North Somerset Safeguarding Adults Board Executive Summary

Safeguarding Adults Review: Learning from the circumstances of treatment and support for Colin

Introduction

This Executive Summary outlines the learning from a Safeguarding Adults Review (SAR) for Colin. This Safeguarding Adults Review (SAR) was commissioned by the North Somerset Safeguarding Adults Board (NSSAB) under S44 of the Care Act 2014. This was in response to the circumstances surrounding the support for and treatment of Colin who died on 29 January 2021.

The review process commenced December 2021 and concluded September 2022. The Executive Summary includes recommendations made by the Independent Reviewer and a summary of actions taken by NSSAB partners. Siân Walker-McAllister was appointed as the independent reviewer for this SAR. She is a retired Director of Adult Social Services and currently works as an Independent Safeguarding Board Chair. She has three years' experience of conducting statutory Safeguarding Adult Reviews. She has no connection to any agency in North Somerset.

Colin and his family – a pen picture

Colin was described by his family as very, very active for somebody (of any age) and despite his medical condition of Parkinsons Disease and recent diagnosis of heart failure; he would go on daily walks up to Cadbury Camp, albeit with difficulty, but determined to do it. He cycled a lot, but not so much in recent years, because his Parkinson's affected his balance. He was frustrated with the Parkinsons symptoms and a constant tremor in his right (dominant) hand, but his frustrations were fleeting. Losing the ability to do exercise frustrated him occasionally.

Colin's son described laying a floor with him about 3 months before his stroke and that up until he suffered the stroke, he could still drive. Colin was formerly a bricklayer, described by his son as thin and wiry, and incredibly strong. He was 71 when he died but was not frail. He was strong willed and family-oriented and had been a single parent to his children since his divorce when they were very young (ages of 4 and 6). He never married again. He had really good relationships with his grandchildren.

Colin's daughter used to see him 2/3 times a week, before his stroke, and also at the weekend "we always saw him on a Saturday". His children believe that his divorce affected him a lot, in that he felt overprotective of them and wasn't trusting of other people.

Colin's son described "never having met anyone so multi-skilled in all my life". He said, "I learned car repairing from him, plumbing, electrical works and we felled a 40-foot tree in his back garden". He fitted all his own double glazing and heating. He would teach himself a skill if he didn't know it. He was extremely practical. He felt that he had to compensate for what we didn't have materially. He could be difficult sometimes; he found his poor health frustrating. And I felt he was also disappointed that, as we grew up, we didn't need him so much.

Colin had previously lived in a house in Nailsea in shared ownership - he moved from there with half the value of the sale and bought a top floor flat in a retirement place in Clevedon. However, he didn't like living in close proximity to others and moved from there to a 'Park Home' in Tickenham, where he was living up until he was admitted to hospital following his stroke.

Circumstances leading to the review

Colin, a white British man, who had previously been described as very physically fit, suffered a severe stroke in May 2020 which led to him being hospitalised at Southmead Hospital (North Bristol NHS Trust or NBT) on 12 May 2020. The stroke caused a severe long-term physical disability and also affected his mental health, affecting his capacity to make decisions around his care and support and causing some behaviours termed as psychotic episodes.

Colin had one attempted discharge from Southmead Hospital to a nursing home on 28th July 2020 which failed on the same day, owing to a physical incident/altercation between him and member of staff, and he returned to hospital the same day.

A further discharge then took place later on 28 August 2020 to a Nursing Home which had been specified for dementia care. Known as a Pathway 3 bed – this placement was part of the national Covid mandated "discharge to assess" pathway introduced to manage patient flow during the pandemic. Pathway 3 describes the route by which patients were discharged from acute medical care into an intermediate, but where ongoing 24-hour care is thought likely to be required, and where the placement was funded by the NHS as part of the Covid response. The process of discharge to assess enables a person to have a full assessment in a non-hospital environment, usually where conditions mean that it is more possible to re-acquire skills which may have been lost in hospital.

It was determined that Colin did not to have the mental capacity to make any decisions in relation to his care and support and as a result of this a best interest decision was made to move him to a nursing home on discharge from hospital. As it was not safe for him to be returned home at that stage and he would be provided with 24-hour care. A standard Authorisation under the Deprivation of Liberty Safeguards (DoLs) was granted.

Colin resided at the nursing home until 29 January 2021 when he was found deceased, having taken his own life, in his bedroom, there. During his time at the nursing home, Colin regularly expressed his desire to return home and specifically that he did not wish to be living in a nursing home for people with dementia, because he did not have dementia.

Specific areas of focus and scope of the SAR

- Exploration with Colin's son and daughter about each of their perspectives on the matters relating to the death of their father.
- An analysis of review activity undertaken, and national and local guidance and procedures, in respect of the Pathway 3 (P3) decision making on Colin's discharge from hospital, and the appropriateness of the placement.
- A review of the decision making to place Colin in a nursing home registered for people with dementia.
- A review of the information provided to the nursing home prior to admission and the reasons given for their acceptance of the placement providing he was able to access 1:1 funded care and AWP support.
- Consideration of whether Colin was ever offered the opportunity to realistically contribute to the placement decision.
- An analysis of the hospital discharge assessment to determine whether a full assessment was undertaken, determining the impact of a stroke on his mental health as well as his physical health, and whether if this took place this influenced placement decisions.

Following placement of Colin in the nursing home

- An examination of the information passed to the nursing home upon hospital discharge and on an ongoing basis which may have impacted on their care and support plan and its ongoing review. Was the Nursing Home aware of the deterioration in Colin's functional mental health?
- Evidence of the assessment prior to determining that a Deprivation of Liberty Safeguard (DoLS) be authorised for Colin at the Nursing Home.
- An analysis of the responses given to Colin when he was expressing clearly that he didn't have dementia and any subsequent actions taken.
- Consideration of why the Nursing Home staff proposed that Colin's son remove his mobile phone, following calls to the Police.
- Consideration of 2 allegations of assault by Colin against nursing home staff members (1/11/20 and 1/12/21) by 999 call and an analysis of the police response to these and any safeguarding follow up or referral of a safeguarding concern to the local authority (S42 1).
- Consideration of the views of the advocate to enable understanding of the context of the appeal against a DoLS authorisation, through a review of the advocate perspective and appeal documentation.
- Investigation of whether there were delays by the Nursing Home in calling the ambulance.

Recommendation and Subsequent Actions

Recommendations for the North Somerset Safeguarding Adults Board

Assurance about referring safeguarding concerns
NSSAB should seek assurance from all Board partners that their staff and agencies they commission, understand, in what circumstances, a safeguarding concern should be referred.

Assurance about partner agency practice - NSSAB and partner agencies should review how they seek assurance on individual agencies' practice standards.

Person-Centred Practice and importance of communicating clearly with individuals and their families
NSSAB should ensure that practice audit is undertaken by all organisations which commission health and social care placements. This is to ensure that person-centred practice is not only outlined in care and support planning but delivered by practitioners within those services.

The NSSAB should consider how it may garner feedback from families supporting people to be safeguarded, so that it is able to lead the development of system-wide culture change, working with families (where appropriate) as partners in care and support, with the ability for their views and feedback to influence systemic change across all agencies.

Sharing intelligence and information with regulators
The NSSAB should issue a copy of this SAR to CQC and should engage in a discussion with CQC about the outcome of this report and how the SAB receives assurance from CQC and the Integrated Care Board/ Adult Social Care commissioners about the delivery of person-centred care, which is at the heart of quality care.

Further, that the SAB should engage in discussion with CQC about how it responds to notifications, such as the notification provided by the nursing home about the death of Colin; and how it follows up on issues raised in subsequent inspections, and from published SARs.

Improved understanding of DNACPR

The NSSAB should seek assurance that every organisation involved in the provision of health, social care and support, understands how DNACPR might be applied and where it should not be applied. Moreover, the NSSAB should seek assurance that agency recording on a DNACPR is clear and unambiguous.

BNSSG ICB (Formerly CCG)

Quality Assurance

BNSSG Integrated Care Board (ICB) reviews the assurance process in respect of the delivery of care quality for Pathway 3 beds in residential and nursing homes, whether CHC funded or not, by ensuring that there is a proactive stance to appropriate care and placements for individuals as well as good quality and safe person-centred care delivery by each of the care providers.

BNSSG (ICB), together with Adult Social Care Commissioners must consider how residential and nursing homes can be better supported in a more robust way to manage delivery of care to those with complex needs.

Learning Points and Key Issues identified by the ICB and what has changed since January 2021.

It became apparent from discussion at the second SAR Panel meeting, that the CCG was always assured that Pathway 3 (P3) protocols were followed in hospital discharges to care or nursing homes, though the contract management process operated by Brokerage and via quality assurance process of those placements relies on self-assessment by providers and is carried out virtually.

Sirona Care & Health

Delivery of Therapeutic support to patients as part of hospital discharge planning

To consider with commissioners whether there is a need for greater clarity around therapeutic support on discharge to P3 beds, even when they are funded by CHC.

Sirona to agree with NBT and North Somerset Adult Social Care, a protocol for ongoing therapeutic support at the point of hospital discharge and on an ongoing basis, with multi-disciplinary discussion, even when a patient is funded by NHS Continuing Health Care. This should be an action for all health and social care partners where assurance should be sought by the Board.

NBT

Safeguarding Training & Escalation of DoLS assessments - Patient-facing staff at NBT must complete mandatory safeguarding training on a three yearly cycle and be reminded to escalate DoLS assessments when a person is objecting to being accommodated there for their care and treatment.

NBT to review ward staff understanding of safeguarding and risk, to ensure that this is thoroughly considered as part of the multi-disciplinary team decision making in completing a Single Referral Form

Discharge planning - NBT to ensure that as part of discharge planning arrangements, there is a requirement to outline in and specify in multi-disciplinary discussions, the ongoing support e.g., a rehabilitation plan which would be needed to support a patient's recovery.

Learning Points and Key Issues identified by NBT Southmead Hospital and what has changed since January 2021.

Information received from Southmead Hospital stated that their involvement was a significant length of time before Colin's unfortunate death. They stated that in analysing what could have been done differently, the hospital team was unable to find evidence of escalation of a Deprivation of Liberty Safeguards (DoLS) assessment while Colin was an inpatient. He was clearly agitated whilst an inpatient at Southmead Hospital and voiced on more than one occasion that he wished to go home. Southmead Hospital stated that patient-facing staff must complete mandatory safeguarding training as per the Intercollegiate Document and ICB quality contract and are reminded to escalate DoLS assessments when a person is objecting to being accommodated in the hospital for their care and treatment. NBT stated that this will continue to be emphasised on the face-to-face Level 3 adults safeguarding training.

Positively, Colin's ability to make decisions was assessed frequently and appropriately because his capacity was quite variable. There is evidence of formal recording of Capacity Assessment and Best Interest Decisions where formal recording is required.

The NHS already has mandatory assurance processes in place around safeguarding knowledge and compliance. NBT recognise that safeguarding and risk were not completed specifically in the safeguarding section of the Single Referral Form, however it is the Trust's position that the Single Referral Form overall had sufficient information on Colin's requirements post discharge, relevant risks were clearly identified around his behaviour, risks, and functional ability.

NBT's Assistant Director of Nursing for Integrated Discharge has stated that North Bristol NHS Trust has moved on significantly from ways of working at this time. They have moved from a Single Referral form to a Transfer of Care Document that allows staff to better describe a person's needs so that the discharge destination can be determined to best meet those needs. Risks are managed in a more collaborative and shared way. NBT stated that they continue to embrace an MDT way of working but no longer look for acute hospital professionals to provide rehabilitation plans as these are developed once a person has been discharged, as they are most often more meaningful in a community setting. Furthermore, NBT have commented that they have adopted a much more person-centred way of working and they have used learning from the covid pandemic to move to a more optimal way of delivery. They have recognised the value of working with partners in securing individualised and appropriate discharge pathways and post-discharge care and support. Previously, a person with significant needs would have routinely been supported in a Care Home setting rather than been supported home, whereas they have now adopted a 'Home First' approach to facilitating people to be discharged to the environment they were admitted from to continue their recovery.

AWP

Transfers of care between teams - The local arrangements for transfer of care between the hospital mental health liaison team and other AWP services should ensure that appropriate risk assessments and care plans are completed by the referring and receiving teams.

Managing Risk -The 'Care Programme Approach & Risk Policy' should be amended to clarify the duties for recording risk assessments at the point of transfer to other services. AWP staff, including doctors, must be directed to use the risk form provided on their 'RiO' (health care recording) system when undertaking risk assessments. The CPA & Risk Policy should be reviewed to include a minimum timeframe for completion of key documents including risk assessments and care plans.

Ability for staff to access reports - The technology enabling reporting functions within AWP should be reviewed to ensure team managers can easily access details of team caseloads and check on status of CPA & Risk documentation.

Staff understanding of Safeguarding processes and training - AWP to provide assurance to the NSSAB that:

- It provides robust guidance for staff on how to deal with repeated safeguarding allegations. These allegations may be genuine or made in the context of mental ill health, for example as part of a delusional belief system, or made for other unspecified reasons.
- It is assured about staff awareness of the adult safeguarding policy and when it should be implemented and further that such assurance is audited on a regular basis
- The views of families and carers are adequately reflected in AWP risk assessments

Participation in system-wide learning - AWP must work proactively in partnership with the NSSAB in delivering a system wide learning review of this case.

Learning Points and Key Issues identified by AWP and what has changed since January 2021.

The AWP RCA Report cites the following and these will also be used to formulate recommendations in this report:

- The local arrangements for transfer of care between the hospital mental health liaison team and other AWP services should ensure that appropriate risk assessments and care plans are completed by the referring and receiving teams.
- The 'Care programme Approach & Risk Policy' should be amended to clarify the duties for recording risk assessments at the point of transfer to other services. AWP staff, including doctors, must be directed to use the risk form provided on their 'RiO' system when undertaking risk assessments. The CPA & Risk Policy should be reviewed to include a minimum timeframe for completion of key documents including risk assessments and care plans.
- The technology enabling reporting functions within AWP should be reviewed to ensure team managers can easily access details of team caseloads and check on status of CPA & Risk documentation
- AWP must provide guidance for staff on how to deal with repeated safeguarding allegations. These allegations may be genuine or made in the context of mental ill health, for example as part of a delusional belief system, or made for other unspecified reasons.
- AWP needs to be assured about staff awareness of the adult safeguarding policy and when it should be implemented.
- AWP to assure itself that the views of families and carers are adequately reflected in Trust risk assessments
- AWP to seek to engage their local safeguarding partners to hold a system wide learning review of this case. AWP should be a partner in that review.

Nursing Home (& all commissioned residential and nursing homes)

These recommendations apply to the nursing home where Colin died. However, it is recommended that all Commissioners ensure that these recommendations are included in contractual updates with all residential and nursing care homes commissioned by the ICB and North Somerset Council.

The nursing home must always review a DNACPR decision with each resident, on admission. They must also ensure that all staff have clarity that this only applies in cases where decisions need to be made in respect of prolonging life.

The nursing home must ensure that all staff are familiar with and understand the policy in relation to attempted suicide and death by suicide; particularly that a DNACPR is not valid when it comes to responding to and providing immediate First Aid, following attempted or actual suicide. The nursing home must ensure that all staff are clear about this, through training and induction.

The nursing home should review its approach to supporting people with complex mental health needs and consider how staff are better supported to understand how to deliver person-centred care.

The nursing home needs to review its understanding of when and how to report safeguarding concerns, especially when residents are making allegations of harm, even if staff believe these are untrue, as they should be investigated independently.

The nursing home should be much clearer in its communication to families, particularly in respect to where there are concerns and risks. The nursing home should consider how they improve communication with families and how they evidence learning from this matter under review. The nursing home should also improve the way they communicate sensitively with families following the death of a loved one and develop a protocol of sensitive and dignified handover of a person's possessions to their family members.

The nursing home should regularly discuss significant risk assessments with staff to ensure that mitigations are updated and that staff (with most one-to-one contact with residents) can influence any review of information.

The nursing home must ensure that there is a clearly stated requirement to call emergency services i.e., ambulance, to preserve life without delay, and must update emergency call procedures so a resident is not left on their own in such circumstances; with appropriate measures taken whilst awaiting ambulance i.e., removal to a place of safety and application of CPR.

The nursing home should take appropriate steps to clarify with the Nursing & Midwifery Council, whether, given their employer responsibility (as employers of registered nurses); they should refer concerns that the Registered Nurses did not take any action in respect of immediate contact with Ambulance services and application of CPR.

Adult Social Care & BNSSG ICB Commissioning

<u>System-wide understanding of supporting people at risk of suicide and responding to suicide attempts</u>
Commissioners to provide assurance and evidence to the NSSAB that providers and particularly their staff working face to face with people who use services, fully understand the provider briefing on suicide prevention and risk management.

<u>System Learning about appropriate residential care and nursing home placements</u>
ASC Commissioning, together with BNSSG ICB Commissioners must consider how residential care and nursing homes can be better supported in a more robust way to manage delivery of care to those with complex needs whether those needs are for therapeutic input; to support delivery of care to those with complex mental health needs and behaviours or to improve delivery of quality person-centred care. Such input should be multi-disciplinary and include support from those with clinical experience as well as social care experience in provider services.

<u>Appropriate placements for people recovering on a stroke pathway</u>

Commissioners must investigate the feasibility of commissioning appropriate resources for people recovering from strokes and in particular where a person has post-stroke psychosis, so that appropriate skilled interventions are available.

Reporting Safeguarding Concerns

Commissioners must seek assurance that all providers understand their responsibility to report safeguarding concerns and further should work with the NSSAB, to deliver regular events to providers to promote improved understanding and evidence through data to the Board that appropriate referrals are being made. Commissioners should amend provider contracts to ensure that the requirement to report safeguarding concerns is detailed within contracts.

Learning Points and Key Issues identified by North Somerset Council and what has changed since January 2021.

North Somerset Council Commissioners in consultation with the local CCG, Sirona and AWP Mental Health Trust, following the death of Colin, immediately developed a briefing to be used by care providers in supporting people at risk of committing suicide and those who have attempted suicide. It is noted that the nursing home also responded quickly to the issue of this document.

Learning Points and Key Issues identified by Avon & Somerset Police and what has changed since January 2021.

Following discussion at one of the SAR Panels, it was identified that there was a need to ensure police understanding of DoLS and MCA as relevant to whether decisions are taken forward in investigations and safeguarding referrals. This was also highlighted in the chronology provided by the police, which reviewed contact with Colin prior to his death and is in the context of a safeguarding adult concern referred to adult social care. I do not believe this is a particular issue in this case, though clearly the whole discussion about mental capacity needs to be nuanced, so that front line practitioners in any/ all agencies understand that the mental capacity assessment is decision specific. In respect of Colin the matter assessed was his ability to make an informed decision about the risks of being at a nursing home or returning home from hospital. It is believed that he did have the ability to make other simple decisions with executive capacity – that is the ability to weigh up the risks of any of his actions.

How are we monitoring?

An agreed action plan to deliver these recommendations was created and monitored by the North Somerset Safeguarding Adults Board. The SAB will also be coordinating a learning review across agencies. The aim will be to minimise the risk of similar concerns arising in the future and to promote the safety and wellbeing of adults at risk in the locality and nationally. The action plan and learning will be periodically reviewed for ongoing assurance.

Glossary

CHC – Continuing Health care funding is granted to **individuals who require nursing care and meet set criteria.** This type of funding is provided and organised by the National Health Service (NHS)

D2A – Discharge to Assess (see Pathway 3 below)

DNACPR – Do Not Attempt Cardio-Pulmonary Resuscitation. All patients will usually have had the opportunity to consider this and record their wishes on an appropriate form

MCA - Mental Capacity Act (2005) is a comprehensive legal framework for decision making for people who lack capacity to make particular decisions for themselves. It is accompanied by a Code of Practice and is based on common law and good practice. It puts the needs and wishes of the person at the centre of any decision making process. This applies whether the decisions are life changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act. The presumption in the MCA is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in adult safeguarding. All interventions need to consider the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability to understand the implications of their situation, to act themselves to prevent abuse and to participate to the fullest extent possible in decision-making.

MDT – Multi-disciplinary Team

Pathway 3 (Beds) - The aim is for people leaving hospital to be discharged home: however due to variety of clinical and safety reasons, some people will need to be transferred to an alternative community setting first to ensure they are safe, supported, and able to continue their recovery. This may be a transfer to an NHS bed in a residential care and nursing home setting (Discharge to Assess (D2A) Pathway 3 (P3) or to specialist community rehabilitation units for a short period of time (Pathway 2 -P2). In these settings it is planned that assessment of the individual may continue until an assessment concludes that a return home can be made or discharge to a different setting or to remain in the current residential care and nursing home environment

SAR – Safeguarding Adults Review