Adult Practice Review Report

***North Wales* Safeguarding Adults Board**

Extended Adult Practice Review

Re: NWSAB2/2017

Brief outline of circumstances resulting in the Review
The criteria for adult and child practice reviews have been clearly referenced within the Safeguarding Board (Functions and Procedures) (Wales) Regulations 2015 which came into force April 2016. A Board must commission an extended adult practice review where an adult at risk who has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has: - died; or - sustained potentially life threatening injury; or - sustained serious and permanent impairment of health. The criteria for this review were met as Adult A had been subject to an Adults at Risk report prior to her death. http://www.northwalessafeguardingboard.wales/policies-and-procedures-adults/ This Extended Practice Review has been undertaken in line with the APR guidance Working Together to Safeguard People, Social Services and Well Being Act (Wales) 2014. On completion the review will be presented to the Regional North Wales Safeguarding Adult Board for approval.

The reviewers, by following the above guidance have worked within the principles of transparency, multi-agency collaboration, lessons learnt, accountability and reassurance to individuals, families and public.

The purpose of practice reviews is to clearly identify multi-agency learning for future practice. To this end, the two reviewers held a learning event with key practitioners, mangers and senior officers involved in the care of Adult A exploring the detail and context of agencies` work with the individual and their family and have fed into the shaping of themes, learning and action sets to strengthen and where possible acknowledge good practice. Additional meetings also took place with a representative from the GP Practice to enable further detail to be explored more fully.

We have referred to documents (for example, minutes of POVA meetings, statements prepared for the Inquest) which were produced after Adult A's death but which provide useful information about the time period reviewed. We have identified the source of information where appropriate.

Background and Summary

For the purpose of this report, the Care Home will be referred to as the Beach Residential Care Home.

Adult A was 81 years old and had a long standing Mental Health condition, had been living in a specialised mental health care home since 2007. Due to deterioration in her physical health Adult A was subsequently placed at Beach Residential Care Home in in November 2010 by the Local Authority.

Beach was a privately owned care home regulated by Wales (CSSIW since now named as Care Inspectorate Wales – CIW) registered for 13 residents.

Adult A's daughter noted that Adult A and themselves as family members were happy with the care provided for the first 7 years at Beach.

Further comments described that carers knew Adult A well and it is understood that she liked costume jewellery and bought items for her.

On July 18th 2016, The Social Worker received a phone call from Adult A's daughter who stated that her mother had a Grade 4 Pressure Ulcer and had become very unwell. It appeared that neither the home owner nor the care staff had sought medical assistance for Adult A until her daughters visit. Adult A's daughter contacted the District Nursing Service on the 19th July, the District Nurse attended on an urgent visit and subsequently arranged a hospital admission via the GP. It is known that Adult A had a Grade 4 Pressure Ulcer to the sacral area with bone exposed and both her heels also had a Grade 1 Pressure Ulcer. It is documented by the GP that Adult A had a systemic infection. It is also recorded that Adult A had not had a bowel movement for two weeks and that Adult A's mouth was dry. It is also recorded that there was a foul smell (DN).

Adult A sadly passed away in hospital on the 5th August 2016. A POVA referral was triggered upon her admission to hospital on the 19th July 2016 in addition to x2 further POVA referrals from different sources containing the same concerns.

The interim death certificate recorded the cause of death –

- Lower respiratory Tract Infection
- Congestive Heart Failure
- Sacral Ulcer with Sepsis
- Arterial atheroma

An inquest followed and the Coroner found that that neglect contributed to Adult A's death because timely medical attention was not sought.

Time Period Reviewed:

Section 7.21 of the practice guidance indicates that timelines for review should focus on a maximum of twelve months preceding the incident. Whilst there is digression within the guidance for extending this, the panel agreed that the review would commence from April 2015 until to December 2016 following closure of Beach Residential Care Home.

We are grateful for each agency for their valued and proactive contribution towards this review, and are confident that the views expressed within this report are directly attributed to narratives and views expressed during individual and group discussions during the learning event.

Practice and organisational learning

As a result of all information received and shared there are five (5) main themes for practice and organisational learning.

Identification of themes:

Theme 1: Communication

1.1 Lack of escalation: It has emerged that the management style at Beach could be autocratic. Care staff were instructed that any escalation of resident's condition should there be any concern of deterioration could only be reported to any health practitioner by the home owner. It is also noted that the Deputy Manager for Beach and the cook were related to the owner. It is a consideration that having family members on the management team may have impacted on the staff confidence and eagerness to whistle blow.

One statement received included “Care home owner did not like nurses coming in…. all decision had to go through care home owner and I regret now that at the time I did not go over her head to get medical attention for Adult A”

1.1.2 It is reported in another statement that Adult A had not had her bowels opened due to constipation for approximately 2 weeks, this had been escalated to the care home owner who stated that it could not have been that long or she would have acted upon it. Carer followed up with care home owner the request for medication to assist Adult A with her constipation, there was no response to this request. Carer continued to be concerned due to lack of bowel movements in the daily records however it was approximately 7 weeks before the care home owner eventually contacted the doctor and advised re constipation. GP advised to increase Laxido however there was no follow up for this. It was noted during the inquest that Adult A was found to have severe faecal impaction in whole of the colon

1.1.3 Adult A was identified with “hole in her back” by a carer in April 2016. There is no record that District Nurse or GP had been advised. However, contact had been made with GP in relation to over sedation on the 18th April 2016 but no reference made to the Pressure Ulcer to the GP.

1.1.4 The Pressure Ulcer was not referenced by the carers in the daily records again until the 24th June 2016 and the 4th July 2016. The care home owner contacted the GP on the 7th July however did not refer to the Pressure Ulcer. There is no documentation identifying that any attempt to contact the GP, Tissue Viability Nurse or District Nurse until the 18th July 2016 in relation to the Pressure Ulcers.

1.1.5 There are references on more than one occasion whereby the GP prescribed or adjusted medications for Adult A without a face to face consultation. The care home owner relayed information and symptoms but failed to mention the pressure ulcer to the GP nor escalated to the District Nurses.

On the 18.7.16 – Care home stated that they telephoned the GP 3 times requesting a visit. DN to visit the next morning.

Note: It is acknowledged that primary care services face an enormous strain regarding capacity and the lack of GP’s. Following meeting with a representative from the GP Surgery it was noted that it is not unusual for a practice to provide advice over the telephone. The medics and DN’s would be reliant on the carers/ manager to relay relevant information relating to the patients’ health needs. Similarly, if not escalated by staff, Doctors would not examine every aspect of the patient, nor would they have the capacity to double check if a treatment has worked. These issues should be escalated by the care home staff.

There are a number of additional instances of poor communication however the above examples are predominantly focussed on the Pressure Ulcer, and constipation and the significant delay in seeking medical assessment.

1.2 The home was inspected by CSSIW in 2014 with visits in June and July when four noncompliance notices were issued. In October 2014 the home sent CSSIW evidence of compliance with the regulations. A focussed inspection was

undertaken in March 2016 at which time the home was not compliant with three of the four previous areas of non- compliances. The report was not published until 9 June 2016 it is noted that none of the non-compliance or technical failures were reported to Local Authority.

1.3 JIMP minutes from the 8th September 2016 notes that the out of area commissioners would be notified that the provider was under the escalating concerns procedures. Commissioners were requested to review their residents and invited to the next meeting. It is unclear if this was actioned as it remained as an action in the Home Closure minutes on the 25th October 2016 that the Adult Safeguarding Coordinator was to make contact. Therefore, it is unclear when these residents were reviewed.

Theme 2: Poor record keeping

2.1 The changeover book and daily record entries did not reflect Adult A's poor physical condition; this is reflected as per ref 1.1.4

2.2 The LA monitoring officer visited Beach Care Home in June 2016 but as the home paperwork was in disarray and the Care Home Manager not available, and the staff member could not answer the questions. LA monitoring team reported that they would return in August 2016.

Rather than rescheduling the visit the lack of paperwork should be considered as concerning and the visit should have continued as planned or rescheduled for the same week.

CSSIW inspected in March 2016 and published the inspection report 9 June 2016. The LA monitoring officer visited 1 June 2016. There is no evidence of any communication between CIW and LA after the visits.

Theme 3: Lack of timely reviews and monitoring.

3.1.1 Adult A's Care Coordinator within the Mental Health Team left her post in October 2015. Adult A's case remained unallocated until January 2016 this was then allocated to CPN. There is no identified record in this time period of change of care co-ordinator to Adult A, family or care home.

3.1.2 Adult A's GP computer records record that Adult A had "Frail elderly assessments – enhanced service proforma for Nursing and Resident" in Sept 2014, March 2015, July 2015 – no further assessments after July 2015 however it is noted by representative of the GP surgery that this is no longer standard practice, given this was historic practice the standard criteria was not known. There is an expectation for care workers/ manager to escalate any health concerns to the GP.

3.1.2 The Care and treatment Plan and the risk assessments were due to be reviewed in early January 2016 but this was not undertaken. Although there are multiple staff member's names recorded within the CMHT case notes.

3.2.1 On the 18th July 2016 Adult A's daughter contacted the CMHT concerned regarding her mother and stating that she believed that her mother had a Grade 4 Pressure Ulcer. The CMHT decided that the duty team would offer an appointment for assessment. Adult A deceased prior to the appointment.

3.2.2 Continuing on the 18th July 2016 Adult A's daughter spoke with the home owner of Beach who was defensive, however the home owner agreed to contact the GP. It is recorded that Beach made 3 telephone calls to the GP surgery requesting a visit, advised there would be a call back. No telephone call back was made on the same day. Daughter also spoke with Social Worker at 14:00, it is recorded that a Social Worker who had a telephone conversation with Adult A's daughter would escalate her concerns with Team Manager the Social Worker was opportunistically at the CMHT Office where Adult A's notes was on a hot desk and therefore shared with a locum duty officer, Adult A's daughter also requested that the duty officer call her back. Care home owner contacted the District Nurse at 18:45 hours same day, DN agreed to attend the following morning.

3.2.3 District Nurse attended on the 19th July 2016 as requested by the care home owner the evening before and at 08:00 hours by Adult A's daughter the morning of the 19th July 2016. It is recorded that an incontinence pad was covering the sacral area held in place by net pants. The District Nurse has recorded that one of the carers informed the District Nurse that she was about to be shocked by what she was about to see. It was assessed by the District Nurse that this was a Grade 4 Pressure Ulcer, it was a cavity with extensive tissue loss, the appearance and odour indicated that it was infected and necrotic, with no dressing covering the wound. The District Nurse admitted Adult A to the hospital with immediate effect via Ambulance transfer.

3.3 On 19th July 2016, POVA referrals were made in relation to Adult A, this was in line with the All Wales interim Policy and Procedures for the Protection of Vulnerable Adults (2005). On the 20th July 2016 the information was escalated to both Section Manager for Mental Health and Quality Monitoring Manager, this instigated the Escalating Concerns Procedures on the 20th July 2016. It is recorded that the Team Manager contacted BCUHB Safeguarding and the case was to be investigated under Safeguarding Procedures and allocated a Designated Lead Manager. It was on the 27th July 2016 that Adult Safeguarding Coordinator LA requested that all the residents within Beach were reviewed. No records are available of these reviews. There is reference in a JIMP meeting on the 8th September 2016 that the LA commissioned service user's resident at Beach had been reviewed. There was no reference to the two residents that had been placed out of county by other Local; Authority placement or to the self-funding resident in relation to their respective reviews having been carried out.

There are clear missed opportunities to identify concerns by the Health Board and Local Authority, (CMHT and the LA Monitoring Team) to review the suitability of the

placement and the quality of the care provided to Adult A. The Care and Treatment Plan review was missed in January 2016. In addition, it is noted that CCSIW inspected Beach Care Home in 2014 and reported non compliances; the non-compliances were again evident at date of next inspection in March 2016.

Prior to the inspection in March 2016, LA Monitoring Officers undertook a monitoring visit in May 2015 and that 2015 monitoring report recorded the Care Home as being in the green category. This would suggest that the Care Home had taken steps to bring about improvements following 2014 CSSIW inspection but that the Care Home was unable to, or neglected to maintain those improvements and the standards had again deteriorated by March 2016

Theme 4: Training

4.1. **Tissue Viability**

The care home owner and the care staff referred to the Pressure Ulcer noted in ref 3.2.3 as “a hole” in previous care home records. On contacting the District Nurse on the 18th July 2016 the care home owner referred to the Pressure Ulcer as a “small broken area on her sacrum that had been washed, creamed and a plaster put on it.” There is also a reference that Adult A was creamed with Sudocream. This demonstrates clear lack of knowledge.

4.2 **Escalation: Safeguarding and Whistleblowing**.

4.2.1 Although it is acknowledged that safeguarding procedure has changed since the implementation of the Social Services and Well Being (Wales) Act 2014. It is evident that staff were unaware of their responsibilities to escalate.

4.2.2 Beach did not have a Whistleblowing policy and staff had not been training accordingly

4.3 **Record Keeping**

The standards of record keeping as noted in paragraph 2.1 is an area that clearly required training however there was no evidence of such training. CSSIW report also identified during inspection one file was reviewed which almost had no information regarding the needs of that resident, in addition to no evidence of care planning or reviewing of this resident’s needs. These include absence of, MAR Charts, Bowel Movement Charts, Fluid Charts or evidence of any bathing.

4.4 **CSSIW Report on Training**

There were no assurances within CCSIW Report published on the 9th June 2016 following their March 2016 inspection that staff received training that provided them

with the knowledge required to complete their roles. There was limited information regarding training courses attended in staff files, also no training matrix to demonstrate the planning and delivery of training. The care home owner informed CCSIW that there had been little opportunity to arrange training due to staffing levels being short. In the report CSSIW noted their disappointment at finding that little action had been taken to resolve the non-compliance notice issued at the last inspection (June 2014) and remained as non-compliant.

Despite the unresolved non-compliance issues from the March 2016 visit and previous inspection CSSIW did not inform or escalate to Local Authority.

Theme 5: POVA and Escalating Concern Process.

5.1 **POVA**

On the 19th July 2016, there were 3 POVA referrals (which all related to the same incident) for Adult A. A strategy meeting was scheduled for the 2nd August 2016 but was postponed until the 22nd August 2016. There is no record identifying why there was a significant delay from receipt of the POVA referrals to first strategy meeting, however it was identified this was due to internal staff absences. The subsequent meeting was then held in a timely manner with the process followed appropriately. North Wales Police did not attend as they were not informed by the Local Authority of Adult A's death until 8th September 2016.

On 27/9/16 CSSIW contacted North Wales Police following the POVA meeting to check if this was the case the Police would have cause to investigate.

On 28/9/16 the POVA minutes were reviewed and confirmation that once again there was not a requirement for Police involvement based on the information known at the time.

On the 7/9/17 Assistant Coroner sent information regarding Adult A's inquest to North Wales Police for further investigation. Between the 11/9/17 and 22/1/19 the circumstances surrounding Adult A's death were investigated by North Wales Police. The case was reviewed with no further action following Crown Prosecution Services advice.

It is to be acknowledged that the POVA Procedures have changed since Safeguarding Procedure of the Protection of Vulnerable Adults (POVA) has been changed since the implementation of the Social Services and Well Being (Wales) Act 2014.

A safeguarding investigation was undertaken by social services, as a single agency as CSSIW declined on the basis that they are an inspection, not investigation service BCUHB also declined to undertake a joint investigation because Adult A care home had not been commissioned by them. BCUHB initiated a Serious Untoward Incident Review but did not involve the Local Authority.

The Escalating Concerns process was initiated; however, the home owner decided to close the care home so it became a home closure process. Subsequently it was then decided that a joint investigation between North Wales Police and CIW would be undertaken and submitted to Crown Prosecution Service whose decision was not to proceed with the case and therefore no further action.

5.2 **Escalating Concerns**

LA instigated the Escalating Concern Procedure on the 20th July 2016, however the JIMP was not held until the 8th September 2016, this is noted as a considerable delay. The JIMP had noted that there were significant concerns around leadership and management, knowledge, wellbeing, basic care and environment and the way the care was provided. The next meetings held were Home Closure meetings on the 25th October 2016 and 1st November 2016 following notice of closure of Beach by the care home owner.

The CIW enforcement process was followed after the Escalating Concerns meeting and resulted in the decision to issue the notice to cancel the registration of the service.

Notable Good Practice

- Beach Care Home Carers – there is some evidence that the carers at Beach demonstrated thoughtfulness by recognising Adult A's fondness of costume jewellery.

- District Nurse timely actions and accurate assessment resulting in immediate admission of Adult A to hospital.

- Local Authority Project – The Local Authorities Care Home Project have a professional multidisciplinary team with a focus to enhance the quality of life and care of older people in care homes specifically in areas of multidisciplinary assessment and specialist clinical assessment. The project is time limited and the funding is non-recurrent/substantive. Currently the project is only in this Local Authority area and is only delivering this enhanced service within 4 identified care homes.

- The GP practice have introduced a triage system in September 2019. The practice receives approx. 120 telephone calls on a daily basis. The triage system ensures that all patients are contacted by a Dr or ANP in order to determine if they can be helped over the telephone, can be signposted to a more appropriate form of support or offered an appointment.

- ANP's within the practice have two yearly reviews of all patients residing in care homes.

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. As per compliance with RISCA, each individual commissioners of care should ensure that the following areas of training are incorporated as mandatory training and induction for all staff, to include agency staff:
   - whistleblowing,
   - escalation when concerned about residents' well-being
   - when to call in a GP and/or other experts, e.g. TVN
   - record keeping
   - delivery of basic care

2. LA to review quality monitoring process to ensure timely monitoring and reviews. Consideration of a consistent approach to be adopted across North Wales via the Regional Commissioning Board.

3. Care homes should have a visual aid to assist in identifying pressure ulcers and varying grades in addition to how to refer to District Nurses and/or TVN and/or GP's to be made available in all Care Homes office/ staff rooms. These will be in line with the NHS All Wales Guidance Pressure Ulcer Reporting and Investigation (2018). To share Principles of Safeguarding Investigation Screening Guidance for Pressure Damage.

4. As best practice, the GP consulted from Adult A's practice has recommended that each GP surgery to identifies a Safeguarding Lead.

5. CIW to share information with commissioners of non-compliance which may affect safety and well-being of residents.

6. A recommendation to measure timeliness of Safeguarding and EC process and to ensure that there is no need to wait for strategy to start EC process and no delay in reviewing other patients in the care home.

7. NWSAB to continue to raise awareness in relation to pressure ulcers and referencing Operation Jasmine and the Flynn report "In search of accountability which identified similar themes to those contained within this review. Other Adult Practice Reviews have also identified a lack of knowledge around tissue viability and is evidence that lessons are not being learned, therefore another avenue of learning needs to be explored.

Statement by Reviewer(s)			
REVIEWER 1	Frances Mary Millar	**REVIEWER 2**	Mannon Emyr Trappe
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review: - • I have not been directly concerned with the individual or family, nor have I given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.		I make the following statement that prior to my involvement with this learning review: - • I have not been directly concerned with the individual or family, nor have I given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 *(Signature)* **Name** *(Print)* Frances Mary Millar **Date** 16th September 2020		**Reviewer 2** *(Signature)* **Name** *(Print)* Mannon Emyr Trappe **Date** 16th September 2020	

Chair of Review Panel	
(Signature)	
Name	Phil Gilroy
(Print)	
Date	16th September 2020

Appendix 1: Terms of reference **Appendix 2:** Summary timeline

Adult Practice Review process
To include here in brief: • *The process followed by the Board and the services represented on the Review Panel.* • *A learning event was held and the services that attended.* • *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

1. Following agreement that the referral was to proceed, representation was sought and staff identified from the Local Authorities concerned and the Health Board to form a scrutiny panel. Representatives were also the organisational links to ascertain any additional information required from their respective agency.

   The panel met on a regular basis to up-date the progress of the review and were instrumental in ensuring that their respective agency was appropriately represented. Panel members had an opportunity to review the final draft of the report prior to presentation to the Adult Practice Review Group and the North Wales Adult Safeguarding Board.

2. The host Local Authority presented a case for an Adult Practice Review to the Adult Practice Review Group on the 10/06/2017. The Adult Practice Review group accepted that the criteria for an extended adult practice review had been met and advised the Chair of the Regional Safeguarding Adults Board (who agreed and notified Welsh Government).

3. However, a request from CPS to put the review on hold whilst a decision was made was received which resulted in another significant delay until end February 2018.

In line with national Practice guidance for completing practice reviews, a multi-agency Review Panel was established to manage the review and appointed two reviewers (representing Betsi Cadwaladr University Health Board and Gwynedd Council).

The panel which consisted of the two reviewers, representation from agencies involved with the Chair on the 16th April 2018 to discuss terms of reference and outline basic parameters (timeline for chronologies of agency contact, provisional date for learning event, and an expected date for completion).

Learning Event

4. The learning event was held on 02.07.19 attended by the following agencies

- BCU Health Board Mental HLD
- Local Authority representative of the MH team
- BCUHB Area Central Nursing
- GP Area Central
- LA Monitoring Team
- LA associated to the POVA process of this case
- Care Inspectorate Wales

An additional meeting was held with the GP who attended the learning event in order to clarify some of the issues that emerged during the learning event.

Feedback from the participants generated positive discussion around areas of both good practice and those requiring some improvement and development.

The feedback has contributed to the basis of the recommendations of this report.

Family Contact

5. Reviewer 2 had a meeting with Adult A's family on 20.03.19. The purpose of an APR was explained to them and whilst they are glad that lessons will be learnt, they wanted to note that the APR process will not give them the closure that they require as they want someone to be accountable for their Mother's death and were disappointed that the Crown Prosecution Service had decided not to prosecute the home owner.

   A further meeting with Adult A's family will be held to discuss the report once approved by Board.

☐ Family declined involvement

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Date information received ………………………..

Date acknowledgment letter sent to Board Chair …………………………

Date circulated to relevant inspectorates/Policy Leads ………………………….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	