GwASB
Bwrdd Diogelu Oedolion Gwent Gyfan
Gwent-wide Adult Safeguarding Board

Adult Practice Review Report

Gwent Wide Adult Safeguarding Board
Concise Adult Practice Review

Re: *GwASB 1/2017*

Brief outline of circumstances resulting in the Review

A concise Adult Practice Review was commissioned by the Chair of the Gwent Wide Adult Safeguarding Board on the recommendation of the Joint Practice Review Sub-Group in accordance with 'Working Together to Safeguard People: Volume 3, Adult Practice Reviews, Social Services and Well-being (Wales) Act 2014, following the death of a 82 year old woman who will be known hereafter as A

Circumstances Resulting in the Review

A was a frail adult with a diagnosis of Alzheimer's Disease and other health conditions, who was resident in a privately managed Care Home. During the period of time she was resident she experienced a significant number of falls as her wellbeing and mental health deteriorated.

Between entering the Care Home on the 3rd March 2015 and 13th April 2015 A suffered 9 falls, and despite varying levels of mobility and reporting of pain it was not until 23rd April 2015 that an x-ray indicated she had a fractured neck of the left Femur. An Adult Safeguarding investigation was undertaken in June 2015 and "Neglect" was not found "on the balance of probability". The incidence of falls continued during her residence.

In January 2016, A experienced 2 falls within a 24-hour period. Following the first fall A was examined in the Emergency Department and returned to the Care Home. Following a second fall an intracranial bleed was identified and A was documented in the hospital record as "not for intervention". The family were aware of her prognosis and were with her when she passed away on the 16th of January 2016. A Police investigation was undertaken in relation to concerns in the Care Home however, no criminal charges were brought.

Time Period Reviewed.

The Adult Practice Review Panel decided to review the case for the 10 months prior to A's death.

The review period was from 3rd March 2015 to 16th January 2016

Practice and Organisational Learning

In undertaking this Review, we are grateful for the agency chronologies submitted and the information and time given by family members. We would also like to thank the professionals who attended the Learning Event who, due to the length of time since A's death, had not necessarily contributed to the care of this resident personally but were committed to agency learning opportunities. It should be noted there was limited information made available from the Care Home. However, the Police had all the records from the Care Home so the majority of information ascribed to them in this report is taken from the Police Investigation notes.

From this information the following themes were identified.

1). Communication and Documentation

1.1 Communication issues within the Care Home have contributed to the care experience of A. No evidence of policy or process in relation to how information is recorded, shared, and how risk is identified and mitigated was presented to the panel. In looking at care notes there are some very clear, concise and meaningful recordings, from both nursing and care staff and in particular an agency carer. These demonstrate appropriate medical and support intervention, also they demonstrate empathy and genuine care from the staff. However, in general the recording of notes was inconsistent, there were obvious missing notes, missing detail and no consistent narrative in relation to shift handovers.

1.2 During the period of the review A is recorded to experience 15 falls in the Care Home. Records demonstrate some of this information was known by the GP and Continuing NHS Health Care (CHC) and contributed to both medical and care support assessments. However the sharing of this information was inconsistent which meant care and medical risks were not fully assessed.

1.3 In discussion with the Reviewers, family members stated they were unclear about the care plan for their wife and mother, they were not aware that a review of the 1:1 support could be requested, and it appears that there was a general understanding and assumption by care staff that any information passed to one

member of the family would be shared with other family members. Equally, family members confirmed their assumption was that if they raised an issue with a member of staff that this would then be followed up and actioned.

1.4 A pureed diet was prescribed for A. The family were never informed why A had her food pureed and her liquid's thickened. Therefore, concerned about her weight loss, (A dropped from a dress size 22 to 14) the family fed her biscuits and chocolate on a daily basis (also sometimes by staff). The risk of A choking was never identified to family members.

2). <u>Response to Falls:</u>

2.1 There was a policy in the Care Home which gave instruction and guidance in relation to residents who fall. However, its content was limited, brief, and did not consistently relate to best practice. The panel was not made aware of any training programmes, Care Home Induction processes, or Continuing Professional Development in relation to falls which would have supported staff with the confidence and competence to respond to residents

2.2 Good Practice and understanding was evident in the use of crash mats and pressure pads in reducing risk of falls rather than A try to get out of bed over bed rails however it should be noted that during some falls the pressure pads in the home failed to work;

2.3 Evidence provided to the panel showed poor levels of consistency in the monitoring of vital sign observations post fall. There was also inconsistent quality of recording of falls and what action was or was not undertaken;

2.4 Care Home records describe and refer to falls, slips, trips, unwitnessed falls, and "lowering self to the floor"; indicating there was inconsistency in staff understanding.

2.5 On the 6th of January 2016 following A's first fall, she was taken to the Emergency Department and found to have a cut to her head. The Panel considered whether a CT scan should have been undertaken however she was observed to have no clinical signs that would indicate a CT scan of her head was required. At approximately 7:00pm A was returned from the Hospital to the Care Home. It was noted that her speech and movement were significantly different from when the Care Home staff had last seen her. There appears to be no risk management strategy for this event, the manager was not contacted, out of hours advice was not sought, no clinical observations taken, and no request for emergency 1:1 cover provided by the Home. There is evidence that subsequently the Care Home has implemented a Head Injury Policy (April 2016) and a procedure of re-assessment following a hospital admission.

3. Risk Management:

3.1 A's health was clearly deteriorating in relation to her levels of agitation, her emotional wellbeing, weight loss and increased frequency of falls however, observation of her vital signs was often unclear and inconsistently recorded and the Care Home staff did not provide a narrative of the deterioration in A's health status. The panel were not provided with clear evidence of risk management regarding the physiological observations;

3.2 The identification and evaluation of concerns does not appear to be delegated to a specific staff role, which contributes to a failure to recognise and escalate concerns to the appropriate professional in a timely manner. A had suffered a number of falls, was limping and complained of pain however, it was not until 20.04.2015 when the GP was requested in relation to cellulitis to the right leg that the GP was then made aware of A's reduced mobility and multiple falls and at this point an x-ray was arranged on 23.04.15 which discovered the fractured neck of the femur ;

3.3 General observations and wellbeing changes do not appear to be collated or the responsibility of a named member of staff. Resident A had a significant weight loss dropping from a dress size 22 to a size 14, but this did not result in a review of the pureed diet or a referral to a dietician;

3.4 A was admitted to the Care Home for dementia care in March 2015. No further assessment of her mental health can be evidenced outside of G.P. review of medication and CPN support in December 2015. The deterioration in A's mental health was not disseminated by the Care Home to other health professionals, and it is not clear whether the Care or Nursing staff were adequately trained to understand fully the complexities and care requirements of residents with dementia;

3.5 There was an initial Falls Assessment determination by the Care Home on the 3rd April 2015 which deemed A to be at "Medium" risk of falls. This rating was raised and kept at "High" risk of falls in 3 subsequent reviews and this directly related to the CHC funding for 1:1 support for A. Despite deterioration of A in terms of physical and mental health, no requests were made by the Care Home to CHC to undertake a further review of her care needs.

3.6 Despite the number of falls and increasing concerns only one Regulation 38 (RISCA Reg 60) was submitted to Care Inspectorate Wales (CIW) up to the 6th of January. However it is important to note that this was made at the request of the CIW inspector. Following the final 2 falls on the 6th of January 2016 a Regulation 38 notification was made by the manager.

4. Leadership

4.1 During the period of review, there were a number of changes of management and clinical leadership in the Care Home. From the information provided it is highlighted that:

4.2There were periods of time where no senior clinical nurse support was being provided to the registered nurses. Senior Management of the home were aware of this and anticipated that the Head of Care would cover any "gaps" in supervision. Senior Management were also aware of inadequate staff levels during this period. There was no Risk Assessment undertaken of the impact of these issues on the resident's A's care or wellbeing;

4.3 Nor was a named senior nurse assigned by the Care Home to provide clinical supervision and support with nursing issues;

4.4 There was a policy which related to actions to be undertaken in relation to resident's falling. However, this policy was neither robust nor did records indicate that it was fully implemented. It appears that the Induction process was limited for new staff or agency staff this may clarify why the response to A falling was not consistent and not in line with best practice at that time.

4.5 Care plans were recognised as poorly completed by the Registered Nurses (RN's) as identified by the new Manager in October 2015, however despite an audit process in place there was failure to review and update care plans by the RN's. Both the Care Home Manager and Senior Management were aware of this failure, but no disciplinary process was undertaken, and there were no extra resources available to ensure the care plans were updated in a reasonable timescale;

4.6 In October 2015 the New Manager of the Care Home was recruited as a Business Manager and not a Clinical Lead Nurse. The Panel were aware that this manager had previously been a Registered Nurse however, the Manager could not offer nursing direction or support in this role.

5. Restriction of movement - Use of Stair Gates/ "Baby Gates"

5.1 Access through A's bedroom door was restricted by the use of a baby gate/stair gate. This use is not formally documented however, is part of some recordings by staff in the Care Home and was acknowledged by other professionals and family members. There appears to be an acceptance that the widespread use of gates across the resident's room doors related to "safety of residents who may wander". Again, there is no documentation and their use is not part of any CIW report. The gates were reported by family as heavy and difficult to move and no consideration appears given to issues of Fire Risks.

5.2 Any restriction of liberty should have resulted in a Deprivation of Liberty Safeguards (DoLS) application. Within the safeguarding investigation in June 2015, it is mentioned a DoLS application was made however there is no record of an application in relation to A's residence in the Care Home or the use of baby/stair gates. There appears to be no trigger within any of the professionals' processes to ensure or request evidence of a DoLS or application.

6. Loss of Dignity:

6.1 It is important to raise a recurring theme which ran throughout the review of all information. Family information and photographs demonstrate that A was a well-loved, well cared for woman, whose day to day presentation was important to her.

6.2 Within 3 weeks of her entry to the Care Home her dentures were missing, and whilst a dentist visited the home in April 2015 A was resistant to examination. Subsequently, there was no evidence that any dental or oral service was requested throughout the length of her stay at the Care Home.

6.3 Photographs showed bruising to her face and hand and whilst her hair may be clean it regularly looked lank and unkempt. Family reported her toe nails being yellowed and uncut, and feet being calloused but no evidence of chiropody services being sought.

6.4 For the family, their wife/mother being taken to hospital in a nightgown with no underwear but an incontinence pad "tucked" between her legs was particularly distressing and would have been a humiliation for her, should dementia not have robbed her of her understanding.

7. Powerlessness of Family:

7.1 During A's stay in the Care Home, her husband visited every day and remained with her throughout the day and there were many visits by family members. They remember many times when carers and individuals provided warmth and good care to their wife and mother. However, for the family members there are many occasions which frustrate them and caused them anguish in retrospect. These include possessions moved to different locations for staff or communal use, inconsistent information particularly related to falls, equipment not working, and no clarity about bruising evident on A. They are clear that they raised complaints and spoke to staff and managers however it is apparent that the family members did not always know who they were complaining to and how to follow it up, what is the duty of professionals and what rights they had, and what rights Residents have. The family's experience of inclusion and care from hospital staff prior to A's death was very positive and only highlights for them the feelings of distress and anger at the

lack of inclusion previously.

Improving Systems and Practice

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

It is recognised that there are pressures on staff and management of Care and Nursing Providers which relate to the difficulties of recruiting and retaining good quality staff, and meeting the needs of extremely vulnerable individuals. Use of agency staff, high turnover of staff, and staff working in a second language can result in a reactive service rather than a responsive service. The following recommendations are made to support the service providers, staff and most importantly the residents and their families.

Recommendation 1: Policy and Procedure (cross referenced with themes 1,2,3,4)

Care Homes (including nursing and residential care) should have clear policies and procedures in place as required by the Regulation & Inspection of Social Care (Wales) Act 2016 in the following key areas:

- Falls policy in line with NICE guidance
- Record keeping supervision, appraisal and disciplinary procedures
- Recruitment and Induction of staff (including agency workers)
- Reviews of Care Delivery Plans

Recommendation 2: Risk Management (cross referenced with themes 3)

The Responsible Individual is required to ensure that:

- The Clinical Lead role must be suitably registered and experienced in line with regulations;
- Sufficient staffing resources are in place at all times in order to meet the needs of residents;
- Where there are staffing shortages the Responsible Individual must ensure that a risk assessment and action plan against those risks are in place;
- Care Inspectorate Wales, Local Authorities and Continuing NHS Health Care Commissioners should have access to those staffing rotas and risk assessments when required;

Recommendation 3: Developing Good Practice (cross referenced with themes 1,2,3)

The Boards Protocols and Procedures sub group should review the learning from this adult practice review and consider the potential opportunities to publish good practice, examples and exemplars across the Care Home sector e.g. via the provider forums;

Recommendation 4: - Recruitment (cross referenced with themes 3,4)

Care Inspectorate Wales and Commissioners should be reminded of the need to ensure Care Home providers have Safer recruitment processes in place.

Recommendation 5: - Deprivation of Liberty (cross referenced with themes 4,5,6,7)

a) Responsible Individuals and Managers of Care Homes must ensure their services are compliant with the Mental Capacity Act and Deprivation of Liberty Safeguards.

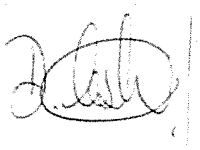
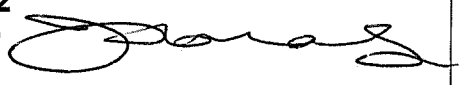
b) A review of the use of safety gates as a restriction in Care Home should be undertaken.

Recommendation 6 – Dignity and Empowering Families (cross referenced with themes 1,6,7)

a) Care Homes should provide easy access to their Statement of Purpose and clearly identify the Responsible Individual and/or Manager to whom they should raise concerns and make complaints

b) There should be effective communication between Continuing NHS Health Care and families to ensure they understand the processes and that they have the right to request reviews of care needs at any time.

Statement by Reviewer(s)

REVIEWER 1	**Diane Corrister** Service Manager Safeguarding Monmouthshire County Council	**REVIEWER 2**	**Jill Thomas** Clinical Practice and Education Facilitator Aneurin Bevan University Health Board
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 child 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 child 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)*	Diane Corrister	**Name** *(Print)*	Jill Thomas
Date	18/7/2019	**Date**	18/07/2019

Chair of Review Panel (Signature)	
Name *(Print)*	Gareth Jenkins – Assistant Director, Caerphilly County Borough Council
Date	15.07.19

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Adult Practice Review process
To include here in brief:: • *The process followed by the Gwent Safeguarding Adult Board and the services represented on the Review Panel* • *A learning event was held on 22nd March 2019 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.*
☐ Family declined involvement

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Date information received .....

Date acknowledgment letter sent to LSCB Chair .....

Date circulated to relevant inspectorates/Policy Leads .....

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