Learning On One Page (LOOP)

Derby Safeguarding Adults Board (DSAB): Audit – Self-Neglect – September 2024

Description of audit context

Multi-agency case file audits on self-neglect were carried out in the previous years, and it was agreed by the Quality Assurance (QA) Subgroup, in 2024, to revisit new cases that have been processed following April 2023 where the theme was on self-neglect. The aim of audits on a repeated theme was to establish if there had been an improvement in learning and practice.

The DSAB completed a multi-agency audit in September 2024, reviewing seven case files where safeguarding concerns had been raised for individuals who were referred for self-neglect.

The recent multi-agencies case file audits were completed with support from a panel of practitioners who sit on the QA Subgroup. It was not possible to obtain feedback from adults as part of this audit.

Good practice

- In 86% of the cases, information exchanges were carried out with all appropriate agencies.
- In 86% of the cases, the referral was promptly followed up within 24 hours of being received.
- There was good multi agency working between organisations.
- In 100% of the cases audited it was clear that the voice of the individual was at the heart of the enquiry and was and the Adult's/Representative's wishes and desired outcomes in relation to the concern were raised.
- Safety plan was in place for 68% cases audited.
- In 71% of the cases, professionals felt that the Adult had benefitted from the safeguarding process.
- Feedback was provided to the referring agency for 100% of the cases.
- In 86% of the cases, the Adult felt safer as a result of the safeguarding intervention.

What didn't go so well

- In 14% of the cases audited, appropriate agencies were not contacted during the information exchange process, and it was agreed that Housing and Fire Service needed to be followed up on for additional information that may have been relevant for the safeguarding.
- Inappropriate understanding of care and support needs in some cases, where a case was closed with no care and support needs but was deemed otherwise afterwards.
- In 14% of the cases, further consideration was needed to discuss whether a face-to-face, home visit was required.
- In 14% of the cases, the referral agency should have sent the safeguarding referral to the right department within Derby City Council. As a result, there was a delay in processing the safeguarding referral.
- In 29% of the cases, further consideration was needed when determining whether the children's team was needed for the case.
- In 14% of the cases, a Next Step meeting may have been beneficial for the safeguarding process.
- Views of the Adult/Rep was not considered in 14% of the cases during the closure stage.
- Mental Capacity Act assessment should have been considered and completed in 14% case.

Key learning themes

- Carrying out information exchanges with appropriate agencies.
- Understanding of care and support needs for individuals are properly assessed.
- Assessing whether home visits are necessary for individuals in their own homes.
- Consider the Mental Capacity Act assessment where there is doubt with the individual's capacity.
- To submit the safeguarding referral appropriately and promptly to the Multi-Agency Safeguarding Hub (MASH) Team.

DSAB recommendations

- Adult Social Care to consider all partner agencies during information exchanges to ensure all pieces of the jigsaw are collated.
- Agencies to consider each case and assess if a face-to-face meeting is required at the Adults house / consider appropriate locations to meet with the Adult.
- Where required, agencies to consider completion of a formal Mental Capacity Assessment.
- All agencies to promote and raise the awareness of submitting all safeguarding adults referrals to the MASH Team.