

The audit of 2<sup>nd</sup> February 2021 reviewed the records of six adults who were referred to Adult Safeguarding because of Neglect. The aim of the audit was to ascertain whether there were good multi-agency standards for managing cases and whether organisations have implemented a robust and consistent response in line with statutory and good practice guidance, SGSAB policies and procedures and the six key principles underpinning all adult safeguarding work.



The adults reviewed for this multi agency audit are aged between 28 and 87. Three are male and three female. Four of the adults live in their own homes with a package of care, and two live in residential care homes.

The adults in the audit have a range of care and support needs including, dementia, physical disability, wheelchair use, learning disability and long term or complex health needs.

## What we are worried about?

The audit group saw Neglect in terms of:

- Medication delays and errors
- Feeding errors
- Missed visits
- A lady with dementia leaving home by herself
- Over sedation
- Burns
- Inappropriate actions by carers

## What Good Practice did we see?

- Good protective factors, including care provider working closely with the family
- Robust risk assessment
- Inclusion of others working with the same adult
- Evidence that new Adults Social Care Structure is working well, where the locality team undertook the S42 enquiry as they were already working with the adult. For one of the adults there was really good evidence of
- listening to his voice, and empowering the adult to speak up

Organisations that audited their involvement with the six adults were: Adult Social Care, GPs, Sirona, NBT, Police, Next Link, St Peter's Hospice, Bromford Housing

## Multi Agency Quality Assurance Audit: Neglect February 2021

## **Themes for Learning - Communication**

- Issues were identified with communication across agencies
- There was often a lack of communication with family •
- Consideration of the use of an advocate when • safeguarding to ensure voice of person is heard
- $\bullet$ For some of the adults in this audit their voice was not heard by professionals

Impact of Covid-19 Check understanding especially when having to see adults virtually or wearing PPE

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Use a 'name and address card' for adults with dementia who go out alone

All organisations should remind practitioners of their own whistleblowing policies

Listen to the adult and work closely with their family

Themes for Learning – Information Sharing and Recording

- When a care provider is under organisational • safeguarding, the team ensure proportionate information is shared with other agencies working with the adult, and seek evidence of good as well as poor practice
- Practitioners should check who else is involved at the earliest point and link with them
- When a professional makes a safeguarding referral a copy should be included in their organisation records
- Organisations should request to see evidence of power of attorney when this is in place and record this
- Ensure that when any paperwork (for example risk assessment, S42 enquiry) is completed, or updated, this is included in the adult's record

Click these circles for more information

**Resolution** of Professional **Differences Policy** (Escalation)

'Soft Signs' Early intervention tool for Care providers

**Dementia Support** during the Covid-19 Pandemic for families/carers

Dementia Wellbeing during the pandemic (NHS England)