Adult Practice Review Report

North Wales Safeguarding Adults Board

Extended Adult Practice Review

Re: APR3 / 2016 / Conwy

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken.*
- *Circumstances resulting in the review.*
- *Time period reviewed and why.*
- *Summary timeline of significant events to be added as an annex.*

An extended Adult Practice Review was commissioned by the Chair of North Wales Adult Practice Review Group in accordance with the guidance and following the completion of a complaint process and investigation by the Public Services Ombudsman for Wales.

Adult A was placed in an out of county specialist dementia residential home in February 2013 by Authority A. The residential home was in Authority B's area. Before Adult A's death 3 months later, Adult A sustained three falls at the home which led to an admission to hospital early May 2013. Sadly, Adult A never recovered from the injuries from her last fall and passed away in hospital a few days following admission, the cause of death was recorded by the Coroner was a Pulmonary Embolism, Deep Vein Thrombosis and a Fractured Left Pubic Ramus.

Following Adult A's death, a Protection of Vulnerable Adult (POVA) referral was made to Authority B four days later. Five strategy meetings took place over the following 9 months culminating in an independent POVA investigation being commissioned in April 2014.
The independent POVA investigation report was published in May 2014 and a subsequent case conference meeting was held with the family in July 2014.

Following the completion of the POVA process a complaint was received by Authority B which specifically related to the way the POVA investigation was undertaken. The complaint proceeded to a Stage 3 Panel .The complaints process concluded in April 2016 when the Public Services Ombudsman for Wales issued his final report.

Authority B's officers met with the Adult A's family and recommended that if they could not accept the findings of the Public Services Ombudsman for Wales and the POVA process, the case should be referred to the North Wales Safeguarding Adult Board APR Group to review any aspects of multi-agency learning from this case.

The APR Group felt that the investigation by the Public Services Ombudsman for Wales had already identified the learning and included them in the recommendations. The group agreed that taking these recommendations and putting them into a Regional Action Plan to be submitted to the Board would be the most appropriate action and that proceeding to APR would not draw out any further learning.

The family appealed against the decision not to conduct an APR, an Appeal Panel convened and a decision to proceed to APR was reached.

- The Public Services Ombudsman for Wales' report made recommendations, which were relevant to POVA process whilst an APR would consider potential multi-agency learning from events prior to Adult A's death.
- The APR process may offer a multi-agency review in relation to this particular case and offer a clear chronology of incidents leading up to the death of Adult A.
- Part of the APR could also consider the robustness of the POVA process.
- The panel agreed that the remit of an APR was not to re-investigate the POVA itself or any aspects of concerns in relation to care offered (which has been heard by the Public Services Ombudsman).

Terms of Reference agreed:

- Authority A's involvement in the case from 1 month prior to admission to hospital, to the date of death (4.5 weeks) *and whether or not this was sufficient and appropriate.
- The development of an appropriate care package/plan on reception of Adult A into the Residential Home, and role of relevant agencies in assisting or advising in this regard.
- The scrutiny of such a package/plan and follow up of actions.
- Any confusion with the ownership of the case.
- The operation of the POVA process, the timeline associated with this and whether it was appropriate. Given the safeguarding referral wasn't done until after Adult A's death.
- Identify whether a safeguarding referral was considered at any point in the month prior to Adult A's death, and if not then why?
- The communication between agencies (in particular the sharing of information across agencies) in the POVA process. This will include examining the outcome of

the initial POVA meeting in May 2013, at which time officers in authority A were directed to investigate the reported falls whilst Adult A was resident in the home.

- The communication with the family as part of the POVA process.
- Discussion was held at the second review panel meeting on 13/3/17 re CIW's involvement. The chair had sought guidance from the APR group that CIW as a non-statutory agency should not be part of the panel. Reviewers were asked to liaise with CIW as necessary.

* The Reviewers decided, after examining the timelines, to extend the investigation period to the date of Adult A's first fall at the residential care home (an extension in the time period of 13 days).

At the conclusion of the aforementioned process the family had raised a series of 17 questions with Authority B senior officers. At the time the senior officers advised the family that these questions would be addresses through the APR. However, many of the questions are outside the agreed Terms of Reference for an APR. The family, through the APR process have been advised by the Reviewers that some of the initial questions remain outside the remit of an APR. No agreement was reached with the family to answer the questions as part of this Adult Practice Review Process, however, the report does make reference to all 17 questions.

Process of Review

- Timelines were prepared by the four key stakeholders (Authority A, Authority B, the Care Home, the Health Board)
- The Reviewers also had access to other relevant written material, as appropriate. During discussions, issues for clarification arose and the Reviewers asked services to respond and provide further information as appropriate.
- The Chair of the APR met with Adult A's family to share with them the remit of the review, its purpose and to clarify what was out of scope.
- The Reviewers met with Adult A's family to hear from them the sequence of events leading up to the death of Adult A. The Reviewers reiterated the remit of the review (as previously covered by the Chair) and shared the Terms of Reference with the family.
- Adult A's family provided a box of information and correspondence which proved useful to the Reviewers when triangulating information throughout the review process.
- The Reviewers conducted a site visit of the Residential Home and met with the Responsible Individual and Registered Manager.
- Reviewers contacted CIW and obtained Adult A's care home file.
- A Learning Event was held to discuss lessons learnt prior to the date of death.
- A multi-agency desk top review of initial and the independent POVA processes was undertaken facilitated by the Reviewers and attended by independent representative from Betsi Cadwaladr University Health Board (BCUHB) and North Wales Police.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

Key themes and learning points arising from the Review

1. **Hospital admission and hospital notes**
   - Care home staff felt hospital admission could / should have been considered sooner.
   - Issues were raised regarding the care home's ability to challenge the opinion of Health professionals (i.e. GP, District Nurses) and that a lack of weight given to the Care Home's staff observations and opinions of Adult A's deterioration.
   - Care Home staff felt they were not seen as part of the continuum of care.
   - Following admission to hospital, the ward medical notes appear to show only information sourced from the family in relation to Adult A's previous care. It is recognised that as Adult A had been admitted through the Emergency Department there was little time to obtain background information from the Care Home. However, this resulted in the recording of only one perspective of the care Adult A had received prior to admission.

2. **Recording / documentation in the care home**
   - The Care Home and the Reviewers identified the need for improvements in record keeping to ensure that informal communications and discussions with families are recorded accurately.
   - The care home and the Reviewers identified the need for accurate recording of falls. The home had been recording incidents as "found on the floor" implying a fall, but a more accurate recording of "found sitting on the floor in … position" together with details of witnesses, any injuries to the individual, any damage to furniture and items surrounding the individual, etc. This question was raised by the family in their 8th and 13th question in the list of questions presented to Authority B and detailed in Appendix 3.
   - The Independent Review noted the lack of a care plan at the Care Home. This was also highlighted during this APR process, this is linked to the question raised by the family (Q. 14).

3. **Recording the POVA process. POVA investigations were instigated by Authority B**
   - Rationale for decisions taken at Strategy Meetings was not recorded in the minutes of the meetings, this was also commented upon by the Public Services Ombudsman for Wales in his findings. It is clear that there is a need to ensure that the evidence on which decisions are made is accurately recorded in the relevant meeting minutes.

- The format of the minutes of the Strategy Meetings made it difficult to clearly record or identify key points, these key points being:
  a) A record of follow-up actions from previous meetings
  b) A clear record of key decisions, point by point, together with clear actions, responsibility for actions and timescales. (An example was the minutes of the 5th Strategy Meeting where much detail was recorded around the Independent Investigation, but little recorded about the actions that would be taken, by whom and by when.)
  c) In addition, the actions should be clearly defined, responsible individuals identified and timescales for completion noted.
  d) The overall outcome of the POVA investigation was a statement of the POVA process outcome 'options' as per the POVA procedures, and lacking narrative content. The outcome recorded in the minutes noted "no significant harm", this phrase was very difficult for the family to understand. The Reviewers felt that the statement was incomplete and at the very least should have included the words "… in the context of abuse". The Reviewers noted that the POVA outcome recorded on the Client Information System more accurately reflected the findings of the POVA investigation - which it was "…unlikely on the balance of probability that abuse had occurred". This wording should have been recorded in the meeting minutes and would have provided more clarity for the family.
  e) The Protection Plan section of the minutes was not clearly recorded, the information recorded in this section did not constitute a protection plan but was a summary of the discussion and issues raised. It did not detail the actions to be taken, by whom and by when to protect others within the care setting.
- The voice of Adult A's family was absent from the POVA process.
- Throughout the POVA process, there was no evidence that Advocacy was offered to support the family of Adult A.
- The POVA process took a long time to complete. However, the Reviewers felt the delays were legitimate as they were a result of parallel processes being undertaken e.g. the Coroner's Investigation and the findings from the Independent Investigation.
- The timelines did not provide evidence that any agency involved in the care of Adult A, prior to her death, had considered making a POVA referral.

4. Communication

- There appeared to be no clear ownership of communication with the family. No one agency (Authority A or Authority B) was identified as the lead contact for the family and there was no evidence of proactive contact with the family. This is linked to the 10th question raised by the family.
- There was no documented evidence of discussions with the family regarding their preferred method of communication or the frequency of that communication.
- The family were advised to apply for the minutes of POVA meetings through a Freedom of Information Request. The Reviewers felt that support for the family through this process would have created less of a barrier to overcome. This point was raised by the family in their 6th question.

- Whilst the Reviewers did not obtain evidence of redacted meeting minutes, it was confirmed by Authority B that the minutes of Strategy Meetings were redacted and this was raised again in the 6th question asked by the family. Whilst there is a need for the redaction of minutes, care should be given to ensure this is kept to required minimum.
- There was no documented evidence that professionals had explained to the family the POVA process, the implications of criminal and non-criminal investigations and the burden of proof required.
- There was no documented evidence that the timescales for the POVA process were clearly communicated with the family. No documented information appears to have been shared with them about the legitimate delays caused by the Coroner's Process and the Independent Investigation.

5. Out of county placements / Participation in Out of County POVA processes.

- Prior to Adult A's death there appeared to be no documented issues with the out of county placement process for this individual.
- The Care Home requested a Social Worker from Authority A, review Adult A's placement following a breakdown in relations between the home and the family. This review did not take place.
- There is no evidence that Authority A had any further contact with the Care Home, Adult A or the family until they were notified of Adult A's death.
- Following Adult A's death, Authority A made a POVA Referral to Authority B because of the family's concerns regarding the number of falls Adult A had sustained in the 6 weeks prior to death.
- Five Strategy Meetings were held during the 15 month POVA investigation. Authority A only attended the 4th and 5th Strategy Meeting and the Case Conference. Authority A were invited to the 1st, 2nd and 3rd Strategy Meetings, but tabled their apologies.
- There is no documented evidence of any discussion being held between Authority A and Authority B to determine who would be the lead communicator with the family. This should have been decided at the initial POVA strategy meeting.

6. Overview / care planning

- Evidence was provided that there was no Care and Support Plan in place at the time of Adult A's admission into the Care Home.
- There is no evidence that a subsequent Care and Support Plan was in place for Adult A during her time at the Care Home.
- The Care Home has expressed anecdotal concerns that they could no longer meet the needs of Adult A and that she should be considered for a nursing home placement. There is no documented evidence that this was explored further.
- The Care Home also express anecdotal concerns about their ability to control positive interactions with the family.

Improving Systems and Practice

In order to promote learning from this case the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes:-

Recommendations:

1. Record Keeping:
   Record keeping in the Care Home was limited, particularly in relation to:
   a. The accurate recording of falls.
      The care home's record keeping should be improved to provide detailed information concerning the circumstances of a fall, the location, witnesses, those present, injuries suffered, damage to property in the vicinity, etc. This would have helped to address the family's concerns raised in their 4th, 8th and 13th question to Authority B.

      Records in relation to Adult A's falls made reference to "Found on Floor" (Primary Care Notes 28.03.13; Adult Protection Investigation Report by Authority B 19.05.14).

   b. The recording of verbal communications with families.
      It is recommended that information be recorded about who participated in the communication, what issues were discussed, what actions were agreed (if appropriate) and who would be responsible for those actions.
      The Care Home's records of verbal communications with families and other agencies needs to be improved to provide more detail.

2. POVA process:
   a. The Reviewers noted that from the start of the APR timeline to the death of Adult A, no documented evidence was found that agencies had considered raising or had raised a Safeguarding Referral in relation to Adult A. Whilst the Social Services and Wellbeing (Wales) Act 2014 now places a 'duty to report' on agencies, prior to the Act's implementation in April 2016, agencies were expected to consider Safeguarding referrals and to record their rational for not submitting referrals if they so decided**. As legislation has surpassed this recommendation it is hoped that if the same situation arose in the future, agencies would report their concerns immediately.** This addresses the 13th question raised by the family.
   b. **It is recommended that the format of Strategy Meeting minutes be improved to make them easier to read. The minutes should accurately reflect the discussion in the room and not replicate information presented which can be presented as an appendix.** An example of this was the Independent Investigation Report, the content of which was recorded in detail in the Strategy Meeting minutes of the 6th May 2014).

c. **It is recommended that families are supported to obtain information under the relevant access request processes.** This addresses the 6th question raised by the family.

d. **Actions from the Strategy Meetings should reflect the decisions made within the meeting.**

'It is recommended that a clear Action Plan (Including roles, responsibilities and timescales) be completed and recorded within the Strategy Meeting minutes and that this Action Plan is reviewed in subsequent meetings and the outcomes recorded. This addresses the 16th question raised by the family.

An example is the Actions recorded in the Strategy Meeting held on the 22nd May 2013. These actions were not reflected in the discussions recorded within the main body of the minutes. The Reviewers also noted that not every action detailed within the Strategy Meeting minutes recorded who would be undertaking the action. Finally, the date by when the action would be completed either read "ASAP" or was left blank. Strategy meeting minutes did not record if actions from previous meetings had been completed and neither were any follow up activities recorded.

e. **It is recommended that the 'Individual/General Protection Plan section is completed to accurately record the general protection plans put in place, even if the individual concerned has passed away.**

The details recorded in the *'Individual/General Protection Plan'* section of the Strategy Meeting minutes did not include details of the protection plan or the outcomes anticipated from its implementation. An example of this is in the minutes of the Strategic Meetings held on the 22nd May 2013, 22nd November 2013 and 28th February 2014.

f. **It is recommended that the rational for decision made or conclusions reached in Strategy Meetings is not limited to the 'options' within the POVA Procedures but that more detail is provided in the narrative together with reasons/rationale.** The minutes of the Strategy Meetings do not accurately record the rationale for decisions or conclusions made. This was also recorded by the Public Services Ombudsman for Wales in their written report.

3. Communication:
   a. **It is recommended that a leaflet explaining the Adult Safeguarding process be produced,** paying specific attention to the criminal and non-criminal investigations (including an explanation of the Burdon of Proof), the role of the Coroner, the Public Services Ombudsman for Wales, Advocacy Support and the Complaints Process.

b. **It is recommended that a Communication Agreement be created with the Service User and / or their family to agree who will be their lead professional point of contact, the family or Service User's agreed frequency of communication and their preferred method of communication** (e.g. e-mail, phone call, etc.).

c. **It is recommended that guidance be developed to assist providers and commissioners to support the communication between Care Homes and families when difficulties and differences of opinion arise.**

4. Involvement in the POVA Process:
   It is recommended that all Local Authorities involved in an Adult Safeguarding process attend Strategy Meetings, take responsibility for relevant actions and are part of the decision making process.

   The minutes of the Strategy Meetings held on the 22nd May 2013, 14th June, 2013 and the 22nd November 2013 record apologies from Authority A.

Points of note:

- The Care Home and Authority A were willing to be actively involved in the APR Learning Event (please note: Authority B was not invited to the Learning Event as it concentrated on the events which took place prior to Adult A's death and Authority B was not involved at this point in time). The Care Home and Authority A used the opportunity to reflect on professional practice at the time of Adult A's death and translate that into current practice.
- Throughout Adult A's stay at the care home she was visited regularly by district nurses / health care assistant and GPs – which indicated her health needs were regularly reviewed.
- The Reviewers felt that the decision to commission an independent POVA investigator was a positive step and that whilst this investigation delayed the POVA Process the information provided in the report was comprehensive and benefited the final outcome.
- Supporting paperwork relevant to this APR Review made reference to a 'Lessons Learnt' session held by Adult A's GP Practice. The GP Practice reported the outcomes of the event to their Clinical Governance team for primary care within the Health Board and the Practice confirmed that a letter was sent to the family detailing the outcomes of the session. Please note. Reviewers were not sighted on this letter or the outcomes.
- Throughout the Review it has become apparent that the voice of the family was not as prominent as it could have been. Valid concerns regarding Adult A's care were raised by the family, but these were not always given the prevalence and may have been dismissed when the relationship between the family and professionals was proving difficult.
- The Reviewers relationship with the family was a positive one and despite the fact that the family had experienced a great deal of distress, they were willing to actively engage in the APR process and provide the reviewers with helpful information. We would like to take this opportunity to thank the family for their engagement.

Conclusions:

It is the opinion of the Chair and the Reviewers of this Adult Practice Review that if all the recommendations detailed above were in place, there would be an improvement in practice.

Sadly the Reviewers could not locate any evidence to suggest that if the recommended practices had in fact been followed in this case, it would have resulted in a different outcome.