**Adult Practice Review Report**

**Gwent Wide Adult Safeguarding Board**
**Concise Adult Practice Review**

**Re:** *GwASB 2 / 2018*

## 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 64 year woman who will be known hereafter as Caroline (a pseudonym chosen by the family), who was known to social and health services and voluntary agencies.

The case met the criteria for a concise review; as Caroline had not on any date in the 6 months preceding her death, been a person in respect of whom a local authority had determined to take action to protect her from abuse or neglect following an enquiry by the local authority.

Caroline lived in sheltered accommodation. Caroline's medical history was unremarkable until in May 2014, when she broke her leg, was diagnosed with a myloproliferative disease and a chronic lung condition. Caroline was assessed to establish if she had a learning disability; but it was concluded that she did not. Nonetheless there were concerns about her ability to manage her cleaning, laundry, finances, clutter and food preparation. Caroline was allocated a MENCAP support worker and rehoused. At the end of Dec 2016; Caroline was referred by the MENCAP worker to the District Nurses and General Practitioner (GP). From this date, up until her final admission to hospital she was supported by a MENCAP worker, was under the care of the District Nurse Team, Social Services and Housing. Further support and opportunities for peer socialisation was provided, as Caroline attended and enjoyed day centre x 3 week & craft class x 1 week.

A Duty to Report [DTR] was made by the MENCAP worker in August 2017, but was not progressed. On the 30th September 2017, Caroline's health deteriorated to a point whereby she was unable to mobilise and was unable to give access to the District Nurses. Caroline died on the 5th October 2017; the cause of death was septic shock / infected leg ulcers. The second DTR raised concerns about

Caroline's treatment prior to admission and a 5 hour delay in the ambulance attendance and transfer to hospital.

**Time Period Reviewed**.

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

The review period was from 1st October 2016 to 31st October 2017.

## Practice and organisational learning

**What worked well in this case?**

- An exceptional level of care and support was provided by the MENCAP worker, including engaging with and referring to other agencies as appropriate.
- Consistent regular attendance by Caroline at day centres.
- Oversight and support of housing providers.
- Prompt referral to GP and from GP to vascular team and to specialist Tissue Viability Nurse (TVN) service.
- MENCAP worker raised Safeguarding concerns, raising concerns about the lack of improvement to Caroline's legs.
- Patient focused approach. When Caroline refused hospital admission on 29.12. 2016; appropriate actions were taken by the GP e.g. referrals to community resource team.
- There was evidence of some individuals going the extra mile e.g. the driver of the day hospital transport, recognised that Caroline's mobility was deteriorating and also made a referral to social services.

**Key Theme 1 : Importance of professionals exercising professional curiosity**

It is not straightforward for practitioners in some cases to balance patient choice and self-determination against professional judgement and intervention. This can be problematic, particularly in cases of self-neglect and this difficulty is aptly illustrated by this case. A significant event established by the review, was that Caroline was prescribed antibiotics to treat an infection in her leg. This was essential medication and the failure to take the drugs may have had a significant impact upon her health and well-being. An assessment was conducted to establish if Caroline had a learning disability [LD] which is good practice; the assessment established that Caroline did not meet the threshold for a learning disability. Nevertheless, a degree of vulnerability was noted, with Caroline's family and on

occasions some agencies referring to her as having a learning disability.

- Family and agencies working with Caroline felt that she always presented a positive face and did not want to be a nuisance. The agencies in contact with her, appeared not to have inquired beyond this positive portrayal. The most striking example of this, was the fact that Caroline did not actively seek help and was self-caring for her leg wound for around 2 years. The professionals she had contact with in this period, did not appear to recognise that she was having no assistance with wound management or the legitimacy of this.

- Caroline's family felt that she had capacity to make decisions and expressed that she sometimes could just not be bothered e.g. failed to attend appointments with vascular team and dietician and did not take her medication. Closer multi-agency communication and a more co-ordinated multi-disciplinary approach, including the sharing of information; potentially may have improved Caroline's compliance with her clinic attendance and medication.

**Recommendation**

- The GWASB Protocols and Procedures Group to develop a Gwent Wide Self Neglect Policy which aligns to the Mental Capacity Act.

**Key Theme 2: Missed opportunity for a coordinated multi-agency approach**

There were a significant number of agencies involved in Caroline's life including MENCAP, day centres, supported housing, social worker, District Nurses, GP and other health care professionals. However, there appeared to be a lack of communication between agencies.

- On Caroline's initial admission to hospital, good practice was evident as a multi-agency approach to the assessment of Caroline's physical and social needs was swiftly commenced. However the information shared between different disciplines and agencies did not accurately reflect Caroline's needs and vulnerabilities. Consequently, a decision was made that a multi - disciplinary meeting was not required and the opportunity for all agencies to fully share information and holistic overview was missed.

- A discharge letter was not sent from the hospital to District Nurses and therefore information relating to recommended treatment, including the recommendations from the Tissue Viability Nurse were not shared.

- There was no communication between the social worker and the District Nurses and the care and the support plan was not shared with the District Nurses, as a result the District Nurses were naïve to the fact that Caroline had other care providers

**Recommendations**

- That Social Workers in all cases communicate directly with the District nurses in cases where they are aware that District Nurses are involved.

- ABUHB to review current hospital discharge procedures, to ensure the transfer of care needs from hospital to community.

- The implementation of Welsh Community Care Information System (WCCIS): NHS Informatics Service; will give community nurses and social workers the digital tools they need to work better together. It will allow access to relevant information on the care provided to other professionals, to show where a patient is with their treatment.

**Key Theme 3 : Importance of agencies using shared language for allocation of ambulance**

There was a 5 hour delay from the time of the first 999 call, until the ambulance arrived on site; a number of factors contributed to this delay.

- Careline and the District Nurses made a total of [5] 999 calls between them, urgently requesting an ambulance. WAST's call taker did not re-prioritise the call as per duplicate call process.

- When the district nurses made the second 999 call, they were asked by the call taker if they were querying 'sepsis'. This was assumed by the District Nurses to indicate the seriousness of the call and the need for an urgent ambulance. The call taker advised the District Nurse; that as she had stated that Caroline's condition did not present an immediate threat to life, the response would be up to 4 hours. The District Nurse responded by requesting a 1 hour response, at this time the original 999 call was closed in error.

- The review established that different language was being employed by different sections of the NHS and WAST i.e. at the time, Cardiff and Vale were using the terminology Red Flag Sepsis as trigger points for sepsis as part of a pilot and this may have influenced the call taking. Nationally the 1000 lives Improvement Service for NHS Wales employs the Triple Trigger Scoring System, which does not use the word 'red flag sepsis'. This applied to the acute sector, as at the time of the incident it had not been rolled out to the community sector. The national 'Rapid Response to Acute Illness Learning Set' [RRAILS] programme, acknowledges that extending the use of the Red Flag system had not been agreed across the whole of Wales.

**Recommendations**

- That WAST ensure they have a robust system in place to recognise and act appropriately in the case of duplicate calls

- That there is an agreed national common language / criteria that is recognised across the NHS around the recognition of sepsis and nationally agreed actions.

**Key Theme 4 : Monitoring of Commissioned Packages of Care**

The care provider was commissioned by Social Services to attend for 30 minutes each day to prompt Caroline with her personal hygiene, home tidiness and encourage meal preparation and monitoring nutrition. The provider notes are held at the patient's home and in this case were lost, therefore there is no evidence of the care that was commissioned and provided. Information recorded by other agencies suggests the visits were often only for 5 minutes.

**Recommendation**

- The commissioner for Social Services works with the care providers to develop a process to ensure that records are retrieved, retained and stored securely.

**Key Theme 5 : Standard of Nursing Assessment, Care Planning, Evaluation and Documentation**

From the 29.12.2016, the District Nursing Service had been caring for Caroline's leg(s) on a regular basis. Some shortcomings were identified in the standard of care provided by the District Nursing Team. The practitioners at the learning event identified that Caroline would not always wish to comply with recommended treatments and this can present a challenge. An example of this was that the practitioners advised that Caroline preferred 'Conotrane' cream to be used as a moisturiser. However, this product is not licensed as a moisturiser, but as a barrier cream and may have been contra indicated. Registered nurses are required to 'balance the need to act in the best interests of people at all times, with the requirement to respect a person's right to accept or refuse treatment' [NMC: 2015, 4.1]. Nonetheless, the quality of the nursing documentation was such that it failed to record the assessment of need, planned care and or the rationale for the treatment provided. As a result there was a lack of assurance that the nursing care was provided in line with best evidence and an overall absence of evaluation. There were a number of referrals made to the Tissue Viability Service (TVN service), which was good practice. However, the advice / treatment proposed by the specialist nurse was not implemented and no clear justification as to the reason why the advice was not followed. The nursing records would indicate that despite the complex presentation and problematic skin condition; there was a preponderance for Caroline's call to be allocated to a Health Care Support Worker [HCSW] and very extended periods of time between visits / reviews by a registered nurse. It was indicated that on occasions the HCSW took responsibility for decisions relating to the treatment choice, regime and regularity of visits.

When Caroline was admitted to hospital on 30.09.17; the assessment of sepsis risk was undertaken; reflecting compliance with current 1000 Lives Improvement Service guidelines. However, the gold standard of antibiotic treatment within 1 hour was not achieved. There were some inconsistencies in the record keeping in relation to the ongoing monitoring, response to, and recording of physiological observations and National Early Warning Score [NEWS] which did not fully reflect the requisite standardised approach to recognising deterioration. Best practice would have been to liaise with the ITU outreach team, who would normally support the medical team in the overall review of a deteriorating patient.

As acknowledged by National Rapid Response To Acute Illness Learning Set [RRAILS] programme the use of screening and diagnostic tools should never replace the application of appropriate and timely clinical judgment and despite the gaps in documentation, practitioners at the learning event identified that there would have been verbal communication between the medical and nursing teams in response to NEWS scoring. Whilst this did not impact on the overall medical management and final outcome of Caroline's condition, a referral to the outreach team may have facilitated a more cohesive, timely and tailored approach to Caroline's end of life care to ensure optimal comfort, quality of life and more sensitive communication with the family.

**Recommendations**

**Community Nursing Service**

- ABUHB to implement an education programme for the District Nurse Team to include standards of documentation, evidence based practice, the requirement to work within NMC and HCSW: Codes of Conduct and the All Wales Guidelines for Delegation and Mental Capacity Act (2005).

- ABUHB to ensure that in cases where wound care is delegated to HCSW's; a Registered District Nurse should visit and review at regular 'prescribed' times e.g. weekly.

**Hospital Care:**

- Ongoing promotion of the 1000 lives Improvement Service Programme / National Rapid Response To Acute Illness Learning Set [RRAILS] programme

**Key Theme 6: Importance of following Safeguarding processes**

The Local Authority [LA] safeguarding team did not inform the Health Boards Corporate Safeguarding Team [CST] of either of the two 'Duty to Reports' raised in relation to Caroline. The LA contacted the District Nurses directly and made unilateral enquires and decisions. Neither did the District Nurses report that any concerns had been raised. Subsequently, the health board were unaware that concerns had been raised about the care provided by the District Nursing Service, clinical incident reporting processes were not followed and the CST was denied the opportunity to commission a review of the District Nurse care and possibly to intervene in care provided.

- ABUHB and Local Authorities develop the existing Gwent Wide Adult Safeguarding Board Standardised referral pathway to ensure that all relevant health safeguarding leads are sent copies of the duty to report referral.

- ABUHB to ensure that District Nurses to be reminded of their duty to report to their manager and or the Corporate Safeguarding Team / escalate any enquiries that are made in relation to their staff or services under Part 7: Social Services and Well-being (Wales) Act 2014.

## Improving Systems and Practice

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

**Key Theme 1 : Importance of professionals exercising professional curiosity**

**Recommendation**

- The GWASB Protocols and Procedures Group to develop a Gwent Wide Self Neglect Policy which aligns to the Mental Capacity Act

**Key Theme 2: Missed opportunity for a coordinated multi-agency approach**

**Recommendations**

- Social Workers in all cases communicate directly in cases where they are aware that District Nurses are involved.

- ABUHB to review of the current hospital discharge procedures, to ensure the transfer of care needs from hospital to community.

  Already Implemented: Health Inspectorate Wales [HIW] have recently published the results of a national [Wales] thematic review of 'Patient Discharge from Hospital to General Practice [2017-2018]'. Based on the report's recommendations, ABUHB have developed an action plan and is in the process of populating and reviewing required actions.

- Ongoing National Implementation: The Welsh Community Care Information System (WCCIS): NHS Informatics Service; will give community nurses and social workers the digital tools they need to work better together. It will allow access to relevant information on the care provided to other professionals, to show where a patient is with their treatment.

**Key Theme 3: Importance of agencies using shared language for allocation of ambulance**

**Recommendation**

- That WAST ensure they have a robust system in place to recognise and act appropriately in the case of duplicate calls

  Already Implemented: By the 30th October 2017; WAST had implemented an upgraded System which makes it easier to identify duplicate calls, whereby a call is already waiting for a response.

**Recommendations**

- That there is an agreed national common language / criteria that is recognised across the NHS around the recognition of sepsis and nationally agreed actions.

- Already Implemented: WAST head of Clinical Operations is in discussion with 'Rapid Response to Acute Illness Learning Set' [RRAILS] to set up a process where Call Takers will be trained to understand NEWS score as a means to upgrade calls, rather than the Red Flag Sepsis.

**Key Theme 4: Monitoring of Commissioned Packages of Care**

**Recommendation**

- Social Services commissioning teams work with care providers to develop a regional process to ensure that records are retrieved, retained and stored securely.

**Key Theme 5: Standard of Nursing Assessment, Care Planning, Evaluation and Documentation**

**Recommendations**

**Community Nursing Service**

- ABUHB to implement an education programme for the District Nurse Team to include standards of Documentation, evidence based practice, the requirement to work within NMC and HCSW: Codes of Conduct and the All Wales Guidelines for Delegation and Mental Capacity Act (2005).

- ABUHB to ensure that in cases where wound care is delegated to HCSW's; a Registered District Nurse should visit and review at regular 'prescribed' times e.g. weekly.

**Hospital Care:**

- Ongoing promotion of the 1000 lives Improvement Service Programme / National Rapid Response To Acute Illness Learning Set [RRAILS] programme

**Key Theme 6: Importance of following Safeguarding processes**

**Recommendations**

- ABUHB and Local Authorities develop the existing Gwent Wide Adult Safeguarding Board Standardised referral pathway to ensure that all relevant Health safeguarding leads are sent copies of the duty to report referral

- ABUHB to ensure that District Nurses are reminded of their duty to report to their manager and or the Corporate Safeguarding Team / escalate any enquiries that are made in relation to their practice or service under Part 7: Social Services and Well-being (Wales) Act 2014.

## Statement by Reviewer(s)

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|---|---|---|---|
| **REVIEWER 1** | **Diana Binding**<br>Assistant Chief Executive<br>Wales Community Rehabilitation Company | **REVIEWER 2** | **Annette Morris**<br>Senior Nurse Adult Safeguarding 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:-<br><br>• I have not been directly concerned with the child or family, or have given professional advice on the case<br>• I have had no immediate line management of the practitioner(s) involved.<br>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review<br>• 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:-<br><br>• I have not been directly concerned with the child or family, or have given professional advice on the case<br>• I have had no immediate line management of the practitioner(s) involved.<br>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review<br>• 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)* | Diana Binding | **Name** *(Print)* | Annette Morris |
| **Date** | 22nd May 2019 | **Date** | 22nd May 2019 |

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|---|---|
| *Chair of Review Panel (Signature)* |  |
| **Name** *(Print)* | Deborah Davies |
| **Date** | 22nd May 2019 |

**Appendix 1**: Terms of reference

**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 on 5th June 2018 that it was commissioning a Concise Adult Practice Review.

**Reviewer**: Annette Morris, Senior Nurse Adult Safeguarding, Aneurin Bevan University Health Board

**Reviewer**: Diana Binding, Assistant Chief Executive, Wales Community Rehabilitation Company

**Chair of Panel**: Deb Davies, Safeguarding Manager, Torfaen County Borough Council

The services represented on the panel consisted of:

- Gwent Police
- Adults Services
- Aneurin Bevan University Health Board

- Housing
- Care Line
- MENCAP
- Welsh Ambulance Service Trust

The Panel met regularly from June 2018 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 October 2018 and was attended by the following agencies:

- Gwent Police
- Adults Services
- Aneurin Bevan University Health Board
- Housing
- Care Line
- Welsh Ambulance Service Trust

Family Members

Family members were informed that the review was taking place and meetings took place with Reviewers.

☐ Family declined involvement

**For Welsh Government use only**

Date information received ……..

Date acknowledgment letter sent to LSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

| Agencies | Yes | No | Reason |
|---|---|---|---|
| CSSIW | ☐ | ☐ | |
| Estyn | ☐ | ☐ | |
| HIW | ☐ | ☐ | |
| HMI Constabulary | ☐ | ☐ | |
| HMI Probation | ☐ | ☐ | |

**Appendix 1**

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Gwent Safeguarding

# Terms of Reference
# Concise Adult Practice Review

## 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.
    - WAST – Internal Review
- Hold a learning event for practitioners and identify required resources.

## 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.
- The timeline period is 1st October 2016 to 31st October 2017.
- 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.
    - Social Services (Caerphilly)
    - Gwent Police
    - Aneurin Bevan University Health Board
    - Caerphilly Housing
    - Care Line
    - Mencap
    - Welsh Ambulance Service Trust
- 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.