ADULT PRACTICE REVIEW REPORT

Cwm Taf Morgannwg Safeguarding Board
Extended Adult Practice Review

Re: CTMSB1/2019

Circumstances resulting in the Review

An extended Adult Practice Review (APR) has been undertaken in line with the Social Services and Well-being (Wales) Act 2014 "Working Together to Safeguard People Volume 3". The guidance states that an extended review will be commissioned by the safeguarding board 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.

Due to the nature of the event it was agreed at the Cwm Taf Morgannwg Safeguarding Board's Adult Practice Review Group that the criteria was met for the extended review. The circumstances of the case are as follows.

Adult F was known as a proud and dignified lady, who enjoyed her previous employment as a primary school teacher. Her first language was Welsh and she was an independent lady who lived alone. Adult F was an only child, her father died when she was young and her mother, to whom she was a dedicated carer, passed away aged 86 years. Adult F never married and didn't have any children, in her later years her neighbours were caring and supportive towards her. Following a period of assessment and treatment at home Adult F was admitted to hospital with cognitive impairment in September 2017.

Adult G is described as a very chatty man who had been educated at Grammar School. He spent a period of time in the Armed Forces. Following this he owned his own business and is described as a well thought of man in his local community, often supporting his neighbours. Adult G has three children although they are estranged. He has a diagnosis of mixed

dementia and was admitted from a care home setting to hospital under section 2 of the Mental Health Act in in July 2017.

Adult F and Adult G became familiar to each other whilst in an Older Persons Acute Mental Health setting and subsequently both became inpatients on the Specialist Dementia Assessment ward. Whilst there Adult F became preoccupied with Adult G as she believed him to be her neighbour.

On the 12th June 2018 Adult F was struck by a fellow patient (Adult G) to the nose. Both were inpatients on a Specialist Dementia Assessment ward. Following the assault Adult F was admitted to hospital with a bleed on the brain. The initial prognosis was poor and there were concerns that Adult F would not survive the assault. Adult F recovered from the assault but sadly passed away some months later in a care home from natural causes.

In 2017, prior to Adult G's admission to hospital he was a resident in a care home. Whilst at the care home, there were several violent incidents which were recorded and reported to Adult Safeguarding. One of these incidents led to his detention under the Mental Health Act. The victim on this occasion also sustained life changing injuries and died later in a care home setting. This resulted in a police investigation which concluded that there was no direct causal link between the assault and victims death. Adult G would therefore not face any criminal prosecution. However an Adult Practice review was also commissioned following this incident.

Practice and organisational learning

A practitioner learning event was held on the 7th November 2019, the purpose of which was to bringing those professionals involved in the case together to review their practice. A timeline of significant events in respect of both individuals was shared with practitioners who had the opportunity to identify areas of effective practice and areas for improvement. Through the course of the learning event the following themes where identified:

1: The use of appropriate legislation for adults requiring care and treatment
2: The patient pathway between older persons mental health wards
3: The reporting and recording of safeguarding incidences
4: The role of the Multi-disciplinary team

Theme One:

<u>The appropriate use of legislation for adults requiring care and treatment</u>

In respect of Adult F, the admission to hospital via a Mental Health Act assessment undertaken in September 2017 was necessary and proportionate to facilitate a period of assessment. She quickly settled and was discharged from the Mental Health Act and placed on a Deprivation of Liberty Safeguards, (DoLS). The reviewers observed that this was the appropriate and least restrictive option for her at the time. Following this a best interest meeting held in January 2018 recommended a nursing home placement to support Adult F's safe discharge. As Adult F had consistently expressed a wish to return home a Court of Protection application was required. It is positive to note that despite her lack of capacity, Adult F's views were sought and she remained informed of the possibilities involved in her future care pathway. Noting that Adult F's first language was Welsh, it was identified that Health and Social Care staff made every effort to assess her capacity through this medium and the English language. The Court of Protection referral was appropriate however there was a significant delay in discharge planning due to incorrect legal advice received from the Local Authority. The reviewers are aware that lessons have already been learnt and appropriate actions have been taken to prevent this from happening again.

In respect of Adult G, the admission to hospital via a Mental Health Act assessment undertaken in July 2017 was necessary and proportionate to his needs and risks at the time. He was later discharged from a section 2 of the Mental Health Act in August 2017 in favour of DoLS only to be re-detained on section 3 at the beginning of September 2017. At this time Adult G was continuing to display challenging behaviour including non-compliance with care and aggressive behaviour. It is therefore unclear to the reviewers why continued detention under the Mental Health Act was not maintained during this period. This pattern of detention and discharge under the Mental Health Act is repeated again in March 2018. Following an assault on a nurse, Adult G was again discharged from the Mental Health Act in favour of DoLS only to be re-detained later in March 2018.

Despite Adult G being detained under the Mental Health Act during his hospital admission there is no record that a referral for Advocacy was made until after the incident with Adult F in June 2018.

Learning Points

Decisions relating to the appropriate use of legislation need to be based upon the individual's presentation at the time and leading up to the decision. Good practice is to consult with all relevant professionals involved in the patient's care and treatment prior to such decisions being made.

Improved understanding of the responsibilities and process supporting referrals to the Court of Protection.

Where patients are assessed as lacking capacity and are admitted to hospital, a timely referral to advocacy services should be made by ward staff.

Theme Two:

The patient pathway between older persons mental health wards

Adult G was initially admitted to the Older Persons Acute Assessment Ward. He remained an inpatient there from July – September 2017. During his admission there were frequent incidents of aggressive behaviour to other patients and occasionally staff. Medical and Nursing interventions were required, Adult G was on intermittent and continuous observations and received regular additional medications to manage his distress and agitation. Adult G was re-detained on section 3 Mental Health Act on 5th September 2017 prior to his transfer to a Specialist Dementia Assessment Ward on the 20th September 2017.

On the day of transfer and intermittently throughout the following days, Adult G continued to be aggressive towards others. A section 117 Aftercare review meeting was held on the 25th September 2017. Transfer back to Acute Assessment Ward was considered but did not proceed in favour of additional staffing being provided to support Adult G in the same environment on enhanced observations. Despite these observations Adult G's behaviour continued to escalate with further aggressive and sexually inappropriate behaviour. Following a Ward Round on the 6th November 2017 Adult G was placed on the highest level of observation (within arm's reach of a dedicated staff member) and prescribed intramuscular injections to manage his challenging behaviour.

A Care and Treatment Plan (CTP) review on the 11th December 2017 concluded with Adult G requiring a Specialist Placement on discharge. Levels of observation were reduced to afternoon and evenings which had been assessed as the high risk times. Despite ongoing and escalating incidents of aggression and agitation, including assaults on patients and staff requiring physical interventions, Adult G remained on the Specialist Dementia Assessment Ward until the incident towards Adult F on the 13th June 2018.

At the learning event staff recognised the persistent efforts of ward staff to manage increasing challenging behaviour and risk. There were weekly Ward Rounds attended by Medical and Nursing staff. Both individuals physical health care was reviewed and treated in a timely manner, with interventions from more specialist practitioners when required. There was a comprehensive risk formulation undertaken with Psychology to understand Adult G's challenging behaviours and the least restrictive approach to managing them. However the appropriateness and timeliness of Adult G's care pathway was discussed at length. It was noted that despite his initial challenging presentation on the Acute Assessment Ward, the rationale for transferring Adult G to a Specialist Dementia Assessment Ward was to provide a quieter, less stimulating environment. However despite this, Adult G's behaviour continued to challenge, there were serious risks to patients and staff recorded, yet there was no apparent consideration given to transferring back to the Acute Assessment Ward. Whilst discharge planning had identified the need for a 'Specialist Placement' on discharge, it was not clear from the notes what type of placement was required, (Nursing Home or Hospital). Consideration for transfer to a more intensive mental health care environment only features in the records following the serious incident involving Adult F.

Case recordings evidence discharge planning for Adult G as early as October 2017. Care and Treatment Plan (CTP) reviews had been held in September and December 2017. Requests for Nursing Assessments and Continuing Health Care (CHC) eligibility were referenced in November 2017 and again in February and March 2018. It is likely that the

changes in Adult G's day to day care and treatment delayed these being completed. However there were missed opportunities for a Multidisciplinary review of the current placement and possible alternatives given Adult G's ongoing challenging behaviour.

Learning points:

The appropriateness of a patient's environment of care should routinely feature as part of the Multidisciplinary review of care. Such opportunities should be brought forward where there are concerns over a person's care and treatment.

Pathways to support timely access to appropriate environments of care need to be established. This is relevant both to the NHS provision and Independent Specialist Placements where required.

Theme Three:

The reporting and recording of safeguarding incidences

It became evident to the reviewers that there was inconsistency in the reporting of incidences both internally to the Health Board and externally to the Multi Agency Safeguarding Hub. Had this been completed then there would have been increased opportunities for these incidents to have been reviewed internally by the Health Board and or externally from Adult Safeguarding.

A summary of the incidents involving Adult G are as follows:

31st August 2017: Adult G observed kicking and punching another patient who fell to the floor. Health Board DATIX completed but no referral to Adult Safeguarding completed.

20th September 2017: Adult G alleged to have punched another patient in the face. Health Board DATIX report completed but no referral to Adult Safeguarding completed.

27th September 2017: Incident of sexually disinhibited behaviour recorded between Adult G and another patient on the ward. Health Board DATIX completed but no Adult Safeguarding referral completed.

2nd October 2017: Adult G hit another patient causing him to fall to the ground. No Health Board DATIX report or Adult Safeguarding referrals completed.

8th January 2018: Adult G was observed to punch another patient causing them to lose their footing, staff were required to intervene there was no evidence of this being recorded in the Health Board DATIX incidence reporting system. There was also no record of this being referred to Adult Safeguarding.

5th February 2018: Adult G was observed to slap a fellow patient, no evidence of this being recorded in the Health Board DATIX incidence reporting system. There was also no record of this being referred to Adult Safeguarding.

19th May 2018: Adult G required physical intervention to prevent an assault on staff, there was no evidence of this being recorded in the Health Board DATIX incidence reporting system.

Learning points:

In environments where there are a high number of incidents between vulnerable adults there is the danger that a culture of professional tolerance develops, resulting in high staff thresholds for challenging behaviour and an under reporting of serious incidents.

Following this serious incident the Health Board Safeguarding Team has undertaken additional training and facilitated learning with the Older persons Mental Health wards in respect to the reporting of incidences which could be considered abuse or neglect.

Based upon discussions within the learning event there is still confusion amongst professionals about when they report to Safeguarding and or the Police.

Theme Four:

The Role of the Multi-disciplinary Team

Evidenced based mental health care involves a wide range of approaches and interventions provided by professionals across health and social care. It is important that there is timely access to professional assessments and interventions as predicated by an individual's assessed needs and risks.

At the learning event those present reflected upon what they felt was a strong medical model of care on the Older Persons Mental Health Wards. It was discussed that each ward had a dedicated Consultant Psychiatrist. It had been observed that transferring patients between wards was often challenging due to the roles and responsibilities of the Consultant Psychiatrists. The Health Board has since reviewed its position and the Consultant roles and responsibilities are now not restricted to individual wards, and patient transfers are predicated by need at the time.

Whilst it was positive to note the Psychological formulation that Adult G was subject to during his admission, there was discussion at the learning event which highlighted limited access to Therapies including Occupational Therapists and Psychologists on the Older Persons Mental Health wards. Ward rounds and clinical reviews were often led by medical and nursing staff and would benefit from increasing Therapy involvement to reflect the different professional views and interventions required.

Learning points:

A wide range of evidenced based interventions should be available to all patients on Older persons Mental Health wards. As well as the individual benefits this provides this will also ensure a balanced multi-professional approach to minimising potentially restrictive practices.

Improving Systems and Practice

Recommendations:

Recommendation 1 – Practitioners need to ensure that they use the most appropriate and the correct legislation in respect of the individual needs and risks at that time.

Recommendation 2 - Partner Agencies need to ensure that staff are fully aware of the roles and responsibilities where a person is assessed of lacking capacity with particular reference to timely access to advocacy and referrals to the Court of Protection.

Recommendation 3 - Partner agencies are aware of how Care and Treatment Plan Reviews (Mental Health Measure 2010) provide an opportunity to review an individual's accommodation needs. Practitioners involved should be routinely reviewing the appropriateness of the current and future environments of care.

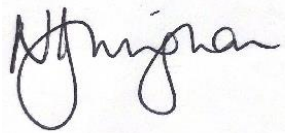
Recommendation 4 – The Safeguarding Board is to consider how they support practitioners to understand when they report to safeguarding and when they report to the Police.

Recommendation 5 – The Health Board review the access to Occupational and Psychological Therapies on the older person's mental health wards.

Statement by Reviewers

REVIEWER 1	Alex Beckham	**REVIEWER 2**	Mark Abraham
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, or have given professional advice on the case		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, or have 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 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)* Alex Beckham **Date 26/10/2020**	**Reviewer 2** *(Signature)*  **Name** *(Print)* Mark Abraham **Date** **26/10/2020**

Chair of Review Panel *(Signature)*  **Name** *(Print)* Nikki Kingham **Date** **26/10/2020**	

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Adult Practice Review process

The circumstances of this case were considered by the Cwm Taf Morgannwg Safeguarding Board's Adult Review Group in May 2019 where it was agreed that it met the criteria for an Extended Adult Practice Review.

The review was carried out in accordance with the Social Services and Well-being (Wales) Act 2014 “Working Together to Safeguard People Volume 3" guidance and a Panel was convened attended by the following services/agencies:

- RCT Adult Services
- South Wales Police
- Wales Ambulance Service Trust
- Cwm Taf Morgannwg Emergency Duty Team
- Cwm Taf Morgannwg University Health Board

A learning event was held on the 7th November 2019 attended by the following services/agencies:

- RCT Adult Services
- South Wales Police
- Wales Ambulance Service Trust
- Cwm Taf Morgannwg University Health Board

The families of Adult F and Adult G were written to outlining the commissioning of and Adult Practice review and their invitation to contact the reviews should they wish to participate, however neither family responded.

☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads ……

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