Richmond and Wandsworth Safeguarding Adults Board

# Safeguarding Adults Review (SAR) 'Robert'

**Date** June 2021

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To protect the identities of individuals involved, this report uses randomly selected pseudonyms for the person referred to in this report.

# INTRODUCTION

Richmond and Wandsworth Safeguarding Adults Board (RWSAB) considered the case of Robert who died in hospital in September 2020 about 2 weeks after being assaulted by a fellow resident of the care home where they both lived. Both Robert and James received input from several services. In November 2020 the RWSAB agreed that Robert's case met the criteria for a statutory Safeguarding Adults Review (SAR) under section 44 Care Act 2014. As there had been a comprehensive multiagency Section 42 Safeguarding Enquiry and a Root Cause Analysis completed, it was agreed to undertake a proportionate SAR using the information already gathered and to undertake a multiagency reflection to highlight the leanings, rather than undertake a comprehensive re-examination of the case. Staff from the local authority led the multiagency refection work and the final report was agreed by all participants.

The focus of the reflection was to produce learnings which were focused on 'systems findings'. These are the social and organisational factors that make it harder or easier for practitioners to do an excellent job day-to-day, within and between agencies. The final report aims to be as succinct and practical a document as possible. Therefore, details of the findings from the Serious Incident review undertaken by the Mental Health Trust and the multiagency Section 42 safeguarding enquiry, do not form part of the published report.

## About this document

This document forms the final output of the SAR. It provides the systems findings that have been identified through the process. Each finding attempts to describe the systems barrier or enabler and the problems it creates. It focusses beyond Robert's case to wider organisational and cultural factors. These findings are future oriented and are potentially relevant to professional networks more widely.

To facilitate the sharing of this wider learning, the detailed case specific analysis as well as details of finding from other processes are not included in this report..

Each systems finding is first described. Then a short number of questions are posed to aid the RWSAB and partners in deciding appropriate responses.

## Contact

If you have any questions or queries about the SAR, please contact the Richmond and Wandsworth Safeguarding Adult Board:

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## SUMMARY OF CASE

Robert was 86-year-old at the time of his death in September 2020. During his working life he worked in the arts and hospitality industries. Towards the end of his life, he was increasingly confused, and his family arranged for him to move into a residential care home after a hospital admission following a fall. He moved into the care home in July 2020 and there were concerns about Robert being unsettled and not sleeping well. There was an unwitnessed incident between Robert and a fellow resident, James, in July 2020. Subsequently there was a further unwitnessed incident between Robert and James in early August 2020. Robert sustained a minor injury but did not need medical attention. On the same day as the second incident, Robert had a fall and was admitted to hospital. He was described as having increased confusion/delirium, which was attributed to a subdural bleed (possibly due to a fall), an infection and low sodium. He was treated for the infection and low sodium and returned to the care home with a plan for further intervention from the GP and the memory clinic. He was moved to a different unit in the care home to create distance between himself and James. Within hours, James attacked Robert, who was subsequently admitted to hospital with an intercranial haemorrhage. The coroner has determined that pneumonia was the cause of death with an antecedent cause of a head injury.

James was an elderly man with a diagnosis of dementia. His family had arranged that he move into the residential care home in March 2020, at the point that the COVID-pandemic began, and the country was moving to ‘lock-down’. He was no longer coping at home and missed his wife who had advanced dementia and was already a resident in the residential care home. The move meant he would be able to spend time with his wife as well as get the extra support he needed. In July 2020, James’ behaviour changed, and he demonstrated aggression on several occasions towards care home staff and residents, including towards Robert. The care home made a referral to the GP and the Community Mental Health Team requesting assistance in managing James' aggression. After a short delay he was seen by the CMHT staff, and a behavioural management approach recommended. Following further incidents James was given medication and the care home offered support from the Care Home Support Team in managing James' behaviour.

## FINDINGS

**Finding 1**

There are no agreed mechanisms for collaborative working and decision-making across the range of professionals who provide support to older people with dementia. As a result, the understanding of escalating risk is hindered by imprecise or incomplete communication about the situation.

### System Finding

Dementia is a complex syndrome, and it affects people in a variety of ways, sometimes resulting in profound changes in behaviour. To support people living with dementia, it is important to have access to a range of skills and a shared understanding of the changes in the person and on the changing risks. In this case, there were examples of effective communication between stakeholders on the incidents where either Robert or James were

involved. There was however not a holistic understanding of the circumstances which gave rise to James' aggression, which was a new facet of his dementia, or of the fact that James and Robert had aggressive exchanges on two occasions. Given that the incidents between James and Robert were unwitnessed, there was no way of knowing the precise cause of the incidents between the two men. An assumption was made that as these occurred in the evening, when Robert was unsettled, that this was the risk which could best be managed by moving Robert to a room away from James' room.

Both Robert and James were relatively new residents in the care home and neither man had shown any tendency to being aggressive before admission. Both had a degree of confusion. While James had a diagnosis of dementia and was known to the Community Mental Health Team (CMHT) in the past, Robert was not known to the CMHT and had no formal diagnosis of dementia but was displaying confusion and sleeplessness. The care home identified that they needed support in managing James' increasingly challenging behaviours and made a referral to the Care Home Liaison Support Team. The referral was processed appropriately, however, when this was allocated, there was a delay as it was initially missed by the practitioner due to the increase in email traffic due to the impact of COVID-19 and agile working. During the 15 day delay in reviewing James' mental health specialist support, a further incident of challenging behaviour occurred. The care home had a historically supportive relationship with the CMHT, however changes in the structure and staffing of the CMHT meant that there was a degree of uncertainty about the level of support the care home could expect and with whom they should communicate. Communication between professionals was further hindered by much of it being undertaken either by phone or email, with little face to face interaction with one another, due to the COVID-19 pandemic.

The range of professionals involved, the fact that the person alleged to have caused harm was vulnerable, and the lack of established working relationships between agencies contributed to poor communication between professionals from different agencies. This was compounded by visiting restrictions to the care home being in place due to the COVID-19 pandemic. There were several Section 42 adult safeguarding enquires being undertaken where James was the person alleged to have caused harm, however, the full range of incidents was not known to everyone supporting Robert and James. James, as the person alleged to have caused harm, could have been involved in the safeguarding enquiries with support from an Independent Mental Capacity Advocate (IMCA) and this may have led to a more holistic understanding of the extent of his challenging behaviours and the 'triggers' for this. The GP, who was pivotal to supporting both men, reported not always being aware of the incidents which had occurred or of the emerging challenges in managing James' behaviour. The risk assessment undertaken in relation to James' challenging behaviour appears to have not been revised and nor was there a holistic reassessment of his care plan by the CMHT. There was a degree to which the various professionals were making assumptions about what others would do and how they understood the concerns being shared.

The review group reported that there is now a monthly multi-disciplinary team meeting in the care home attended by staff from the CMHT's Care Home Support Team and Social Services staff, where information and concerns about residents is shared. This has improved communication and supports a shared understanding of the residents. This is unique to this care home and does not take place across all 17 older people care homes in Richmond. A formal mechanism for sharing information and concerns is likely to be of assistance in many residential care homes who support older people with dementia and could be considered as part of the wider developments set out in the NHS Long Term Plan and in the recent proposals for a Health and Care Bill in the white Paper 'Integration and innovation: working together to improve health and social care for all' (February 2021).

**Questions for SAB and partners**

- *Where the person alleged to have caused harm is vulnerable how much consideration is given to ways to involve them in the safeguarding enquiry and/or the use of IMCA?*
- *What can the Board do to ensure that there is an agreed mechanism and shared language concerning risk regarding people with dementia?*
- *Are there models of MDT discussions between organisations set around residents of care homes who have dementia, which could be applied locally?*
- *How can GPs be more involved in and informed of emerging risks amongst residents of care homes?*
- *Is there a need to consider whether the current specialist care home in-reach support is adequate to meet the needs of care home residents with dementia, in Richmond?*

**Finding 2:**

All staff across health and social care need to have a shared understanding of the nature of dementia and skills in managing behaviours that challenge and of the level of expertise available in a residential care home.

## System Finding

The term Dementia covers a wide range of specific medical conditions caused by abnormal brain changes. These changes trigger a decline in cognitive abilities and affect behaviour, feelings, and relationships. Dementia is progressive and while treatment can slow the symptoms for some people, there is no known cure. Many people with dementia need 24-hour care and this may be provided by a residential care home which puts the person at the centre of their care and considers how their dementia affects them. Providing care and support is complex because of the variation in individual symptoms and the growing number of physically strong and able people living with dementia.

Before agreeing to admit a person to any care home the manager of the care home must determine the person's needs and whether these can be met by their service. When people apply to move into care homes via a public funding route, the care home manager will receive detailed documentation such as a Care Act Assessment and Support Plan or a detailed Continuing Health Care Assessment. When people apply to a care home through a privately funded route, the documentation is less specific and is often reliant on the family's account of the person's needs and information shared by the GP. In this case, both Robert and James were admitted via a privately funded route. Given that both men had a disorder of the mind or brain, there was no evidence of a mental capacity assessment regarding the decisions on where to live and if appropriate, a clearly articulated best interest decisions. Both families initiated the discussions with the care home in the belief that this was in their family member's best interests. It is not likely that a formal best interest's process would have reached a different conclusion for these two men; however, it is a consideration for all future care home admissions where people may lack capacity to make the decision on where they live. The assessment undertaken at the point of admission for both men was appropriate as neither had a history of 'challenging behaviours.

The residential care home provides accommodation and personal care and offers specialist services for residents with dementia. The staff are skilled care workers who will have a level of

understanding of working with people with dementia, however they do not have access to specialist psychiatric nursing knowledge and are reliant on the CMHT for support in this regard. The distinction between the level of support to people with dementia provided by a residential care home and a nursing home is often not clear, and as a result there are expectations of higher levels of support than is routinely available in a residential care home. In addition, policies, training provided to staff and resources will differ between residential care homes as they are managed by different organisations. This can make it difficult for external agencies to understand what they should expect from individual care homes. In this case, this lack of understanding of what were reasonable expectations was apparent in areas such as the expectations that the use of 'Antecedent, Behaviour and Consequence (ABC) charts' would be routinely used, and the expectation that residents would be subject to hourly 'checks'. This lack of a shared understanding of the extent and limitations of support available in a residential care home hindered effective joint planning to support both James and Robert, which was exacerbated with limited face to face interactions between professionals during the COVID-19 pandemic.

Given the significant prevalence of dementia throughout the UK alongside good physical health and growing life expectancy, it is inevitable that residential care homes offering dementia services will be faced with situations where the persons behaviour changes to the extent that they are no longer able to meet the needs of the person. This is often a difficult issue for families and professionals to understand and there is a reluctance to move people with dementia as such moves will inevitably result in a degree of being unsettled. It is vital that in the first instance such homes have regular and easy access to expert secondary mental health professionals. Established mechanisms for multiagency review of the needs of care home residents with dementia, and early plans for any necessary changes, would ensure that changes are planned and avoid the occurrence of crises. Risk management and care planning to support the person and their family to understand changing needs is vital.

**Questions for the SAB and partners**

- *How well is the level of support offered by a residential care home with dementia care understood across the health and social care system?*
- *What specialist training and support is available to the care staff in residential care homes and what assurance is there that this is amended based on the changing needs of residents?*
- *To what extent are there established multiagency mechanisms to review changing needs of people with dementia and to engage in early planning for the persons future care needs?*