Adult Practice Review Report

North Wales Safeguarding Adults Board

Extended Adult Practice Review

Re: NWSAB1/2018

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 North Wales Safeguarding Adults Board on the recommendation of the Adult Practice Review Sub-Group in accordance with the Statutory Guidance for Adult Practice Reviews.

This report concerns the final four months of the life of Mr K. Mr K had had a successful career in engineering. He lived with his wife W. They had an adult son, a retired health professional, who lived in the local area and two granddaughters. Mr K liked being outdoors. He was a football supporter, a good dancer and a keen hillwalker. He liked to look smart and took interest in his clothes and personal appearance.

Mr K died in hospital on 22nd April 2017, aged 87, having been admitted there on 5th March 2017 to receive treatment following a fall at the nursing home where he had been living. During the fall Mr K had broken his right hip. He had also hit his head causing a small cut.

The circumstances of this fall were referred to the safeguarding team on 20th March 2017.

An initial strategy meeting was held on 11th April 2017 and it was decided that the referral met the criteria for a safeguarding investigation. That investigation was also carried out by a member of the Local Authority and BCUHB Safeguarding Teams. A further strategy meeting was held on 16th May 2017 and a safeguarding case

conference took place on 17th July 2017. The case conference concluded that neglect had taken place and further agreed to refer the case to the North Wales Safeguarding Adults Board as a situation that met the criteria for carrying out an Extended Adult Practice Review.

The review time frame was initially set as 31st January 2017- 22nd April 2017 and then extended, by the panel, to cover the period 14th December 2016 – 22nd April 2017. This was the timeframe for which organisations were requested to provide detailed timelines.

Key themes were the **coordination and monitoring of care plans, making of and response to safeguarding concerns where the adult causing harm is also at risk and the process for information sharing in respect of a 'service of concern**'. In keeping with the guidance relating to Extended Adult Practice Reviews the reviewers, the panel and the learning event also considered how previous actions by agencies had contributed to the outcomes for Mr K.

This report was being finalised as restrictions due to the Covid 19 pandemic were introduced and as partner agencies were faced with resulting major challenges. In the event it was presented to a virtual meeting of the Adult Practice Review sub-committee in September 2020. The timeline set by the report author for the recommendations to be met have been removed and the action plan for implementing the recommendations was drafted by the Wrexham and Flintshire local delivery group who will oversee the implementation of the plan as agreed by NWSAB.

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

(Relevant circumstances supporting each learning point may be informed by what was learned from the family's contact with different services, the perspective of practitioners and their assessments and action taken, family members' perspectives, evidence about practice and its impact, contextual factors and challenges)

1) **Learning and improvements made**
   Some of the organisations involved in the circumstances described in this review have already carried out their own reviews and instigated changes that would help prevent similar circumstances arising for another person.

   a) Under new management **the ward** where Mr K received care following the operation to address his fractured hip until his death has made a substantial action plan, the majority of which has been implemented. This includes the management and provision of 1:1 care for those who need it.

b) The new manager of **Nursing Home A** has implemented the action plan that was agreed in response to the provider meeting held on 2nd March 2017. As a result, the Home is no longer in breach of regulations. The latest CSSIW (now CIW) report about the Home noted the improvements in care planning, staffing skills and levels and the employment of an activities coordinator. They also highlighted some good practice.

c) The manager of the **Emergency Duty Team** will work with adult social care team managers to ensure there is a clear process that EDT will follow in making out of hours' emergency placements in care homes and that any emergency placements made by EDT are followed up the next working day by the Local Authority's Contracts Monitoring Team. EDT will offer to attend a meeting of the care provider's forum to discuss how the team and providers can work more effectively together.

d) The North Wales Social Care and Wellbeing Services Improvement Board has drafted a comprehensive document **Quality Services: Delivering What Matters.** When implemented this will provide a robust framework for multi-agency risk assessment and evidenced based action planning in relation to the quality and safety of commissioned services. This document clarifies the role of the Joint Interagency Monitoring Panels (JIMP) and gives terms of reference and guidance for Professionals Escalating Concern Groups (PECG).

e) **Strategic development of service for people living with dementia**
The Local Authority where Mr K lived carried out a strategic review of the Care Sector for people living with dementia in 2017 and the North Wales Collaborative is in the process of developing a regional dementia strategy referenced to national best practice guidance; for example the National Institute for Health and Care Excellence (NICE) guideline (NG97) and the Dementia Action Plan for Wales 2018-2022.

There are some award winning dementia initiatives and services in North Wales, however, the reviewers found that those who had offered a service to Mr K and his family did not reflect on their individual or collective practice in reference to relevant best practice standards and did not report being part of a network of vibrant and successful services.

2) **Professional resilience, behaviours and values**
Individuals can make a real difference to people's experience. Although Mr K's family were distressed by Mr K's unplanned discharge from the Residential Home, Mr K's son praised the staff there for the care they gave to his father. He also singled out individual workers at Nursing Home A and the hospital ward for caring, treating himself, his mother and his father with respect and for trying to make a positive difference.

Mr K's son told us that he had encountered workers who were unable to bring empathy to the situation. The reviewers met with some professionals who were frustrated and disillusioned. Many were overly familiar with the issues they had experienced providing services to Mr K and his family and appeared to feel helpless to change the

situation. Several professionals emphasised the inequity between the quality and coordination of services they work within to provide support to older people with dementia and those provided to working age adults with mental health issues.

Lack of motivation or energy to 'go the extra mile' means that human compassion, ingenuity and skill is not mobilised to take on the challenges of the complex situations where it is most needed. The reviewers concluded that this was one of the factors in professionals not galvanising a person centred plan to support Mr K and his family.

Supervision and the opportunity to reflect and learn are key factors in preventing 'burn out'. Whilst some professionals were clearly being supported by their managers to process the circumstances of this case, to learn and to make changes to services and their practice, there were others who did not appear to have been offered/or to have taken advantage of such support

3) **Working together:**
The learning event demonstrated the willingness of individuals to work together across organisational boundaries to create improvement. However, the reviewers encountered some unhelpful attitudes in their interviews with some of the professionals from the statutory sector who had been involved in Mr K's care. In particular, some anger was directed at private sector companies making profit from the provision of residential and nursing care to older people.

Unfortunately, this appeared to have played a part in preventing professionals from the statutory services recognising professionals in the private sector as equal partners in the provision of care and support to Mr K. This was a key factor in the build up to and the circumstances of Mr K's move from the Residential Home to Nursing Home A via the Emergency Department of the hospital. Staff in both the Residential Home and Nursing Home A had raised the difficulties they were having with managing Mr K's behaviour with the CPN and the Social Worker on several occasions. Managers from both homes had also shared their professional opinion that Mr K would benefit from a Mental Health Assessment. During the review they expressed their view that, if they had been respected as equal professionals, their requests might have been treated more seriously. As no multi-agency meetings were called there were no formal mechanisms open to them to challenge the decisions being made.

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: -

The Social Services and Well-Being Act (Wales) 2014 was enacted on 6th April 2016, four months before Mrs K asked for help from her GP and over a year before Mr K died. This review took the framework of that legislation as its reference point for good practice.

Safeguarding reports, enquiries and actions taken

1) **Safeguarding processes:** The safeguarding reports that were made, the enquiries made and decision making about what actions needed to be taken took place before the publication of the Statutory Guidance 'Safeguarding People. Volume 6 Handling Individual situations of adults at risk' (May 2017) and the decision making process followed would not meet current legislative requirements. The safeguarding process used in June 2017 in response to the report of potential neglect of Mr K by Nursing Home A followed the Protection of Vulnerable Adults (POVA) procedures and had not been updated to reflect a person centred approach to safeguarding. The statutory guidance was further updated and the Wales Safeguarding Procedures published in November 2019.

   If safeguarding adult's procedures consistent with the current legal framework had been in place the outcomes of the safeguarding reports made should have been different. North Wales Safeguarding Adults Board needs assurance that the appropriate changes have been implemented.

   Recommendation 1a
   Local Authorities who are partners of the NWSAB must assure themselves and the Board that their safeguarding process has been updated to reflect Part 7 of the Social Services and Well-Being Act, relevant statutory guidance and the Wales Safeguarding procedures

   Recommendation 1b
   Each partner Local Authority must assure itself and the NWSAB that, where there is immediate risk of harm to an adult with care and support needs within a care setting, this is being proactively addressed with appropriate enquiries made and an immediate care and protection plan put in place on the same working day.

   Recommendation 1c
   Each partner LA must assure itself and the NWSAB that safeguarding reports about situations where risk is caused by another adult with care and support needs follow statutory guidance; that the person about whom the concern is raised (and any person involved in making best decisions on their behalf) is aware of the concern being raised and central to decision making about any plan for their care and protection.

2) **Risk from Mr K to other adults at risk:**
   Both the Residential Home and Nursing Home A raised repeated concerns about the

deterioration in Mr Ks behaviour and its impact on other residents to the Social Worker and the CPN. Neither of those professionals nor the Residential Home made safeguarding referrals about the harm caused by Mr K's aggressive behaviour to other residents.

Nursing Home A did make safeguarding referrals about incidents where Mr K made abusive physical contact with other residents (e.g. punching them). In total the home made 6 referrals concerning 8 incidents and 4 other residents. The safeguarding team decision was that 5 of those referrals did not meet the threshold for a safeguarding enquiry. There is no evidence that the adult at risk or their representative was informed in any of those 5 cases. Relatives were involved in the remaining case and a strategy meeting was held about resident P. This also discussed a separate safeguarding referral about potential neglect of P by Nursing Home A. No actions were recorded as to how Mr K's care and support/treatment would be changed to safeguard P from Mr K's actions.

One consequence of these decisions was that information about the risk Mr K posed to others was not shared on his admission to hospital as it would have been if the risks had been formally addressed and flagged on Mr K's records.

Recommendation 2a
NWSAB must be assured that guidance is in place within all relevant partner organisations and within commissioned care providers to support person centred safeguarding in the response to any concern that there is an adult at risk due to the actions of another adult who has care and support needs (for example: an adult experiencing verbal abuse, sexual touching or physical assault by another resident).

Recommendation 2b
NWSAB partners must assure the Board that services they provide, or commission, to people living with Behavioural and Psychological Symptoms of Dementia are able to put in place a range of immediate care and protection plans to prevent harm when an adult is at risk from another adult with care and support needs.

Recommendation 2c
Flintshire Local Authority's Safeguarding Adults team collaboratively review the decision making that took place in response to the safeguarding referrals made about adults at risk from Mr K's behaviour and also their decision making in relation to similar referrals made in 2020. That they use this exercise to assure themselves that they have a shared understanding of the issues and relevant processes in place that support person centred outcomes based decision making in line with the Wales Safeguarding procedures and make any changes needed.

3) **Safeguarding reports and actions when an adult is at risk due to their care needs not being met by a provider (neglect)** The review found a fragmented and inconsistent response to safeguarding adults at risk from neglect in provider settings**.**

The deputy manager of Nursing Home A and an agency worker there both raised

concerns that the Home could not meet Mr K's needs with the Local Authority on 10th February 2017. These were logged as a safeguarding referrals but the safeguarding team took no action. This was because Mr K's behaviour was reported to have stabilised in the 3 days from the referral to safeguarding enquiries being made and because an alternative mechanism – the overdue MDT meeting - was assumed to be going to provide the same improvement in Mr K's outcomes as a safeguarding investigation could. The current Wales Safeguarding procedures allow for such a decision to be made. However, the safeguarding team did not maintain this as an open safeguarding case and took no steps to highlight the urgency of the MDT meeting nor to gain assurance that the MDT had taken place and that the outcomes of the MDT meeting were compatible with safeguarding Mr K and other adults at risk from his behaviour.

When the deputy manager of Nursing Home A raised the safeguarding concern about the Home not being able to meet Mr K's needs she was not doing so as a 'whistle-blower' but in order to gain a resolution to the problem of how to gain effective support for Mr K which she had not been able to achieve by other routes.

The context of concerns held by CSSIW (now CIW), the local authority's contracts team and the BCUHB CMHT team does not seem to have been sought or considered as part of the Safeguarding teams' decision making. The decisions were also made in isolation from information known from safeguarding referrals and strategy meetings held about other residents at Nursing Home A.

The safeguarding referral that led to the conclusion that Mr K had experienced neglect in Nursing Home A was a retrospective safeguarding referral by a member of the safeguarding team about the circumstances of three falls Mr K's experienced in Nursing Home A. This was followed through with a safeguarding investigation and after considerable delay the conclusion that neglect had taken place was reached. Following the POVA process (rather than the Statutory Guidance of May 2016) meant that the investigation focused on finding out whether neglect had taken place. It did not take a person centred outcomes based or a systemic approach and so did not consider whether or not Mr K was at risk in hospital or whether he might be at risk in a future placement. Evidence was not sought from the hospital. This would have evidenced that, contrary to the safeguarding inquiry report, Mr K had received antibiotics for a UTI in the 6 days up to his admission from Nursing Home A.

The second strategy meeting which took place on 16th May 2017 considered whether other residents at Nursing Home might be at risk and records a list of actions to be taken by the Home to prevent harm to other residents. It did not however, set any mechanism for those actions to be monitored e.g. by the LA Contracts Monitoring team. The case conference took place nearly three months after Mr K had died.

The hospital ward caring for Mr K were also unable to provide effective 1:1 support to Mr K. There are records of Mr K falling 6 times on the ward. On the first occasion he sustained injury to his nose and had a small internal cranial bleed. No safeguarding referrals were made by the ward, the risk management team in the hospital or the social worker.

Recommendation 3a
NWSAB must enable consistency of practice across the region and all organisations by giving guidance on the reporting of safeguarding concerns and the actions to be considered where there are concerns that there is a risk of abuse or neglect due to any person's care and support needs **not** having been assessed or if assessed **not** having been met (for example: experiencing multiple preventable falls). This should include a mechanism for such issues being escalated and the necessary assessments or care and support put in place as a matter of urgency.

Recommendation 3b
NWSAB must enable consistency of practice across the region by giving guidance to ensure that, where a safeguarding report concerns a provider not providing appropriate care and support, that:
i) The report must be shared with all relevant partners of the Board and other statutory bodies who are responsible for commissioning and regulating that provider
ii) One of the actions considered by all relevant Local Authorities in response to such a safeguarding report must be the use of the Escalating Concerns process to safeguard all adults receiving a service from that provider

Recommendation 3c
BCUHB and the relevant LAs will develop a regional protocol to enable care providers to have a mechanism for escalating issues directly to the commissioners in cases where there is professional disagreement leading to a viable safeguarding plan not being in place for an individual or a group of individuals at risk.

Recommendation 3d
Each partner LA must assure itself and NWSAB that in circumstances where a Safeguarding Referral is made about an adult at risk who has moved from the setting about which the concerns were raised :
i) the safety of the adult at risk in their current setting
ii) the safety of adults in the setting

Recommendation 3e
LA's should assure themselves and NWSAB that the response to reports of adults at risk are being made within the statutory time frame

Recommendation 3f
BCUHB should provide assurance to the NWSAB that Acute Hospitals are using the DATIX incident and management system effectively to identify situations where there is a requirement to make a safeguarding adults report

4) Escalating concerns
Nursing Home A had been a service of concern to CCSIW since 2014. Some improvements had been made. However, Mr K was admitted to Nursing Home A on 21st January 2017 at a time when both CCSIW and BCUHB Continuing Health Care (CHC) team were aware of an increased level of risk at the Home. The Local Authority Contracts Monitoring team were aware of the safeguarding concerns relating

to Mr K, including a direct referral to them from a whistle-blower.

Regular Joint Interagency Monitoring Panel (JIMP) meetings take place to coordinate the response to concerns arising about the quality of service provided to commissioners. In January 2017 the JIMP membership comprised CSSIW (now CIW), the Local Authority Contracts Team, and BCUHB Continuing Health Care Team. This meeting is the mechanism by which agencies can agree to carry out a joint risk assessment and can coordinate action to address situations where a provider is not delivering the standard of care required. This is a fundamental process through which people using services are safeguarded from abuse and neglect. The relevant statutory guidance for this process is Welsh Government Guidance on Escalating Concerns with, and Closures of, Care Homes Providing Services for Adults (2009).

Nursing Home A was discussed at the JIMP meetings during the period considered by this review on 1st December and the 3rd, 10th, 17th February and 8th March 2017.

There is no record of evidence based risk assessment or action planning at these meetings. For example, there is no record of information about risks identified by CCSIW's inspection, the outcome of the CHC QMT risk assessment or a clear list of safeguarding reports concerning residents at Nursing Home A being shared at the JIMP. On 24th February 2017 the CHC carried out an assessment of risk to residents at the Home using the Escalating Concerns documentation. The assessment was that there was a very high risk to all residents at the Home. This was one week before Mr K fell and was admitted to hospital. There is no record of how this risk assessment informed decision making and there is no record of a multi-agency discussion at the JIMP or elsewhere as to whether the escalating concerns process should be instigated.

The plan to address the concerns that were raised at the JIMP is also not clearly stated. It was agreed that a meeting would take place with the providers of Nursing Home A to state the accumulated concerns and make an agreement about the improvements required as well as a timescale for achieving them. There is no record of any systematic consideration or planning of actions needed to mitigate the risk to residents prior to the meeting with the provider.

The providers appointed a new manager at the Home, who came into post on 27th February 2017. The meeting between CSSIW, BCUHB and Local Authority commissioners and the provider and new manager took place on 2nd March. A requirement was made for Nursing Home A to develop an action plan within 14 days of that meeting. This was done and Nursing Home A has subsequently succeeded in making necessary improvements.

On 21st January 2017 when Mr K was accepted as a temporary resident at Nursing Home A there were no restrictions on admissions to them from the Local Authority or BCUHB. BCUHB CHC team were however, offering extra support with assessment of people requiring nursing care prior to admission. The mechanism for alerting the team to a new resident requiring nursing care is the application for CHC funding. Nursing Home managers are advised that they should check funding is in place before

accepting a resident for nursing care. Mr K's admission via the Emergency Duty Team (EDT) on a temporary basis and with emergency funding from the EDT budget and the expectation that he would be assessed by another nursing home the next day circumvented this process, meaning that the CHC team were not involved in ensuring there was an effective assessment of Mr K's needs and whether or not Nursing Home A could meet them.

The Emergency Duty Team, which is a partnership created by three local authorities, did not have any information about the level of perceived risk at Nursing Home A. Even where restrictions to admission are in place they do not easily have had access to that information, for example, as a flag placed against the provider details. Information about restrictions on admission are communicated to EDT via e mail from the LA Contracts Monitoring team. There is no record of a decision being made by the JIMP as to whether or not any other agencies/departments needed to be made aware of concerns about Nursing Home A's ability to provide care to residents with nursing needs.

Concerns about Mr Ks care were specifically discussed at a JIMP meeting on the 10th February. The action taken was to contact the CPN directly from the meeting. He explained that he was hoping that measures taken to ensure Mr K received his medication correctly would improve the situation. Mr K's admission via the Emergency Duty team and the agreement by Nursing Home A to admit him on an emergency basis without an assessment was noted at the JIMP, however, no action was put in place to address this with the provider.

A framework to implement many of the recommendations below will be in place if the region adopts and implements **Quality Services: Delivering What Matters –** due to be considered by the North Wales Social Care and Wellbeing Services Improvement Board.

Recommendation 4a
The Chair of NWSAB to write to the Chair of the North Wales Social Care and Wellbeing Services Improvement Board to underline the importance of Quality services, Delivering what matters for the safeguarding of the most vulnerable members of society and to request its publication and implementation are proceeded with as a matter of importance.

Recommendation 4b
Local Authority should assure NWSAB that there is a formal process for the Joint Interagency Monitoring Panel (JIMP)/Professional's Escalating Concerns Group (PECG) to routinely consider all safeguarding reports received about risk of abuse or neglect and relevant action plans, within a provider setting, as part of its risk assessments.

Recommendation 4c
NWSAB must be assured that there is:
i) a mechanism for a formal safeguarding report to be made when a JIMP/PECG identifies circumstances where one or more or all/a group of residents are at risk of

abuse or neglect in a care setting
ii) a mechanism for safeguarding reports abuse or neglect in a provider setting to be assessed in the context of information held by BCUHB, LA commissioners, CIW and HIW.

Recommendation 4d
Each JIMP must assure NWSAB that the PECG's actively consider a range of measures, including the restriction on admission of people with complex care and support needs, when there is an evidenced risk that a provider cannot safely meet the needs of the residents already living there.

Recommendation 4e
A protocol must be put in place as soon as possible with BCUHB and the North Wales LA's for the JIMP/PECG's to make referrals for re/assessment of health and/or care and support needs of individuals or groups where there is evidence that their needs are not being met and for those to be responded to as a matter of urgency.

Recommendation 4f
Immediately: Where there is disagreement within the JIMP/PECG about the level of risk of abuse or neglect posed or the actions to be taken the NWSAB Board process for resolving disagreements should be used.

Recommendation 4g
The members of the Flintshire JIMP should hold a meeting to consider this report and review the format for meetings held to risk assess providers. They should ensure that the meeting structure facilitates the systematic sharing and recording of relevant evidence held by each agency, an evidenced based multi-agency risk-assessment and a clear multi-agency plan to address issues in a proportionate manner – including taking immediate action if needed.

Recommendation 4h
Immediately: BCUHB Commissioners of health services, LA commissioners in NE Wales and the managers of the EDT should ensure that information that restrictions or special mechanisms are in place for the commissioning of care (e.g. for people with complex care needs) from any given provider must be easily accessible to the Emergency Duty Team workers.

Recommendation 4i
As soon as possible**:** The chair of NWSAB to write to the Chair of the North Wales Social Care and Wellbeing Services Improvement Board to request that Appendix 3g of the draft document **'Quality Services: Delivering What Matters**' to be revised so that communication with the relevant EDT is specifically considered in the Communication Plan by PECG's

5) Assurance by NWSAB

Recommendation 5a
NWSAB should carry out a regional audit to assure itself that safeguarding reports,

enquiries and actions concerning an adult with behavioural and psychological symptoms arising from dementia either as an adult at risk or causing others to be at risk are consistent with person centred best practice

Recommendation 5b
NWSAB to receive a report from a peer audit examining decision making by the PECG's. This should be carried out across the region to ensure and promote consistency in decision making about the threshold for using the escalating concerns process and the effective implementation of evidence based risk assessment and action planning

Prevention of abuse and neglect
Safeguarding includes the prevention of abuse and neglect. This review considered the events leading up to Mr K's admission to Nursing Home A and the management of his care whilst there.

The learning event considered the existing services for care and support, working together across those services and how harm to Mr K could have been prevented, as well as how other people experiencing behavioural and psychological symptoms of dementia can be safeguarded.

The learning event and the reviewers identified the following contextual themes and issues including improvements that could prevent risk to and from people experiencing behavioural and psychological symptoms of dementia. The over-arching themes were 'system design', 'assessment and care planning' and 'crisis management'.

6) **System design:** The system providing care and support to Older People experiencing behavioural and psychological symptoms of dementia is under resourced and fragmented. It was unable to provide a cohesive seamless service providing the right care at the right time for Mr K.

   The learning event discussed how Mr K's experience illustrated the benefits of people living with dementia and their families feeling able to access services early in a persons' illness so that they can be supported to engage in care planning whilst the person still has the capacity to do so. Advanced decision making about care planning and clear arrangements for Lasting Power of Attorney create resilience for everyone involved, providing reassurance for the person living with dementia and their carer and enabling a planned response to any deterioration in their health. A public awareness campaign and an information resource available via GPs could help more families start to think and talk about these issues.

   The North Wales Social Care and Well-being Improvement Collaborative are due to publish the region's Dementia Strategy. This includes the development of public information to increase early engagement of people who may have dementia with services.

   It is important that the NW Safeguarding Adults Board can be assured that the strategy will support specific improvements that help safeguard Older People experiencing behavioural and psychological symptoms of dementia in North Wales

   Recommendation 6a
   NWSAB makes a presentation as soon as possible to the North Wales Social Care and Well-being Improvement Collaborative based on this report so that Mr K's experience and that of his family inform the development of the regional dementia strategy.

   Recommendation 6b
   NWSAB assures itself that the dementia strategy includes and maintains a clear focus

on achieving good outcomes for people living with dementia who experience behavioural and psychological symptoms that cause risk to themselves and other and makes appropriate representation to the North Wales Social Care and Well-being Improvement Collaborative if that is not the case.

7) **Assessment and Care planning**

The overview provided by this review illustrates that care and support was offered to Mr K and W on a reactive basis rather than engaging them in systematic person centred planning to meet their needs. The frameworks that would have enabled practitioners to meet the requirements of the Social Services and Well-being Act (2014) and the Mental Health (Wales) Measure (2010) were not in place or not used. There was no reference to a dementia care pathway providing for changes in Mr K's needs as his illness progressed. The lack of planning meant that there were several avoidable crises, including the one in which Mr K fell and broke his hip.

Eleven sub- themes were identified which are detailed below:

i) Universal Assessment/ Assessment of needs for Care and Support:

There is no recorded assessment of Mr K's care and support needs at the time of his referral to statutory services and therefore no record of Mr K's views or those of his carer or wider family as to what matters to them or the outcomes being sought through interventions from health and/or social care. In line with the Social Services and Well-Being Act 2014 this assessment should have underpinned work with Mr K and his family to create a care pathway that acknowledged the deteriorating and progressive nature of his illness, cognitive impairment and mental health difficulties.

Such an assessment would have provided more information to the EDT when they became involved on 21st February 2017.

ii) Mental Health Assessment

Mr K received a diagnosis of Alzheimer's disease that had progressed to a moderate or severe stage from the CPN in September 2016. This diagnosis was made in consultation with a psychiatrist that had not met Mr K. In line with the Mental Health (Wales) Measure 2010 a Mental Health Assessment should have been available to Mr K in the community.

Also in line with the Mental Health Measure the CPN as Care Coordinator should also have worked collaboratively with Mr K and W to produce a written care and treatment plan designed to support Mr K to meet his outcomes across a full range of aspects of his life. Best practice in Dementia Care would have been for Mr K to have received an early assessment that included clinical, environmental and behavioural interventions. These could have been included in a treatment plan.

Although Mr K's symptoms intensified as his illness progressed the times and circumstances in which he was likely to be distressed and his resulting behaviours showed a clear pattern and changed very little in form from those identified whilst he was living at home. The Residential Home, Nursing Home A and the hospital all faced similar difficulties to those W had experienced at home. At each crisis point there was

an assumption made that 'the current situation cannot continue/be improved' and that 'someone else' would be able to provide more effective care to Mr K. This approach did not provide continuity of familiarity for Mr K or for those providing his care.

Had Mr K received a holistic assessment within a community setting, for example, within specialist day services or through a respite admission to a specialist care home, a way to address Mr K's anxiety and fear, may have been found at an early stage. Mrs K and any carers could then have received support to provide care in a way that prevented Mr K's behaviours being triggered. This would have provided him and Mrs K with greater levels of rest and reassurance. Mr K may then have been able to spend more time at home and the crises experienced by W and by the Residential Home may have been avoided. Given that Mr K only started to receive care and support once he was experiencing moderate to severe symptoms of dementia the need for assessment and care planning whilst he was able to participate would ideally have been a priority.

iii) Nursing needs assessment

No nursing assessment or application was made for CHC funding whilst Mr K was at Nursing Home A. The lack of assessment and clarity about funding – especially for the one to one support Mr K required – contributed to Nursing Home A feeling unsupported and unable to care effectively for Mr K. Without a CHC funding application in place there was no formal mechanism for the CHC team to be aware of the problems Nursing Home A was experiencing with providing care to Mr K. If Mr K had been receiving CHC funding the home would have received support from the Practice Development Nurse with his care. Responsibility for this assessment and funding application lay with the CPN as Care Coordinator.

iv) Medication

The review identified six professionals who had a role in prescribing medication to Mr K's to address symptoms arising from his dementia from August 2016 until his admission into hospital. These were his long-term GP, the GP he registered with whilst at the residential home and a subsequent GP when he was living at Nursing Home A, the CPN, the psychiatric consultant based in the Community Mental Health Team and the Psychiatric Liaison service from the Emergency Department. The GPs who had Mr K as a patient when he lived in the care homes had only known him for a very short period of time and did not know him before his health was affected by dementia. The consultant in the Mental Health Team did not meet Mr K and made judgements based on information provided by the CPN. The review team are not medically qualified but we were concerned about instances when Mr K's medication changed reactively, apparently without time for assessing the impact of the changes and sometimes in contradiction to the direction of another medic. Additionally, the decision that medication could be administered covertly to Mr K was not communicated clearly and was not implemented for some-time after it was made.

v) Mental Capacity Act 2005

Mr K was judged by the CPN to understand the reasons for his receiving respite care at the Residential Home. However, after Christmas when it was clear his health and

his mental capacity had deteriorated there is no record, by any professional, of Mr K's ability to take part in decisions that were being made on his behalf or of what Mr K's views and wishes might be or of how those were taken into account, until he was an inpatient. The hospital ward was the first service to complete the 'This is Me' documentation to allow staff to provide more person centred care. This, for example, included supporting Mr K to watch football match replays of his favourite team.

The Emergency Duty Team (EDT) did not use the Mental Capacity Act as a framework for decision making about Mr K's placement on 21st January 2017. There was no reference to a Mental Capacity Assessment, to taking steps to enable Mr K to make a decision or to making a Best Interests decision. EDT did not acknowledge that they were the decision maker and did not record any consideration of what Mr K's known views might have been or whether or not an advocate was needed.

The inclusion of a dementia advocate or a dementia champion from the point Mr K was referred to the Memory Clinic could have enabled Mr K to negotiate the services and for his wishes, for example, to spend time outdoors, to be incorporated in his care plan.

vi) Lack of planning and clear decision making

Losing a partner to dementia as well as the demands of caring for them creates circumstances and emotions that can make it hard to plan and W found it hard to engage in conversations about Mr K's future care. This is not unusual and professionals need to use many skills to engage people with dementia and their families in planning and decision making. The Universal Assessment and Outcomes Framework of the Social Services and Well-Being Act and the assessment, care and treatment plan requirements of the Mental Health Measure, together with regular reviews, provide a framework that, if they had been used, might have helped support Mr K and W to engage in such a process.

Using the structure provided by legislation could have enabled Mr K and W to consider the future. For example, if they had discussed the circumstances in which Mr K might want, or need, to receive care in a residential or nursing home Mr K may have had the opportunity to become familiar with a service (and the service with him) on a day-care or respite basis and enabled him to feel more in control of the changes. This could also have avoided the need for crisis admission to the Residential Home. If a written plan had been made for Mr K to stay at home then the details of how this might have been achieved and the different services available (e.g. use of telecare, what to do in a crisis) could have been systematically explored.

Using a clear person centred framework for planning and decision making would have enabled professionals to identify when they needed to make Best Interest decisions on Mr K's behalf and to have some knowledge of his views to inform that decision making.

vii) Leadership and multi-agency working

There was a lack of active consistent leadership and coordination of Mr K's care across the virtual multi-agency team of people involved in his care and support.

Both the Residential Home and Nursing Home A contacted both the SW and the CPN when they needed help. This created duplication of effort in some circumstances but at other times they did not receive a response when they needed. The opportunity for setting up a deputising arrangement for each other's functions at times of leave/sickness was not taken.

There is a lack of clarity across the NWSAB area as to who takes responsibility for the coordination of multi-agency working when there is both a CPN (with the role of Care Coordinator) and a SW involved in a case.

The Mental Health Measure 2010 describes assessment as being the responsibility of the Care Co-ordinator (in this case the CPN), whilst acknowledging that this role overlaps with the role of the Local Authority Social Worker. A further responsibility of the Care Co-ordinator is to organise Multi-Disciplinary Team meetings.

Multi-agency meeting combining the perspectives of the CPN and the SW as well as the organisations involved in supporting Mr K and his family at home would have benefited a more holistic assessment of Mr K. Multi-agency meetings shortly after his admission to both the Residential Home and Nursing Home A would have enabled them to provide more informed care and could have included planning for potential crises.

The Measure states that there should be a protocol in place between Local Health Boards and relevant Local Authorities that clearly identifies the roles of staff from each agency in these situations. There was and is no relevant protocol in place.

Without such a protocol it is hard for staff to have clarity about each other's role and for constructive challenge to be made if one professional perceives another as not fulfilling their part in joint arrangements.

In Mr K's case the failure to hold multi-agency meetings meant that the opportunity to create a 'team around the individual' was missed.

viii) Communication – electronic records

The Older Peoples CMHT members do not consistently use computer based records. This is a key factor in information not being easily transferred to and from that team as is needed in order to facilitate good multi-agency and multi-disciplinary working.

This was a particular problem for the EDT on 21st January 2017 as they had no access to CMHT information about Mr K's situation.

ix) Communication – co-location

In this area the CMHT and social services teams for working age adults are co-located enabling a much greater degree of coordination and collaboration than is possible for staff working across separate CPN and SW teams for Older People. This leads to potential inequity between the MH services provided and for potential discrimination towards older people in this regard.

x) Recognition and responding to the symptoms of a crisis about to unfold

Delay in responding to the symptoms of crisis is illustrated throughout by Mr K's 'journey'. It took 6 weeks from W going in crisis to her GP before any services were mobilised to support her and a further 3 weeks before she received practical day to day help. The learning event recognised the impact of this on decreasing her resilience and increasing Mr K's agitation.

W, the Residential Home and Nursing Home A all raised their concerns that Mr K's symptoms were becoming worse prior to Mr K's various mental health crisis. The CPN made notes at each of those times acknowledging that the care plan might need to change. The CPN did ensure Mr K's medication was reviewed and changed at these times and advice was provided to W and to Nursing Home A about how to minimise Mr K's agitation. However, the multi-agency team was not informed, consulted nor brought together and the opportunities to make coordinated changes to existing care arrangements or to make planned moves were lost.

The Mental Health Measure specifies that a 'crisis plan' should be included in a care and treatment plan. This records the signs and symptoms that might indicate that a persons' mental health is deteriorating and the steps that should be taken to intervene. Had such a plan been in place it would have been a useful tool to help W, the Residential Home, Nursing Home A and the Hospital Ward to support Mr K.

xi) Dealing with professional disagreement

Both care homes raised the need for Mr K to have a Mental Health Assessment. This was discussed by the CPN with the consultant for the OP CMHT who disagreed. There was no option for the people who had direct experience of providing care to Mr K to discuss their professional opinion with the consultant. As there was no multi-agency forum created there was no forum for addressing these professional disagreements.

When Mr K was taken to hospital as a result of Crisis 2 the psychiatric liaison team made their assessment on the basis of Mr K's presenting behaviour in the Emergency Department and concluded that he did not need to be admitted for a MH Act assessment. The consultant did not communicate directly with the Residential Home and appeared to minimise the concerns they had. The doctor was therefore unable to include the observations and experience of experienced professional colleagues in the assessment. The assessment might also have been helped if the Residential Home had had sufficient staff to accompany Mr K to hospital and/or if they had communicated the difficulties they had been having clearly to W and Mr Ks son.

Recommendation 7a: BCUHB and each Local Authority Partners of NWSAB must take immediate steps to ensure an effective protocol is in place between Older Peoples Mental Health services and the relevant social services teams and present this to NWSAB so that:

a) The Care Coordinator for each older person receiving secondary mental health services is specifically allocated and recorded in BCUHB files and the Local Authority electronic case file
b) It is clear who holds the responsibility for leading an assessment of the person's needs for care and support in line with parts 2 and 3 of the Social Service and Wellbeing Act (2014) and/or an assessment leading to a care and treatment plan to fulfil the requirements of the Mental Health Measure (2010).
c) Where possible these assessments are carried out jointly or by delegation so that people do not need to repeat themselves to different professionals
d) Consent should be requested from the adult so that, where-ever legally possible, the assessment/s and the resulting care and support and/or care and treatment plan should be recorded in both the BCUHB files and the Local Authority electronic case files
e) A framework is provided to enable Care Coordinators to carry out/ensure Mental Capacity Assessments are made where there is doubt as to a person's mental capacity and to carry out and record best interest decisions where those are needed
f) A framework is provided to enable Care Coordinators to carry out or arrange for behavioural assessments and to ensure behaviour plans are in place and are updated on a regular basis
g) A framework is provided to enable Care Co-ordinators to form crisis plans with older people living with dementia
h) There is clear guidance to Care Coordinators as to when to hold multi-agency meetings 'team around the individual' meetings to facilitate effective information sharing and care coordination.
i) There is an assumption that a dementia advocate or champion will be part of each team around the individual
j) It is clear who has responsibility for ensuring that there is clarity about how the care package is funded and that nursing assessments and applications for Continuing Health Care funding are made as soon as this is appropriate
k) Team managers carry out a joint quality audit of case work with OP with mental health needs on a 6 monthly basis.

Recommendation 7b: By April 1st 2021 BCUHB to assure NWSAB that local services have sufficient capacity to respond promptly to the referral of any person living with dementia whose behaviour is a risk to themselves or others - including out of hours – and provide

i. Physical health screening
ii. Mental health diagnosis and assessment
iii. A treatment plan
iv. Psychological assessment
v. A behaviour plan that enable carers to support people living with dementia to manage anxiety and other psychological disturbances that can cause harmful behaviours

This must include the capacity to promptly review such assessments in response to evidence that the interventions being provided need to be changed.

Recommendation 7c: BCUHB and each local authority where OP CMHT and relevant social services teams that are not co-located to immediately instigate a series of events to bring managers and staff together to
i) ensure staff have up to date knowledge of legislative requirements, national and regional dementia strategies and best practice
ii) to identify and implement 'quick wins' for improving working together and to jointly provide a 'wrap around' person centred service to older people living with dementia.

Recommendation 7d: The Medical Director of BCUHB must assure themselves that there are clear and effective arrangements between GP's and Consultants for the oversight of the clinical assessment and care for each individual Older Person living with dementia who experiences behavioural and psychological symptoms.

Recommendation 7e: The Medical Director of BCUHB sponsors a working group including GPs, Community Pharmacists, Psychiatric liaison, Psychiatrists working with the OP CMHT, CPNs (including nurse prescribers) and Nurses working in Care Homes, Older People and Carers to recommend a protocol for delivery and oversight of clinical care of Older People living with dementia for implementation

8) **Crisis management:** Not all crises can be avoided. A key issue identified by the learning event and the panel is the lack of crisis support available to older people living with dementia living in their own homes and to those living in residential and nursing homes. A crisis team able to provide extra support as well as advice and training for carers and staff in behavioural techniques for de-escalating harmful behavioural and psychological symptoms of dementia could be a useful resource to be developed.

Inequitable pathways: The response to Mr K's mental health crises and in particularly the events that took place on 21st January 2017 were identified as being of great concern to Mr K's family, to staff involved and it is assumed to Mr K himself.

Both managers of the Residential Home and of Nursing Home A confirmed their experience that the out of hours GP service would rarely attend a situation where a person with dementia was experiencing a mental health crisis. They also reported that the consultants who offer Mental Health Act assessments out of hours will not attend an older person living with dementia unless organic causes of increased distress e.g. infections have been ruled out.

The care homes reported that the consequence of this decision is that older people living with dementia have to attend the hospital Emergency Department (ED) to access tests for relevant infections and access to the Psychiatric liaison team if their symptoms arise or become unmanageable 'out of hours'. There is a different process for working age adults including those with learning disabilities, who are assessed in the place where they are living.

There is widespread recognition that the Emergency Department is not the best place for older people with dementia especially at times when it is likely to be crowded. The

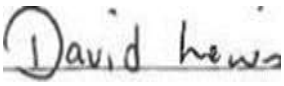
formal positon is that older people experiencing a mental health crisis should be assessed ‘at home’ unless they are unsafe where they are and in those circumstances they should be admitted to the ED as the nominated as the ‘place of safety’

Recommendation 8a: Commissioners from BCUHB and all the Local Authority Partners of the NWSAB to work with providers of care services to proactively consider the business case and partnership funding to develop a service that can provide crisis support to older people living with dementia living in their own homes or care homes when that person’s behaviour creates a risk to themselves or others.

Recommendation 8b: BCUHB and all the Local Authority Partners of the NWSAB work with Care Home Providers and Older People to develop a protocol for delivering Mental Health Act Assessments ‘out of hours’ to older people living with dementia in their own homes and within care homes.

Recommendation 8c: The North East Wales Emergency Duty Service protocol is reviewed and updated to reflect its role in supporting the relevant Local Authorities to implement the Social Services and Well Being Act (2014) for older adults in crisis and a process for making best interest decisions in line with the Mental Capacity Act (2005) out of hours **and** all EDT staff have received training about the implications of these Acts’ for their work.

Recommendation 8d: A mechanism is put in place to enable workers on duty at the North East Wales Emergency Duty Service protocol to easily access information when there is evidenced based risk about a provider of care to adults via an alert/flag in the relevant data base.

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2** ***(as appropriate)***	
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** *Eleri Lloyd Burns (did not* Finish review) **Date**		**Reviewer 2 and report** (*Signature)*  **Name** *(Print)* **Ruth Ingram** **Date** **8th March 2021**	
Chair of Review Panel *(Signature)* **Name** *(Print)* **Date**		 Pp Christopher Pearson 26/02/2021	

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.*

The Chair of the APR Panel for this review was Christopher Pearson (DoLS Manager/Safeguarding Specialist Practitioner BCUHB)

The APR panel met 5 times. The members of the panel were:

Flintshire County Council:	Senior Manager Safeguarding & Commissioning.
Care Inspectorate Wales:	Senior Manager (Adult Services Inspection).
BCUHB:	Safeguarding Specialist, Corporate Safeguarding Team.
BCUHB:	Acute Surgical Matron
Shadow Reviewer:	Safeguarding Team Leader - Alzheimer's Society

This review was carried out by Eleri Lloyd-Burns – Designated Nurse -National Safeguarding Team- Public Health Wales (lead reviewer Nov 2018-Dec 2019) and Ruth Ingram - Independent Safeguarding Consultant (Nov 2018 – May 2020). Bev Perkins Safeguarding Team Leader/Advocacy Manager (Wales) Alzheimer's Society assisted with facilitating the Learning Event.

The review included:

1) A meeting with Mr Ks son R. Mr Ks wife W had initially planned to come with her son to meet with the reviewers but then decided that she did not want to do that. Mrs K had already shared some of her views at the safeguarding case conference.
2) Considerations of timelines generated by the organisations involved in Mr K's care and support
3) Examination of documentation supplied by organisations that augmented information in the timelines
4) Meetings with the registered managers of both of the care homes where Mr K had lived - neither of whom had been the registered manager at the time Mr K was resident.
5) A meeting with the Community Psychiatric Nurse who had been Mr K's Care Coordinator. A meeting with the CPN's manager was not possible as they had recently retired. The CPN themselves retired shortly after our meeting with them.
6) A meeting with Mr K's Social Worker and their manager
7) A meeting with the organisation providing Social Services Emergency Duty Team service. Two current managers and the worker from the team who had been involved in Mr K's placement at Nursing Home A.
8) A learning event that focused on Mr K's care pathway
9) Discussions in the APR panel meetings

The Learning Event was attended by:

Mr Ks Social Worker
Social Worker from the Safeguarding team who carried out the investigation
The manager of the CMHT for older people
Manager -Nursing Home A
A member of staff from the ward in the General Hospital where Mr K received treatment
Manager of the commissioning team for the Local Authority
A member/manager from the Continuing Health Care team