Staff Briefing

Multi-Agency Case Audit

‘MR’

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MR BRIEFING

Background: *MR was a resident at a care home in North Lincolnshire for a number of years where he was receiving support for a mental health condition. Unfortunately MR's physical health began to deteriorate and it was felt by some professionals that his current placement may no longer have been suitable and unable to meet his physical needs. A safeguarding concern was received however sadly a short time later MR passed away.*

A Safeguarding Adults Review (SAR) referral was received by the SAR Action Group in relation to MR. The Group considered the referral and agreed that although the referral did not meet the criteria for a SAR review it would be beneficial for a learning review to take place in the form of a multi-agency audit. All partner agencies have completed chronologies of their professional involvement and identified areas of both good practice and learning to take forward. These outcomes are reflected within the briefing below.

Areas of good practice:

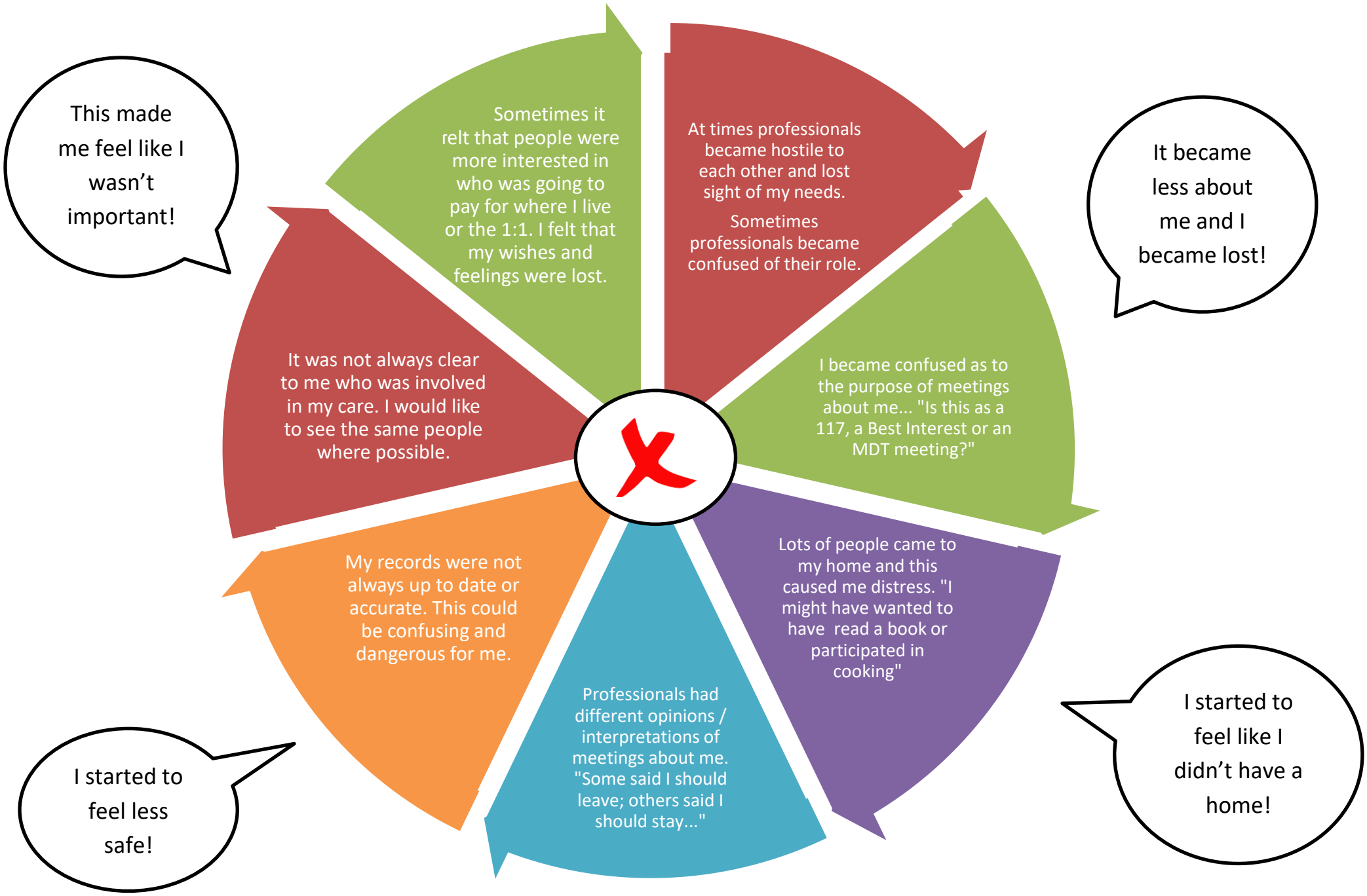
- **The care home had identified a change of personal need with the service user and had requested an urgent review be undertaken.**
- **Evidence of good working partnerships between the care home and the service-users GP.**
- **Evidence of timely responses within specific areas / assessments.**
- **Several best interest meetings convened and needs explored, including the alternatives for the service user.**
- **Where risks had been identified within the care setting, actions had been taken within good time scale in order to reduce these.**
- **Clear evidence of person centred care from the Social Worker and also from staff within the care setting.**

KEY THEMES	WHAT GOOD LOOKS LIKE…
DOCUMENTATION	
There were significant differences between agencies and their record keeping.	All agencies to consider and reinforce the requirement for recording on appropriate systems within a timely fashion, accurate recording within 24-48 hours. This includes all sources of information (i.e. emails, phone calls) which should be entered into the person's main record.
Notes/minutes and actions from meetings were not consistently distributed and agreed.	The note/minute taker is agreed at the start of the meeting. Notes/minutes include the agreed decisions and actions. The records are distributed in a timely manner and there is an opportunity for amendments to be made, resulting in one agreed record of the meeting.

COORDINATION OF CARE	
There were a number of professionals involved, some aspects of care and whose responsibility this was became confusing.	Where possible, all agencies are to ensure and to maximise the opportunity for consistency of named workers when engaging with service users, particularly with those individuals who have complex care needs. Consideration should also be given to professional membership and participation at multi-agency best interest and safeguarding meetings to again ensure consistency of practice.
There was a lack of co-ordination around the visits of professionals to the service-users home, which led to frequent and replicated visits to the home. This was distressing to other residents and to staff working there and impacted upon day to day activities and routines.	All agencies are to consider the impact of / time / day of unannounced visits on service users and their individual routine. Multiple professionals attending at one time can be distressing and unsettling for residents who are, in essence, in their own home environments. Coordination should be managed across all agencies to prevent this occurrence.
EFFECTIVENESS OF MEETINGS	
The purpose of meetings was evidently misinterpreted by various professionals, and the purpose, aims and objectives were unclear.	The framework for which the purpose of the meeting is occurring (including legal purpose i.e. best interest, section 117 review) should be clear and explicit with aims and objectives outlined at the start of the meeting. The need for consent or advocates should always be explored and documented. Caution should be exercised around the use of 'professionals meetings'. All meetings should have an appointed chair and an agreed separate minute/note taker.
Meetings were confusing at times. Outcomes were conflicting across agency record keeping (for example there was discrepancy surrounding continuation of placement provision).	Following the conclusion of a meeting there should be a clear outcomes and action log which can be inputted onto appropriate clinical systems at the earliest opportunity.
Notes/minutes and actions from key meetings were not consistently distributed and agreed.	The note/minute taker is agreed at the start of the meeting. Notes/minutes include the agreed decisions and actions. The records are distributed in a timely manner and there is an opportunity for amendments to be made, resulting in one agreed record of the meeting.
PROFESSIONAL CONDUCT	
There was evidence of agencies not always working within their specific role.	Professionals must remain role specific within meetings and work with service users to ensure that advice given is from the accountable professional and that they behave within the scope of their contractual employment regardless of previous expertise or professional registration. Professional challenge, however,

At times the voice of the service user was lost due to professional hostility. Quite often hostility was linked to disagreements over funding.	should not be discouraged, but must proceed through the appropriate channels and escalated if required. Agencies should aim to maintain healthy and professional working relationships with partner agencies at all times, including the skilful use of professional challenge. Staff to be reminded of appropriate escalation procedures if resolution cannot be achieved. The individual should remain at the centre of all decisions.
ASSESSMENTS	
Multiple assessments / reassessments were conducted with the service user. **There was a delay in the allocation and required assessments being undertaken to determine whether a Deprivation of Liberty Safeguard (DoLS) would be authorised, following a change in need. This appeared to be as a result of the information not being effectively communicated to the DoLS Team.**	Practitioners are to be reminded of the principles of 'SMART' working when considering if there is a clinical need and co-ordination for reassessment and the number of visits to a service user. Where a DoLS assessment has been requested for a person, and their needs and situation changes, this additional/new information needs to be communicated to the DoLS Team to enable the reprioritisation of the request.

In the spirit of maintaining the voice of the adult and making safeguarding personal the following images have been created to consider the perspective of the service user.


This made me feel like I wasn't important!
Sometimes it relt that people were more interested in who was going to pay for where I live or the 1:1. I felt that my wishes and feelings were lost.
At times professionals became hostile to each other and lost sight of my needs.
Sometimes professionals became confused of their role.
It became less about me and I became lost!
It was not always clear to me who was involved in my care. I would like to see the same people where possible.
I became confused as to the purpose of meetings about me... "Is this as a 117, a Best Interest or an MDT meeting?"
My records were not always up to date or accurate. This could be confusing and dangerous for me.
Professionals had different opinions / interpretations of meetings about me. "Some said I should leave; others said I should stay..."
Lots of people came to my home and this caused me distress. "I might have wanted to have read a book or participated in cooking"
I started to feel less safe!
I started to feel like I didn't have a home!