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Safeguarding Adults in North Yorkshire

What is a Safeguarding Adults Review (SAR)?

A SAR is a multi-agency review process, which seeks to determine what relevant agencies and individuals involved could have done to have prevented harm or death from taking place. It will establish whether there are lessons to be learned and promote effective learning and improvement to prevent future deaths or serious harm happening again. A SAR should reflect the six safeguarding principles of **empowerment, prevention, proportionality, protection, partnership and accountability.**

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Background

Mrs A was an 88 year old lady who died in June 2015 of septicaemia. She had received care at home four times a day since 2010 and despite some physical frailty, socialised regularly with friends and was described as having an 'iron constitution, sharp views and a strong mind' by her family. In March 2015 she broke her femur while being assisted with personal care. Due to a breakdown in communication between professionals they weren't aware of this. Complications lead to septicaemia and Mrs A refused treatment. Following two hospital admissions she died in June 2015.

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Key Learning: Person Centred Working

"Making Safeguarding Personal" guidance should be embedded in all practice, including Social Work Practice – we need to ensure that the person is at the 'heart' of the process.

We must promote a holistic approach to patient assessment and care planning to ensure it is personalised to the individual.

Care plans should be personalised to reflect decisions of the patient – even if contrary to medical advice.

Key learning: Training

All practitioners across all SAB Partners should undergo a rolling programme of Safeguarding Training that is relevant and appropriate to their job role and function.

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Key Learning: Support and Guidance

All agencies should provide support and guidance to staff around safeguarding, the role of their organisation and make any support offered to staff easily accessible.

Consideration should be given to the level of support offered to smaller agencies to enable them to engage more effectively with future SAR's.

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Key Learning: Information Sharing and Communication

A review of systems and processes is required to facilitate multi-disciplinary working. This includes a system which enables agencies to 'talk to each other' with a system for checking that urgent tasks have been received and there is confirmation of actions taken so each agency knows who has done what and if they have any outstanding actions so that things don't get missed.

Each organisation must have an appropriate mechanism for escalating concerns.

Key Learning: Mental Capacity and Unwise Decisions

Everyone has the right to make unwise decisions. Mental Capacity Assessments must be time and decision specific. Any capacity decision must be recorded accurately: it is not enough to record that a person has, or may have previously 'had capacity'.

A person's right to decline assessments under the Care Act must be weighed sufficiently, fully and carefully against professional standards in Health and Social Care.

The full SAR report is available here

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