Diogelu Gwent
Gwent Safeguarding

Adult Practice Review Report

Gwent Safeguarding Board
Concise Adult Practice Review

GWASB 2/2020

Re: Adult A

Brief outline of circumstances resulting in the Review

A Concise Adult Practice Review was commissioned by Gwent Safeguarding Board on the recommendation of the Case Review Sub-Group in accordance with the Guidance for Multi Agency Adult/Child Practice Reviews.

Adult A was found deceased on the morning of the 29.06.20. Two carers found her deceased in an unnatural position with her arm caught in the bed rail on their morning visit to her home. Due to a report of a sudden death, the Police attended the scene and a referral was submitted to the Local Authority by the care agency. Adult A's family raised concerns to Police around the suitability of equipment, which they stated they had reported previously to Social Services.

Following a number of enquiries, a multi-agency strategy meeting was arranged. It transpired that the equipment documented on the Occupation Therapists (OT) WCCIS notes, was different to what was supplied to Adult A.

It was the opinion of the OT attending the strategy meeting that the equipment in the photograph was different from what they had requested. It was similar but not what the OT expected to see in the photograph. It is possible that had the equipment been as requested, Adult A would not have been able to get her arm trapped/caught. The equipment would have had a solid partition and not open rails. Adult A only had use of her left arm, and this was the arm, which caught in the bed rail equipment.

Prior to her death, on the 23.06.20 the ambulance service attended following one of Adult A's falls but did not admit her to hospital as per Adult A's wishes. It is important to note that

Adult A had full capacity at this time and made decisions about her care provision, alongside her family.

Family had made contact with Adult A's GP advising them of her decline and they prescribed a second lot of antibiotics but did not complete a home visit to see her.

Prior to Adult A's death, her son-in-law made contact with Social Services on 24.06.2020 advising Adult A's current presentation and deterioration in health. He reported Adult A had had a number of falls and was hallucinating. He reported that she was falling out of the chair. Adult A was at the time taking prescribed antibiotics for a recurrent Urinary Tract Infection. Her son-in-law advised Adult A was dehydrated and that the GP reported she is vulnerable. Social Worker had made contact with the family following the referral and advised to wait for the infection to clear before completing any assessments. An assessment by Social Care did not take place prior to death as the infection did not clear.

There had been input via Social Services and Occupational Therapy over the 12 months before her death and it appears through reading case notes that Adult A's capacity to understand the risk of remaining at home fluctuated, however it was unknown if a formal mental capacity assessment was completed or recorded in any records.

Time Period Reviewed.

The Adult Practice Review Panel decided to review the case for the 12 months prior to Adult A's death.

The review period was from 29th June 2019 to 29th June 2020.

Practice and organisational learning

What worked well in this case? Good Practice points.

There were many points of good practice by all agencies involved with Adult A throughout the work undertaken with her throughout the timeline period that has been reviewed. It is important to highlight these to ensure that the practice is acknowledged, and good practice can be built on and learned from in the future.

- **District Nurses** - Visiting regularly and consistently and were completing care plans during their visits. Appropriate diagnosis of moisture lesion by an experienced Sister. Consent was regularly gained from Adult A prior to checking areas/wounds, completing observations. They communicated with the family. Body map / skin checked each visit. Notes stayed with Adult A in her home for others to access.

- **Social Worker (SW) -** Review in July 2019 evidences good practice. The Social Worker arranged a timely review given demands and capacity following the report of confusion. Joint working CPN and SW Capacity Assessment. Letter with Care and Support Plan and Review sent to the daughter. Case goes on the list to review

annually, and care package continues 4 times a day. Lockdown contingency plans made between Adult Services and Family

- **SW – OT -** Communication was good at times. The OT was commended for her thorough approach to assessments prior to the review**.** Joint working **OT** and **Care agency; Care agency** contacted the OT to re-assess the stand aid**.**

- **Review** – The review was held as a face to face with the family. All involved would have been in attendance, the OT was doing assessments and wanted to ensure all other assessments were complete to ensure that the best decision was made for Adult A. The OT was commended for the work on this.

- **Information -** Adult A's care delivery was written in her notes, the notes (DN's & Carers) stayed with the patient so that all can be informed; Joint working and Communication with family and praise for carers (District Nurse and Carers Notes).

- **Community Psychiatric Nurse** - asked Adult A's views on staying at home, this demonstrated that Adult A's capacity was being assessed and her wishes included in her care.

- **Medically reviewed well** – good **MDT** approach; an example of this was by **GP** when concerned around whether Adult A needed a pressure relieving cushion.

- **Multi-agency -** conversations and involvement at periods (all agencies).

Learning Points and Key Themes

<u>Key Theme 1: Falls – No Formal Falls Risk Assessment undertaken or referral to responsible team; other risk assessments</u>

The timeline clarified that Adult A experienced numerous falls over the 12 month period before her passing. The Reablement Team had been involved previously due to the falls and there was a falls assessment in 2018. However, since this time no further assessment was undertaken.

In the Learning Event it was clarified that if a person falls, carers cannot pick them up in case they cause or exacerbate an injury for the person or in case they hurt themselves. The family can be called and if the family cannot assist, they need to call 999.

There were no referrals to the Falls Team despite Adult A experiencing numerous falls, it was suggested that if there were significant memory issues, the Falls Team may not see them. The first stage of a Falls Assessment will be for the team to see the person and their family to try to work out why they are falling. At one point, observations had been undertaken on Adult A and her blood pressure was 100/55 which is low, consequently standing could make her blood pressure drop further and cause her to fall. Adult A was also very unsteady and fell to the floor whilst using her Zimmer Frame. There was no note to reflect that this had been reported.

The question posed is therefore whose responsibility it is to report a fall? There were a number of agencies involved in Adult A's care, both statutory and independent services. There appeared to be a lack of ownership from all agencies in escalating exacerbation in the frequency and significance of falls. There was a lack of discussion between the

agencies to share the bigger picture of Adult A's condition, which may have further evidenced Adult A's deterioration in coping in her home.

It was suggested during the Learning Event that if the carer's knew about or had concerns about a fall, they should have raised this with their manager who would have had a conversation with the Social Worker or District Nurse. It was suggested that people had become desensitised to Adult A falling. They felt that with the interventions and implementation of the action plan the occurrence of falls had reduced.

There are other examples of assessments which were not undertaken or where risks were not identified. There were issues with the bed and bed rails which were not reassessed after falls; issues with the pressure cushion Adult A used which was not regularly reviewed and different advice was given by different agencies at different times.

This again questions the robust nature of assessment and whose responsibility is it to coordinate, communicate and holistically assess the changing needs of adults at risk.

Recommendations

- All agencies, including statutory and independent providers, can demonstrate assurance that team members clearly understand their roles and responsibilities in relation to falls and indicators of deteriorating wellbeing when living in the community.

- When multi-agency care packages are in place, there is assurance of escalation and communication processes in the community with all agencies taking ownership. These processes must evidence that they include the partner agencies, the family and the person at risk.

- All agencies to remind staff of the importance of understanding and clarifying roles and responsibilities in multi-agency involvement with clients specifically in relation to repeated falls and risk assessments.

Key Theme 2: Silo working and how that might have impacted upon information sharing between individuals/professionals/agencies.

There are many good examples that the agencies involved with Adult A were communicating and collaborating. There are however points where it is evident that agencies were working in isolation.

The district nursing teams that were regularly visiting were keeping patient notes and recording all visits and actions taken. This was also undertaken by the Carers. The shortfall here is that different agencies were using different recording mechanisms and not always viewing each other's recordings to establish what had happened the previous visit/day and if any action needed to be taken.

It is evident that each agency has their own terminology, and this can be a barrier in effective communication and information sharing. For any agency attempting to understand each other's abbreviations, caution should be taken to ensure that the correct interpretation

is used and not assumed. Notes should be read properly, and any actions are communicated properly to ensure key messages come though.

Specifically, in relation to Carers' notes and care plans, it became evident that District Nurses (DN's) and Carers keep notes in separate books. On occasions there were joint visits with DN's and Carers whereby the information could be passed on, sometimes they leave notes and other times the DN may ring the agency. It was not clear how good the communication was and the different methods of record keeping were confusing and did not aid communication and the sharing of key messages.

Agencies have noted that there is no mention in the notes of when issues are changing, healing, worsening etc. This information needs to be in the notes and available to professionals. During the Learning Event it was noted that the carers stated that they were rolling Adult A regularly, however Adult A was never seen in her bedroom, which was separate to the living area. The review has considered that the carers may have meant that Adult A was regularly standing. Further issues have been raised around care plans being followed for example, records state that dressings were being used for a moisture lesion, but moisture lesions do not require dressings. The group considered the possibility that the care plan was not read.

In terms of sharing notes, the family had asked to see the written notes, without access to these they may be unaware what has been done, what was difficult, how often Adult A had been moved. Many agencies use different recording systems. Most Local Authorities now use WCCIS, there is also a plan for Health to access this, this is considered a beneficial way forward as viewing the information on a united system is helpful.

Recommendations

- Where communication between agencies is challenging due to different mechanisms of recording, a communication book/ virtual log may be helpful in cases where there are a number of agencies involved. This should be kept in the community location and provides an area where communications can be recorded inter agency, and between families and the patient.

- All agencies to remind staff of the importance of communication and engagement with all relevant agencies involved in delivering care and support to an individual.

- Commissioners should ensure that escalation of key incidents from external providers to case managers is part of the core contract requirements.

Key Theme 3: In the absence of a formal care coordinating role, how does everyone know who is doing what, who has responsibility to share concerns and information?

Through this review it is evident that there were numerous agencies involved in the care of Adult A including GP, District Nursing, Social Care, Carers and OT. When a multi-agency package of care is in place it appears that there should be a Key person/Lead professional who is responsible for coordinating the care.

The question has been raised during this review about how different agencies communicate in the absence of a Care Coordinator. In Adult Social Care it is not the

Social Workers responsibility to be the Care Coordinator and to ensure that everyone knows the plan, the care plan is not managed by one person. If there are communications between DN's and carers, they would do this directly. Social Workers may be involved for cases on review, but once the review is complete the case is closed. There are also lots of transfers to different teams, making it difficult to identify the key worker with the most involvement, as once an intervention is complete the individual is removed from the case load. The current situation in Adult Services is that caseloads are exceptionally high across the board and therefore no plan in individually managed or reviewed regularly, after being implemented. Therefore, there is no definite care coordinator.

It appears that on Adult A's case despite numerous agencies being involved, there was no point of contact for actions to be taken forward on a regular basis. An example of this was in June 2020. Significant deterioration was noted, and Adult A was not drinking, she was suffering from chest infections every month and hallucinations. A social worker was allocated on the same day however it was noted that there was no OT referral even though Adult A was sliding from her chair. It therefore asks the question about who noted this deterioration and who should have requested OT assessment and followed up with her deteriorating health needs. This was a particularly difficult time as the Covid Pandemic was at its first Peak and service delivery by all agencies was affected. This is commented on later in this report. This issue was not resolved.

This element of the review also contributes to Silo working and information not being shared. Effective communication is the key to safeguarding and ensure that we are collaborating to achieve the outcomes desired for services Users. The Learning Event offered many suggestions to support the thinking that even coordinated note taking and systems recording can be effective in ensuring actions are taken forward.

There needs to be clear roles and responsibilities in effective care planning to ensure there are no gaps in service delivery.

It has been acknowledged during this review that significant work has taken place in the Local Authority regarding case management to rectify this.

Recommendation

- All agencies to be reminded of their responsibilities to share concerns and information with other agencies and family members. This should include reminding staff of the importance of identifying key actions and responsible agencies on the care and support plan (or equivalent).

- All agencies and Local Authorities to ensure that effective systems are in place to ensure that there are clearly defined roles and responsibilities within care planning.

Key Theme 4: Impact of COVID - family having a greater role, delegated responsibility due to COVID

The timeline covers the period of 12 months prior to the passing of Adult A in June 2020. In March 2020, Wales was placed in lockdown overnight due to the COVID- 19 pandemic. The pandemic had a detrimental impact, with all agencies facing unprecedented change and demand on services. Services were forced to adapt the way they provided care and contingency planning was put in place with immediate effect.

During a meeting with Adult A's family as part of this review, the family were asked what instructions they received, and they advised it was pretty much down to the family and care agency; there wasn't any direct contact from Social Services. It was noted when the son-in-law wanted to speak to Social Services, he phoned the general phone line and was then passed around the department.

Social Services confirmed that they contacted all service users with the aim of RAG rating them to identify those at higher risk. Call backs were made depending on what they were told. Social Services also contacted all on the shielding list to ensure that they were okay. In Adult A's case the phone call was to the family. The family were not sent any information in writing about Agency COVID plans.

In relation to the GP, Adult A's daughter phoned the GP due to falls and confusion; the GP did not visit but ordered investigations via the DN's who were operating business as usual. It would appear that there was a delay in the GP requesting the investigations, resulting in a delay in issuing prescriptions for antibiotics. Other than Carer's, from 21st May until 23rd June, Adult A had no contact from other agencies. The carers visited 4 times a day and family visited regularly. DN's were due to visit monthly, however with the visits from carer's the DN's did not need to attend. The duty of care to report concerns therefore lay with the Carer's at this point.

On the 23rd June Adult A fell and pressed the Careline button, a St John's Ambulance Falls Responder attended to help her up. She was unwell at this point with a urinary tract infection, confusion, and irritability. The family felt that her health had deteriorated. The family questioned that if COVID was not a factor, would Adult A have been admitted to hospital at this time due to the deterioration in her health. However, her clinical presentation did not support admission to hospital. It was also raised that it would be helpful to understand the care agency point of view around this time. Thistle Care did not attend the Learning Event and have not met for discussion with the reviewers.

Discussions within the review have taken place regarding the care agencies duties to feedback and the pressures they were clearly under during the first part of the pandemic. The family's perception of the care agency is they were over worked, under pressure and were struggling to keep to times. Family did not criticise the care agency.

COVID-19 has impacted on roles and responsibilities and there is undoubtedly learning across all agencies and for Welsh Government. Adult A's health was deteriorating, and it appears that the pandemics impact on services did affect the level of care that Adult A received.

There was a lack of face to face contact with Adult A from March to June 2020 from services other than the care agency. Social services involvement (including OT) was minimal (as was appropriate for Adult A at the time when their assessment was conducted). To notify social services of Adult A's deteriorating condition, a referral would have been required to request another assessment, and this did not occur. Consequently, the increase in Adult A's falls was not known to social services.

The GP and the District Nurses did not visit Adult A in her home despite contacts made by the family to primary care. Treatment was however provided for her infections.

There appears to have been a reliance from all statutory agencies on the carers contact with Adult A 4 times daily to manage her needs. It poses the question if this was appropriate given the increasing falls, and infections that Adult A was experiencing- that primary care were made aware of by the family. It also raises questions if independent

carers are given the training and resources to understand the holistic, longer term indicators of deteriorating health and wellbeing.

A referral to social care should have been made to escalate the need for assessment but this was not completed by the agencies who had contact with Adult A up to her death.

It is hard to ascertain if these issues in the care of Adult A were related to the pandemic and reduced visiting, requirement to only see the most vulnerable, or if this would have been usual practice.

Recommendations

- Agencies and Local Authorities to contribute to the regional and national review of COVID responses and to be cognisant of the recommendations when published.

- All agencies to review their communication to external partners, service users and their families when service provision is being affected by external factors (health pandemics, severe weather etc). This should promote a clear communication process through a variety of means, which gives mechanisms to discuss care, answer questions and to reassure service users and families.

Key theme 5: Voice of the service user not evident in assessment, lost the sense of the person, feeling of process / equipment led rather than person centred

The review process has highlighted that concerns regarding process, and within the timeline there is certainly evidence of discussions across professionals but in the assessment, there is not necessarily Adult A's voice or the family's voice included.

The Social Services & Wellbeing Act 2014 revisited the way we engage with service users and their family and places emphasis on an integrated approach to assessment and care planning; ensuring that the voice of the service user is heard and we capture 'What Matters?' to the family.

This does appear to be lacking throughout all agency involvement and it not solely the responsibility of Social Care. There is a sense that there is too much focus on equipment and process and what is needed as opposed to hearing what Adult A and her family were asking for and what mattered to them.

Recommendations

- All agencies to be reminded that families and the citizen themselves should be included in conversations and communications about their developing care needs.

Improving Systems and Practice

(What needs to be done differently in the future and how this will improve future practice and systems to support practice)

Learning Points and Key Themes

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- All agencies to remind staff of the importance of communication and engagement with all relevant agencies involved in delivering care and support to an individual.

- Commissioners should ensure that escalation of key incidents from external providers to case managers is part of the core contract requirements.

Key Theme 3: • Who had co-ordinating role? Is this a gap, how does everyone know who is doing what, who has responsibility to maintain oversight?

Recommendations

- All agencies to be reminded of their responsibilities to share concerns and information with other agencies and family members. This should include reminding

staff of the importance of identifying key actions and responsible agencies on the care and support plan (or equivalent).

- All agencies and Local Authorities to ensure that effective systems are in place to ensure that there are clearly defined roles and responsibilities within care planning.

Key Theme 4: •Impact on COVID - family having a greater role, delegated responsibility due to COVID

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Recommendations

- All agencies to be reminded that families and the citizen themselves should be included in conversations and communications about their developing care needs

Statement by Reviewer(s)			
REVIEWER 1	Sam Payne Detective Chief Inspector Gwent Police	**REVIEWER 2**	Rachel Price Team Manager Children's Services Blaenau Gwent SSD
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)* S) Payne		**Reviewer 2** *(Signature)* RPrice	
Name *(Print)*	Sam Payne	**Name** *(Print)*	Rachel Price
Date	27.03.23	**Date**	27.03.23
Chair of Review Panel (Signature) p.p. Richards.			
Name *(Print)*	Gill Pratlett, Head of Service, Torfaen SSD		
Date	27.03.23		

Appendix 1: Terms of reference

Adult/Child Practice Review process
To include here in brief: • *The process followed by the SAB and the services represented on the Review Panel* • *A learning event was held and the services that attended* • *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*
Adult Practice Review Process The Gwent Wide Adult Safeguarding Board (GwASB) Chair notified Welsh Government in September 2020 that it was commissioning a Concise Adult Practice Review. **Reviewer:** Samuel Payne, Detective Chief Inspector, Gwent Police **Reviewer:** Rachel Price, IAA Team Manager, Children's Services, Blaenau Gwent. **Chair of Panel**: Gill Pratlett, Head of Adult Services, Torfaen Social Services The services represented on the panel consisted of: • Police • Adults & Children's Services • Health Board • Welsh Ambulance Service Trust The Panel met regularly from October 2020 in order to review the multi-agency information and provide analysis to support the development of the report. **Learning Event** A Learning Event took place in July 2021 and was attended by the following agencies: • Police • Adults Services • Aneurin Bevan University Health Board • Occupational Therapists • Adult Services **Family Members** Family members were informed that the review was taking place and meetings took place with Reviewers.
☐ 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	☐	☐	