Learning Together From Safeguarding Adults Reviews

Key findings and learning outcomes from 'Damien' Case Review, March 2017, Somerset Safeguarding Adults Board

Adult:
Damien had diagnoses of Asperger's Syndrome and ADHD. He had a mild learning disability and misused a variety of substances, causing him to come into frequent contact with the police and mental health services. His vulnerability was exploited by others who stole from him and misused his home for their own purposes. Meeting the dual requirements of protecting both the public and Damien from harm, at the same time as treating him as capacitous and allowing him to live his own life with only the necessary oversight and control, tested services in Somerset. In the last fifteen months of his life he was detained under Section 2 of the Mental Health Act on three occasions. He was also made subject to MAPPA arrangements. Damien died in hospital in July 2015 following an incident of self-strangulation in the residential unit that had been his home for two weeks following discharge.

Key Considerations:

Supporting transition between inpatient mental health settings and community/ care home settings

A key issue affecting transition is a lack of integrated and collaborative working between mental health and social care services, practitioners based in hospitals and those in the community, resulting in inadequate and fragmented support for people using mental health services

Practitioners should:

- Ensure the aim of care and support of people in transition is person-centred and focused on recovery
- Work with people as active partners in their own care and transition planning
- Support people in transition in the least restrictive setting available, in line with the Mental Health Act Code of Practice and Mental Capacity Act 2005
- Begin discharge planning for people with autism when the person is admitted and involve health and local authorities to work together in the interests of an individual to ensure appropriate community-based support is in place before discharge, in line with the Mental Health Act 1983: Code of Practice.
- Record the needs and wishes of the person at each stage of transition planning and
- review
- Identify the person's support networks and work with the person to explore ways in which the people who support them can be involved throughout their admission and discharge
- Enable the person to maintain links with their home community.

Planning for admission:

- Mental Health practitioners supporting transition should respond quickly to requests for assessment of mental health from: people with mental health problems, family members/carers, primary care practitioners, specialist community teams (e.g. LD Teams); staff such as housing/community support workers
- If admission is being planned for a treatment episode, involve the person being admitted, their family members, parents or carers, community accommodation and support providers
- When planning treatment, take account of the expertise and knowledge of the person's family/carers, and involve them in risk assessment planning
- Allow more time and expert input to support people with complex, multiple or specific support needs to make transitions to and from services, including those on the autistic spectrum
- For planned admissions, offer people opportunities to visit the inpatient unit beforehand, or consider using accessible online/printed information to support discussions about their admission
- During admission planning, record a full history or update that covers the person's cognitive, physical and mental health needs, includes details of their medication and identifies services involved in their care
- Ensure there is ongoing communication between the inpatient team and other relevant involved teams, including community mental health team, learning disability team, housing support teams.
- Support people who have had more than one admission to develop a crisis plan as part of their care planning process, to include relapse indicators and plans, crisis contacts, coping strategies, preferences for treatment and specific interventions and advance decisions.

Planning for discharge:

- Ensure there is a designated person responsible for writing the care plan in collaboration with the person being discharged, and their carers if the person agrees
- If a person is being discharged to a care home, involve care home managers and practitioners in care planning and discharge planning
- Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. Ensure the process is collaborative, person-centred and suitably paced
- Discuss the person's housing arrangements to ensure they are suitable for them and plan accommodation accordingly. Take into account any specific accommodation and observation requirements associated with risk of suicide
- Mental health practitioners should carry out a thorough assessment of the person's personal, social, safety and practical needs to support discharge, including risk of suicide

Supporting families, parents and carers

Good communication leads to better coordinated care and better experiences

- Identify a named practitioner who will ensure that the person's family members, parents or carers receive support and timely information
- Respect the rights and needs of carers alongside the person's right to confidentiality. Review the person's consent to share information. Good practice would be to gain consent to share information with appropriate family members early to avoid delay or complications later on
- Take account of carers' needs, especially if the carer is likely to be a vital part of the person's support after discharge. The Care Act 2014 has strengthened the rights and recognition of carers and includes a right to a carer's assessment

Follow-up support

The consequences of a poor transition can be very serious for the person and their family or carers. National evidence tells us that the first three months after hospital discharge continue to be a period of high suicide risk

- Discuss follow-up support with the person before discharge and arrange support according to their mental and physical health needs. This could include contact details, for example, of a social worker or CPN, support and plans for the first week, or practical help if needed
- Consider booking a follow-up appointment with the GP to take place within a fortnight of the person's discharge and give the person a written record of the appointment details or alert those caring for them to the appointment as a reminder
- If a person is being discharged to a care home, hospital and care home practitioners should exchange information about the person
- In collaboration with the person, identify any risk of suicide and incorporate into care planning
- Follow up a person who has been discharged within 7 days
- Follow up a person who has been discharged within 48 hours if a risk of suicide has been identified

Further reading: **NICE GUIDANCE**

Promoting Person-centred practices

By working in a person-centred way, we can ensure people are truly listened to and are kept at the heart of all decision-making

- In person-centred care, health and social care professionals work collaboratively with people who use services.
- Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care. It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion and respect.
- Often, care does 'to' or 'for' people rather than 'with' them, and practitioners can find it difficult to include people in decisions, viewing people's goals only in terms of particular outcomes.
- A way of supporting people with long-term conditions or disabilities is to work together with their other involved professionals to plan their care. The process involves exploring what matters to the person; identifying the best treatment, care and/or support; and supporting them to set goals and think about actions they can take to reach them

Statutory Duty of Candour

- The Duty of Candour places a requirement NHS bodies and other care providers to be open and honest with patients, families and each other when things go wrong or mistakes are made. This is a fundamental and really important as of care towards families and patients affected by incidents.