safeguarding adults at risk
a cumbria partnership

Safeguarding Adults Review

Adult Y

Report Author – Sarah Ward

August 2015

Context and summary

1. Adult Y was born on Barrow Island and married her husband when she was 20 years old. They had 4 children and Adult Y had worked initially at Lakeland laundry during the war and then went on to have a stall on Barrow market for 25 years. She was a well known and respected community figure and liked to keep busy; volunteering at Furness General Hospital twice a week. She was known as a well presented lady who enjoyed getting her hair done regularly. Since becoming a widow, Adult Y continued her busy and active lifestyle and considered herself to be very independent.

2. Unfortunately as Adult Y got older, she began to suffer with a number of health problems and was diagnosed with Alzheimer's and Crohn's disease. In January 2012, Adult Y's son had raised concerns with Adult Care Services in January 2012 about his mother's ability to safely care for herself at home as she'd had a fire in the kitchen and he was concerned about her wellbeing. Adult Y was receiving some community care from mental health services but her son and daughter-in-law felt this was no longer sufficient and a further assessment was required. This was completed on the 7/2/12 by the community mental health team. An occupational therapy assessment was also scheduled for the 28/3/12 but practitioners were unable to carry this out due to Adult Y's apparent incapacity to provide consent. A multi-agency case review was then scheduled for the 19/4/12

3. At the meeting on the 19/4/12, which Adult Y's son attended, it was agreed to admit her to a mental health unit for a period of assessment to try and establish what her future care needs would be; she was admitted on the 30/4/12. Adult Y's son believed she would remain at the unit for a period of 6-8 weeks, which had been agreed, however she was considered fit for discharge from the 6/5/12 and remained there until the 20/6/12 when a placement had been found for her at a residential care home in Furness.

4. Adult Y presented as upset and anxious from her arrival at the care home as she did not want to be there and regularly requested to be allowed to return home. She became upset when she saw or spoke to her son and he was advised not to visit her to allow her a period of settling in. As her distress continued a deprivation of liberty assessment was undertaken to enable her to remain where she was. Consideration was given to returning her home but this was not considered possible due to her capacity issues.

5. The GP surgery responsible for Adult Y's care changed from a Barrow practice to Ulverston on the 9/7/12. Records indicate they were aware of her Alzheimer's and Crohns diagnoses and were aware of what medication she was being prescribed. During her stay at the care home, documents evidence a number of falls, concerns around her steady weight loss and conflicting practice around the administration of her various medication. In October 2012, Adult Y had been found on her bedroom floor and after complaining about pain in her knee and ambulance was called and she was transferred to Furness General Hospital where she was diagnosed with a broken hip. She was operated on and seemed to recover well, despite having a further fall whilst admitted in hospital. She returned to the care home on the 17/10/12 but records note Adult Y's sons concerns that he was unsure if they could continue to meet his mother's needs. Throughout October and November, Adult Y had at least two more falls and her reduction in weight had been recorded on three separate occasions. In December 12 a further reduction in weight was recorded and Adult Y was treated in hospital again after suffering another fall. When she returned to the care home she was reported as being unwell and presented with loose bowels. Advice was sought from her GP regarding her medication as it was noted her previous regular medication had been stopped. She was prescribed an alternative medication over the telephone on the 10/12/12 and staff at the care home were advised regarding dosage. After two different types of medication arrived at the care home for the same condition, it was clear that staff were confused about which to administer. The GP surgery clarified this on the 18/12/12. Four further falls are recorded over a period of 11 days in December 2012. A referral was made to the falls clinic on the 2/1/13 and the GP surgery suggested a review of her medication during a telephone consultation with the care home on the same date. Blood tests were arranged and the GP planned to visit before referring to the falls clinic. Staff at the care home requested a GP visit on the 3/1/13 as Adult Y was complaining of pain in her left hip.

The GP attended and found a faecal mass and suggested stopping her Crohns medication as he believed her to be constipated. On the 4/1/13, Adult Y was admitted to hospital as a result of chronic abdominal pain early in the day but was returned to the care home. Later the same day, after the GP had checked her blood tests results, he requested that she be transported to Furness General hospital again that day. The family were informed and attended hospital and advised of her significant weight loss over recent weeks. A scan on the 6/1/13 confirmed that Adult Y had a perforated bowel and after consideration of her suitability for surgery, it was agreed that she was not fit and began receiving palliative care. Adult Y passed away on the 7/1/13 aged 84 years as a result of a perforated bowel.

Rationale for completing a Review and Analysis and methodology

6. The Case Review Group, a sub-group of the Cumbria Safeguarding Adults Board received a referral in respect of Adult Y in November 2014 and was asked to consider if a full review and Analysis of the case was required. Chronologies were requested from the relevant agencies, which were Cumbria Partnership NHS Trust, University Hospitals of Morecambe Bay Trust, the Clinical Commissioning Group (CCG), Health and Care Services of the Local Authority and Cumbria Care, who were the providers of the residential home.

7. After consideration of the chronologies at the following meeting of the 3rd December 2014, it was agreed that there were sufficient concerns about the way agencies had worked together to justify a Full Review and Analysis of the case, as per Guidance paper 6 of the Multi-Agency Procedures, Appendix B. The Chair of the Board approved this and Adult Y's son was informed of this decision and indicated his wish to be involved in the process.

8. The terms of reference, Appendix C, were drawn up by the Case Review Sub-Group and approved by the Board and Adult Y's son. Full Individual Management reports (IMR's) were then requested from the above listed agencies and these were received in June 2013. A review panel meeting was then convened. The panel was made up of expert representatives from the Health and Care Services, the Partnership NHS Trust, the CCG and the Safeguarding Adults Board and were chosen for their ability to identify practice issues in the way Adult Y's case had been managed and their understanding of what the expected standards of practice should have been. The IMR's were sent to the review panel members in advance of a meeting scheduled for the 11th June 2015 and this enabled them to be read in the context of the chronology and terms of reference. The authors of the IMR's were then invited to the meeting to present them to the review panel and enable any additional queries to be considered, without the need to delay the process further and request updated/additional IMR's. The process seemed to work smoothly and all agencies co-operated to a very high degree; submitting insightful, comprehensive and analytical reports that meant a frank and honest appraisal of the practice was possible.

9. Adult Y's son was kept informed of the process and the minutes of the review panel meeting were shared with him.

10. Following the meeting on the 11th June 2015, the review panel met again on the 6th July 2015, to enable adequate time to reflect on the information gathered in June and to formulate a realistic multi-agency action plan that the relevant agencies would be required to implement. Adult Y's son was also sent a copy of the minutes from this meeting so he was appraised of the process and was aware of the likely learning to be identified in this report.

11. This report will consider the findings from the IMR's and review panel meetings and provide a multi-agency action plan, which will become the responsibility of the Case Review sub-group to monitor, to provide assurance to the Board and Adult Y's son that the learning from this process has been implemented and embedded into every day practice. The group will also seek assurance about the implementation of the individual action plans each agency had completed as part of the IMR process.

Analysis of findings and learning points

12. The first point to note is that this case took a considerable length of time to be referred to the Safeguarding Adults Board and it transpires that this was as a result of an internal complaints process Adult Y's son had made against Cumbria Care, the providers of the residential care home. The review panel felt it was important to note that the case review process did not necessarily need to be delayed until the outcome of the complaint was known. The drawing out of this process over a prolonged period of time has had a negative impact on the family of Adult Y and causes unnecessary delays in the improvement of practice.

13. **Learning Point** – Any case that is considered to meet the criteria for a case review should be referred at the earliest available opportunity. If there is the possibility that the process will impinge on other investigations, a pragmatic decision should be made on how to proceed involving all of the relevant parties and this can be documented.

14. The terms of reference, Appendix C focused on the time period between the multi agency meeting of the 19/4/12 and the month following her death (8/2/13). The analysis in the review panel meeting addressed each key issue identified in chronological order and each agency provided and account of their involvement in that issue/decision/practice.

15. The first significant event was the meeting of the 19/4/12. Records indicate that this was attended by Adult Y's two son's and daughter-in-law, a consultant, the care co-ordinator, Occupational Health, the Social Worker and a home care supervisor. The review panel and terms of reference were particularly interested in the decision to place Adult Y in a residential home rather than a nursing home. It wasn't clear from the initial chronologies provided if this was something that family had agreed to and if it was considered appropriate given Adult Y's presenting needs. The Partnership Trust were able to produce records of the meeting and clarified that a number of sources of information were considered in the meeting, including risk assessment tools, care notes and reports, cognitive examinations and mental capacity opinions. A discussion took place around the analysis of risks and the documented outcome of the meeting was that it was felt appropriate to act in Adult Y's bests interests and pursue a long term care facility. Records indicate that the family were in agreement with this position. It was agreed that Adult Y would be admitted to the mental health unit for a full mental health assessment with the view to her being placed in a long term care facility appropriate to her needs. At this stage, it is not specified whether a residential placement or a care home would be the best options.

16. The IMR by the Partnership Trust acknowledged that although the decision to admit Adult Y was agreed by all parties, it was clear that Adult Y herself would not be in agreement as she wished to remain at home. However, due to the various assessments that had already taken place, the general consensus was that Adult Y lacked the capacity to make this decision for herself and therefore a best interest decision was made on her behalf by the involved professionals and the family members. The review panel did not feel this process was detrimental to Adult Y, however it was acknowledged by all parties that a Mental Capacity Act assessment should have been undertaken at this stage. A deprivation of liberty assessment was started on the 13/7/12, but this is some time after Adult Y was admitted to the care home The Partnership Trust advised in their IMR that their practice has changed in relation to this procedure now and where a patient is resistant to remain in a placement, the least restrictive condition should be initiated to avoid any deprivation occurring. Where this is not possible, the deprivation must be legally authorised in the shape of a Deprivation of Liberty (DOL's) assessment.

17. When discussing this meeting and the subsequent decision with Adult Y's son during the case review process, he advised that the meeting had suggested an admission to the mental health unit of around 6-8 weeks, during which time the family would be able to make a decision about where she would be placed long term. The decision to move her into more long-term care was progressed sooner than this and as a result, Adult Y's son felt 'rushed' into making a decision about where she should be placed. This is noted in the IMR completed by Adult Social Care who stated that a social work assessment was undertaken prior to considering discharge from the mental health unit,

which determined that Adult Y's needs could be safely and appropriately met in residential care. It is recorded by the social worker at the time that Adult Y's son had contacted them to say he felt his mother was being moved too soon and that the assessment period had not been as long as he had expected. There was also an issue highlighted that the social worker had offered Adult Y an 'interim placement' but her son objected to this, not wanting to have to move his mother on more than one occasion due to the distress it may cause. Upon further analysis of this issue, the IMR from Adult Social Care reflected that this terminology is regularly used by professionals when they are referring to an initial placement on a temporary basis, with a view to it becoming permanent. It was clear that this was not how it was perceived by Adult Y's son and when discussing this particular issue with him, he reflected that his understanding was that Adult Social Care had planned to move his mother to a placement in Millom on an interim basis and that this would not have been long term, which would have meant a further move. He felt that it would have been beneficial for him to be provided with a targeted list of available care and residential homes that were suitable for his mother as he was given an extensive list and had to work through phoning and visiting them, only to be told if he liked them, that they couldn't cater for his mother's specific needs. The IMR from Adult Social Care acknowledges that the discharge planning process in this case was not as robust as it could have been and that social workers had a role to support families going through this process as it was complex and unfamiliar and it appeared Adult Y's son had not been supported as well as he could have been.

18. **Learning Point** – The discharge planning process needs to be carefully co-ordinated and Adult Social Care have a pivotal role in supporting families to make difficult decisions about the future care of their relatives. A targeted list of suitable establishments should be provided to families to assist in the decision-making process.

19. However, despite this, agency records indicate at this stage that the decision to place Adult Y into residential care as opposed to a nursing home was the correct one at the time, albeit there are some process issues that could be improved in the future. It becomes clear as we work through the review, that there were stages in Adult Y's deteriorating presentation that should have prompted further consideration of this issue and these will be highlighted as they occur in the report.

20. Adult Y therefore moved to the care home on the 20th June 2012, by agreement of all parties and Adult Y's son. However, several records indicate that Adult Y was unhappy with both her initial admission to the mental health unit and her subsequent move to the care home. Her condition was noted as being distressed and anxious on several occasions and her son also advised that it was difficult to see her behave in this way as she was placing blame on the family for removing her from her home. It is clear from the records and was the view of the professionals attending the Review meeting that Adult Y did lack capacity at the time and the decision to place her into full-time residential care was in her best interests. However, the review panel were concerned about the advice given to Adult Y's son not to visit her after her initial admission to the care home. Whilst it was acknowledged that the rationale for this was to allow a period of settling in, it was concerning to see that Adult Y's period of distress was continuing and although it may have exacerbated when her family visited, it did not abate when they weren't visiting either. Adult Y's son described a difficult period of time where he felt visiting her was upsetting her but not being able to visit either, increased anxiety on his part and potentially Adult Y's too. Adult Social Care acknowledge in their report that in this particular instance, the advice not to visit appeared to have been accepted without challenge, when perhaps social workers had a role in ensuring family relationships were maintained. It was noted that there are advocacy workers available to help support residents with capacity issues and an early referral may have been able to alleviate some of the distress of Adult Y. This example demonstrated a passive approach by Adult Social Care when the culture they want to promote amongst staff is to have an investigative approach to their cases and not work on assumptions.

21. **Learning Point** – All agencies should adopt an investigative approach to their cases and not passively accept decisions that may affect the well-being of residents in all types of care homes.

22. **Learning Point** – Referral for Mental Capacity support should be considered for every case where an adult is considered to lack capacity, even when they have supportive family members acting in their best interests.

23. It is worth noting at this point in the report that the residential care home have been investigated thoroughly as part of a complaint raised by Adult Y's son in relation to the level of care she received whilst in their care and the review panel had sight of the outcome of the complaint and supporting documents and the action plan which they are monitoring to ensure this situation does not arise again in the future. However, in the context of this review, it is important that we document the areas of concern and provide assurance to the Board that these are either being considered on a single agency basis by their action plan but also to draw out the learning for other residential and care homes across the County.

24. The representative from Cumbria Care at the review panel meeting was honest in acknowledging that the systems in place at the time of Adult Y's residence were not to a good standard, particularly in relation to falls, recorded weight loss and management of her medication. As noted on pages 2 and 3, Adult Y had a number of falls whilst at the care home and it is unclear what action had been taken by them to document this and ensure her future safety. The most significant of the falls was in October 2012 when Adult Y was admitted to Furness General Hospital with a fracture to the neck of her femur. She was assessed as suitable for surgery and this was successful, however it was recorded that Adult Y suffered another fall whilst in hospital. There was no evidence that an assessment had been undertaken to try and minimise the risk of future falls, especially in light of previous falls and her recent fracture.

25. There were also significant failings in the process to monitor weight loss as records indicated that staff had noted on several occasions that Adult Y's weight was reducing but there was no evidence that any action had been taken as a result of this. It showed a lack of a pro-active response to an obvious concern; passively noting the weight loss in line with the relevant process but failing to make the connection that this may be indicative of a more serious issue or that it required further attention.

26. **Learning Point** – Residential and Care homes and Acute Trusts need to have a robust process in place to ensure falls are documented and escalating patterns can be easily identified and appropriate assessments undertaken.

27. **Learning Point** – Residential and Care homes to have a robust process in place to ensure weight loss is recorded and more importantly, appropriately acted upon.

28. The IMR author representing Furness General/Morecambe Bay Trust advised that practice has moved on since the time of Adult Y's admission and there is now a Care of the Elderly Team who assesses all patients over the age of 75. This would have included Adult Y.

29. Adult Y's stay in hospital also raised issues in terms of her prescribed medication. Prior to her admission to the care home, Adult Y had been registered to a GP surgery in Barrow but this was moved to Ulverston when she took up residence at the care home. The IMR report in respect of the GP practice indicates that electronic records were satisfactorily transferred over but that it would have been good practice for the GP to have visited Adult Y in person within 2 weeks of her becoming registered at the new surgery. This did not take place.

30. **Learning Point** – GP's to ensure new patients are visited within good practice guidelines to assess any longstanding medical complaints and review medication.

31. Whilst Adult Y had been in the mental health unit for assessment, a referral had been made to a dietician in respect of her diagnosis of Crohn's disease, however there were no records to indicate if this had been followed up.

32. **Learning Point** – All agencies need to have robust systems in place to ensure appropriate referrals are followed up.

33. It became clear from discussions in the Review Panel meeting that Adult Y had been prescribed a number of medications throughout the time period of the Review, often by differing clinicians. It transpires that it is not unusual for a patient to be prescribed medication by their GP, from the mental health services/Psychiatrists and Acute Trusts if there are any admissions to hospital. What also became

clear is that there was no system in place for co-ordinating these prescriptions and the potential impact of this could be harmful and in the case of Adult Y, have significant implications. The GP IMR highlighted that a number of medications prescribed to Adult Y had side-effects of constipation. This is significant given that her cause of death was due to bowel perforation and she had a diagnosis of Crohn's disease. When discussing how this situation can be avoided in future, the Acute trust advised that as part of their Care of The Elderly Team, referred to earlier, there is a pharmacist who is responsible for reviewing all medication, to ensure there are no conflicts in side effects as described in Adult Y's case.

34. **Learning Point** – Acute Trusts to provide assurance that medication is holistically reviewed for elderly patients on each admission to hospital.

35. The review panel felt that Adult Y's admission and subsequent discharge from hospital had been a missed opportunity to review if Adult Y's needs could continue to be appropriately met in a residential home and felt that there should at least have been a multi-agency discussion/meeting at this stage to consider this issue, involving the family.

36. **Learning Point** – The required care needs of each patient should be reviewed after any significant incidents, including admissions to hospital.

37. In addition to this, there seemed to be the added complexity of Adult Y having physical and mental health needs due to dementia. However, it has to be recognised that Adult Y's case is not unique and in order to take learning from this tragic case, systems and processes need to be put into place to manage these issues. It is frustrating to note that in several case reviews spanning across the children's and adults arena, often the same learning points are identified but still we have examples of individual cases where this learning has not been applied. The review panel took this issue very seriously and felt that although there were pockets of some good practice in individual agencies, it was clear that no single agency had taken responsibility for co-ordinating the care provided to Adult Y and this was felt to have had a significant impact on the outcome. When discussing how this could be realistically addressed, given that it is not an uncommon finding, it was agreed that the Safeguarding Adults Board should commission a task and finish group to include Cumbria Partnership Trust and Adult Social Care to make recommendations to the Board about how a lead practitioner/agency can be identified in each case and what their role would be in the care of complex patients. There was discussion around the social worker being the appropriate person in some cases and the mental health care co-ordinator in others so a universally understood framework needs to be introduced in the relevant agencies so that frontline staff can be made aware of their responsibilities.

38. **Learning Point** – There needs to be a framework in place to identify a lead professional who is able to co-ordinate the care of complex cases.

39. Another issue that became clear from the GP IMR was that a certain amount of diagnosis and prescribing happened over the telephone between the GP and the staff at the care home. The IMR author rightly commented on the inappropriateness of this arrangement as staff in residential homes are not medically trained and are therefore unable to diagnose conditions, which the review panel strongly agreed with. It was recognised that the people who cared for Adult Y on a regular basis were aware of her differing presentation when she was ill and it was important that their observations were recognised and listened to, however they should not have been expected to make suggestions/recommendations to GP's. They also need to be given clear advice on what medication is being prescribed and why as there was a particular incidence in Adult Y's case where two differing types of medication arrived to treat the same issue for Adult Y and staff were unclear about which to administer.

40. **Learning Point** – GP's should not rely on the opinion of untrained staff in residential homes and should visit patients themselves to be assured of accurate diagnosis and treatment.

41. It is noted that the GP did attend to see Adult Y in early January 2013 and the result of blood tests taken were what prompted the GP to arrange for her urgent admission to hospital, however at this time, the infection to Adult Y was too severe and she died shortly after her admission to hospital.

42. When an individual dies and is subject to Adult Safeguarding procedures, an unexpected death meeting is held to see if the criteria is met for a safeguarding adults review. This did not take place in the case of Adult Y as her case was not active to the safeguarding team, despite a number of missed opportunities being identified by IMR authors throughout the review. This meant an unavoidable delay in the case being referred for a review, as outlined earlier. However, more significantly, had Adult Y been referred into the Safeguarding Procedures earlier, issues around medication and the suitability of residential care following a deterioration in her physical health may have prompted a more holistic review of her needs.

43. **Learning Point** – All agencies to ensure frontline staff are aware of how to make a safeguarding alert and under what circumstances they should.

Conclusion

44. Although it was clear from the Review Panel meetings that it was the intention of all of the agencies involved with Adult Y that she be cared for appropriately, a holistic review has highlighted a number of deficiencies in practice and a failure of agencies to work together in an effective way. It is most tragic that it takes the death of a vulnerable adult to prompt such reviews, however in order to ensure this does not happen again, The Safeguarding Board will take action to implement the attached action plan to address the learning points identified in this case, in full consultation with Adult Y's son.

Summary of Learning Points

1. Learning Point – Any case that is considered to meet the criteria for a case review should be referred at the earliest available opportunity. If there is the possibility that the process will impinge on other investigations, a pragmatic decision can be made on how to proceed involving all of the relevant parties and this can be documented.

2. Learning Point – The discharge planning process needs to be carefully co-ordinated and Adult Social Care have a pivotal role in supporting families to make difficult decisions about the future care of their relatives. A targeted list of suitable establishments should be provided to families to assist in the decision-making process.

3. Learning Point – All agencies should adopt an investigative approach to their cases and not passively accept decisions that may affect the well-being of residents in all types of care homes.

4. Learning Point – Referral for Mental Capacity support should be considered for every case where an adult is considered to lack capacity, even when they have supportive family members acting in their best interests.

5. Learning Point – Residential and Care homes and Acute Trusts need to have a robust process in place to ensure falls are documented and escalating patterns can be easily identified and appropriate assessments undertaken.

6. Learning Point – Residential and Care homes to have a robust process in place to ensure weight loss is recorded and more importantly, appropriately acted upon.

7. Learning Point – GP's to ensure new patients are visited within good practice guidelines to assess any longstanding medical complaints and review medication.

8. Learning Point – All agencies need to have robust systems in place to ensure appropriate referrals are followed up.

9. Learning Point – Acute Trusts to provide assurance that medication is holistically reviewed for elderly patients on each admission to hospital.

10. Learning Point – The required care needs of each patient should be reviewed after any significant incidents, including admissions to hospital.

11. Learning Point – There needs to be a framework in place to identify a lead professional who is able to co-ordinate the care of complex cases.

12. Learning Point – GP's should not rely on the opinion of untrained staff in residential homes and should visit patients themselves to be assured of accurate diagnosis and treatment.

13. Learning Point – All agencies to ensure frontline staff are aware of how to make a safeguarding alert and under what circumstances they should.