incomplete and lacking information.

Summary of findings of safeguarding audits for 2016 -17 again indicate improvements in the content and quality of strategy meeting minutes.

A recent referral for an Adult Practice Review made it necessary for a senior manager to review strategy meeting minutes and they were pleased to see good quality minutes with clear rationale for decisions reached.

4. Timeliness of strategy meetings and safeguarding cases left incomplete.

A process has been developed setting out clear timescales for holding strategy meetings, completing and circulating minutes.

The Act sets out a standard for the completion of the enquiry stage (7 working days), however to date further guidance has not yet been published by Welsh Government recommending any timescales for the rest of the Safeguarding process. These timescales have been adapted from the Wales Interim Policy and Procedure.

Meeting these timescales are proving to be a challenge, mainly because of the need to ensure representation from key agencies, which is not always available. New

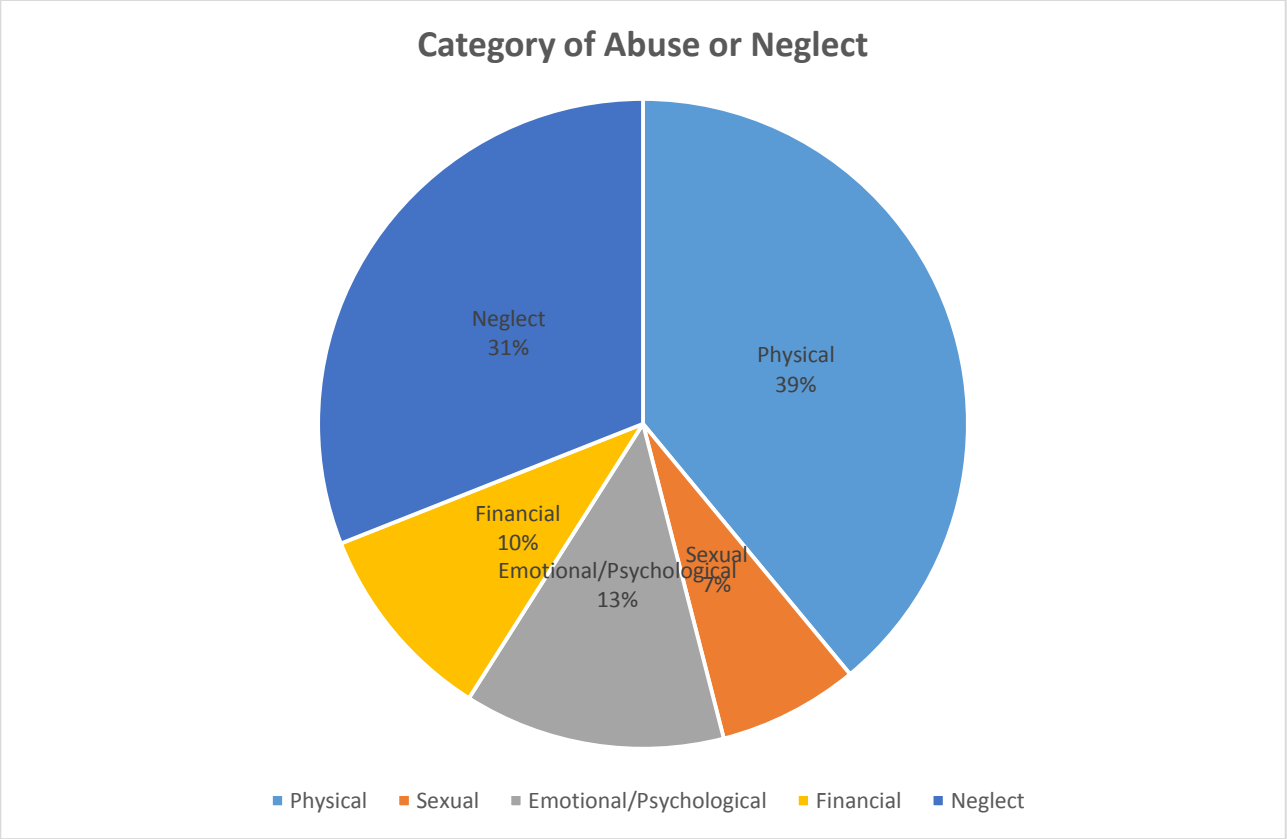
guidance regarding proceeding to a strategy meeting without all participants needs to be embedded in to practice.

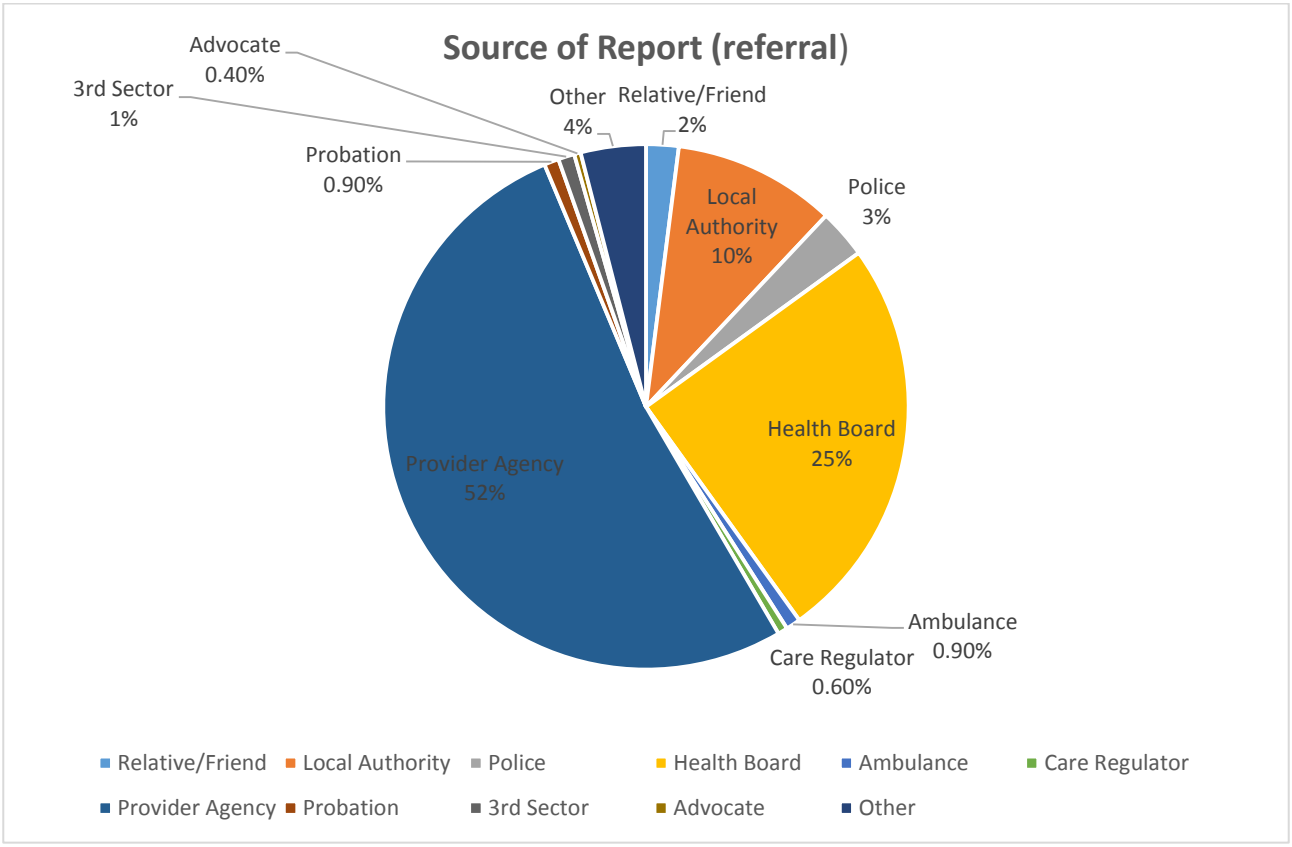
Since strengthening the Safeguarding Team's capacity, a great deal of work has been undertaken to streamline processes and ensure safeguarding referrals are dealt with and completed in a timely manner. The number of safeguarding referrals closed within a year indicates the improvement in this area:

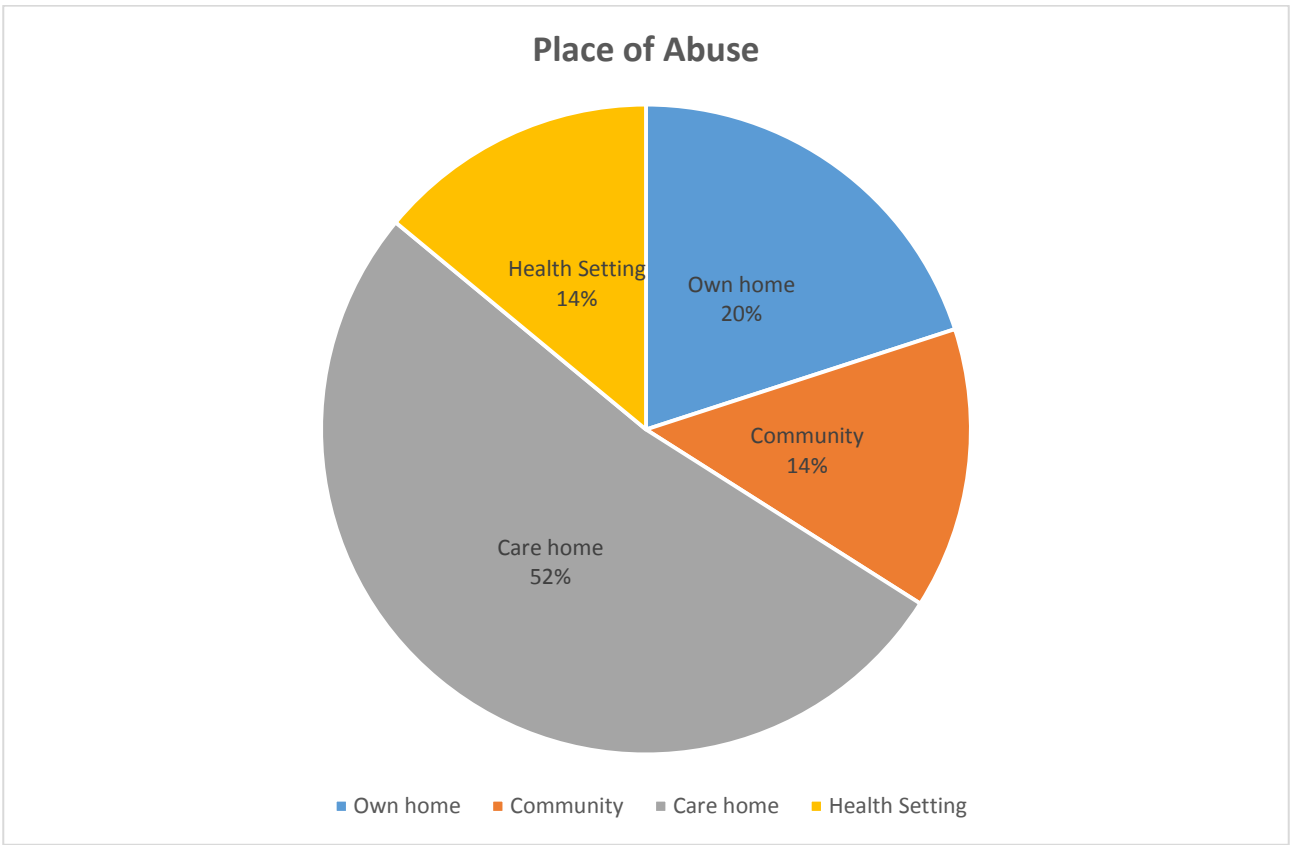
2014 – 15	79
2015 – 16	101
2016 - 17	186

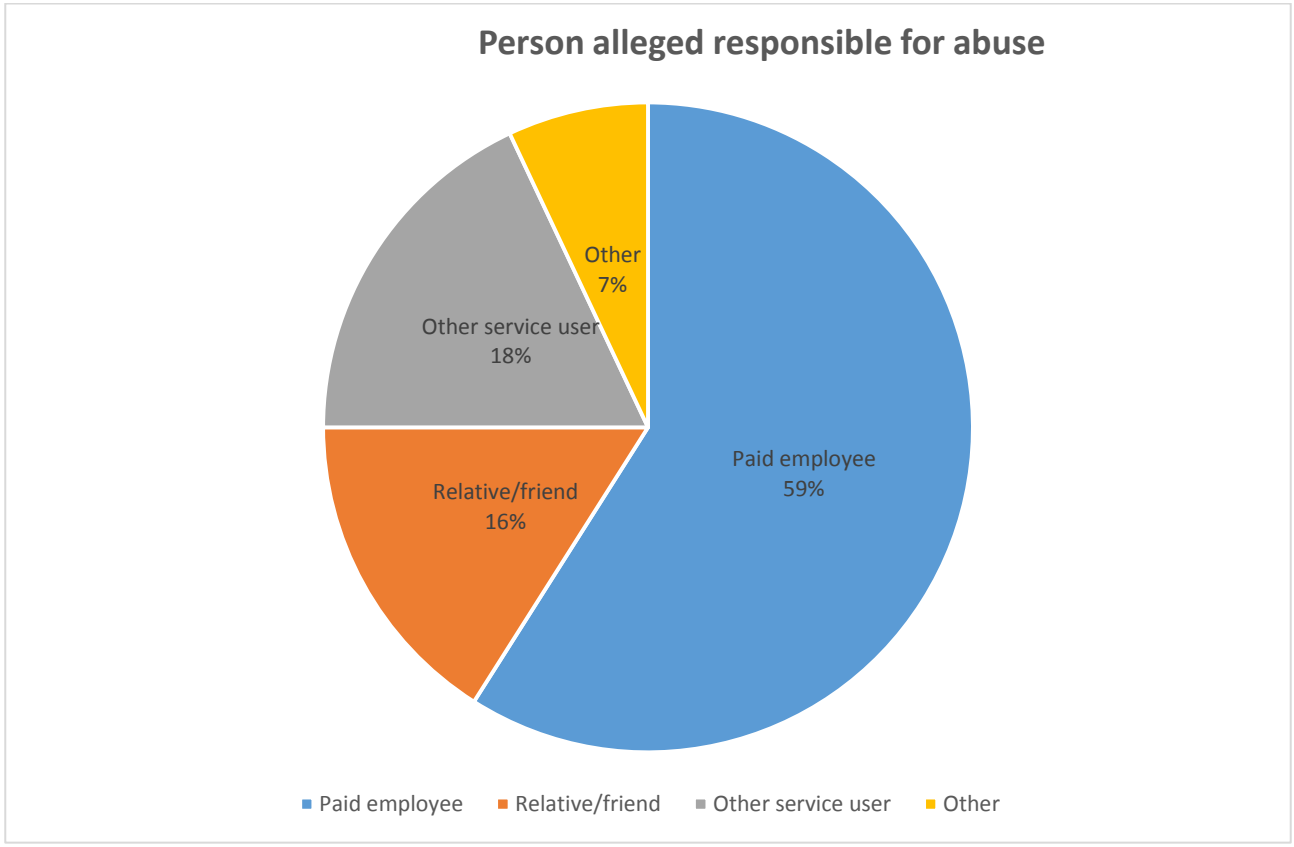
Appendix 2

Headlines from Welsh Government Returns.




Source of Report (referral)
Advocate 0.40%
3rd Sector 1%
Other 4%
Relative/Friend 2%
Probation 0.90%
Local Authority 10%
Police 3%
Health Board 25%
Provider Agency 52%
Ambulance 0.90%
Care Regulator 0.60%
Relative/Friend
Local Authority
Police
Health Board
Ambulance
Care Regulator
Provider Agency
Probation
3rd Sector
Advocate
Other


Place of Abuse
Health Setting 14%
Own home 20%
Community 14%
Care home 52%
Own home
Community
Care home
Health Setting


Person alleged responsible for abuse
Other
7%
Other service user
18%
Relative/friend
16%
Paid employee
59%
Paid employee
Relative/friend
Other service user
Other

Appendix 3 – Case examples

Case 1

Overview of concern raised

Nursing home setting – allegation of neglect as result of lost controlled medication. Agency nurse allegedly failed to follow controlled drugs medication protocol, resulting in citizen with known historical drug addiction being able to steal large quantity of medication during drug administration period.

Threshold met on grounds that although no apparent harm occurred the potential to cause serious harm was evident, it was agreed that an investigation was required to determine how this error occurred. Police were involved and deemed the incident failed to meet their threshold for a criminal investigation on the grounds that no harm occurred and the incident was not intentional.

Initial strategy meeting was convened, the MDT agreed that a non-criminal investigation was required to fully review how the incident occurred and to review safeguarding measures for the individual and to consider the wider safeguards towards other residents within this home.

Immediate safeguarding action was taken at the time of reporting, with the agency worker being removed from the service and the agency was informed to support any wider safeguarding measures with other potential employers.

Action taken

Terms of reference were agreed to guide the investigation. The concluded outcome was that the agency nurse had been neglectful in their duties by failing to administer controlled drugs in accordance with NMC guidelines and in line with the home's policy and procedures, a delay in alerting management when the loss of medication was initially detected and a further failure to follow the home's local procedures in these situations.

Appropriate risk assessments were completed by the agency nurse's other employer, additional supervision and training completed along with completing a reflective practice piece of work.

The Home reviewed its own induction process for agency staff members, which were identified as being of a high standard. However, they did make amendments to further strengthen the safeguarding measures by reviewing their own policies and procedures in relation to equipment and staffing levels to support a more robust cover when administering controlled drugs, as result of the findings from the safeguarding investigation

Further disciplinary process was followed by agency and referral to the NMC regarding practise issue/competence of the RGN.

The difference/impact to the Citizen and or the service

The citizen involved has also reflected on his actions in taking the medication and has taken more responsibility in relation to his own rehabilitation programme, by engaging in community activities and exploring further education opportunities in attending college.

The revision of policies/procedures should reduce further risks in relation to medication dispensing for the individual and for others living in this service.
The agency workers practise will also be reviewed by the regulatory body and consider any other action required to address any wider safeguarding issues.

Case 2

Overview of concern raised

A is 102 years of age and resident in a Care Home.
A has been diagnosed with dementia but is physically very active. After eating her tea, at approximately 17.35 she was able to leave the care home without staff knowledge and was returned 30 minutes later by a relative of a member of staff who had seen her walking alone. A was unable to identify herself or where she resided.
In response to this, additional safeguards were put into place by the Care Home including additional observations of A.
At 20.25 the same day, A was again able to leave the building without staff knowledge and was returned by the police having been found wandering along the road some distance from the home.
Further observations were introduced and staff advised to be more vigilant of A's whereabouts.

Action taken:

Safeguarding enquiry stage completed which included discussion with CSSIW Inspector, DCC contracts officer, North Wales Police, care home provider.
Initial strategy meeting held.
In response to these incidents the provider has:

1) Undertaken a comprehensive risk assessment of all residents.
2) Completed a comprehensive Safeguarding Adults General Protection Plan
3) Reviewed and amended Risk management Plan
4) Amended Safeguarding: missing persons policy
5) Introduced a comprehensive training programme for all staff to include up to date safeguarding

In addition to the above, the provider has installed a new and more effective door closing mechanism that will eliminate the risk of the door being left open. Introduced a new visitor book with instruction relating to ensuring the door and outer perimeter gate is closed. Introduced a "Sun downing" activities programme that supports people with memory problems.

The difference/impact to the citizen and or the service:

Having had this concern raised, the owner has responded positively having undertaken a thorough review of all risk management plans and general safeguarding protection plan. A is now benefitting from the support of the "Sun downing" programme