Adult Practice Review Report

Gwent Wide Adult Safeguarding Board
Historical Concise Adult Practice Review

RE: GWASB 1 / 2019

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 94 year old women, who will be referred to as Adult A. However Adult A will be referred to as 'Mam' in accordance with family wishes when information in the report is relayed from the family's perspective.

Circumstances Resulting in the Review

An Adult Practice Review was commissioned by Gwent Safeguarding Adults Board following the recommendations of the Case Review Group. Reviewers and Chair where identified at the Case Review Group however agreement was made to sequence this review in line with other adult practice reviews therefore there was a delay in the start of this Adult Practice Review. There was a change of one of the Reviewers in May 2019 due to unforeseen circumstances.

Welsh government were notified of the intention to commence this Adult Practice Review on the 9th of January 2019.

Adult A was aged 94 years at the time of her death she had previously been resident at a Residential Care Home where issues were raised regarding a serious injury she sustained and the standards of care she received at that time.

Adult A was admitted to hospital on the 17th April 2016 with a fractured neck of femur, she was found on the floor next to her bed at the Residential Care Home. Following hospital admission Adult A was moved to a Nursing Home where she passed away on the 16th August 2016. There was no allegation of abuse/neglect at the time of incident, however her adult grandson later alleged that the fall at the Residential Care Home precipitated her decline and was a result of negligence and requested an investigation. The referral to Safeguarding was not made until 12th May 2017.

An initial strategy meeting was held on the 26th May 2017 where it was agreed that a non-criminal investigation would be conducted by the Local Authority Safeguarding Unit.

The examination of the documentary evidence at the Residential Care Home clearly highlights that Adult A was at risk of falling and daily records confirm that there was a significant deterioration in her mobility during her stay.

There were a total of 7 accident records completed for Adult A at the Residential Care Home, including the record dated 17th April 2016 which resulted in hospital admission and a diagnosed fractured neck of femur.

The falls risk assessment was first completed on 25th March 2015 but only reviewed on 2 occasions in a 12 month period and lacked detail.

Recorded falls were as follows-

- **22/02/15** – Slide to the floor
- **27/04/15** - Fall
- **25/5 TO 30/5** – 1 fall plus 1 lowered to the floor
- **11/7/15** – Slide to the floor
- **14/07/15** – Slide off bed
- **2/8/15** – Lowered to the floor
- **29/8/15** – Fallen out of bed-skin tear to left upper arm
- **05/01/16** – Slide to the floor
- **15/02/16** – Slipped off bed
- **14/04/16** – Fall- fractured neck of femur

Due to Adult A having slept in a double bed at home prior to admissions to the Residential Care Home and her feeling unsafe in a single bed, she requested bedrails be put in place. The Residential Care Home was unable to provide a double bed. A risk assessment for use of bedrails was completed on 12th April 2015. It was agreed with Adult A that bedrails would be used but the risk assessment was never reviewed after 17th September 2015 and nothing was documented to confirm if they were still being used or had been removed.

The information provided to the panel highlighted that there was a significant deterioration in mobility and by February 2016 Adult A was being hoisted for all transfers. There was evidence to suggest poor and unsafe manual handling practice in the records.
Despite a deterioration in Adult A's mobility and increase in her care needs, there was no evidence to support that she lacked mental capacity or positive assessment that a mental capacity assessment had been completed.

It is documented in Adult A's review at the Residential Care Home on 23rd February 2016 that due to an increase in needs Adult A was waiting a nursing assessment. The assessment was completed on 31st March 2016 and the outcome was that Adult A's needs would best be met in a general nursing home setting.

The conclusion of the safeguarding investigation highlighted evidence that clearly

supports an outcome of neglect regarding the care afforded to Adult A while in the Residential Care Home.

A case conference meeting was held on the 20th December 2017, to discuss the outcome of the safeguarding investigation findings with Adult A's family members. The family felt that communication between agencies was poor, they felt that information was withheld by the Residential Care Home. There was a clear message from the family that lessons needed to be learnt to ensure that what had happened to Mam did not happen to anyone else.

Adult A as described by her Daughter and Grandson.

Mam always spoke of a happy childhood and a loving family and often shared memories of her early days, feelings of love, belonging, family and happiness. Mam is described as having a great sense of humour, who would love to cook in her little kitchen, baking cakes so tall that they needed extra-large tins to contain them. Mams grandson recalls that her catchphrase was 'you can do it' and that the family enjoyed many holidays, Christmases, New Years and family get togethers. Mam really enjoyed holidays, hunting for bargains at markets, walks through fairs, the slots, bingo, and days on the beach.

Mam was blessed with so many great friends and had wonderful neighbours. Mam volunteered until she was nearly 80 at Oxfam and loved to attend lunch clubs due to her being such a sociable person.

Mam was also a person of faith and received Holy Communion every week in her home. Mam was kind, generous and compassionate, she never complained. Mam was a great believer in family and togetherness and was proud of her families' achievements, and was concerned about ensuring happiness and that her family were loved and belonged. Nothing made Mam happier than family and friends. Mam was kind, naturally warm and chatty and interested in people, she cared for others and people were drawn to her because of such fine qualities.

Mams family members shared that they had a lifetime of quality time with Mam, happy memories, unconditional love and a beaming smile.

Time Period Reviewed.

17th of February 2015 to 16th August 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 Adult A's death, had not all necessarily contributed to the care of this resident

personally but were committed to agency learning opportunities.

It is noted that this Adult Practice Review has taken place sometime after the death of Adult A and during the interim period it was acknowledged that changes to practice had already been made, such as the implementation of the "I Stumble" Such changes have not been included in the report, which has focused on further learning required.
Below is a link to the NICE Guidance from which the 'I Stumble' work has been developed.

https://www.nice.org.uk/guidance/cg161

Themes and Learning Points

There were three overarching themes identified which have informed the learning points from this review.

- Communication – both with Family and between Professionals
- Assessment
- Identification and Management of concerns

Theme 1- Communication

It was identified via the learning event and panel that there were 2 main areas evident under the theme of Communication-

- Communication between professionals
- Communication with the Family

COMMUNICATION BETWEEN PROFESSIONALS

1. **Robust clear recording**

As advised in the learning event, District Nursing notes and risk assessments were not fully available to inform the review in the detail that would have evidenced additional specific learning for the District Nurse Service. District Nurses completed regular visits to Adult A, however, questions regarding the level of deterioration for Adult A appears not to have been picked up or noted. There was no presented evidence for the review that discussions had been held by the Residential Care Home and District Nurses regarding the decline in Adult A's presentation.

The District Nursing records showed that they visited Adult A weekly to administer an injection. The records note that an injection was given and some entries refer to Adult A's mobility. However, the evidence for an assessment of adult A's mobility was not available nor was an onward referral for specialist review. The Residential Care Home records show a deterioration in Adults A's mobility but this change was

not as clearly recorded within the District Nursing daily record.

Learning point 1:- *The records presented for the review indicated that the frequent visits to administer medication/ injections by District Nurses was task centred rather than considering a holistic approach to all of Adult A's needs. It appeared that those involved in the care of Adult A were working in silo's within their role as opposed to giving consideration to all service providers or highlighting issues of concern such as Adult A's physical decline.*

Practitioners at the Learning Event stated that they now have established regular patch based meetings for all community staff to discuss vulnerable adults including residents in care homes.

Learning point 2:- *Consideration should be given to how meetings such as those described above can be further developed to ensure that patients whose condition is changing are discussed and their care needs documented and updated by the appropriate professionals involved. This will include the need for regular multi agency reviews.*

2. Weight loss

On admission to hospital on 17th April 2016 Adult A weighed 59.8kg and on 28th July 2016 she weighed 48.2 kg. At the Learning Event the Dietician confirmed that a referral was made to their service as part of the Continuing Health Care assessment. Once involved there was a month period where her weight remained unchanged which was good practice. During this time Adult A was prescribed supplement drinks. These are available in a juice or milky format and of different flavours.

Adults A's unintentional weight loss was deemed clinically significant and therefore maintaining a high calorie diet including supplement drinks was a priority as part of her care planning. Unintentional weight loss is a decrease in body weight when the individual did not try and lose weight.

Adult A could only tolerate one type of supplement drink which was not available on the prescription drop-down menu when Adult A was discharged from hospital to the Nursing Home. There was no evidence of consultation with Adult A to discuss an alternative, the professional selected without consultation with anyone.

Learning point 3:- *Ensuring that patients who require supplement drinks are able to access their drink they require. Where this is not available there should be a discussion with the patient and or family to ensure access to the most appropriate alternative.*

It is apparent that, given the weight loss evident with Adult A, that there was a delay in a referral being made to the dietician service. This appears to have been picked up when an assessment for Continuing Health Care (CHC) was commenced rather than due to observations of feeding problems and ongoing weight loss. The learning event and panel considered whether malnutrition could have been identified sooner when Adult A was admitted to hospital and the presenting history. NICE guidelines state that this should be picked up within 24 hours of admission to hospital.

Learning point 4:- *Adult A's weight loss was recorded and some actions were taken in line with best practice guidance. However, the significance of her weight loss was not recognised and a timely referral to Dietician was not made.*

3. Follow up on Referrals

The Family had been told that a referral to the memory clinic had been made by the GP while Adult A was still in the Residential Care Home, however it appears this referral was lost. As part of the CHC assessment it was identified that no referral had been made. Adult A had Urinary Tract Infection (UTIs) and it was never established whether her declining memory was masked as a result of the UTI or other physical issue.

Learning point 5: *A care coordinator role with responsibility for all aspects of care needs to be clear and robust. Many professionals were involved in delivering Adult A's care but still missed opportunities to ensure she received all services to establish her full care and support needs.*

COMMUNICATION WITH THE FAMILY

4. Loss of Role

Prior to her entering the Residential Care Home Adult A's daughter had significant input into her mother's care. She would liaise with the Hospital and GP regarding appointments.

Adult A's daughter visited her daily before admission to the Residential Care Home, the location of the Residential Care Home prohibited this. The daily interaction and attendance at all Adult A's appointments by her daughter was a significant change of role. All professionals need to give due consideration for the impact that this change in role for the main carer has when a person enters full time care.

Family members may assume all care providers will share all information about their family member with them. However if the person in receipt of care has mental capacity it is up to them to give consent and to agree boundaries and circumstances of the information to be shared with their family.

Family members will have a knowledge and understanding of a person prior to their admission. Families have an expectation that incidents such as falls would be reported. They expect that an assessment about their family members care and support needs would be shared with them, so it essential that staff caring for someone, the patient and the family have a shared agreed understanding of the information that will be shared.

Learning point 6: *Consideration needs be agreed at the outset with the resident and family members what information will be shared and when. A consent to share information agreement, at the beginning of the occupancy would alleviate further stress for the resident and family members.*

Learning point 7: *Consideration needs to be given within any formal care setting of the loss of role for the primary care giver when the family role changes from carer to advocate by virtue of the primary care being provided by the care home.*

Practitioners felt that the family lacked an understanding and acceptance of the decline in Adult A's physical health. This was believed to be a constant feature within care communications. Residential and nursing staff recognised that Adult A was very poorly and declining physically but did not explain in detail to the family the severity of the situation. This was confirmed by nursing staff at the learning event, they had to be explicit with the family in Adult A's final hours as they did not recognise her frailty and that she was dying. Nursing and care staff's experience and expertise in nursing frail and end of life patient's requires the staff to be open and honest with family members, preparing them and supporting them to be with their loved one. It was not until the last few hours of Adult A's life that nursing staff discussed the situation. The need for transparency and honesty is difficult when delivering poor prognosis to families but is a vital communication, if we are not open and honest it can leave loved ones feeling betrayed, and can impact on the bereavement process when their loved one dies.

The family report that they were aware that Mam was dying at the time of the Multi-Disciplinary meeting. They acknowledge that there was limited discussion with professionals as to what this meant for Mam and her care.
From the timeline it is clear that Adult A had been slowly deteriorating prior to her transfer to the Nursing Home. Although Adult A was very frail there was no evidence that end of life discussions had been considered as part of the discharge planning or on admission to the Nursing Home.

Learning point 8: *Discharge and admission procedures should consider the frailty of the person and the implications that this will have on their care needs.*

The relationship with the resident and their family is key to understanding a resident's needs. A shared language that supports families to contribute to

assessments and reviews is essential. Families have an expectation that professional understand that they have a deeper understanding of the person in receipt of care. Agreement at the point of admission around the information sought and shared with families is critical.

Practitioners at the learning event felt that family members were difficult to engage with, and expressed high emotion. The Family reported that they felt they had a good relationship with professionals throughout Adult As time in residential care, hospital and the nursing home. This did change during the CHC assessment process.

Adult A's grandson would intervene to advocate for his mother in respect of Mam's care during the period of the CHC assessment. Adult A's grandson acting as an advocate and using his legal knowledge was him seeking to obtain the best assessment and outcome for Mam. Barriers to communication and engagement need to be recognised and addressed within training and working with families that are viewed as adversarial. Staff recognised that challenges to care regimes are not routine and staff should actually be prepared and expect to explain why and how they are conducting themselves in a professional way and not feel threatened.

Families views are important and need to be listened to in all care situations and staff need the skills to work with challenging conversations. Professional empathy and loss of role, impact for families, relief, guilt, lots of high expressed emotions needs to be recognised by all staff. Recognising that family members may have their own care and support needs may not be a priority for staff but it is instrumental when delivering services. When staff feel they are intimidated by a family's behaviour or profession, it can hinder a conducive relationship between staff and family. Adult A's daughter was grieving for her change of role even prior to Mam's death. As part of a separate complaints process Adult A's daughter had requested her mother's records which highlighted for her the lack of communication between the family and care professionals. Adult A's daughter had not been aware of the number of falls sustained by Mam. The relationship and communication between the family and care professionals was exacerbated by the family being asked to leave the Continuing Health Care Meeting.

At the learning event and from panel meetings it is clear that dialogue between professionals and the family was challenging.

At the learning event hospital staff identified that pressures and workloads were such that timely conversations with family members can be delayed due to the demands and pressures of delivering care on the ward.

Learning point 9: *Recognise the importance of a routine communication with patients and their family members.*

Theme 2- Assessment

5. Risk Management of Falls

The risk of falls can never be completely removed but can be managed through assessment. A risk management plan with regular review is essential and would have been pertinent to Adult A's care. As she deteriorated she required a holistic review from all partner agencies. Documenting every fall/slip and the circumstances requires clear record keeping in order to review severity and inform the risk management plan. Falls monitoring is now in place in all formal care setting including differences in how falls are categorised and the mechanism of the fall. Who reviews the records and how external health professionals can inform the risk management plan needs to be considered. This requires a multi-agency review and is not just the responsibility of care home staff.

Learning point 10: *A care coordinator role with responsibility for all aspects of care needs to be clear and robust. (As per Learning Point 5)*

6. Bedrails

The use of bedrails was at the request of Adult A. The bedrails were broken by her climbing over them and falling to the floor. It must be acknowledged that bedrails are not used in residential care settings and were only put in place at Adult A's request. Occupational Therapy and Reablement services were involved with Adult A's care and recommendations made for various aids but had not been fully followed up. There appears to be no evidence that the District Nurse had observed or highlighted as a concern the use of the bed rails with Occupation Therapist services.

Learning point 11: *Consideration should be given to how meetings such as those described above can be further developed to ensure that patients whose condition is changing are discussed and their care needs documented and updated by the appropriate professionals involved. This will include the need for regular multi agency reviews.* (As per Learning Point 2)

Theme 3- Identification and Management of Concerns

7. Practitioners Responses to Concerns

There were missed opportunities by professionals to submit a safeguarding 'duty to report' referral. The duty to report was not submitted to Torfaen Safeguarding until nearly a year after Adult A died. It was evident from the learning event that when

concerns regarding the care provided to Adult A were raised prior to her fall that this was felt to be better managed via Provider Feedback.

Thresholds in terms of referrals needs further consideration and direction for staff to make evidenced based decision making. At the learning event it was noted that prior to her admission to hospital in April 2016 Adult A was being hoisted for all transfers, which raised the question as to how she could have sustained a fall. A Duty to Report should have been considered based on the presentation of the fall.

It was identified that due to faulty equipment for commodes that care staff used an actual bucket to replace the faulty part used to contain bodily fluids. Several professionals were aware of the use of a 'bucket' however this does not appear to have been considered as a loss of dignity or a safeguarding issue. This matter was addressed via Provider Feedback, alongside issues of concern in respect of manual handling, incorrect slings and bed rails being broken.

Good practice identified that communication between commissioning services and safeguarding has been strengthened and as such concerns are routinely considered.

Learning point 12: *Ensure the implementation of Working Together Vol 6 Handling Individual Cases and a threshold document.*

8. Timeliness of Assessments

While in the Residential Care Home staff requested a nursing care needs assessment from the District Nursing service as the staff were concerned about Adult A's increasing care needs. The District Nurses concluded that general nursing placement was indicated however the Social Worker felt that Adult A could continue to be managed by the Residential Care Home. There was no evidence to suggest that the District Nurse challenged this decision. The lack of management in the Residential Care Home at this point further exacerbated the staff's concerns for Adult A's care and support needs.

Learning point 13: *To ensure that all staff are aware of escalation procedures when there is disagreement about a person's care and support needs.*

Summary

Support to Residential Care Homes, what do we expect?

The learning from this review highlights the need for clear, consistent and honest communication when providing services to vulnerable adults in need of care and

support in all settings. It is a shared responsibility across all health/social and accommodation service areas and requires a clear care plan that addresses and highlights the specific needs of the individual. Silo working and task orientated practice places the individual at risk in all care settings and this review evidences that this practice did not enhance the care Adult A received. The Residential Care Home was concerned about the level of care Adult A required and felt that they were on their own managing the risks, even though there were many services involved on a regular basis.

Working with families that appear to be challenging the care their loved one receives requires skills in verbal communication and training for staff.

Adult A did not have a disease or illness that would suggest she had a limited prognosis and therefore end of life discussions appear not to have been had with Adult A or the family, until her final hours.

The family maintain that there was a lack of transparency from professionals involved in mam's care and this continues to impact on their grieving process.

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:-

Learning point 1:- *The records presented for the review indicated that the frequent visits to administer medication/ injections by District Nurses was task centred rather than considering a holistic approach to all of Adult A's needs. It appeared that those involved in the care of Adult A were working in silo's within their role as opposed to giving consideration to all service providers or highlighting issues of concern such as Adult A's physical decline.*

Learning point 2:- *Consideration should be given to how meetings such as those described above can be further developed to ensure that patients whose condition is changing are discussed and their care needs documented and updated by the appropriate professionals involved. This will include the need for regular multi agency reviews.*

Learning point 3:- *Ensuring that patients who require supplement drinks are able to access their drink they require. Where this is not available there should be a discussion with the patient and or family to ensure access to the most appropriate alternative.*

Learning point 4:- *Adult A's weight loss was recorded and some actions were taken in line with best practice guidance. However, the significance of her weight loss was not recognised and a timely referral to Dietician was not made.*

Learning point 5: *A care coordinator role with responsibility for all aspects of care needs to be clear and robust. Many professionals were involved in delivering Adult A's care but still missed opportunities to ensure she received all services to establish her full care and support needs.*

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Learning point 8: *Discharge and admission procedures should consider the frailty of the person and the implications that this will have on their care needs.*

Learning Point 9: *Recognise the importance of a routine communication with patients and their family members.*

Learning point 10: *A care coordinator role with responsibility for all aspects of care needs to be clear and robust. (As per Learning Point 5)*

Learning point 11: *Consideration should be given to how meetings such as those described above can be further developed to ensure that patients whose condition is changing are discussed and their care needs documented and updated by the appropriate professionals involved. This will include the need for regular multi agency reviews.* (As per Learning Point 2)

Learning point 12: *Ensure the implementation of Working Together Vol 6 Handling Individual Cases and a threshold document.*

Learning point 13: *To ensure that all staff are aware of escalation procedures when there is disagreement about a person's care and support needs.*

Statement by Reviewer(s)			
REVIEWER 1	Nicola Barrett	**REVIEWER 2**	Mary Ryan
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)*	…… Nicola Barrett ……	**Name** *(Print)*	…… …Mary Ryan……
Date	……09/09/2019……	**Date**	……09/09/2019……

Chair of Review Panel (Signature)	……	……

Name
(Print) …… Ann Hamlet …….

Date ……19/8/19…….

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 19th June 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
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	