Partnership Scrutiny Committee Report Appendices

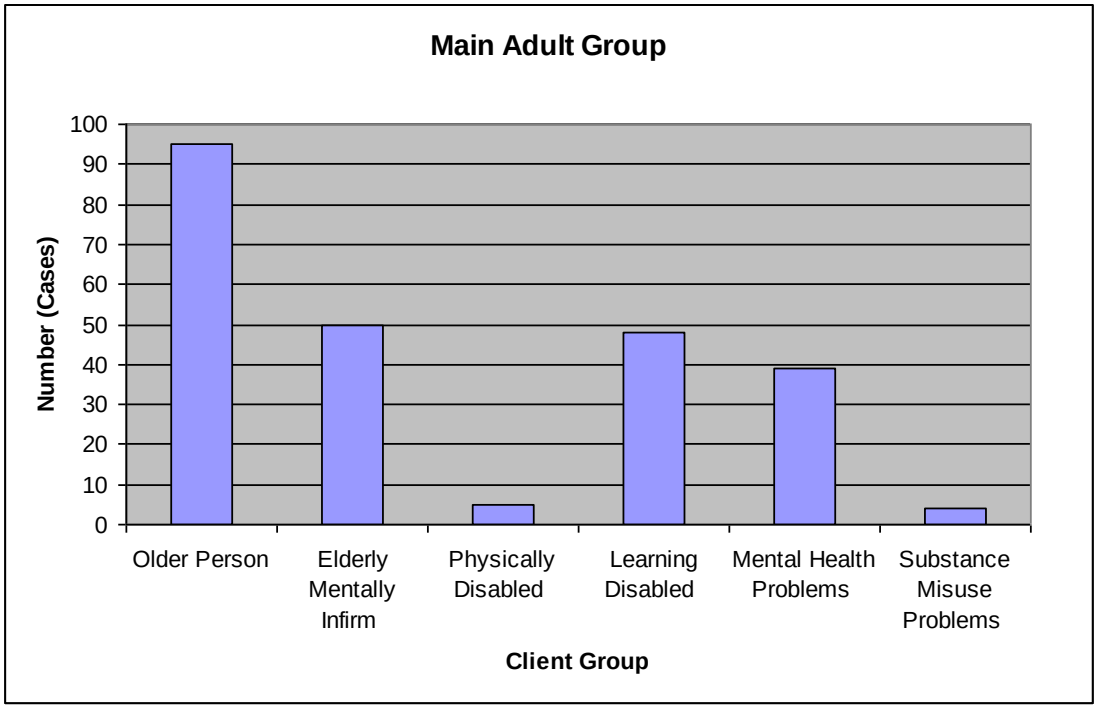
Action Plan:

Action	Target	Responsibility	Timescale	Current Status	RAG Status
1. To improve liaison and co-operation with partner agencies at a strategic level (DAPC).	Improve liaison with key personnel in partner agencies	DAPC	December 2011	The attendance at the DAPC has improved and a representative has been identified for the care home sector	
2. Audit working practices to ensure the new processes due to Wales Policy and improved practices of case recording are embedded in Social Services.	To ensure POVA actions are carried out in a timely and comprehensive manner within the care management process.	POVA Co-ordinator Social Services	February 2012	Audit of POVA cases completed and report being presented to APQS on 18/9/12	
3. Carry out service user/carer involvement survey.	To ensure service is meeting needs of vulnerable adults.	POVA Coordinator DAPC	April 2012	POVA co-ordinator is liaising with colleagues across North Wales gathering information re experience of surveys.	
4. Review Training Strategy	Develop training strategy which is consistent across North Wales	DAPC North Wales Forum	December 2011	Currently being discussed at NWF and sub training group are working on a plan	
5. Ensure we meet aims set out in the 'Big Plan'		DAPC		Actions 1,2,3 & 6 contribute to the outcome 7 within the Big Plan – ' Children, young people and vulnerable adults in Denbighshire are safe'. It was agreed	

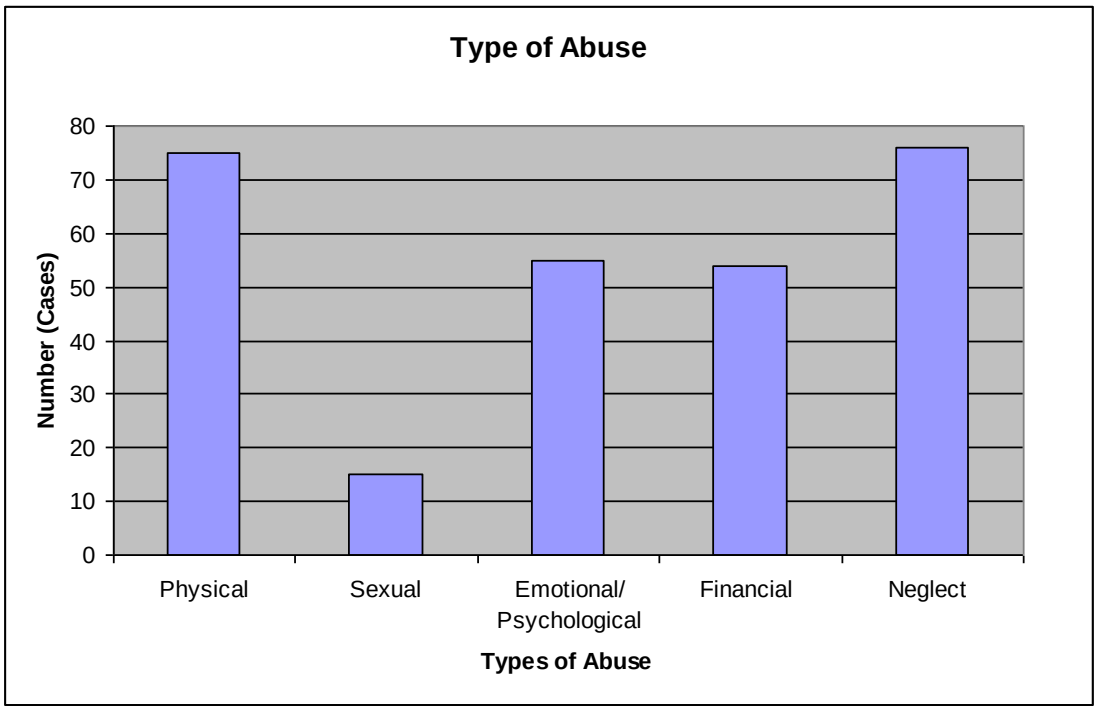
				that a separate action point in relation to this was not required.	
6. Raise awareness of the general public to abuse.	To ensure members of public are aware of the support offered in abuse cases	DAPC	April 2011	Ongoing	
7. To increase police officers awareness of POVA issues	Ensure police officers are aware of POVA policy and need to refer work in partnership	North Wales Police POVA Co-ordinator	April 2011	Processes are in place to train police officers in relation to the police POVA referral form. A bulletin is also distributed to all officers raising awareness re adult safeguarding.	

	Achieved/on track
	Work is in progress
	Not started
	No Status

Appendix 1



Appendix 2



Case Study A – relates to Appendix 2

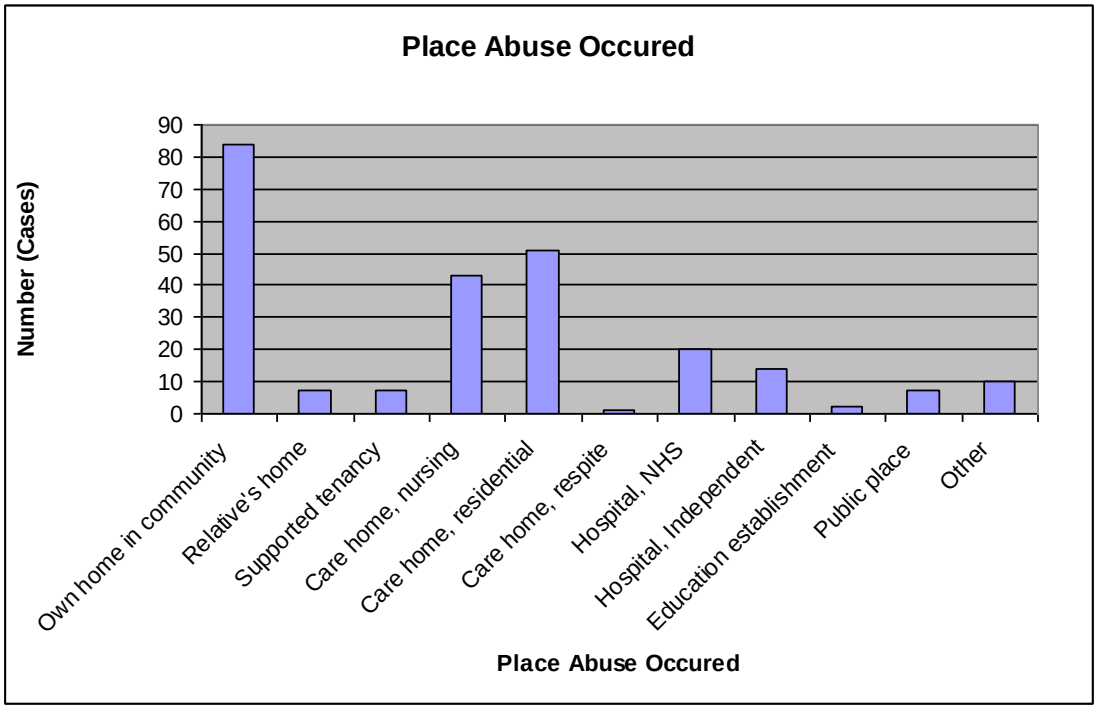
A POVA referral was initially raised by an anonymous caller to CSSIW naming a number of incidents relating to residents suffering neglect.

One of the residents had encountered a number of falls whilst in the care of the home and although risk assessments had been undertaken identifying her

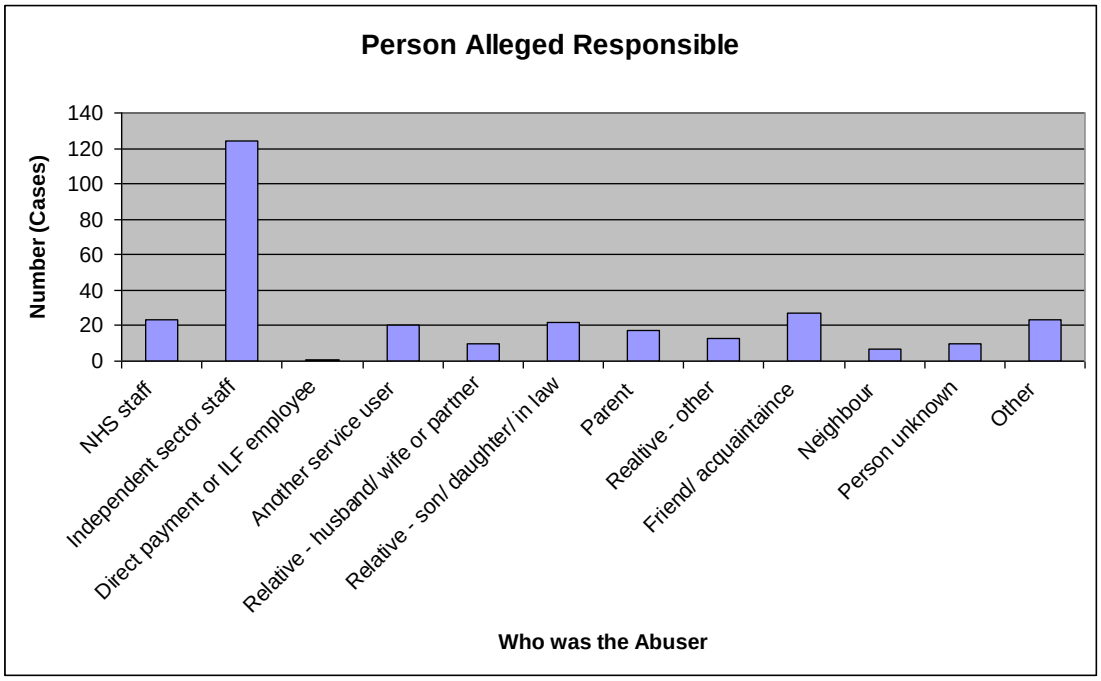
to be at high risk of falls she continued to sustain further falls. Records demonstrated that there was evidence to suggest that the home were failing seek appropriate medical intervention at the times of these incidents, which supported the allegations made by the anonymous caller.

This and other allegations involving two other residents resulted in CSSIW taking the home owner/manger to court. This case was reported in the press in October 2011. The owner admitted five offences, including allowing two residents to develop pressure ulcers and failing to seek appropriate medical intervention even though the condition was causing them pain and discomfort. She also admitted failing to ensure she had enough competent staff on duty. The case concluded on 13th October 2011 with the owner being fined £21,000. It had taken two years to conclude. The outcome following the allegations and the subsequent court hearing resulted in the home being under increased monitoring by CSSIW and Contracts & Commissioning. The home has since closed down.

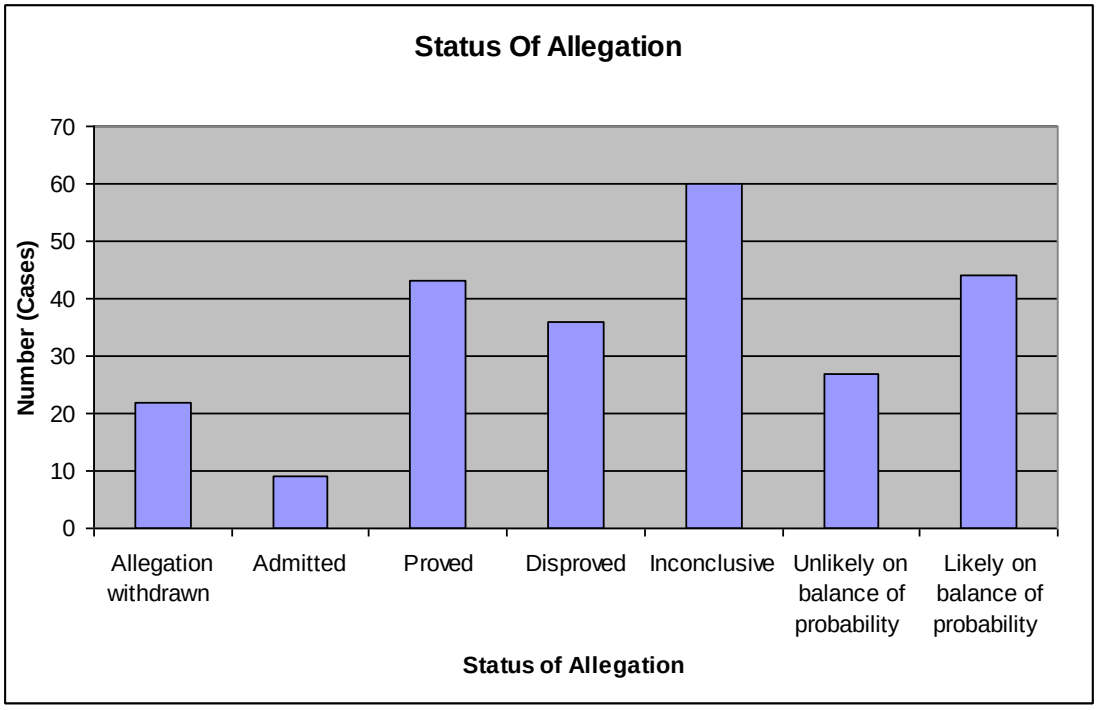
Appendix 3



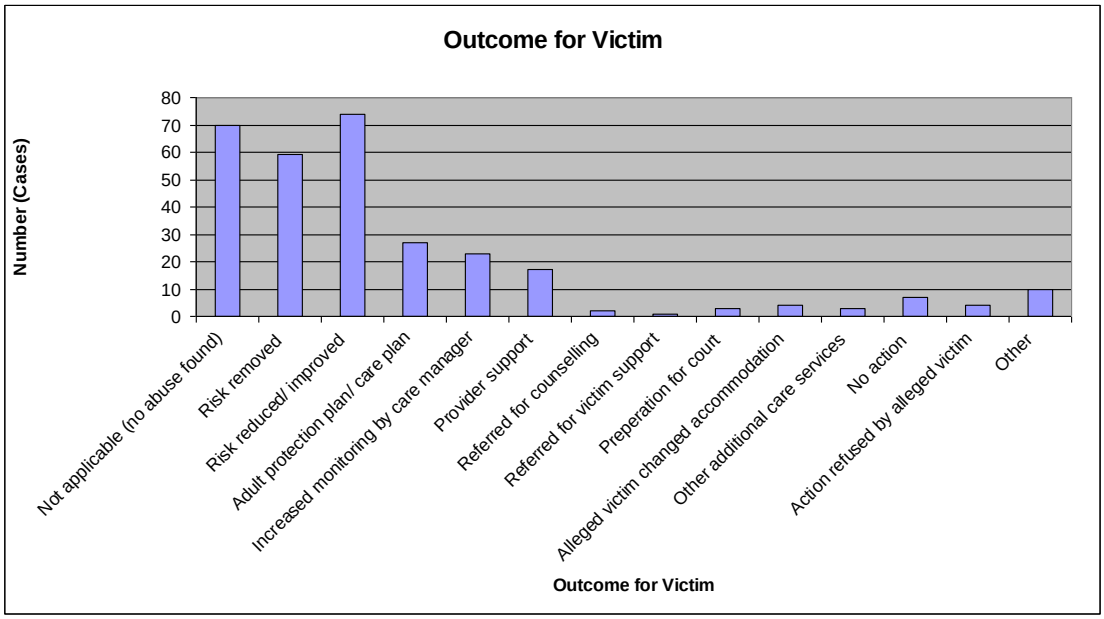
Appendix 4



Appendix 5



Appendix 6



Case Study B – relates to Appendix 6

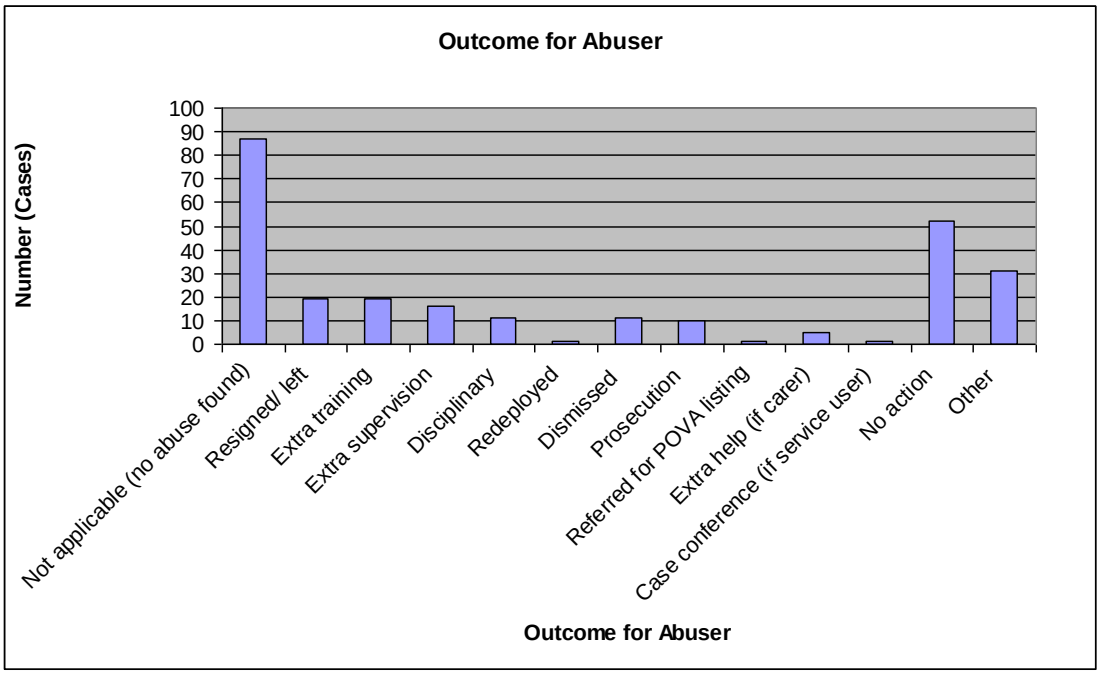
An allegation of physical abuse was made by a staff member against the manager of a home. The allegation related to an incident when the service user in question had to be restrained.

The manager was immediately suspended and further investigations took place with the police taking the initial lead. The home's policies in relation to restraint were requested and staff on duty were interviewed by the police. CSSIW were involved due the need to indentify a new interim manger following the manager's suspension.

Police completed their investigation and came to the conclusion that there was no criminal evidence of physical abuse. It became clear during the investigation that whilst the relevant policies were in place, staff guidelines in relation to the implementation of these policies were vague. With the police role having ended the POVA meeting went on to look at what action need to be addressed in relation to improving safeguarding measures i.e. staff guidance around the policy of restraining and ensuring that all mandatory training was completed. CSSIW completed an unannounced visit and further Multi-Disciplinary Meetings were convened to ensure that the care plan of the service user concerned was reviewed with all appropriate risk assessments clearly specifying how to safely manage episodes of challenging behaviour.

The outcome from this POVA investigation was that the allegation of physical abuse was disproved. Actions relating to staff training and revised policies has resulted in a clearer understanding of the use of restraint thus reducing the risks of possible physical abuse. This in turn has led to improved safeguarding measures for all the residents within this care setting.

Appendix 7


Outcome for Abuser
Number (Cases)
100
90
80
70
60
50
40
30
20
10
0
Not applicable (no abuse found)
Resigned/ left
Extra training
Extra supervision
Disciplinary
Redeployed
Dismissed
Prosecution
Referred for POVA listing
Extra help (if carer)
Case conference (if service user)
No action
Other
Outcome for Abuser