Adult Practice Review

CTMSB1/2019

Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board

1) Incident

Adult F and Adult G became familiar with each other when both became inpatients on the Specialist Dementia Assessment ward.

Whilst there Adult F became preoccupied with Adult G as she believed him to be her neighbour.

On the 12th June 2018 Adult F was struck by a fellow patient (Adult G) to the nose.

Following the assault Adult F was admitted to hospital with a bleed on the brain. The initial prognosis was poor and there were concerns that Adult F would not survive the assault.

Adult F recovered from the assault but sadly passed away some months later in a care home from natural causes.

Adult G was transferred to a Specialist Hospital placement for ongoing treatment of his mental disorder.

2) Action

An extended Adult Practice Review (APR) has been undertaken in line with the Social Services and Well-being (Wales) Act 2014 "Working Together to Safeguard People Volume 3".

Due to the nature of the event it was agreed at the Cwm Taf Morgannwg Safeguarding Board's Adult Practice Review Group that the criteria was met for the extended review.

A practitioner learning event was held on the 7th November 2019, the purpose of which was to bringing those professionals involved in the case together to review their practice.

3) Learning theme 1

Ensuring the most appropriate use of legislation for adults requiring inpatient care.

When applying a legal framework for an inpatient, best practice would include discussions with all relevant parties involved in their care and treatment.

Staff need to have a clear understanding on how and who makes referrals to the COP.

Timely referrals to advocacy services where patients lack capacity.

4) Learning theme 2

The patient pathway between older persons mental health wards.

Where there are concerns over the appropriate placement for any patient these should be escalated through the CTP review process.

Where specialist placements are required there are established processes for accessing these through the Health Board and Local authority funding panels.

Applications will be based upon a current needs assessment.

5) Learning theme 3

The reporting and recording of safeguarding incidences.

In environments where there are a high number of incidents between vulnerable adults there is the danger that a culture of professional tolerance develops, resulting in high staff thresholds for challenging behaviour and an under reporting of serious incidents.

6) Learning theme 4

The role of the Multi-disciplinary team

A wide range of evidenced based interventions should be available to all patients on older person's mental health wards. As well as the individual benefits this provides this will also ensure a balanced multi-professional approach to minimising potentially restrictive practices.

7) Further actions

Duty to Report

https://www.cwmtafmorgannwgsafeguardingboard.co.uk/En/Professionals/RelatedDocuments/CwmTafMorgannwgSafeguardingBoardBulletinSummer2019.pdf

For further information visit the CTMSB website www.ctmsb.co.uk

Adapted from 7 minute briefing created by Hywel Dda University Health Board