BDCT CTSB
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ADULT PRACTICE REVIEW REPORT

Cwm Taf Safeguarding Board
Extended Adult Practice Review

Re: CTSB1/2018

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 Safeguarding Boards Adult Practice Review Group that the criteria was met for the extended review. The circumstances of these are as follows.

Adult D had a diagnosis of cognitive impairment and resided in an EMI residential care home. He was diagnosed with Frontal Lobe Dementia at the beginning of 2016 and his needs became such that he became reliant upon others to support him with all aspects of his daily living.

Adult D was described as a quiet, unassuming gentleman who always had a smile for everyone. He was a passionate and award winning gardener who owned his own nursery, he and his family would travel to various shows around the country. Adult D was married for many years and had one son who died at the age of thirteen.

Adult E's admission to the same care home was a crisis admission following a significant deterioration in his ability to manage independently within the community. Adult E 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 E has three children although they are estranged. He has a diagnosis of mixed dementia and is currently being cared for in a hospital setting.

Both Adult D and Adult E were made subject to Deprivation of Liberty Safeguards during their residence within the care home.

On the evening of the 17/07/2017 Adult D was walking in the corridor of the home when Adult E came out of the lounge area and assaulted Adult D who fell to the floor. Staff were able to distract Adult E and move him away from Adult D. An ambulance was called and Adult D was admitted to hospital. His condition on admission was poor; he had sustained a fractured skull, and numerous small bleeds and haemorrhages. As a result of the injuries sustained, Adult D's needs changed significantly and he was placed in a care home with nursing provision. He passed away in November 2017.

Adult E has a diagnosis of dementia and lacked the mental capacity to understand his actions. He became settled shortly after the incident however does not recall the event. Following the incident and deterioration in his behaviour, Adult E was assessed and detained under section 2 of the Mental Health Act (1983).

There had been previous reports to the adult safeguarding team of violent incidents involving Adult E towards Adult D and an incident involving a member of staff who Adult E had hit and who was rendered unconscious.

Practice and organisational learning

A learning event was held on the 19th June 2018. 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. The reviewers identified the following themes within this practice review:

1) Emergency admission process.
2) Assessment of need and risk.
3) Communication and documentation.
4) Escalation processes.

Prior to the learning event the reviewers met with Adult D's wife to share with her the purpose of the APR and to also gain her views to share within the learning event.

Adult D's wife was complimentary of the support staff within the home who she felt supported her husband very well. She advised that he settled within the home however she herself spent a lot of time there and still continued to take her husband out and about on trips. She felt that this was important to him and enabled him to have quality time outside of the home.

Adult D's wife did raise a concern with the reviewers in relation to a lack of procedure and measures in place to manage the escalation of behaviour that was targeted towards her husband by Adult E. Also of concern to her was the communication from the care home in respect of their perception that her husband required an EMI nursing placement when there

had been no prior indication of this. She also shared that she felt that staffing levels in the home at times were not sufficient; she advised that she often spent a lot of time within the setting and was able to observe this.

In respect of Adult E's family, they are estranged and therefore consultation with them was not undertaken.

Theme One: Emergency Admission Process:

The Crisis admission for Adult E to the care home was appropriate and responsive to need. However, at the learning event there remained some confusion about a clear pathway for emergency placements and responsibilities for commissioning them. District Nursing staff were not clear on the process and the need for this to be commissioned via the Emergency Duty Team. Whilst the admission took place on Sunday the 26th March 2017, the Statement of Aims was not provided to the care home until the 21st April 2017. This is in contravention of the residential and nursing home placement process and would not have provided the care home with clear guidelines on the care and support needs of Adult E.

Learning Points:

1. Clear guidance should be in place across Cwm Taf between health and the local authority on the process of emergency placements out of hours.

2. Statement of Aims/Care and Support Plans must be provided to care homes on admission, or on the next available working day if outside of office hours.

Theme Two: Multi Agency Responsibility and Assessment of Need and Risk

Following the crisis admission to the care home in respect of Adult E there was an agreement in place for this initial placement to be extended to allow for a reassessment of his needs. Liaison between the care home and District Nurses identified that Adult E had been admitted with excess medication which suggested poor compliance in the community. He had also displayed behaviours suggesting deterioration in his mental state. The Care Manager's records suggest that they were unaware of these issues until discussions took place on the 30th March 2017. Adult E was admitted on the 26th March 2017; a reassessment of need was commenced on the 12th April 2017 but was incomplete.

On the 17th April 2017 a referral for a Community Psychiatric Nurse (CPN) was made by the social worker, following an incident of aggression towards a staff member. An initial appointment with Adult E took place the following day. On the 21st April 2017 the CPN visited Adult E at the care home with a psychiatrist where changes to medication were made.

On the 21st April 2017 the Care Manager provided the Statement of Aims to the care home; Adult E had been there for approximately 3 weeks. This would have provided the care home with specific information based upon assessment of his care and support needs and direction on management of risk.

Prior to the incident in July 2017, Adult E was involved in incidents of aggressive behaviour towards others in the care home which indicated escalation. These are as follows:

30/03/2017: Adult E became verbally aggressive towards a resident who stated that Adult E had hit him to the floor. Adult E was witnessed standing over him saying "get up you coward".

7/04/2017: A staff member intervened to prevent Adult E from hitting another resident. Adult E pushed the staff member with force.

16/04/2017: Adult E was agitated and physically hit out at a member of staff, causing her to lose consciousness. This was believed to be related to Adult E thinking that people were in his house.

21/04/2017: Staff at the care home reported that they had found Adult D on the floor bleeding from the head with Adult E standing over him.

There is evidence of collaboration between services responding to Adult E's needs. However these responses appear to be primarily focussed on efforts to maintain Adult E in placement and did not offer the objective assessment and review of the appropriateness of the placement. The completion of a timely, comprehensive needs and risk assessment may have afforded such an objective review of whether the care home was an appropriate placement.

Adult D had received a collaborative multi-agency approach to the management of his care and treatment which had informed his progressive care pathway from hospital to the care home at the end of July 2016. Changes in his behaviour were recorded at the end of 2016. The care home informed Adult D's wife on the 24th March 2017 that they felt the placement was no longer appropriate. Adult D's wife was frustrated with what she describes as the impulsive manner that this was communicated and that it had not resulted from any formal reassessment of need. More detailed analysis of this behaviour was requested by the CPN and a formal Nursing Assessment was commenced on the 26th April 2017

At the learning event professionals acknowledged that Continuity of Care Managers for both Adult D and Adult E remained consistent throughout their Care and Treatment.

Learning Points:

3 Care Co-ordinators should take a proactive approach to crisis and risk management, co-ordinate the responses from all professionals involved and act as the conduit for all communication.

4 Multi-agency partners should have an understanding of respective roles and responsibilities in the provision of care and support. Whilst the Care Coordinator's role is pivotal, that doesn't exclude the importance of independent professional assessment and its influence on decision making.

5 The care and support plan must be provided to care homes on admission or on the next available working day if outside of office hours.

6 Unplanned admissions should automatically prompt a re-assessment of need.

7 Change in need and risk needs to be evidenced through collaborative assessment between professionals and service users/carers. Through this transparent process service users/cares can be empowered to be involved in the decision making process.

Theme Three: Communication and Documentation

At the learning event it was acknowledged that as needs and risks escalate the number of professionals and agencies involved increases. With this, communication can become challenging. In addition, the various Information Technology systems and means of sharing information does not support collaborative and efficient practice. For example, the care home would report issues to one partner agency believing that they were reporting concerns in relation to the escalation of behaviour; however, in turn these were not being reported to the adult safeguarding team or Care Co-ordinator. Therefore only certain members of the multi- agency team were aware of concerns. Had this information been effectively co-ordinated, action may have been taken sooner.

The use of the Welsh Community Care Information System (WCCIS) across health and social care should aid the sharing of information and should be promoted as a central system for the sharing of information.

All professionals should be clearly documenting efforts to communicate with each other and evidence to support decision making. For example, whilst it was positive to see a Best Interest meeting had taken place, documenting evidence was not available to support it. Emails were referred to within the review as a frequent mode of communication; however, they did not always feature in the client record.

Learning Points:

8 Care Homes should ensure that they understand and comply with reporting mechanisms to the Care Manager, Safeguarding and Care Inspectorate Wales (CIW).

9 Health, Local Authority and the care home should ensure compliance with Professional Standards for documentation.

Theme Four: Escalation

The reviewers noted areas of good practice. For example, it was evident throughout the review that the care home worked in a personalised way for both individuals and knew both

of them very well. Adult D's pet dog was allowed to stay with him overnight to help him settle in the care home. The care home was responsive to changes in his needs and made every effort to stabilise the placement.

However, the care home needed to recognise times when the complexity of more than one resident's needs increase and their capacity to respond to other resident's needs. This is highlighted when Adult E's behaviour escalated.

Timely responses were evident throughout the review by mental health services in an attempt to manage the complex needs of both residents. Professionals were able to draw upon the expertise of the specialist dementia intervention team who were able to complete the formulation and develop a better understanding of Adult E's needs. It is worthy of note that this team worked outside of their remit as at the time, the provision was focused predominately on nursing homes.

There is evidence throughout the review that following incidences occurring between Adult E and Adult D and other incidences involving Adult E, there was a lack of clarity about what incidents should be reported and to whom. This is an area that is recognisable in other service provisions; therefore, all service providers should understand the S128 duty to report under SSWB 2014 which includes the need to report to the Police where it is suspected that a crime has been committed.

The increasing complexity of both residents' needs in the care home suggests the thresholds for residential care were being breached. In the context of an earlier escalation of the care home to the Multiagency Operational Group (MAOG) it was noted by the reviewers that the care home was not subject to further review by MAOG.

Learning Points:

10 Both the care home and multi-agency team need to recognise and take appropriate action when the needs or risks of an individual are changing.

11 An appropriate escalation process would have assisted within this case as there were disagreements between multi agency partners and a change of circumstances including an escalation of risk. This would have ensured pro-active action was taken to avoid unnecessary delays.

12 Multi agency practitioners did not effectively report issues and concerns. At the learning event incidents were identified which were criminal in nature and should have been reported to the police. All safeguarding reports must be made to social services and police where it is suspected that a crime has been committed. Moreover, in this case, crimes were reported to adult safeguarding who did not pass this on to police.

13 The provision of the specialist dementia intervention team supported the home in the management of the complex situation and was good practice. Wider consideration for teams/services that can provide this intensive and timely support to complex cases across residential/nursing provision should be considered.

Improving Systems and Practice

Recommendations:

It is evident that agencies responded to concerns in respect of Adult E whilst he was living in the community; however there was confusion regarding the process of emergency placement. Therefore the reviewers recommend that the Cwm Taf Safeguarding Board ensures that:

1. ***A review is carried out of arrangements for emergency admissions that take place out of hours.***

The reviewers noted that there was confusion from the care home regarding roles and responsibilities and how information is co-ordinated effectively to inform risk. It is therefore recommended that the Cwm Taf Safeguarding Board partners ensure that :

2. ***Their staff recognise their roles and responsibilities in the assessment of risk, with the Care Co-ordinator being central to the co-ordination of this process.***

The reviewers identified that there were issues with the recording of pertinent information and the communication of such information. It is therefore recommended that the Cwm Taf Safeguarding Board ensures that:

3. ***Health, Social Care and Providers are aware of their professional standards in relation to the recording of information***

The reviewers recognised that the situation was becoming increasingly complex and there was confusion between practitioners regarding the appropriateness of the placement for Adult E. There was extensive work being put in place to maintain the placements however the reviewers recommend that the Cwm Taf Safeguarding Board ensure that:

4. ***There is an effective escalation process for health, social care and providers that relates to disagreements about an individual's care and support needs.***

The reviewers recognise the complexity of supporting individuals in care settings who lack capacity and may be displaying aggressive behaviour. However, in line with the Social Services and Wellbeing Act, where abuse or neglect of an adult at risk is known or suspected, a safeguarding report must be made to social services and also to the police

where it is suspected that a crime has been committed. Therefore the reviewers recommend that the Safeguarding Board ensure that:

5. ***All agencies ensure that their staff are aware of their responsibilities under section 128 of the Social Services and Wellbeing Act.***

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 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, 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	
Reviewer 1 *(Signature)* …….		**Reviewer 2** *(Signature)* ……	

Name *(Print)*	…….	**Name** *(Print)*	……
Date	…….	**Date**	……

Chair of Review Panel *(Signature)* …….....….

Name *(Print)* …….....…….

Date …….....…….

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Adult Practice Review process

The circumstances of this case were considered by the Cwm Taf Safeguarding Board's Adult Review Group in January 2018 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 Emergency Duty Team
- Cwm Taf University Health Board
- RCT Commissioning Team

A learning event was held on the 19th June 2018 attended by the following services/agencies:

- RCT Adult Services
- South Wales Police
- Wales Ambulance Service Trust
- Cwm Taf Emergency Duty Team
- Cwm Taf University Health Board
- RCT Commissioning Team
- Care Home Representatives

Adult D's wife has been kept informed and her views sought and represented throughout this review.

In respect of Adult E's family, they are estranged and therefore consultation with them was not undertaken.

☐ 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	☐	☐	