Adult Practice Review Report

in respect of Adult A

CWMPAS 1/2016

Date report approved by the Board: 11th October 2018

Adult Practice Review Report

CWMPAS: The Mid & West Wales Safeguarding Adults Board

Concise Adult Practice Review Re:

CWMPAS 1/2016

Brief outline of circumstances resulting in the Review

Legal Context

A Concise Adult Practice Review was commissioned by CWMPAS: The Mid and West Wales Safeguarding Adults Board on the recommendation of the Adult Practice Review Sub Group in accordance with the Social Services and Well-being (Wales) Act 2014[1] and accompanying guidance Working Together to Safeguard People - Volume 3 - Adult Practice Reviews[2].

The criteria for this review are met under section 3.4 of the guidance namely:

A Board must commission a concise Adult Practice Review where an adult at risk has **not**, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- died; or
- sustained potentially life-threatening injury; or
- sustained serious and permanent impairment of health.

The purpose of a review is to identify learning for future practices. It involves practitioners, managers and senior officers exploring the detail and context of agencies' work with an individual and family. The output of the review is intended to generate professional and organisational learning and promote improvement in future inter-agency adult protection practice.

The criteria for Adult Practice Reviews are laid down in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[3]*.* The arrangements came into force from April 2016.

The Terms of Reference for this Concise Adult Practice Review are at Annex 1.

Brief Outline of the circumstances leading to the review

[1]Social Services & Well-being (Wales) Act 2014
[2] Working Together to Safeguard People – V3 – Adult Practice Review s (WG 2016)
[3] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. Regulation 4 (3)

The gentleman at the centre of this review will subsequently be referred to as Adult A.
He died in January 2012. A post mortem into his death was determined as: Bronchopneumonia, Dementia, Peripheral Vascular Disease and Ischaemic Heart Disease.

Adult A was placed in an out of county specialist Dementia Residential Care Home by Local Authority A. The residential home was in Local Authority B's area.

Local Authority A commissioned the placement. Adult A was not self-funding and the social care in Authority A were responsible and accountable for managing his care plan.

Adult A was admitted to hospital in January 2012 with a 3-day history of dehydration, query chest infection and cellulitis of the lower leg. On admission to the hospital he was found to be dehydrated, confused and disorientated. He was found to have 6 Pressure Ulcers, including a grade 3 to both heels and a grade 4 necrotic open wound on his sacrum. He also had redness to his groins and testicles.
On admission to the hospital he was given Intravenous anti biotics and was seen by the Tissue Viability Nurses however his condition deteriorated and he developed Bronchopneumonia.
Following his admission to hospital a Protection of Vulnerable Adult (POVA) referral was made. An initial evaluation of the case by the Police resulted in no criminal offences being made. The POVA investigation concluded in that on the balance of probability Adult A had suffered significant harm as a result of neglect.

Sadly, Adult A passed away 4 days following his admission to hospital.

Methodology

- An Adult Practice Review Panel was convened with a Chair.
- An Independent Reviewer was appointed.
- Terms of Reference were agreed (Annex 1).
- Timelines were developed from each agency and these were amalgamated into a composite timeline.
- A summary / analysis from each service was produced.
- The Reviewer met with Adult A's family to share with them the remit of the review and its purpose.
- Adult A's family shared their emotional story about their journey and their father's life with the participants of the learning event.
- The Residential Care Home were contacted for copies of the care home records. After a lengthy period of time, permission was given for the review panel to obtain the records held by Care Inspectorate Wales (CIW) formerly Care and Social Services Inspectorate Wales (CSSIW).
- An analysis of the care home records was produced by an independent health professional.
- A learning event was held to discuss the lessons learned prior to the date of death.

Time period reviewed and why

The review considered the period from January 2011 until the time of Adult A's death in January 2012.

Family History and Context

Adult A was a gentleman in his 70s. He was a retired Electrical Engineer and had been married and had 2 children whom he raised alone. His first language was Welsh.

Adult A had a diagnosis of Alzheimer's disease and was placed in a Residential Care Home following a hospital admission in 2009. Unfortunately, in July 2010 this care home was unable to meet his care needs and following concerns from the family the Social Worker requested an urgent mental health review and Adult A was allocated to a Community Psychiatric Nurse (CPN). Adult A was transferred to another care home within 2 weeks.

The new placement in the residential care home and personal plan of care was reviewed in October 2010 with Adult A's son and daughter, a Nurse Assessor, the Social Worker, CPN and the Care Home manager and it was agreed that it was meeting his needs. The Pressure Ulcer on his sacrum that had been observed on his admission to the care home was reported to have healed.

The assessment at that time found that Adult A did not have any nursing needs and that an EMI residential placement would meet his needs. His next review was planned for October 2011.

Adult A was known to the Local Authority and the Mental Health Service.

Practice and Organisational Learning

Key themes and learning arising from the review.

Key theme 1. Recording and Documentation in the Care Home.

- The documentation from the care home was reviewed by an independent health professional who found that it was difficult to understand exactly when the Pressure Ulcer developed and how long it had been present.
- There were several entries in the General Practitioner's (GP's) documentation that suggested that Adult A should be seen by the Chiropodist but no evidence in his care home records that this had been done.
- There is no evidence from the care home records that the District Nurse (DN) or GP were consulted with in relation to Adult A's Pressure Ulcers.
- The care home documentation received via CIW was very poor and there are discrepancies in the timelines.
- There appears to have been Pressure Ulcer damage being evident at least a week before his hospital admission but no mention of a pressure relieving cushion until 5 days later and no documentation to suggest that he had a pressure relieving mattress, regular position changes or a referral to the District Nursing Service for advice.
- Though the 2 falls were documented there was no reference to how the falls occurred, how long he had been on the floor, what surface he had been lying on or whether the skin was checked for marks or bruising.

Key theme 2. Clarification of Roles and Responsibilities /Professional Boundaries.

- Although the Care Home staff were not present at the Learning Event it was evident during the Learning Event that the care home staff appeared to be providing nursing care.
- There were blurred boundaries between care home staff and it appears that the District Nurses were not consulted on in relation to Adult A's health or his pressure area care even though it was mentioned in the care plan that the GP or DN should be consulted with if he developed pressure area damage.

Key theme 3. Communication.

- There appears to be a lost opportunity in relation to the management of Adult A in the care home, where he could have been referred to a CPN to manage some of the difficulties they were experiencing in his behaviours, which meant that his care suffered.
- There is no evidence to suggest that the GP or District Nurse were aware of Adult A developing Pressure Ulcers, this would have provided an opportunity for a comprehensive assessment and management plan which would have provided Adult A with the nursing care he required. This could have prevented further deterioration in his Pressure Ulcers.

- There appeared to be a lack of communication between the care home staff and the family, especially toward the end when he was becoming frailer. The family were not informed of visits to the memory clinic and would have liked to have been involved in his appointments.
- Adult A's family shared with the Learning Event their story and it appears that felt they felt disempowered during the process, and though they began to have concerns regarding his care these appeared not to be addressed by the care home staff.
- The family were not aware of the deterioration in his health until the hospital admission.

Key theme 4. Dignity and Respect.

- The family noted that Adult A was wearing other residents clothing on their visits which they found upsetting. Following Adult A's death, they visited the care home to pick up his belongings and they found other people's belongings in the boxes.
- Adult A responded better to male carers and this was not reflected in the management of his care. This meant the care home staff often had problems managing his personal care.
- The family also noted that when visiting their father who was doubly incontinent of urine and faeces was sat in a 'wet pad' and that he didn't always have access to fluids.

Key theme 5. Assessment process.

- Adult A's review by the Local Authority was overdue and in hindsight perhaps prioritising the out of county reviews would have highlighted Adult A's increasing needs.
- There is no evidence of consideration or completion of Adult A's mental capacity and a Best Interest Assessment in respect the use of a baby gate at Adult A's bedroom door. The Deprivation of Liberty Safeguards / Best Interest Assessment Process would have involved the family in the process and highlighting Mr A's increasing needs.
- The plan of care appeared to be largely appropriate until Adult A's first fall occurred and the subsequent development of the Pressure Ulcer to his sacrum. It was at this time that Pressure Ulcer prevention measures, in particular pressure relieving equipment, regular position changes, clinical treatment plan and assessment of pain would have needed addressing. There should have been a number of updated and reviewed body charts over this period of time and a referral to the District Nurses for clinical advice or support.

Key theme 6. Protection of Vulnerable Adults (POVA) Safeguarding Process.

- The Protection of Vulnerable Adults (POVA) procedures were initiated immediately when Adult A was admitted to hospital and a strategy meeting was held. Unfortunately, Adult A died a few days later. The safeguarding process was initiated in a timely manner by the hospital staff and the subsequent POVA investigation commenced.
- The family were disappointed with the process and outcome of the POVA Investigation.

Points to note

The panel and attendees at the Learning Event identified learning in relation to the process, even though it was outside the timeframe of the Adult Practice Review.

- The Local Authority's analysis informed the panel regarding the need for more information on pressure damage and the need to release operational staff for investigations.
- The process also highlighted a need for Commissioners to have a 'Safeguarding clause' in the Domiciliary Framework. This would ensure that services commissioned are aware of their safeguarding responsibilities under the Social Services and Wellbeing (Wales) Act 2014.
- The Police analysis highlighted that the family could have been better supported with the provision of an allocated Family Liaison Officer during the process. There also isn't a specific Adult Safeguarding / Protection training course for the Police and with Adult Safeguarding being on the same statutory footing as child protection this is an area which needs to be addressed. Practice has since changed in Dyfed Powys Police with the focus more on vulnerability and assessment using THRIVE (Threat, Harm, Risk, Investigation, Vulnerability, Engagement) plan e.g what safeguarding measures are you putting into place.
- The CIW analysis highlighted that enforcement work on the Residential Care Home should have started as soon as the case was flagged to them. CSSIW are informed immediately when a referral involving a regulated setting is identified and they are routinely invited to strategy meetings.

Effective Practice

There were many examples of effective practice identified in the care of Adult A.

- There was effective communication between the Social worker and the family, who listened to their concerns when Adult A was in his first Residential Care Home and she initiated a mental health assessment and change of placement.
- There was multi-agency decision making at Adult A's review at the placement with the family, the CPN, the Nurse Assessor, Social Worker and Residential Care Home Manager.
- The CPN brought forward Adult A's review at the memory clinic when the Residential Care Home staff expressed concerns in relation to the management of Adult A in September 2011.
- It was noted that a variety of different Health Professionals were involved in Adult A's care and responsive to his needs. However, they were reliant on the carers to report any concerns about his health.
- The Health staff referral to the POVA process was initiated on admission to the Hospital.

Improving Systems and Practice

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

It has been noted during the process of the review that practice has changed significantly since 2012.

- The Social Services and Wellbeing (Wales) Act 2014 has changed practice significantly in relation to Parts 3 and 4 with an emphasis on what 'care and support' an individual requires to achieve the personal outcomes that 'matter to them', - with 'care and support' plans. The overarching duties in the Act are to promote an individual's wellbeing and to have regard for their culture, dignity and views, wishes and feelings. It created a right to assessment for adults and their carers when they appear that they may have a need for 'care and support'. This involves the practitioner considering whether advocacy support is necessary.
- There have been changes to the thresholds in relation to Deprivation of Liberty Safeguards and Mental Capacity Act. A landmark judgement in 2014 in the case of P v Cheshire West and Chester Council ruled that incapacitated people subject by state decision to continuous supervision and control without the option to leave their setting are deprived of their liberty. Therefore a Best Interest Assessment would now be completed on residents where there is any deprivation of liberty and the family would have been involved in the process, and their views taken into consideration. The DoLS process enables the service user to be seen twice a year by a Social Worker and a Best Interest Assessor.
- During the learning event, staff currently working alongside the care home highlighted significant positive changes over the last few years under the new manager. This included effective multi agency working, monthly meetings with the District Nurses and inclusion of a local pharmacist in the provision of medication to residents.
- Local Authority Commissioners have undertaken a review of the Domiciliary Contracts with a clause being added in relation to 'Safeguarding'.
  This includes:
  Training - ensuring staff attending yearly training in relation to Adult Protection awareness, Protection of Vulnerable Adults, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
  Policies and Procedures - the service provider needs to make a clear commitment to the Wales Interim Policies and Procedures for the Protection of Vulnerable Adults and subsequent local, regional or national guidance, and any legislation which supersede these. Also providing their own organisational policy and procedures in accordance with these procedures.
  Process - The service provider needs to immediately notify any concerns or incidents to Social Services Safeguarding Team and / or the Police and or CSSIW in accordance with the Wales Interim Policies and Procedures for the Protection of Vulnerable Adult. They also need to co-operate fully with Adult Protection Strategy meetings and Investigation processes, with any requested

documentation, and acting upon the recommendations arising from these processes.

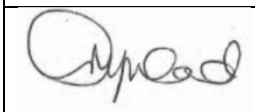
- Practice has also moved on in relation to pressure damage with the All Wales Pressure Ulcer Reporting and Investigation Guidance (2014). Since the introduction of the Social Services and Wellbeing (Wales) Act 2014 all avoidable Pressure Ulcers are reported to the Local Authority Safeguarding Teams. Avoidable Pressure Ulcers grade 3 or above are also reported to Welsh Government.
- Social Care Wales (2017) has commissioned and produced Good Work: Dementia learning and Development Framework. This provides the overarching framework to drive change in workforce development, and support what matters most to people with Dementia regarding their care and support.
- The Regulation and Inspection of Social Care (Wales) Act 2016 has established a new workforce regulator, Social Care Wales. Welsh Government announced in 2015 that all care home workers must register with the workforce regulator from 2020. This is a significant change coupled with the mandatory training that registration will require and it has the potential to drive up standards in care homes. Social Care Wales has been created with the aim of making sure people in Wales can call on a high quality social care workforce that provides services to fully meet their needs.
- Qualification Wales have developed a new Social Care Induction Framework which incorporates training in understanding the physical and emotional needs of people living with Dementia.
- Care Inspectorate Wales (formerly CSSIW) have introduced a new, rights focused inspection regime for Local Authorities. They have produced new guidance about their commitment to promote and uphold the rights of people who use care and support services.

Recommendations

The areas of improvement for agencies, as listed below, are the ones identified through the analyses and through the Learning Event.
As the staff and manager of the Residential Care Home did not participate in the review the recommendations highlighted are seen as essential requirements for all care homes in ensuring that service users have the high quality of care they are entitled to

1. Care Home staff need to have training in relation to record keeping.
2. Care Home staff must undertake basic dementia training as part of their induction and all care staff and care home managers should undertake further dementia training on an ongoing basis as part of their skills and competency development.
3. Care Home staff need to ensure they have basic training on Pressure area care and the recording and referral processes.
4. Care Home staff need to understand how to minimise the risks linked with falls – through staff training, Falls Resource packs and falls risk assessments.
5. Regional implementation of ‘Good Work: A Dementia Learning and Development Framework for Wales’ (2016).’
6. Regional establishment of Dementia Friendly Communities – Care homes are a part of the community.

7. Commissioners of care and support need to work with older people and their families to ensure that care homes can meet individual needs and that providers can be challenged about unacceptable standards of care.
8. Commissioners need to understand and reflect in their commissioning the needs of people living with dementia. Social Care Wales in partnership with the National Commissioning Board have developed a Diploma level qualification for Commissioners, Procurement and Contracting which includes 'understanding the process and experience of Dementia and 'understanding sensory loss.'
9. Police and Social Services need to undertake joint training on Adult Protection Investigations in order to understand each other's roles and responsibilities.

Statement by Reviewer(s)			
Reviewer 1	Pauline Galluccio	**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 adult 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 adult 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 *P Galluccio* *(Signature)*		**Reviewer 2** …… *(Signature)*	
Name Pauline Galluccio		**Name** …… *(Print)*	
Date 11/10/18		**Date** ……	
 **Chair of Review Panel** *(Signature)*			
Name Donna Pritchard. *(Print)*			
Date 11/10/18			

Adult Practice Review Process

The Mid & West Wales Safeguarding Adults Board (CWMPAS) notified Welsh Government in 2016 that is was commissioning a Concise Adult Practice Review in respect of Adult A.
A Review Panel was established in accordance with the guidance and an Independent Reviewer was identified.

External Reviewer: Pauline Galluccio, Independent Reviewer.
Chair: Donna Pritchard – Service Manager Mental Health, Strategic Lead for Safeguarding and Capacity, Ceredigion (Chair).

The Review Panel consisted of representatives from the following services:

- Hywel Dda University Health Board.
- Ceredigion Local Authority Adult services.
- Carmarthen Local Authority Adult services.
- Care Inspectorate Wales (formerly CSSIW).
- Regional Safeguarding Board Manager.
- Dyfed Powys Police.

Process of the Review

- The panel met regularly from December 2016.
- Individual agencies each provided a timeline of significant events together with a brief summary and analysis of their involvement. These were discussed by the Adult Practice Review Panel and used to inform the Learning Event.
- There were significant delays in the Adult Practice Review process due to the Police investigation, legal proceedings and gaining access to the Care Home records.
- The Reviewer maintained contact with Adult A's son and daughter throughout the review.
- Adult A's son and daughter provided the participants of the learning event with a pen picture of their father and their experiences of navigating through the care systems at the time.
- The Learning event was held, though due to the historic nature of this review – the majority of professionals at the event had had no prior knowledge of Adult A and therefore could only use the benefits of hindsight and therefore there were many unanswered questions in relation to the professionals involved in his care.

Learning Event

A Learning Event took place in July 2018. It was facilitated by the Independent Reviewer and was attended by practitioners from the following agencies.

- Hywel Dda University Health Board
- Police
- Local Authority Adult's Services

- Care Inspectorate Wales

Family members informed

Relevant family members were informed that the Adult Practice Review was taking place and were offered opportunities to meet and / or contribute to the review or Learning Event. Mr A's son and daughter engaged with the Independent Reviewer throughout the process and provided a personal story of their father's life and their experiences of his and their journey through the process.

Family declined involvement: No

For Welsh Government use only

Date information received:
…… *(date)*

Acknowledgement letter sent to Board Chair:
……*(date)*

Circulated to relevant inspectorates/Policy Leads:
……*(date)*

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Annex 1 Terms of Reference for CWMPAS 1/2016 Concise Adult Practice Review

Core issues to be addressed in the terms of reference of the review will include:

- To examine inter-agency working and service provision for Adult A through defined terms of reference.
- To seek contributions to the review from the individual/individuals and appropriate family members and keep them informed of key aspects of progress.
- To identify particular issues for further clarification.
- To produce a report for publication and an action plan.

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.

Indicative Roles and responsibilities:

- The Board Co-ordinator will be responsible for maintaining links with all relevant agencies, families and other interests.
- The *Review Panel* Chair will inform the Chair of the Board and the Board sub-group of significant changes in the scope of the review and the terms of reference will be updated accordingly
- The Chair of the Board will be responsible for making all public comment, and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the Final Board Report.
- The Board and *Review Panel* will seek legal advice on all matters relating to the review. In particular this will include advice on:
  - terms of reference;
  - disclosure of information;

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline, initial analysis and hypotheses
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post

event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft adult practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Safeguarding Adults Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- *Review Panel* completes the report and action plan.
- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website.
- Agree dissemination to agencies, relevant services and professionals.

The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Information Sharing and Confidentiality

Ownership of all information and documentation must be clarified in order that the appropriate permission is obtained from the relevant organisation prior to sharing. Organisations can only share information that is owned or originated by them. Responsibility for requesting information from each organisation (including from independent providers) should be clarified and agreed by the Panel, as appropriate. A statement of confidentiality (as below) will be signed at each Panel meeting by all attendees to reaffirm the boundaries within which information is being shared.

In working with sensitive information in relation to an adult practice review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:
- The Panel meeting is called under the guidance of *'Working Together to Safeguard People: Volume 3 – Adult Practice Reviews'* from the Social Services & Wellbeing [Wales] Act 2014.
- The disclosure of information outside of the Panel beyond that which is agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

- If consent to disclose is felt essential, initial permission should be sought from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.

However, the ultimate responsibility for the disclosure of information to a third party from the Multi-Agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose