Safeguarding Adults Review MU

Worcestershire Safeguarding Adults Board

Contents

1.0 Introduction

1.1 Safeguarding Adult Reviews (SARs) were established by the Care Act 2014 to respond to situations where serious harm has been experienced by an adult with care and support needs. This refers to section 44 of the Act, the fuller details of which are set out in Appendix B. In summary the statutory guidance refers to "The mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent – including older people, people with a disability or long-term illness, people with mental health problems, and carers. Care and support includes assessment of people's needs, provision of services and the allocation of funds to enable a person to purchase their own care and support. It could include care home, home care, personal assistants, day services, or the provision of aids and adaptations"

1.2 This review concerns the death of Mr Michael Upward. Mr Upward (born 21st May 1932). He had a diagnosis of Alzheimer's in 2010 and on 15th April 2015 was admitted to Care Home in Upton-upon-Severn, Worcestershire for one week's respite care. On 17th April Mr Upward left the care home without the knowledge of staff between 10:30 and 10:45, it may be presumed that he was searching for his wife, based on the fact that during his first day he made a number of attempts to leave. This was the second day of his respite care. Despite an extensive search by the police and staff Mr Upward was found dead at 19:07 on 18th April close by the care home.

Acknowledgements:

Throughout this review there has been a high level of work and engagement from the individuals and key agencies including those with designated responsibility for safeguarding adults and those responsible for the processes that support this.

Michael Upward's family, primarily represented by his son Mark, have been extremely helpful during what for them all has been undoubtedly a difficult period.

2.0 Safeguarding Adults Reviews (SARs)

2.1 National Requirements

2.1.1 The Care Act 2014 introduced a statutory duty for the Safeguarding Adult Board to conduct an SAR in certain circumstances. These circumstances are set out in Appendix B.

2.2 Local Agreed Requirements of an SAR

2.2.1 A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

2.2.2 The key principles of an SAR are to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The Worcestershire Safeguarding Adults Board (WSAB) have now produced a local protocol and the latest draft (as at December 2015) sets out the following principles:

The current draft principles December 2015

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews must be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases will be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- The adult with care and support needs should be supported to be involved with a SAR and advocacy arranged if required;
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively; and

- The WSAB is responsible for the SAR and must ensure it takes place in a timely manner and seek assurance of the completion of the appropriate improvement action.

2.2.3 However, it should be noted carefully that at the time of commissioning this SAR the first principle of the then draft protocol stated

"To consider whether or not serious harm experienced by an adult with care and support needs could have been **predicted** or **prevented."**

2.2.4 In view of this being in place at the time of the commissioning of this report and during the majority of its completion this issue is fully considered and is set out in section 12.

The circumstances that led to this Review

a) Mr Upward had been known to health services through the Older Adults Mental Health Team since 2009

b) Mr Upward had been known to the County Council since May 2011

c) In January 2015 Mrs Upward made a request to the County Council for respite care for her husband.

d) On 30th January 2015 the County Council made a request to Care Home 1, a residential care home, for a week's respite care in April for Mr Upward. Care Home 1 is run by the Care Home Provider and is described as a purpose-built home to support residents with their individual social and emotional needs. Their website states they provide residential, day care, respite care and dementia care. Their website[1] further states that their highly trained and

[1] https://www.sanctuary-care.co.uk/beechwood-residential-care-home

dedicated team is committed to delivering the highest standards of care in a home from home environment.

e) On 9th February 2015 the County Council faxed a copy of Mr Upward's Personal Support Plan to Care Home 1 ahead of his planned respite care. The personal support plan was undated.

f) Mr and Mr Upward visited Care Home 1 for the pre-admission assessment discussion as was the standard practice of Care Home 1. This was originally planned for 19th March 2015 but delayed because of an outbreak of diarrhoea and vomiting at Care Home 1, and took place on 13th April 2015

g) On 15th April, Mr Upward was admitted to Care Home 1 to start a weeks respite care.

h) Mr Upward was seen in the dining area at 10:30 in the morning of the 17th April 2015 but at around 10:45 staff realised that they did not know where Mr Upward was.

i) Internal searches by care staff at Care Home 1 to locate Mr Upward were unsuccessful. At 12:03 the police were contacted and an extensive search started. Mr Upward was still not found.

j) 18th April at 19:07 Mr Upward's body was found in a ditch on a farm approximately one mile from the care home.

3.0 About This Safeguarding Adults Review

3.1 The SAR was commissioned by Worcestershire Safeguarding Adults Board (WSAB) and managed by the Case Review Sub Group. It was overseen by a panel (see Appendix C for membership) led by an independent chair, who was also charged with conducting the SAR and preparing this report. Biographical details of independent chair are shown at Appendix H.

3.2 Partner agencies provided panel members that were independent of any direct

involvement with Mr Upward. The independent chair offered expert opinion and some challenge and prepared this report based on information provided in written documents referred to as Individual Management Reviews (IMR) and additional questions from the Chair. The IMRs were received from:

- Clinical Commissioning Group (responsible for commissioning primary care including GP services)
- Worcestershire Health and Care NHS Trust
- The County Council: Adult Social Care Community Social Work Service and the specialist home care provider service
- The Care Home Provider (who are the owners and providers of care at Care Home 1)
- West Mercia and Warwickshire Police

3.3. Terms of Reference – Scope of Review

3.3.1 The terms of reference for the independent SAR, agreed by the Panel, were to consider:

(1) The decision to commission a place for Mr Upward at Care Home 1, a Residential Care Home:

i. Were there any issues of supply, availability or choice of suitable care
ii. Was the placement appropriate
iii. How was the decision taken
iv. What assessments were completed by the Local Authority (the County Council), when were they completed and were they shared with Care Home 1. What consideration of risk was there.
v. What Care Plan was put in place as a result of the assessment
vi. What pre-placement assessments were completed by Care Home 1
vii. What Care Plan was put in place as a result of the pre-placement assessment. Were risks considered and if so, what actions were put in place
viii. Was all relevant information shared with all parties

(2) Multi Agency Assessments and information sharing. There were a number of agencies providing health or social care to Mr Upward:

i. What assessment and care was provided by each agency.
ii. Were these assessments shared with Adult Social Care in order for them to provide an outcome focused service to Mr Upward and to Mrs Upward as his main carer.
iii. What risk assessments had been completed.
iv. Were risk assessments shared or risks analysed and discussed
v. IMRs to include any information shared with Care Home 1 and any gaps identified by Care Home 1.

(3) How robust and appropriate was the Care Plan and supervision received by Mr Upward whilst at Care Home 1. What steps were taken to monitor his safety while at Care Home 1.

(4) Policies and Procedures:

i. Identify Care Home 1's policy and procedures for missing persons and their escalation procedures including how these are activated and how staff were made aware of them.
ii. What are standard working practices for residents with dementia and were they applied to Mr Upward.
iii. Are there Worcestershire Safeguarding Adults Board multi-agency escalation policies and procedures in place for missing adults with care and support needs to ensure they are safeguarded.
iv. If they are in place, how have they been communicated to all agencies and providers.
v. What assurance was there that all agencies have relevant policies in place.
vi. Has there been, or is there, an annual audit to seek assurance of the effectiveness of these policies.

(5) The search and subsequent discovery of Mr Upward's body:

i. What actions were taken by all agencies involved
ii. Was there adequate information to ensure prompt search.

iii. When and how were any family members informed of Mr Upward's disappearance.

iv. What further communication and support was provided to Mr Upward's family during this critical period.

v. Was there a designated officer representing all the agencies

3.4. The Scope

3.4.1 The scope of the SAR extended from 14th August 2013, when Worcestershire County Council Adult Social Care completed an assessment of Mr Upward as an adult with care and support needs, to 18th April 2015 when Mr Upward's body was found.

3.5 The Methodology

3.5.1 The methodology agreed for the SAR was primarily an investigative, systems focused and Individual Management Review (IMR) approach. This was to ensure a full analysis of detailed chronology to show a comprehensive overview and alignment of actions. However, to ensure that this Review had maximum impact on practice, learning and development the Learning Together[2] approach was included.

3.5.2 This approach ensured that practical and meaningful engagement of key front line staff and managers will take place on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.5.3 This approach was considered more likely to embed learning into practice and support cultural change where required. A learning event will be held at an appropriate time after the Inquest has been concluded. However, that should not prevent the SAB or individual agencies responding to learning points, indeed many already have as shown in Appendix A

3.6. **Mr Michael Upward**

3.6.1 This information was kindly provided by the Upward family at the request of the SAR

[2] Social Care Institute for Excellence (SCIE) Safeguarding Adults Reviews practice materials

author.

3.6.2 Ernest Michael Upward was born in 1932 in Sussex. He was always known as Michael rather than Ernest. He had a sister Penny, 7 years his junior.

3.6.3 He was educated at Brighton College, trained as an Accountant and spent his National Service in the Intelligence Corps, learning Russian. He then retrained in the field of Horticulture, attending Plumpton College and Wisley as a student, gaining a Diploma and subsequently specialised in Alpine plants. His marriage to Primrose Wiggin took place 1961 and lasted for 54 years until his untimely death. They had two sons, Guy in 1964 and Mark in 1966. At the time of his death he had 5 grandchildren aged from 3 to 14.

3.6.4 Michael held the post of Secretary to the Alpine Garden Society (AGS) for 35 years first working in London, then from home and finally resettling in Worcestershire when he helped establish the new AGS headquarters in Pershore. Michael and Primrose lived in the village of Eckington for 10 years prior to moving to Pershore in 2002.

3.6.5 In his work for the AGS Michael was responsible for winning 10 Gold Medals at Chelsea Flower Show due to his expertise in designing rock gardens and displaying alpine plants, and was a National Judge in the alpine field. He proudly met the Queen and other members of the royal family on several occasions while carrying out his work.

3.6.6 He went on plant-hunting trips all over the world, both with small parties of fellow experts and leading larger commercial tour groups. He visited countries as diverse as South Africa, the States, China, the Falkland Islands, Nepal, Switzerland and Argentina. He achieved one of the highest honours in his profession by becoming Master of the Worshipful Company of Gardeners, playing an active role in promoting public engagement in horticulture. He started up and helped existing Alpine Societies and was an enthusiastic supporter of other gardeners and plant

lovers, giving his time and often going out of his way to share his knowledge and be generous in the supply of plants, cuttings and cheeky advice.

3.6.7 Michael had many, many friends – underlined by the attendance at his funeral in Pershore Abbey of 400 people from all over the country and the hundreds of letters of condolence received by Primrose. He was a very sociable person, enjoying entertaining and being entertained, had a great sense of humour, teasing, positive, kind, did not suffer fools gladly but always the perfect gentleman. In many ways he was old fashioned and traditional but in his work and horticultural pastime he kept up to date and was willing to try new things.

3.6.8 Michael had a strong Christian faith and was an active member of the church congregation wherever he lived, very much becoming involved in the life of the Church. He and Primrose had owned a dog since the late seventies, taking on several rescue dogs, providing them with a caring home and getting out for regular walks. Michael was very attached to the present Collie, Jack.

3.6.9 Michael was diagnosed with Mild Cognitive Impairment in about 2009, which developed over the years into worsening Alzheimer's. His general health was good and he remained an active man, usually to be found pottering in his garden, but more frequently in the past two years, resting often in front of the television.

3.6.10 Primrose became his carer and his interest in plants diminished as he was not able to help in either the garden or house. However, he maintained his lifelong habit of perusing the Daily Telegraph, including out loud, and retained his dignity at all times. He did become anxious and stressed over not being able to express himself by not finding the right words but medication helped lessen this as a concern for him. He laid great store in joining a small group of old friends for coffee most mornings at nearby No 8 community café.

3.6.11 Michael was a proud man and was at times embarrassed by the loss of ability he endured suffering from Alzheimer's. He never lost his sense of humour though, nor

his desire to socialise.

3.6.12 If any consolation can be found in his passing it was that he was doing as he pleased and being outdoors, however fateful his demented decision was to leave a place of safety. There is no comfort though for his wife who is left without her husband of 54 years and with the anxiety that had she not gone away to get a much needed break then things may have turned out very differently.

4.0 Family Involvement

4.1 By agreement beforehand Mark Upward (son) was the main contact during the SAR. Contact was by telephone and by email.

4.2 Mark Upward facilitated a planned telephone call with his mother Primrose Upward.

4.3 He also provided the biographical detail for his father in consultation with other family members.

4.4 The family's assistance in the production of this report is acknowledged and Mark Upward's support in dealing with questions and background has been particularly valuable.

5.0 Key Events

5.1 A full chronology is provided at Appendix E. This has been drawn from all the agency reports. The key events are summarised at Section 2, page 4.

6.0 Individual Management Reviews

6.1 Individual Management Reviews (IMRs) were prepared by each of the organisations that had been involved in caring or providing services to Mr Upward. The people who prepared the IMRs are listed at Appendix C. The authors are employed by the organisation that they reviewed, however they were not directly involved in his care.

6.2 IMRs set out detail of events and actions in an effort to understand the causes of

failure and prevent reoccurrence. Each IMR set out some chronology of events, contained a narrative on those events and a critical analysis. Learning identified by the organisation and any actions planned or implemented were also described. These actions are summarised in Appendix A.

6.3 On receiving the IMRs the Independent Chair asked a number of clarifying questions and sought additional information.

6.4 Led by the Independent Chair, the authors met on 7th September 2015 to review the IMRs collectively and to address any issues, gaps or inconsistencies. Statements that were submitted to the Coroner were also shared with the Independent Chair following that meeting. At the end of the meeting on 7th September 2015 it was confirmed that the Care Home Provider would consider some revisions to their previously submitted IMR.

6.5 The analysis of the IMRs for this report concentrates on the critical issues of:

- The decision to place Mr Upward at Care Home 1 Residential Care Home for a week's respite care
- Multi-agency assessments and information sharing
- Robustness and appropriateness of Mr Upward's care plan
- The search for Mr Upward
- Policies and procedures for situations involving a missing resident

IMR Analysis – Initial Learning and Independent Chair's Comments

7.0 Question 1: The decision to commission a place for Mr Upward at Care Home 1 Residential Home:

7.1.1 The County Council's chronology states that Mrs Upward rang to request respite care at the local home in Pershore (Care Home 2). This was on 23rd January 2015. Mrs Upward had a specific date that she required as she was intending to be on holiday and on this occasion Michael's sister (Mrs Penny Hill) was not available to care for Michael as she had done on previous occasions.

7.1.2 The dates that Mrs Upward required were 15th April to 21st April 2015. This request was referred to the County Council Brokerage Team in the County Council whose role is to find appropriate care services.

7.1.3 When Mrs Upward requested respite care she asked that this should be arranged at Care Home 2, a service run by the same Care Home Provider situated in Pershore near to the Upward's home.

7.1.4 Care for people with dementia is commissioned by the County Council from providers including the Care Home Provider on a one off basis only (often called "spot" arrangements) and would be identified at the last minute and can be anywhere in the county. This does not provide certainty of care for the adult or their carer. In managing their commissioning approach to services most local authorities will have, so called, block and spot arrangements: this is not unusual.

7.1.5 The Care Home Provider is the only organisation contracted by the Council for block purchased beds that enables respite to be pre-booked. Other respite and NHS respite is spot purchased. The Care Home Provider has several homes in the County that provide residential care for people with dementia, including Care Home 2 and two other care homes, and also provide all the respite care for adults with dementia in the County. Care Home 2 is not one of the homes that provides

pre-purchased (block) respite care, so while a bed might be available on a "spot purchase" basis there is a risk of it not being available at the required time. A firm booking might not have been made until the day before it was required. Such circumstances might result in no bed being available anywhere in the County, which would have significantly disrupted Mrs Upward's plans.

7.1.6 The other two care homes have a block contract to provide dementia respite care. Care Home 1 was chosen because of availability, and as there was no provision in the area that Mr Upward lived to book dementia respite in advance

7.1.7 On 2nd February 2015 a manager from the County Council telephoned Mrs Upward and advised her that "*Care Home 2 had declined, but a place had been identified* at Care Home 1". In reality the County Council did not have a contact with Care Home 2 to make a dementia respite care placement at Care Home 2.

7.1.8 In the subsequent documentation there was a level of confusion about why Care Home 2 declined to offer a place for Michael Upward. It is clear that this was based on the contract arrangements with the County Council and not related to his actual assessed needs. Straightforward information regarding what is available would be helpful.

Learning and Development Point 1

Information and Advice to Service Users and Carers

- **Carers/individuals and families should have access to clear information about respite care: the criteria, options and booking process should be set out at the start.**

Q1.2 Was the placement appropriate

7.2.1 The County Council dementia service standard requires that:

- The skills, experience and number of staff will reflect the emotional, psychological and physical needs of the people whose home it is.

- Locks/"keypads" access systems are not used and certainly not in rooms in which there are people. All door furniture is of standard appearance.
- Specialist skills in 'later stage' dementia care are evident in the assessment, care planning, implementation and evaluation process.

7.2.2 The decision to use Care Home 1 was a combination of:

(i) The criteria of the home as stated in its contractual arrangement
(ii) The extant commissioning arrangements (block purchase arrangement with guaranteed booking)

7.2.3 As background, the pattern of placements at Care Home 1 commissioned by the County Council between January 2015 and April 2015 were as follows:

- 21 referrals for respite care for people with some form of dementia
- 10 respite placements for people with dementia
- Of those 10 respite resident placements 1 individual had been identified as being considered at risk of leaving the building however, the risk is described as being lessened by their reduced mobility as a result of their physical deterioration.

7.2.4 The decision to plan Michael Upward for respite care at Care Home 1 was consistent with:

- the commissioning arrangements
- other placements
- the terms of the contractual arrangements,
- the registration criteria of Care Home 1; and
- historical patterns

7.2.5 Based on the Council's stated standards and requirements, which is said that the Home met and had received some extra reward for, this was an appropriate placement arrangement.

7.2.6 Much is made elsewhere in the Care Home Provider IMR, particularly as part of their own critical analysis in August 2015, the revised IMR and statements that have been prepared for the Coroner. These documents question whether the placement of Michael Upward at Care Home 1 was appropriate, and in a number of instances they state that had they (the provider) known that he might leave the premises they would have refused the placement.

7.2.7 Care Home 1 worker MC writes in a statement to the Coroner dated 9th September 2015, "*Had I known at that time of the risks of Mr Upward going for walks by himself I would have declined the placement as Care Home 1 is not a 'locked-door' home*."

7.2.8 This somewhat over simplifies both Michael's condition and his situation. What is evident during the first day of his time in respite care was that Michael was not wandering or walking in an aimless fashion but was searching for something, and it is reasonably safe to conclude he was searching for his wife borne out by the comments that he made at the time. There was undoubtedly a considerable degree of confabulation in Michael's condition and this should have been considered at the time of his placement and some potential for confabulation would undoubtedly be a feature for many individuals placed with this care home provider.

7.2.9 However, the risk of Michael Upward suffering from a greater level of confabulation during respite care was not considered by the County Council in their referral documents either. The additional information received from Mrs Upward by the County Council prior to Michael Upward's admission was also not shared with the Care Home Provider.

Q1.3 How was the decision taken

7.3.1 It was not possible to establish any clear eligibility criteria for the provision of respite care for January 2015 and how this was (or was not) applied to Michael Upward. Subsequently, in December 2015 the Council have stated that respite care was determined by using Fair Access to Care Services (FACS)

7.3.2 The County Council IMR states:

"*Respite care is provided when respite has been agreed as an assessed need as part of the assessment and support planning process. It also needs to be an identified need in a Carers Support Plan. The care plan needs to state how much respite provision has been agreed. The majority of planned respite is arranged by the Central Reviewing Team who receive a request for respite. This is usually from a carer. When the request is received details of the request are taken; confirmation that the information that is held on file is accurate is checked and then a request is sent to brokerage with details of when the respite is required with any preferences for location indicated. Individuals are always advised to arrange a pre visit with the provider prior to the respite, especially if it is the first respite period in a particular home.*

In this case the Support Plan did not identify respite as being an assessed need, nor was there a carer's assessment or review. Manager 2 booked the respite because Mrs Upward had specific dates for her holiday and needed a confirmed booking for respite care*. A Current User Contact was sent to Manager 1 on 23.01.2015 requesting that a Carer's assessment be completed in order for the respite to go ahead; this episode was not completed until 26.06.2015 despite a reminder email to Manager 1 from Manager 11 dated 16.03.2015."*

7.3.3 The County Council's IMR analysis states that, *"If the carer's assessment had been completed as requested this would have enabled the information held about Mr Upward to be updated which would have allowed workers to determine if Care Home 1 was an appropriate placement for Mr Upward."*

7.3.4 The introduction of the Care Act 2014 (from 1st April 2015) brings new emphasis to assessment and eligibility both for individuals who may need care and assessment and eligibility for carers. The County Council now identify the need for respite as part of the support planning process for the adult and also as part of the support planning process for the carer. The social worker remains involved for the first respite placement and this service is then reviewed. If this is an ongoing service then this is passed to Central Reviewing Team who will arrange

any further respite and will review the need for this on an annual basis.

7.3.5 In the case of Michael Upward, it appears, quite reasonably that a manager agreed a short period of respite care for an individual who had an assessed need for ongoing care, whose primary carer was herself on older person who supported and cared for Michael Upward, and both were therefore living with his Alzheimer's.

7.3.6 The decision was taken on the basis of need which showed signs of increasing, it had a preventative element and for which there was a service available at the time requested.

Q1. 4 What assessments were completed by the Local Authority (the County Council), when were they completed and were they shared with Care Home 1. What consideration of risk was there.

7.4.1 This section will deal with the County Council and the assessments that were completed covering the whole period of their work with Michael Upward and prior to Michael Upward's admission to respite care.

7.4.2 The County Council acknowledge the issues of the assessment in their IMR critical analysis as follows:

"*There was no new assessment completed by the Local Authority and the information given to Brokerage to source the placement was taken from the Update Care and Support Plan completed on 16.01.2015 which had pulled through*[3] *and not updated any information from the Update Support Plan which had been started on 09.05.2014. The Care and Support Plan was faxed* to Care Home 1 on *09.02.2015.*

[3] This refers to the use of the electronic records system which allows for a "cut and paste" approach to records or sections of information that can be moved from one record to another. However, this does not show clearly that this is repeated or old information and therefore can be misleading

This Care and Support Plan was not up to date as the information that it contained had been pulled through from an Update Care and Support plan which had commenced on 09.05.2014. It is case noted on 02.02.2015 by Manager 2 that in a telephone call between Manager 2 and Mrs Upward it was identified that Mr Upward wanted to go out more frequently. This information was not acted upon, nor was it shared with Care Home 1*. Mrs Upward also wrote a letter dated 23.03.2015 where she clearly gives information about Mr Upwards care and support needs increasing. No action was taken as a result of this. As there was clearly a change in need this should have led to a reassessment and there should have been consideration about whether Care Home 1 could meet Mr Upwards needs or not.*

It is clear that relevant information was not shared with all parties and there needs to be learning about the need to share any relevant information to minimise the risk of harm occurring."

This level of candour in recognising these issues is worthy of note.

Learning and Development Point 2

Using electronic records

- **The County Council should review its quality standards for assessment and case recording to ensure up to date and timely information.**
- **Where old or pulled through information is used the date and origin of these notes should be clearly marked**

7.4.3 The assessment activity of the County Council is most easily set out in the following table/chronology

A Summary of the County Council's Activity
August 2013 – March 2015

Date	Description of activity	Home visit
14 Aug 2013	Adult Care Referral	n/a
23 Aug 2013	Personal assessment MCA carried out regarding the signing of Client Charging and Assessment Needs assessment – completed 5th September 2015	Yes
4 Sept 2013	Mental Capacity Assessment (on financial matters)	Unknown
6 Sept 2013	Financial Assessment	Unknown
11 Sept 2013	Financial Assessment revised	Unknown
18 Sept 2013	Further Client Charging and Assessment	Unknown
25 Sept 2013	Client Charging and Assessment Financial Assessment revised	Unknown
13 Feb 2014	Needs Assessment/Personal Assessment	Yes
6 Mar 2014	Care and Support Plan	Yes
20 Mar 2014	Home Care Service Assessment	Unknown
31 Mar 2014	Financial Assessment revised	Unknown
2 May 2014	Care and Support plan review	No – by telephone
9 May 2014	Care and Support Plan updated	Unknown
14 Oct 2014	Financial Assessment revised	No – by telephone
21 Nov 2014	Financial Assessment	Unknown
24 Nov 2014	Buddi Assessment	Yes
26 Nov 2014	Care and support plan reviewed	No
16 Jan 2015	Care and support plan updated/reviewed	No – by telephone
12 Feb 2015	Financial Assessment revised Periodic review	No – by telephone

Date	Description of activity	Home visit
18 Feb 2015	Home visit for Buddi collection	Yes
11 Mar 2015	Periodic Review Financial Assessment revised	Unknown

7.4.4 The respite care place for Michael Upward at Care Home 1 was booked on 30th January 2015 and a copy of the assessment information was requested. On 9th February the County Council faxed a copy of the most recent care and support plan that had been completed on 16th January 2015. The faxed document was not dated and it is only possible to give it a timeframe from the chronology of event provided by the County Council.

7.4.5 The care and support plan written on 16th January 2015 appears to have been updated following a telephone call with the specialist home care provider service the same day which reported that there were no concerns with the existing care package, all was going well and there was no reason for a social worker to visit at that time. . Information from the County Council records that there was a home visit in November 2014 to assess Michael Upward's eligibility for the Buddi. It was concluded that he "*did not meet the eligibility criteria for the continued funding for the Buddi from the County Council".* Taken into account in this conclusion was that the Buddi was not being used and that Mrs Upward did not necessarily think it was needed.

7.4.6 Between the updating of the care and support plan in January and Michael Upward being admitted to Care Home 1, the only other contact by the County Council was:

- telephone conversations with Mrs Upward:
  - requesting respite care
  - care cost issues and queries
  - confirmation of a respite place
  - arrangements for collection the Buddi
  - questions about family members visiting Care Home 1 ahead of Michael Upward's admission
  - discussion of increasing care needs on 2nd February in which Mrs Upward states that Michael Upward has been wanting to go out more frequently and that this was sometimes at night, was having increased problems with

continence but declined to wear a pad and that she could continue to care until respite is due.

- correspondence from Mrs Upward on 23rd March raising issues of increased care needs, but not mentioning wandering
- a visit by an officer of the Council on 18th February 2015 to collect the Buddi

7.4.7 The care and support plan faxed to Care Home 1 on 9th February was assembled from existing and old material in January 2015. However it recorded the following:

- There are several references in the document to material being *taken from previous assessment*
- *a stranger or someone who does not have insight into Michael Upward's cognitive difficulties may be misguided in thinking he does not have significant mental health issues* *****
- *Michael Upward is at risk of making unwise and maybe unsafe decisions which might put him in a vulnerable situation******
- *Use of the Buddi when Michael Upward takes local walks or visits venues in the town independently. Mrs Upward feels confident that her husband is able to go out independently and safely in the knowledge that he carries the Buddi****** (there was no reference to the decision to remove the Buddi)
- *Michael Upward also continues to go out and about in the town******
- *The specialist home care provider service team have been providing support with one shower a week since mid March (*This comment was out of date as this service had been increased to two visits per week)

7.4.8 Crucially there were some important and basic comments in this document that should have provided Care Home 1 staff with some key questions for their own pre-admission discussion, for example those elements marked *****. Regrettably this document was not referred to until the day after the pre-admission visit and not referred to at all in any of the subsequent Care Home 1 submissions.

7.4.9 Following the pre-admission visit to Care Home 1 by Michael Upward and Mrs Upward on 13th April, County Council Manager 2 states they telephoned Care Home 1 at 12.50

the same day and spoke to Care Home 1 worker AD to check that the visit had taken place. During this conversation the County Council's chronology states AD reported that "*staff aware that Michael Upward's dementia is progressing and that the picture is different from at the point of the last review*". The Care Home 1 worker AD who carried out the pre-admission visit states that they do not recall this phone call. This call, plus the points above, should have had an impact on the approach of Care Home 1's staff to Michael's care and risk assessment.

7.4.10 The background records to this do not really support a sense of co-ordination, robust social work assessment and case management. There is a feeling that this was somewhat uncoordinated. The local authority should have been aware of the need to consider:

- the Mental Capacity Act and Deprivation of Liberty Safeguards
- the use and value of the Buddi
- the carer's assessment
- the specialist home care provider service
- reviewing case work
- the supportive visits of Admiral Nurses

and then coordinated their response as a basis of good casework management. These activities are considered below.

Learning and Development Point 3

Reviews at Key Events

- **Where planned respite takes place any assessment or care plan should be reviewed to ensure that the most up to date information is available, this should be comprehensively shared with the provider in good time so that it can be considered by the staff.**

7.4.11.i. Considering the Mental Capacity Act (MCA) and Deprivation of Liberty

Safeguards (DoLS)

a) While some consideration of the Mental Capacity Act (MCA) was done on 4th September 2013 and on 23rd August 2014 by the County Council, this was only in relation to financial and property matters. Michael Upward's needs should have been considered in line with the principles of the MCA and this would have taken into account all aspects of his situation and fully involved Mrs Upward.

b) The County Council recognise that there had been no mental capacity assessment in relation to Michael Upward's ability to make decisions about health and welfare. Although the assessment in February 2014 records that Michael Upward agreed to accept formal care provision to assist with showering once a week the County Council highlight that good practice would have been to carry out a mental capacity assessment and so too the change to having formal carers on more than one occasion.

Learning and Development Point 4

Mental Capacity Assessments

- **The application and use of the MCA should be reviewed recognising its use and its requirements are not just the responsibility of the County Council.**
- **The SAB should review current local guidance and where necessary revised it to ensure wide understanding of its requirements**

c) The Buddi system (a global positioning satellite (GPS) tracking alarm) was introduced by Worcestershire Health Care Trust (WHCT) in July 2013. Michael Upward's consent to having the Buddi was sought and given in May 2013. At this point in time mental capacity may not have been a consideration but given the progressive nature of Michael Upward's condition periodic consideration would have been good practice. The use of a Buddi or other similar tracking devices is for some, a contentious issue that raises questions of personal freedom. A DoLs assessment was not considered at this point presumably because Michael was not

in a hospital or care home setting and this took place before the Supreme Court judgement of March 2014. The Buddi system is dealt with in more detail at paragraph 7.4.11.ii

d) On 14 November 2014 a home visit Buddi assessment was conducted by the County Council with Michael Upward, although it was Mrs Upward who answered most of the questions due to Michael Upward's level of cognitive impairment. The broader issue of capacity was not considered or referred to.

e) Although the Council's own specialist home support service carried out a risk assessment visit in March 2014 to draw up a delivery plan for their specific service there was no consideration of any mental capacity issues.

f) In commissioning the respite care for Michael Upward in April 2015 there was no consideration by the County Council of the Mental Capacity Act nor any consideration of the potential for Michael Upward's personal freedoms being infringed.

g) Even if consideration of the MCA and DoLS had resulted in the status quo the task of doing this would have given a focus to his up to date needs and situation and would have been available to all the care staff any future service provider.

7.4.11. ii. **The provision of the Buddi**

a) A Buddi is described as a 'go anywhere, anytime' personal emergency service that uses global positioning satellite (GPS) technology. It detects if the person wearing the Buddi has fallen, it can locate where the person is and also gives the wearer access to the 24hr monitoring service who can talk to them via the Buddi to establish the kind of assistance they require, or call the person looking after them. It helps people to maintain their activity level and maintain their independence while giving carers and family confidence that their loved-one is safe.

b) The County Council's record regarding the Buddi states, "*The majority of Buddi's were provided by Occupational Therapists in Older Adult Mental Health Teams and Adult Social Care have no record of whether Mr Upward had mental capacity or not at the time of the Buddi being provided, nor is any record held by the organisation about why a Buddi was provided. During the time that the Buddi was provided to Mr Upward the equipment and the service was provided free of charge*."

c) The use of a Buddi system was recommended to Mr and Mrs Upward in November 2012 following a home visit by the Occupational Therapist and was issued by the WHCT on 15th July 2013

d) It is not clear what information and advice regarding the use/benefit of the Buddi was given to Michael Upward or Mrs Upward

e) The issue of the Buddi is picked up in the chronology on 24th November 2014 where the County Council record "*Buddi assessment conducted with Mr. and Mrs. Upward – Mr. Upward is not taking the dog out for walks as often as he used to, he now takes the dog for a walk approximately once a week. He goes on a set route which he knows well and has not experienced any difficulties with falling nor with finding his way home. They have not had to ever use the Buddi."*

f) The County Council record continues, "*I discussed that he does not meet the eligibility criteria for the continued funding for the Buddi from the County Council*".

g) The County Council comment in their chronology that they "*have been unable to locate a formal eligibility criteria for a Buddi and following discussion with Manger 10 have been informed that there was no documentation related to the eligibility criteria for the provision of Buddi*". When questioned further about the charging policy for the Buddi the County Council responded "*Buddi's initially provided via assistive technology which initially incurred no cost, Commissioners in 2014 decided that service users would be subject to a financial assessment and an assessed charge for any assistive technology".* This then resulted in the Buddi being given back by Mrs Upward to the Council as its provision would no longer be paid for by the County Council

h) It appears that the eligibility criteria for the Buddi was based on financial considerations.

i) The Buddi was ultimately collected on 18th February 2015 by a social worker and returned to the office.

j) There is no evidence that the potential of the Buddi with its automatic registration of Michael Upward's location was fully explained or worked through and perhaps its full use and value was not fully explored.

k) The original provision of the Buddi and its purpose was unclear; its continued use was unsupported; the decision to remove the service uncoordinated and the basis of the decision to change a service is not properly recorded. The timing of its removal was, to say the least, unfortunate.

l) Modern technology such as the Buddi and similar aids to daily living have tremendous value in the support of individuals and their carers living in the community and it can give significant confidence to carers. The benefits of minimising risk are well proven. In this instance its use appears wasted.

Learning and Development Point 5

Use and issue of technology

- **The availability, the issuing and information to individuals (and carers) who are supported with telecare should be reviewed, particularly where this has a direct impact on personal safety and is a part of managing risk.**
- **The eligibility for any item should be clearly set out and if removal is considered careful account should be taken of all known information and circumstances.**

7.4.11.iii. **Carers Assessment**

a) As from 1st April 2015 the law regarding Carers' Assessments has changed and sets out legal requirements regarding carers' needs and eligibility. Any assessment conducted by the County Council was prior to this legislation.

b) Apparently a carers assessment was offered by the Admiral Nurse Service on 14th August 2013. At that time Mrs Upward did not wish to go ahead with it. A carer's assessment was up by the County Council on 4th September 2013 and the view was taken that the caring role was sustainable and that Mrs Upward was able to leave Michael Upward alone at this time and pursue her employment and own pursuits. It did identify that there may be a need for respite care in the future.

c) The care support plan concluded that no further support was required for Mrs Upward as a carer and the case was closed. In June 2014 Mark Upward in conversation with the County Council expressed concern that his mother rather downplayed the situation and the impact of her caring role.

d) However, the County Council did not pursue a revised a carers assessment then or at any point in the future.

e) The County Council have stated that if a new carer's assessment had been initiated prior to the respite care this would have provided new information for the County Council and subsequently been provided to Care Home 1.

f) The Council should have initiated an assessment of Mrs Upward.

Learning and Development Point 6

Carers' Assessments

- **Carers' assessments are an integral part of supporting individuals. Carers now have a legal right to be assessed according to their own needs. All agencies, in the course of reviewing an individual's needs, should be aware of the needs of carers and the requirements of the Care Act 2014 in regard to the carer's right to an assessment and where eligibility is met the provision of services.**

7.4.11.iv **The specialist home care provider service**

a) The provision of the specialist home care provider service, set up specifically to provide care in individuals' homes, was put in place by the County Council following an assessment in February 2014 on the basis of one visit a week to support personal care (showering). Following a request in August 2014 this was increased to 2 visits a week from 5th September 2014.

b) The service specification states "*The service is long term, person centred and outcome focused, based on what the individual wants to achieve within their life. The service helps the most vulnerable people live their lives in a way that respects their individuality and ensures that their personal history is an integral part of their care. The service believes that assessment for ongoing care/support cannot be defined by a one –off assessment but requires observation over time and requires a flexible and creative approach. The service works in partnership with colleagues from community mental health teams, carers, voluntary and independent sector*."

c) As part of this SAR daily records were requested from the specialist home care provider service for review. The service stated that these records were not available as these were normally kept at the individual's home and that Mrs Upward had not been able to find them.

d) However, since receiving the IMR this was followed up with the family by the independent Chair and the records have now been located and reviewed with the following findings:

- Michael Upward often went up the shop and back again independently
- Michael Upward was compliant with showering
- An indication of things that Michael Upward was physically able to do and what he needed prompting with.
- That Michael Upward only required verbal prompts and that he was physically quite an independent man.

g) The keeping of daily records of care in this way is very common and not unusual. It provides a practical way of keeping contemporaneous notes for each individual, and these notes are also available to the family The aims of the service are set out at para ii above.

h) It should also be recognised that front line workers providing this type of service are getting a unique insight into the needs of an individual, and their carer. This is a legitimate and appropriate way of contributing, from time to time, to any ongoing or updated assessments. So long as this is made clear to the individual concerned and their carer. It makes full use of all available knowledge, insight and understanding. This is in line with the specialist home care provider service's own stated objectives.

i) This kind of information in summary form would indeed have been valuable to the Care Home Provider.

j) There is no doubt that the specialist home care provider service was an important and valued part of providing care to Michael Upward and support to Mrs Upward. Its stated aims in the service specification are clearly an important element of providing services to people with dementia

k) In this situation some of the information about Michael Upward could have been shared to fulfil the full elements of the partnership operation of the service. Based on their current good practice there could be some ways of developing this.

Learning and Development Point 7

Specialist and Other Care Providers

- **All specialist home care providers or other community support and residential, nursing or respite care should be asked to review their information requirements**

7.4.11.v **Reviewing of Case Work**

a) The County Council have a system of reviewing individual case work. The basis of this is that the case is held within an area team. The assessment determines the need for respite and a carer's assessment is undertaken. Once respite has been provided and it has been identified that this is an ongoing need via a review of the service the case is then sent to Central Reviewing Team (CRT) who do an annual review of both the adults and carers needs. During the year CRT will arrange any planned respite. If there is a change in need during the year then the case is sent back to area teams to reassess.

b) In the situation of Michael Upward, this appears to have been confused. The County Council IMR narrative comments "*It was inappropriate to provide additional support without a full review of the care taking place and once provided this additional support should have been reviewed after 4 weeks*".

c) Nonetheless the care plan that was in place was reasonable to provide continuing support to Michael Upward and Mrs Upward, of which the provision of respite care was an appropriate addition.

d) However, it is not at all clear how in this situation new or emerging information is dealt with or used to inform revised assessments or care plans. These additional points were factors, notably:

- Mrs Upward's reporting phone conversation with Manager 2 on 2nd February 2015 saying that Michael had been wanting to go out more frequently and increased continence issues
- a letter from Mrs Upward on 23rd March 2015 about increased levels of need, though not in relation to any wandering concerns
- a further phone call on 8th April that Michael Upward was becoming increasingly resistant to help from Mrs Upward

e) These factors were never drawn together in an updated assessment.

f) It would seem that the Council was unaware of the visits of the Admiral Nurses to support Michael and his wife.

g) All this was put together in preparing this SAR. It was not clear from the case recording and none of it was used to inform the care plan sent to Care Home 1.

h) Therefore even before any assessment should have been sent to the Care Home Provider for the period of respite a joined up approach to understanding Michael Upward's developing needs should have been used. There does not appear to be any clear accountability and this led to poor information being made available to brokerage and then to Care Home 1.

Learning and Development Point 8

Joined Up Assessments

- **Consideration should be given to the Care Act 2014 requirement for joined up assessments that are appropriate, proportionate, relevant and timely.**

7.4.12 To re-cap:

- The Mental Capacity Act was not fully considered and applied
- The Deprivation of Liberty Safeguards was not considered by any agency
- The use and removal of the Buddi was handled poorly in complete isolation

- The specialist home care provider service were operating in apparent isolation
- The Admiral Nurse service was not considered
- There was no clear thread of accountability in relation to case work assessment or decision making

Q1.5 What Care Plan was put in place as a result of the assessment (by the County Council)

7.5.1 Michael Upward received a personal assessment in August 2013 at which both he and Mrs Upward were present, it is unclear if a care plan was drawn up as a result of this assessment however in October 2013 Mrs Upward decided to make private arrangements to help support Michael Upward at home and Michael Upward's case was closed

7.5.2 Following a request by Mrs Upward at the beginning of February 2014 a personal assessment of Michael Upward was made on 13th February 2014 during a home visit. As a result weekly shower were organised from the specialist home care provider service. A care and support plan for this service was drawn up on 6th March and the service started from 17th March.

7.5.3 This care and support plan was reviewed on 2nd May 2014 via telephone call with Mrs Upward. There was no change to the support plan (ie the service provided by the specialist home care provider service) but Mrs Upward reported that Michael Upward's cognitive difficulties seemed to be deepening and flexible breaks were discussed as a resource to consider should it become difficult to leave Michael Upward safely. The idea of residential respite care was also discussed and Mrs Upward was advised to contact the Access Centre if she and Michael Upward wished to arrange residential respite.

7.5.4 The County Council IMR chronology records that on the 6th June 2014 Mark Upward contacted the County Council by phone and followed up with an email on 19th June. He was keen to understand the options open to his mother "now and in future" for managing Michael Upward's Alzheimer's. He asks for information on how care for people with dementia may develop and the process for calculating

the costs. He asks what information the County Council need to ensure that they are kept up to date with developments and to fully understand how Michael Upward's condition is developing and the impact it is having on his mother.

7.5.5 Mark Upward states that he was concerned that Mrs Upward does not give the County Council the right information to help assess the situation and that she tends to play down the problems she faces and thinks she should just be coping with the situation. The County Council responded to Mark Upward in a letter that outlined the support that had been arranged and what support could be offered in the future.

7.5.6 As has been recorded elsewhere in this report the County Council did not complete any comprehensive assessment (including a mental capacity assessment).

7.5.7 On 11th August 2014 Mrs Upward made a request for an increase in the shower visits to twice a week. The request was agreed to and it started from 5th September 2014. There is no record of the written care and support plan being updated at this point.

7.5.8 The next contact that Mrs Upward had regarding any assessment was in November 2014 when the County Council requested a review of the Buddi. This review was conducted on 24th November and the outcome was that the County Council determined Michael Upward did not meet the eligibility criteria for the continued funding of the Buddi. The County Council gave Mrs Upward time to consider the position and the option of making private arrangements and Mrs Upward was given a list of providers of GPS locator systems. In February 2015 Mrs Upward confirmed that they did not want the Buddi and made arrangements for the Buddi to be removed on 18th February 2015.

7.5.9 The record of the Buddi assessment on 24th November does capture that the specialist home care provider services were used twice a week to support Michael Upward. It also records that Mrs Upward had undertaken a carers assessment. However, the last carers assessment was carried out in September 2013. The carer support plan indicated that no further support was required for Mrs Upward

as a carer at that point and the case was closed in October 2013.

7.5.10 There is no record of any later carers assessment being carried out.

7.5.11 There is a note that Michael Upward's care and support plan was reviewed on 26th November 2014, following the Buddi assessment. This document (entitled Personal Assessment) does record that carers from the specialist home care provider service assisted with showering twice a week.

7.5.12 On 16th January 2015 the County Council have recorded that Michael Upward's care and support plan was reviewed and updated. In reality old and existing information was re-presented. This update was done without any reference to Michael Upward or Mrs Upward but on the same day an update was sought from the specialist home care provider service.

7.5.13 The updated personal support plan states "taken from previous assessment" in the sections on outcomes for decision making and communication and outcomes for acquiring and maintaining appropriate accommodation. It also states incorrectly that Michael Upward was receiving once a week shower visits from the specialist home care provider service. It also states that Michael Upward is using a Buddi when he goes out: it does not mention that the Buddi was going to be removed.

7.5.14 This review made no mention of the role of the Admiral Nurses in supporting Mrs Upward and who may well have been significant in providing information about the impact of caring on her and a more up to date analysis of Michael Upward's general situation. It is disappointing that this invaluable work was not brought into the picture.

7.5.15 The County Council's own subsequent reflection recognises the deficiencies of this update. In reality the consequent care and support plan was inadequate and not fit for purpose.

Learning and Development Point 9

Care Planning – Reviews and Assessments

- **Assessment in care planning is the cornerstone of good practice in Social Care and Health. Consideration should be given to how the skill and analysis of professional social care and health staff can be drawn on to ensure that care planning is not just a commentary on the information given.**

Q1.6 What pre-placement assessments were completed by Care Home 1

7.6.1 It is standard practice for the Care Home Provider to have a pre-placement visit for both the individual concerned and their immediate carer a short time before the date of care commencing. In the case of Michael Upward the original booking for the pre-admission visit on 19th March 2015 was cancelled due to a diarrhoea and vomiting outbreak at Care Home 1.

7.6.2 The pre-admission visit was held on 13th April 2015 which was 2 days before Michael Upward's planned admission 15th April. Mrs Primrose Upward accompanied her husband to the visit.

7.6.3 The material provide by the Care Home Provider gives both narrative and comment of what occurred during this visit and copies of papers completed on that day.

7.6.4 The risk assessment and other papers completed by Care Home 1 were as follows:

Description	Typed or handwritten	Dated	Signed
Care Plan for Physical Care	typed content	13 April 2015	signed by AD not signed by Michael Upward though there is space to do so
Care Plan for Eating and Drinking Care	typed content	13 April 2015	signed by AD not signed by Michael Upward though there is space to do so
Moving and handling assessment	filled in by hand	13 April 2015	signed by AD
Physical dependency assessment	filled in by hand	13 April 2015	signed by AD
Waterlow assessment	filled in by hand	13 April 2015	signed by AD
Falls risk assessment	filled in by hand	13 April 2015	signed by AD
Continence assessment	filled in by hand	13 April 2015	signed by AD
Nutritional assessment	filled in by hand	13 April 2015	signed by AD
Risk assessment for medication	first page missing Michael Upward's name and details and any signature 2nd page partly typed.	13 April 2015	Signed by AD but not by Michael Upward or Mrs Upward though there is space to do so.

7.6.5 In addition, the Care Home Provider documents provided for the SAR state that Mr Upward was "*noted as being able to consent to the respite placement at this time (Appendix 6*)". However Appendix 6 of their documentation actually refers to consent to photography and information sharing.

7.6.6 A physical assessment and care plan including risk levels was included with the Care Home Provider IMR. It refers to his assessed risk levels as follows:

Physical Dependency Score: 9	Risk level: Low
Falls Risk Score: 8	Risk level: High
Moving and Handling Score: 7	Risk level: Low
Waterlow : 8	Risk level: at risk
Continence Score(s): 13	Risk level: medium

7.6.7 It is already abundantly clear that material given to the Care Home Provider by the County Council was inadequate and insufficient and that a Mental Capacity Act Assessment should have been fully considered. However, it might have been expected that in the proforma formatted tools/forms used by the Care Home Provider, listed at paragraph 7.6.4, there should have been some consideration of Mr Upward's current psychological, mental health, emotional needs or the impact that these might have on how his Alzheimer's condition was developing. This is concerning given the nature, condition and the likely needs of individuals being cared for by the Care Home Provider. The County Council information did give some pointers to areas of concern (see paragraphs 7.4.8 and 7.4.9).

7.6.8 While some of these forms were completed in the presence of Mr and Mrs Upward, some were not, which of itself is not a key issue.

7.6.9 It is not clear if these forms were made available to any other staff on duty at Care Home 1. However, there are no references to any of this information in any

subsequent recording or statements

7.6.10 It is stated by the Care Home Provider that "*the purpose of the pre-admission assessment visit for Michael Upward would be to discuss his needs with him and his wife so that a care plan could be drawn up in advance to prepare for his stay*..."

7.6.11 In section 7.4 point 1 onwards consideration of the use of the Mental Capacity Act is set out. As stated there consideration of Capacity should not solely be the responsibility of the local authority: all those involved in care and responsibility of individuals should have this at the forefront of their practice. While there should be a presumption of Capacity there should not be a tacit assumption of Capacity. It is of concern that the provider in this instance did not, in their own regard, consider Michael's Capacity in relation to the period of respite care that was about to take place.

Learning and Development Point 10

Pre- Admission Role and Purpose

- **The role and purpose of any re-admission visit and how the information gathered is to be used should be clear.**
- **All providers should be supported and encouraged to review how they consider issues of capacity for individuals within the meaning of the Mental Capacity Act.**
- **A presumption of capacity should be tested and not simply be an assumption of capacity**

7.6.12 The available social services assessment is dealt with in paragraphs 7.4.8 – 7.4.10 above, but there are relevant points to highlight here.

7.6.13 The assessment was received on 9th February 2015 and placed in the respite folder. Information contained in the assessment included:

- There are several references in the document to “taken from previous assessment"
- *“a stranger or someone who does not have insight into Michael Upward’s cognitive difficulties may be misguided in thinking he does not have significant mental health issues"*
- “*Michael Upward is at risk of making unwise and maybe unsafe decisions which might put him in a vulnerable situation"*
- *"Use of the Buddi when Michael Upward takes local walks or visits venues in the town independently. Mrs Upward feels confident that her husband is able to go out independently and safely in the knowledge that he carries the Buddi"* (there is no reference to the decision to remove the Buddi)
- "*Michael Upward also continues to go out and about in the town"*
- *"The specialist home care provider service team have been providing support with one shower a week since mid March" (*this was incorrect)
- There are no actions required to implement or revise the support schedule

7.6.14 While this is neither up to date nor comprehensive, it does contain some important trigger points that should have been used to prompt discussion in the pre-admission visit on 13th April. It was not read until the next day, so this opportunity was missed.

7.6.15 The retrospective comment from the Care Home Provider in relation to this assessment is as follows*. “The assessment detail made general reference to how Michael Upward had liked to go for walks independently, visiting cafes and places locally that he knew and was known to, but did not state whether he still continued to do so. This information was therefore not captured in his care plan and any risk assessments during his stay”* at Care Home 1.

7.6.16 Further to this the County Council record of events states that the County Council Manager 2 phoned Care Home 1 and spoke to worker AD on the day of the pre - assessment visit at around 12:50 to check that the pre-admission visit had taken place and the County Council records show that Manager 2 recorded “*staff aware*

that Michael Upward's dementia is progressing and that the picture is different from that stated in the last review"

7.6.17 In follow up to this point the Care Home Provider has stated that worker AD is "*adamant that she did not speak with anyone from the County Council about the assessment and how it had gone on the day of the 13 April. …. she is convinced she did not take any such phone call. As the person in charge that day it is unlikely the call would be put through to anyone else if that is who they requested to speak to."*

7.6.18 This contrary information has not been possible to resolve.

7.6.19 There is a further comment in the narrative that at the time of the pre-admission visit staff who saw Michael Upward and Mrs Primrose Upward remarked that they looked like visitors to the home not that Michael Upward would be coming in for respite care. There is nothing intrinsically wrong with these comments. It is positive that staff were constructive about Michael Upward however, there are subsequently too many occasions when it is quite clear that staff – on duty- were not aware that Michael Upward was in fact a resident in their care, not a visitor.

7.6.20 It is some concern that the post event narrative recorded in the IMR does not constructively and critically reflect on some of the areas of concern about this pre-admission visit. The subsequent narrative states, "*The care plans drawn up for Michael Upward on the 13 April from the pre-admission assessment and the information provided from Primrose Upward are well written in a personal and individualised way reflecting all the information that was gathered at that point. Michael Upward is described as a "lovely gentleman who lives with Alzheimer's disease". There is sufficient detail to inform staff of Michael Upward's needs, as they were presented, likes and dislikes and how much assistance he required. The language used describes Michael Upward in a warm and sensitive way which would allow staff to see his positive qualities and ensure they were aware of how to maintain his dignity during personal care. There was appropriate and detailed guidance on how to manage the risk of any falls as he would be unable*

to get up from the floor unassisted. The risk assessments were completed fully and the level of risk described and provided for within the care planning. There was no indication that there would be an issue with Michael Upward potentially missing his wife during the respite stay nor of him attempting to leave or abscond. Had there been anything in the content of conversation or Michael Upward's behaviour or responses that indicated during the assessment that this was a risk or had this risk been brought to the attention of staff, this would have been explored with appropriate risk assessments conducted and, if the level of risk considered capable of being managed, risk management measures put in place." It continues *". There were no other assessments provided from other agencies involved with Michael and Primrose Upward.*

The missing information in relation to Michael Upward being at risk of independently leaving his home environment was a crucial piece of information that was not available to Care Home 1 staff to make an informed decision on whether they could accommodate his needs. Had the home known there was a risk of Michael Upward leaving the premises it is unlikely that the placement would have been accepted as Care Home 1 was not a secure unit."

7.6.21 This view is now repeated in the statement by worker MC to the Coroner on 9th September 2015 as follows, *"However to repeat, based on the information now available, I am confident that Mr Upward would not have been accepted for respite stay at Care Home 1."*

7.6.22 In the process of writing this SAR, Mrs Upward gave further information via a planned telephone call of approximately 50 minutes regarding this pre-admission visit. This had previously been discussed with her son Mark Upward and some preparatory areas sent to prompt discussion. Mrs Upward recalls the pre-admission visit. She had driven there with her husband. She recalls completing some of the papers although not necessarily all the detail and then being taken on a tour of the establishment, most particularly where Michael Upward would be staying. She thinks the visit lasted approximately 45 minutes including the look around and coffee. Mrs Upward's recollection of the visit is that home was nice and well presented, she commented that she did not feel that the person she met

was particularly warm or welcoming and that she felt that she was treated in a somewhat officious manner.

Comment and analysis

The pre-admission visit is a critical juncture for anyone being admitted to Care Home 1 for whatever purpose. The fact that the visit had been delayed seems to have no bearing on its outcome. The basic requirements that were worked through using the proforma risk assessments provided a good basis for the care plan and covered a number of key risks and care requirements. The narrative from the IMR supports this.

However, there are significant and important gaps. These are surprising from an establishment that on its own statement sets out that 14 people requiring respite care between January 2015 and April 2015 suffered from dementia and that over 50% of their residents (19 out of 38) were considered at risk of leaving the building.

With this background and notwithstanding the standard proforma paperwork that was used, it is extremely surprising that no questions were asked at this pre-admission visit that related to the impact of Michael Upward's Alzheimer's. There was no risk proforma on the impact of any confabulation or searching behaviour or more general walking or wandering. Primarily there was no consideration of this being Michael's first occasion in respite care or being the first time that he was being cared for by anyone other than his wife or a known close relative. It was a very short step indeed to conclude he would be missing his wife and as result of his stated condition that he might search for her. For all the faults with the County Council's care and support plan faxed to the Home on 9th February the two key statements below were key

- *a stranger or someone who does not have insight into Michael Upward's cognitive difficulties may be misguided in thinking he does not have significant mental health issues*

- *Michael Upward is at risk of making unwise and maybe unsafe decisions which might put him in a vulnerable situation*

The onus of exploring this rests squarely with the staff at Care Home 1. In part it should have been informed by a proper and up to date assessment from the Council (which it was not), in part informed by the establishment's skills and knowledge of working with people with dementia and, in part informed by the pre-admission visit and close scrutiny during the early period post admission. It seems very little of this happened.

The Care Home Provider have acknowledged this in the intervening period and the revised material submitted after the Panel Meeting on 7th September 2015 states "*It is recognised that the way in which Worcestershire and other Social Services assessments are reviewed by Care Home 1 and other Care Home Provider Homes, in the light of this incident, required additional strengthening so that, where appropriate, the information and content is discussed and questions in relation to the person being potentially referred are explored to further ensure the assessment information provided is current, up to date and sufficiently detailed before any decision is made to accept the referral." "Full and complete use of all the respite care documentation as well as completing the generic risk assessment to include information on potential risks of a resident to leave the building. Staff require further training on ensuring there are even more detailed and timely recording in the resident care notes so all information is available to staff to inform on any changes in presentation and therefore care needs. Senior care assistants must ensure that information on a resident's presentation, behaviour or other concerns in relation to care needs is transferred to the resident care notes and not only entered in handover or communication books."*

The fact remains that from the information set out at the time and the apparent conduct of the pre-admission visit, there was no real questioning or professional inquiry in Care Home 1's process to support a full care plan or risk assessment. Specifically when this related to an individual who had a known progressive condition and who in many ways is described as denying his condition. The experience and skill that would be expected at an establishment that has, as one of its stated roles, to provide respite care for people with dementia was lacking.

Learning and Development Point 11

Assessments: Gaps and Conflicting Information

- **In the process of care planning any gaps, contra-indicators or differing opinions should be drawn out and considered.**

7.6.23 In summary, the real opportunity to understand Michael Upward's needs and the risks associated with this placement were missed at this pre-admission visit, but also missed by the Council. There was nothing to suggest that this placement was inappropriate.

Q1.7 What Care Plan was put in place as a result of the pre-placement assessment. Were risks considered and if so, what actions were put in place

7.7.1 As stated above, a number of care plans/ risk papers were completed. All are dated 13 April 2015 and all those that have space for a signature are signed by AD. This is set out at paragraph 7.6.4

7.7.2 These care plans/risk papers provide a good basis by which physical care and health on a day to day basis can be managed. They cover areas of risk in daily living, medication and personal care needs.

7.7.3 There does not appear to be a core care plan although there is a document "Agreement to Care Plan" signed by Michael Upward (although undated) that consents to the core care plan linked risk assessments. However the Care Home Provider describes the suite of plans/assessments as being the core care plan.

7.7.4 Therefore while there was some good individual personal care recording, including daily living and falls management basic requirements, there was no bringing together of the care elements of the multiple care plans into something that synthesised the total impact of Michael Upward's needs. There was no consideration or enquiry into the impact of Alzheimer's on Michael Upward, the context of him being in a strange and unknown environment, with carers whom he

had never met, other residents who would be exhibiting their own particular needs and in a geographic location that was new to him was never considered.

Q1.8 Was all relevant information shared with all parties

7.8.1 There are no indications in the IMR from the Care Home Provider about how the above information (subject heads care plan and risk analysis) were shared or made available to the care staff in the establishment.

7.8.2 Comments in paragraph 7.6.18 indicate a recurring theme in which some staff were unaware that Michael Upward was receiving respite care but assumed him to be a visitor.

7.8.3 There is discrepancy in how this is presented. The statements from staff make it clear that they actually thought Michael Upward was a visitor. Whereas subsequent analysis from the Care Home Provider refers to staff knowing he was in respite care but thinking he looked more like a visitor.

7.8.4 Processes for sharing information in a shift-work based workforce need careful mapping by the Care Home Provider and good processes for information sharing and hand over should be implemented.

Learning and Development Point 12

Information Regarding Individuals

- **Consideration should be given to ensure that information held regarding individuals is relevant and accessible to staff.**

8.0 Question 2: Multi Agency Assessments and information

sharing. There were a number of agencies providing health or social care to Mr Upward

8.1 This section will bring together the work of all the agencies that were providing either health or other support to Michael Upward.

8.2 The NHS Clinical Commissioning Group (CCG) responsible for commissioning primary care has provided an IMR that records contact with Michael Upward by the medical practice with the current GP. This record has to be read in conjunction with the WHCT IMR as WHCT manage the Enhanced Care Team (ECT).

8.3 There are a number of follow up records. Those that directly relate to the circumstances of this SAR are recorded below:

- 19th February 2014 the GP had a telephone consultation in which it is recorded "*there are some increasing problems where Michael Upward can be more awkward and verbally aggressive at times. No wandering, and doesn't become lost*". Referral was made for review by Consultant Older People Psychiatrist.

- 10th March 2014 request for blood samples as Michael Upward had refused to have bloods taken at the clinic.

- 12 March 2014 MMSE of 7/30. Despite the low score Michael Upward was still functioning well and risk of wandering was considered to be mild. Michael Upward was walking the dog regularly.

- 14th March 2014 the practice nurse conducted a dementia review and bloods were taken.

- 19th March 2014 the GP reported to Mrs Upward the results of the blood tests and recommended further blood tests and an ECG.

- 21st May 2014 Dementia annual review

- 23rd May 2014 review by Consultant to Older Adult Psychiatrist, referral made to Admiral Nurses Michael Upward noted to be able to walk to the local shop and buy the newspaper – although sometimes he bought the wrong paper. He could walk the dog and there were no concerns about getting lost

- 17th July 2014 review of Buddi by Occupational Therapist

- 29th September 2014 Consultant Older Adult Psychiatrist. Noted to be at moderate stage of Alzheimer's and displaying some irritability and agitation, continuing to take the dog for a walk, sometimes by himself, in the local area and had not got lost. Risk identified as agitation.

- 15th January 2015 – Michael Upward arrived at GP surgery but was unsure why. Sent home and GP spoke to Mrs Upward on the phone

However it should be noted that the primary care offered to Michael Upward throughout this period was consistent, responsive and appropriate.

8.4 GP records state that Michael Upward was noted to have a cognitive problem in 2009 and was subsequently diagnosed with Alzheimer's in 2010. There was then apparently a period soon after the diagnosis of Alzheimer's when Michael Upward expressed unwillingness to see the mental health consultant but the GP persuaded him to continue his follow up and he was subsequently seen in May 2014 and September 2014 by the mental health team.

8.5 Reviewing the chronology, and despite Michael Upward's reluctance to engage with the mental health team, there is clear evidence that the GP medical practice made continued and appropriate attempts to remain in contact with Michael Upward.

8.6 Telephone consultations occurred regularly with Mrs Upward or on occasions with Michael Upward from the GP.

8.7 General health issues were identified and treated and concerns regarding the progression of his Alzheimer's condition were referred to the appropriate service.

8.8 In all it is clear that both Michael Upward and Mrs Upward received considerate and attentive follow up from the GP practice.

8.9 There was one glimpse of further difficulties in January 2015, when Michael Upward arrived at the GP practice for no apparent reason and was given directions and sent home. Michael Upward was not seen by any GP on that occasion but on reviewing the circumstances of this the GP has stated that,

"*on reflection perhaps this incident should have triggered a referral to the consultant in older adult psychiatry to re-assess Michael Upward's situation*".

8.10 In the chronology 29th September 2014 the Older Adults Consultant Psychiatry letter says,

"*Noted to be at a moderate stage of Alzheimer's dementia and displaying some irritability and agitation. Mrs Upward advised to use distraction techniques*."

"*Mr Upward continued to take his dog for a walk, sometimes by himself, in the local area and had not got lost. Buddi system lost at this time and a new system was reordered Risk was identified as agitation*"

8.11 As a part of this review the CCG have acknowledged that this letter was shared with the GP but not copied to other professionals, particularly they have said, "*Apart from the GP this clinical letter was not copied to any other professionals. Copies should have been sent to Admiral Nurses and Social Care as the specialist home care provider agency was involved with supporting his personal hygiene.*"

8.12 The subsequent learning and development point picks this issue up. Simply scattering further information may not of itself improved agencies knowledge and information. It would be better to ensure that information is shared within some context particularly as part of reviewing or care planning.

Learning and Development Point 13

Sharing Records

- **Consideration should be given to determining what records need to be shared across agencies involved in the support of an individual. It is recognised that it would not necessarily be helpful to share all records all of the time and any information sharing protocol should focus on the sharing of material that is essential to manage risk or potential safeguarding issues.**

Q2.1 What assessment and care was provided by each agency. Were these assessments shared with Adult Social Care in order for them to provide an outcome focused service to Mr Upward and to Mrs Upward as his main carer.

8.12 Relevant information was not shared with Adult Social Care but nor was up to date information shared by sections of the Council either. While individual agencies were responding to Michael Upward and Mrs Upward there was not real co-ordination of their approach, no sense of a seamless service and most importantly no collation or aggregation of any of the key risks to either Michael Upward or Mrs Upward in the demands of the day to day care that she was providing to her husband. Consequently, none of the information from health care was shared with the Care Home Provider, indeed the health care agencies were totally unaware that a period of respite care was planned.

8.13 GPs are not routinely made aware of respite care. The narrative of the CCG IMR states that the GP had not been informed of the planned respite care and was only made aware of it when telephoned by the Coroner's Office. This issue was discussed by the Independent Chair with the IMR authors and generally it was felt that this would not be standard practice unless the person receiving respite care was receiving ongoing care from the GP or required a home visit. It was felt that respite care for the duration of a week was no different to an individual going on holiday and that most people would not consider informing their GP in these circumstances. In any event the GP not being aware of the planned respite is unlikely to have contributed in any way to the circumstances of this SAR. The Care Home Provider have confirmed that it is not their standard practice to inform the GP in cases of respite care.

8.14 The Care Home Provider did not seek any information from Michael Upward's GP on the basis that all respite residents are automatically registered with the care home's local GP as temporary residents and there were no obvious health issues. However, an updated prescription was sourced for additional medication that was not supplied at the time of admission.

Specialist Home Care Provider Service

8.15 While the specialist home care provider service is run by Worcestershire County Council, the arrangements are conducted through a commissioning and contracting approach in which the specialist home care provider services are used for specialist provision of domiciliary care for older people who have been assessed by the Council as meeting its current eligibility criteria, have a diagnosis of dementia and are living in their own homes.

8.16 In addition to the weekly and later twice weekly home visits the specialist home care provider service staff also made contact with Mr and Mrs Upward as follows:

- A home visit to carry out a provider risk assessment for the provision of the service was made on 17th March 2014.
- 20th March 2014 initial provider visit to conduct a Service Delivery Plan
- 5th September 2014 home visit to review Service Delivery Plan due to increase requested

8.17 The daily log of the visits to provide personal care to Michael Upward has now been made available and provides a communication log for each visit between March 2014 and 15th April 2015. Records show that the log book simply includes what Michael Upward was like during visits, compliance with showering and what he was physically able to do and what he needed prompting with. Michael Upward only required verbal prompts: he was physically quite an independent man.

8.18 This service was clearly an important element in supporting Michael Upward and Mrs Upward and could be seen as both supportive and preventative. As stated in

para 7.4.11.iv much more could be made of the importance of a service like the specialist home care provider service, not just in the day to day provision but in the contribution that insight into an individuals' care needs and situation.

8.19 This front line service is of itself as important and vital as any other element of the assessment.

8.20 The records from the visit log book were not made available or shared elsewhere despite the specialist home care provider service's stated objective that "*The service believes that assessment for ongoing care/support cannot be defined by a one –off assessment but requires observation over time and requires a flexible and creative approach. The service works in partnership with colleagues from community mental health teams, carers, voluntary and independent sector"*

Worcestershire Health Care Trust

8.21 Michael Upward had been known by the Older Adult Mental Health Team since 2009 when he had investigations for short term memory loss. Michael Upward was subsequently diagnosed with Alzheimer's in January 2010 and received regular review and support until 17th October 2013

8.22 The service changed in 2011 and became the Evesham and Pershore Enhanced Care Team (ECT).

8.23 Involvement with Michael Upward was as follows:

- June 2010 – diagnosed with mild Alzheimer's. Mini Mental State Examination (MMSE) score of 25/30
- July 2012 - Discharged by ECT. Referred to Admiral Nurses
- November 2012 – reference made to "small risk of wandering and Buddi recommended

- May 2013 – Occupational Therapists visit Michael Upward to discuss Buddi system

- July 2013 - Buddi system taken to Michael Upward's home and set up

- 17th July 2013 – Discharged back to GP from ECT

- 14th August to 23rd August 2013 – notes of interventions and contacts with Michael Upward including Mental Capacity Assessment to consent to personal care completed by social worker

- July 2013 - Buddi system taken to Michael Upward's home and set up

- 17th July 2013 – Discharged back to GP from ECT

- 14th August to 23rd August 2013 – notes of interventions and contacts with Michael Upward including Mental Capacity Assessment to consent to personal care completed by social worker

- 14th August 2013 – carers assessment declined

- 9th October 2013 – Carers assessment had been completed and private care package was to commence

- 17th October 2013 – MMSE 7/30. Patient discharged back to GP

- 26th February 2014 – GP requests appointment. States does not wonder but requests medicine review in response to changing behaviour

- 12th March 2014 – MMSE 7/30 but still functioning and risk of wandering considered to be mild

- 12th May 2014 – Symptom profile made regarding continence issues

- 23rd May 2014 – Outcome of consultation on 12 March 2014 consolidated and planned to be reviewed in 2 months

- 26th June 2014 – Michael Upward seen in clinic. No changes made

- 28th October 2014 Michael Upward missed appointment and new appointment arranged for 26 March 2015

- 24th February 2015 letter sent offering new appointment on 23 April 2015 to replace appointment on 26 March that was cancelled by the department

- 6th March 2015 referral to continence services received from community staff nurse

8.24 The CCG IMR recognises that a clinical letter from the Older Adult Psychiatrist on 29th September 2014 regarding Michael Upward's health needs and mental health review was not copied to social services and the specialist home care provider service who were providing a service to Michael Upward at the time. There was however, no evidence in the GP records that the practice knew what other services were involved in supporting Michael Upward and his wife.

8.25 Along with the involvement of the GP, the WHCT had ongoing contact with Michael Upward and Mrs Upward as shown by the chronology. It might perhaps be said that they had the most technical knowledge of Michael Upward's condition. This was available to the GP but it was deemed clinical information and not shared with the County Council Adult Social Care.

8.26 This approach should be reviewed as it seems that it is in the best interest of individuals that information is shared and analysed and Michael Upward's clinical assessment was absolutely intrinsic to his social care assessment. The current approach exemplified by the Care Act 2014 makes clear that assessments should be seen as, and based on, proportionality and appropriateness. Certainly Michael Upward's Alzheimer's condition and its progression were of primary relevance to his ongoing social care and daily living needs.

8.27 It would appear that this would have enabled a holistic risk assessment to be drawn together. The siloed disciplines of social work and health care for people living in the community are of limited benefit.

8.28 The WHCT IMR sheds some light on the initial provision of the Buddi GPS system, which it seems was first discussed by an Occupational Therapist with Michael Upward and Mrs Upward in May 2013, with the Buddi being set up on 15th June 2013.

8.29 As recorded elsewhere, the whole issue of the Buddi was poorly managed from the outset.

Learning and Development Point 14

Sharing Clinical Assessments

- **Consideration should be given to how relevant information from clinical assessments is shared with other agencies involved in the care and support of an individual, ensuring that this is done in a timely and appropriate way to make certain that key factors are included in assessments, risk analysis and care planning.**

Q2.2 What risk assessments had been completed.

8.30 CCG:

- 21st May 2014 Dementia Annual Review

8.31 WHCT:

- 14 - 23 August 2013- notes of interventions and contacts including Mental Capacity Assessment to consent to support with personal care (completed by social worker)
- 23rd May 2014 Review by Consultant Older Adults Psychiatrist
- 29th September 2014 Review by Consultant Older Adults Psychiatrist

8.32 The County Council:

- 23 August 2013 - Personal Assessment carried out and MCA carried out regarding Client Charging and Assessment
- 4 September 2013 - Mental Capacity Assessment (on financial matters)
- 17 March 2014 – level 1 risk assessment (an environmental assessment completed by domiciliary care to outline what the property is like in terms of access and risk factors in the vicinity for carers to be aware eg down a dark alley with no lights)

8.33 Specialist Home Care Provider Service:

- 17 March 2014 - Home visit for provider risk assessment

8.34 The Care Home Provider:

- April 2015 pre-admission visit and risk assessment forms as detailed in paragraph 7.6.4.
- There is a note on the pre-admission form that Michael Upward has capacity to consent to care and accommodation.

8.35 Warwickshire and West Mercia Police:

- 17 April 2015 – 12:03pm Michael Upward reported missing. Identified as high risk. Resources deployed immediately.

Learning and Development Point 15

Consideration of Risk

- **Consideration should be given to ensuring that risks are considered for every individual**

Q2.3 Were risk assessments shared or risks analysed and discussed

8.36 There is no evidence that any assessment of any kind of risk was shared with any of the agencies involved in the support of Michael Upward.

Q2.4 IMRs to include any information shared with Care Home 1 and any gaps identified by Care Home 1

8.37 This is covered elsewhere. The County Council assessment was inadequate and no gaps were identified by Care Home 1.

9.0 Question 3: How robust and appropriate was the Care Plan and supervision received by Mr Upward whilst at Care Home 1. What steps were taken to monitor his safety while at Care Home .

9.1 As has already been established, there was not a robust and comprehensive care plan in place for Michael Upward while at Care Home 1. While this failure was due in part to the lack of up to date, accurate or comprehensive assessment from the County Council or from the specialist home care service provider (see above) the pre-admission visit did little to improve the situation.

9.2 From the information received there was no discussion with Michael Upward or Mrs Upward about the impact of his progressive condition. Consequently, there was no risk analysis of how his Alzheimer's might impact on his behaviour or emotional state, not least when in a new, and strange environment with all new people around him.

9.3 The additional material from the Care Home Provider IMR states
"Without any information indicating Michael Upward was inclined to leave his home without informing others, his generally pleasant and co-operative demeanour at the time of the pre-admission assessment at Care Home 1 on the 13/04/15, there was no indication of a need for a generic risk assessment to be completed on any risk of him leaving Care Home 1. There appears to have been no indication that there was a risk of Michael Upward deliberately attempting to leave the building or missing his wife. Therefore, this was not considered in the risk assessment process. It is more usual to be provided with this information from either a Social Services assessment or from relatives who may be concerned that it may occur during a stay at Care Home 1."

9.4 It continues, "*To be clear, no concerns regarding Michael Upward wanting to go out for walks and doing so without informing others or that his movements may need monitoring in case he went walking on his own were raised during the assessment. Similarly, nothing was said that Michael Upward may miss his wife. On the contrary, Michael Upward was aware that he would be staying at Care Home 1 without Primrose Upward. Michael Upward was content and sociable and appeared happy with the discussions at this time. He was not noted to be restless or anxious."*

9.5 The care plan and risk analysis at the Care Home Provider has already been described as incomplete.

9.6 The preparation of IMRs is an important element and has some real strength. The Care Home Provider provided a very detailed outline based on chronology and their own critical assessment of this situation. Their own statement says "*Therefore, a reasonable assumption appears to have been made, on all the information provided to Care Home 1, that there were no issues in terms of any behaviour that may pose a risk, including missing his wife or wishing to leave the premises."* While outside the scope of this review separate comments will be made to the SAB regarding the preparation and use of the IMRs.

Support for Michael Upward Between 15th – 17th April 2015

9.7 On the 15th April Michael Upward was brought to Care Home 1 by his wife as arranged. They arrived at approximately 3pm. Mrs Upward describes it as difficult to persuade Michael Upward to go into the establishment as he was quite resistant.

9.8 Care Home 1's records that were written on the 15th, 16th April and 17th April describe:

- 15th April – 3pm Michael Upward arrived at Care Home 1 with Primrose Upward. Spent time with wife doing itinerary etc, watched television and chatted, prompted with bed time routine, lay in bed reading (daily log entry written at 21:45)

- 15th April - 2 hourly checks maintained throughout the night and Michael Upward appeared asleep and comfortable. Awake at 06:45, declined to dress but had a cup of tea. (daily log entry written at 03:20 on 16th April)

- 16th April – Michael Upward enjoyed walking in the garden (daily log entry written at 20:00)

- Michael Upward had tried the garden gate (handover note, entry not timed or dated, believed to be 16th April)

- 16th April - Michael Upward taken to bed at 11pm but declined to stay in his room preferring to sleep in the lounge. Appeared to sleep well. (daily log entry written at 03:10 on 17th April)

- 17th April - assisted to bed and appeared to sleep well (daily log entry written at 03:45)

- 17th April - Assisted with care at 08:30, enjoyed breakfast at 09:15, took medication at 09:30 with prompting. Michael Upward implied he was leaving now but was reassured that his family had arranged for him to stay until 21st April. (daily log entry written at 17:15)

- 17th April - 10:30 Michael Upward seen at breakfast table speaking to another resident. At 11:30 it was brought to my attention that staff were unable to locate Michael Upward after a thorough search of the building (daily log entry written at 17:25)

9.9 The Care Home 1 IMR chronology records that there was an issue regarding Michael Upward's medication. It states that Mrs Upward "*Primrose Upward … had brought in the tablets in a blister pack that she had filled herself and AD told her that these couldn't be accepted as AD didn't know that what in them was what Primrose Upward claimed. Primrose Upward had to go home and return with the original packs of medication."* This is further backed up by the comments in the narrative "*AD acted correctly, following the Care Home Provider's medication policy in*

relation to medication for respite residents". The situation as explained to me by Mrs Upward was that her husband's tablets were contained in one of the over-the-counter type pills boxes in which tablets for each day, or parts of it, were organised, as would be used by many informal carers or individuals.

9.10 Mrs Upward is clear that she returned to the establishment with the required blister packs of tablets later in the afternoon of the 15th. Mrs Upward was leaving for holiday the next day (16th) and travelling to Essex.

9.11 In a statement written by AD on 22nd July 2015, it says "*Primrose Upward was agitated that she had brought in the tablets in a blister pack that she had filled herself …. Primrose Upward was in a hurry to get out of Care Home 1 to go on holiday"*

9.12 The available records state that Michael Upward settled following his wife's departure, watched TV and prompted/supported to bed.

9.13 There are no records that state what information was made available to staff during any handover period regarding Michael Upward apart from one record "*Michael Upward had tried the garden gate*". This is in the handover records but the entry is not timed or dated.

16th April

9.14 On the 16th April, the first full day that Michael Upward spent at Care Home 1, the daily record of events in the establishment provide some information regarding Michael Upward. It is recorded as follows.

- 15th April – (entry written at 21:15) "*Michael arrived at 3pm. Spent time with his wife sorting itinerary etc. Spent time in the lounge watching TV and chatting. Prompted with bedtime routine. Lay in bed reading book"*

- 16th April – (entry written at 03:20) "*Michael appeared asleep and comfortable when completing 2 hourly checks throughout the night. Awake at 06.45. Michael was offered help to wash and dress but declined any assistance. Hot drink given"*

- 16th April – (entry written at 20:00) "*Michael was given personal care during the afternoon. Clothes changed. He enjoyed walking in the garden then ate well at tea time."*

- Handover note (entry not dated):

Night – settled
AM – OK
PM – Likes a good walk - tried to go out the garden gate
Night – washed and dressed
AM – OK
PM – Fine

- 16th April - (entry written at 03:10 on 17th April) "*Michael was assisted to bed at 11pm but Michael declined to go in and came back out. Michael chose to sit in the lounge and go to sleep. Shown to the toilet, Michael appeared to be sleeping very well in the chair.*"

- 17th April -(entry written at 03:45) "*Michael was assisted to bed and assisted with washing and changing at3.40am. Slept well* "

- 17th April -(entry written at 17:17) "*Michael was assisted with care at 8.30am then came through for breakfast at 9.15am which he enjoyed. Lead care assisted with medication at 9.30am prompted (sic) needed. After Michael implied he was leaving now but I told him his family have arranged for him to stay 'til 21st April, Michael accepted this and left the table, I said feel free to sit elsewhere in the home – spoken to staff which was on duty to gather this entry"*

- 17th April – (entry written at 17:25) "*When entering the unit at approx 10.30am to speak to another resident Michael was back sat at the breakfast table, at 11.30am it was brought to my attention that staff were unable to locate Michael after a thorough search of the building"*

9.15 While the above record is adequate as a daily log and is common practice in busy establishments it would perhaps be helpful to develop some way of looking at this in the context more focused on the individual and their particular circumstances eg,

this was Michael Upward's first day in respite care and what might be the importance of some of the events summarised.

Learning and Development Point 16

Informing Staff and Using Information

- **There should be clear arrangements for staff to access information at all times**

9.16 Based on subsequent information from the Care Home Provider and the County Council the following detail has been assembled based on:

- statements from 4 care workers dated between 23rd April and 25th June 2015
- a further 4 statements from staff provided after the IMR was submitted and dated between 23rd April and 22nd July 2015
- From IMR submitted on 20th August 2015
- Additional information from the Care Home Provider submitted on 18th September 2015
- Various emails and questions sent to the Care Home Provider
- Copies of statements provided to the Coroner from the Care Home Provider staff

9.17 There are 2 further statements. One from AD (dated 22.7.15) and one from CA5 (undated). The statement from AD is somewhat perfunctory and gives little detail, including any comments on the following:

- That person's central role in the pre-admission visit,
- The conversation with the County Council social worker on 13th April after the pre-admission visit (which is not recollected by AD)
- A statement by the Care Home Provider worker AR in their chronology that refers to AD being asked for support to lead Michael Upward away from the front door on the 16th April.
- A conversation with contract managers late in the afternoon on the 16th April. Although AD does remember speaking with the local authority contracts visitors

on the 16th, AD states it was specifically around another matter and that they requested care plans which were discussed but that they do "*not recall them mentioning Michael Upward or expressing any concerns regarding him*"

9.18 It is not possible to draw on a single text that describes Michael Upward's activity and any issues on the 16th April and all the significant references were written on various dates after the tragic events of the 17th.

9.19 There are 2 striking elements of Michael Upward's first full day (16th April)

(1) Michael Upward mistaken as a visitor

9.20 On 6 separate occasions throughout the day Michael Upward was mistaken by staff as a visitor

(2) Michael Upward apparently attempting to leave or saying he wanted to find his wife

9.21 There are 3 occasions between 14:00 and 14:45 on 16th April when Michael Upward attempted to leave Care Home 1 through the front door. One at 14:00 when worker AR was asked by Michael Upward if he could get out that way, worker AR again at 14:20 saw Michael Upward try the front door and asked worker AD for support in leading Michael Upward away from the door and finally at 14:45 worker AR prevents the maintenance man from opening the door to let Michael Upward out of the building. At least one member of staff was aware of all three of these occasions.

9.22 In a statement made on the 22nd July 2015 worker AD states that at 19:00 on the 16th April the shift left and no-one had mentioned Michael Upward trying to leave the building. This is repeated in AD's statement to the Coroner on 9th September 2015.

9.23 At around 16:15 a worker states that she heard Michael Upward say he was going to find his wife. At the same time he had suffered continence issues and these were dealt with.

9.24 The contract monitoring officers for Worcestershire County Council record the

following from their visit at Care Home 1 on 16th April 2015. The officers are referred to as Worker 34 and Worker 35.

"*13:30-14:30 After lunch, Michael Upward became unsettled, and got up from the table and began to look around the unit. He appeared unsettled and asked care staff where his wife was...A visiting Art Student came in to the unit and offered to make a cup of tea…*

The visitor sat down with Michael Upward and had a drink and a chat with him. Shortly afterwards the visitor left, at the same time or shortly after Worker 34 saw Michael Upward walk into the garden, he appeared to have been incontinent, and was distressed. .. 15:45 Worker 34 went to find a member of staff to assist Michael Upward… A further 15 minutes went by and another care assistant came into the communal area Worker 35 then informed this staff member of the situation and the Worker 34 had gone to find help as well. The member of staff said she was unaware of Michael Upward's needs but insisted that she had tried to get Michael Upward to visit the bathroom and he had declined strongly, she then went to look for him. Michael Upward could not be found. Worker 34 returned and said that the staff were looking for Michael Upward and couldn't find him. Worker 35 and Worker 34 then also tried to find Michael Upward. Worker 35 was on another unit still looking for Michael Upward when a member of staff said they had found him and were changing him.

I recall asking Worker 34 what had happened and Worker 34 said that Michael Upward had been found and had said to her he wanted to leave and go home. In total Michael Upward had been unaccounted for, for approximately 20 – 30 minutes.

17:00 Care Home 1 worker MC and Care Home 1 worker AD joined Worker 34 and I on the unit and verbal feedback was provided to MC and AD about the day. Part of the feedback given included the concerns that Michael Upward had disappeared for a period of time (although he was in the home) and had been distressed, wanting to go home and looking for his wife. MC took this on board but stated that she thought this was usual for people on respite.

Worker 35 stated that Michael Upward had said to Worker 34 that he wanted to leave and appeared to be trying to find a way out."

9.25 This conversation is not referred to at all in the initial statements from staff at the Care Home Provider or in the narrative or chronology that was prepared. However, on further questioning the Care Home Provider have recorded worker "*AD does remember speaking with the local authority contracts visitors on the 16th. However, she states it was specifically around their concerns regarding a new apprentice in the home … she does not recall them mentioning Michael Upward or expressing any concerns regarding him*"

9.26 In the process of this SAR the County Council staff were asked if they wished to amend their statement. They were clear that the statement was accurate.

9.27 Following this, Michael Upward was seen between 18.00 and 18.15 at the garden gate, indeed one worker states that when she saw this that she shouted to another worker that Michael Upward was by the gate. This was the locked gate that led to the main road.

9.28 At 21.30 a worker states that they were told at hand over that Michael Upward had tried to get through the garden gate. An undated, untimed handover note presented with this IMR states that Michael Upward" *liked a good walk and had tried to go out the garden gate*".

9. 29 This over simplifies the situation for Michael. More than once during the day he had been upset/concerned about where his wife was. He suffered from Alzheimer's which almost certainly caused some confabulation and this was likely to be exacerbated by stress or anxiety. More account should have been taken of the fact that Michael Upward was a man of 82 years of age who had been living with Alzheimer's for over 5 years. He was concerned about where his wife was and he was in new, strange and unknown surroundings.

9.30 The IMR notes from the Care Home Provider record that Michael Upward did not settle to sleep until around 03:40.

9.31 It is important to record that the notes of Michael's first full day at Care Home 1 were those set out in the care log as described at para 9.14. Any worker reading those notes would be unaware of the occasions that Michael had tried to leave Care Home 1 (para 9.21), the comments by the contract monitoring officers for the County Council outlined at 9.24, and the handover note stating that he liked to walk and had tried to go out of the garden gate was inadequate.

9.32 The considerable concern here is that there was no apparent drawing together or triangulation of the information and what it might mean.

The events of the 17th April

9.33 The only care records for Michael Upward on 17th April were written before his disappearance are timed at 03:10 and 03:45. They refer to Michael Upward being assisted to bed at 11:00, and again at 03:45. Statements from staff given later refer to Michael Upward also being assisted to bed at 02:00. There seemed no recognition that Michael Upward had not slept soundly all night.

9.34 This analysis of events for the 17th April is taken from the staff statements or IMR narrative.

9.35 It is recorded that Michael Upward had breakfast. The daily records log written at 17:25 that day says he was seen at 10:30 that morning in the breakfast area.

9.36 At around 09:15 it is reported (statement from CA7) that Michael Upward stood up and said something that included a reference to his wife and that he was going. The worker countered with "*I think you are here for a few days*" after checking, the worker confirmed on what day he was due to leave. The worker suggested he sit in the lounge or reminiscence corridor. He said that he had looked at that yesterday. The worker suggested going to the conservatory or sitting with other residents. Michael Upward said "*Well I'll be off then*". This is undoubtedly ambiguous but was interpreted as Mr Upward leaving the table. Michael Upward was last seen in the breakfast room at around 10:30.

9.37 The IMR statements from the Care Home Provider describe what they refer to as an

unfortunate and unusual series of events that resulted in an unusually busy day with more traffic than usual through the front door and less supervision of this area than would normally be expected

9.38 The Care Provider was adhering to the standards set out by the County Council in relation to providing care on the basis of not having locked doors, among other things. As part of the County Council's policy, the Care Provider was awarded some additional grant to be spend on directly improving facilities people who were living or staying there.

9.39 Throughout the development of this SAR there has been considerable discussion about the issues of security including locked doors when providing care to people who may be at risk of walking/wandering.

9.40 To further understand this, the Care Provider was asked to provide their policy on how an open front door was managed recognising that they were a care home provider for people including individuals diagnosed with dementia. The report that they provided is set out at Appendix K.

9.41 In summary, while there were some safeguards in place and at number of assumed or local custom and practice arrangements established, there was not a clear sequential policy that could be relied on.

9.42 Of itself it is positive that the Care Provider did not simply resort to locked doors/restrictions as too often some see this as the easiest solution.

9.43 It would not be fair to conclude that the Care Provider should have had locked doors, notwithstanding the tragic event that occurred. However, if an establishment is to operate in that way there needs to be very significant understanding of the risks and how these can be mitigated. The first and fundamental of these is that all staff and managers have a broad understanding of the somewhat unpredictable effects of dementia on individuals and therefore day to day routines and awareness must be carefully followed up to take account of this.

Learning and Development Point 17

Managing Risk With Unlocked Doors

- **Where the home has a practice of managing risk with unlocked doors there should be:**
  - **(i) A comprehensive policy that is known and understood by all staff**
  - **(ii) For each individual a clear statement of how to mitigate any potential risks in light of that policy including an analysis of their illness or condition and any likely indicators or behaviours as a result of the new environment.**

9.44 Whatever else was happening on the 17th there does not seem to be any clear instruction about how the front desk should be resourced and the role of any person doing that in managing entrance and egress.

9.45 The chronology of action that was taken after 10:30 on 17th April is as follows (put together from various reports):

Time	Care Home 1 Staff Statements	County Council Contract Officer Statements
10:30	Worker MC sees Michael Upward in dining room Worker AR sees Michael Upward in the Upton Suite	10.30 - Michael Upward seen at breakfast
10:45	Worker SC4 states she was told by worker CA7 that she did not know where Michael Upward was. SC4 and CA7 search inside and outside the building	10.45 - staff seen showing visitors around the home
11:00	Worker CA7 states she asked SC4 if she knew where Michael Upward was. After looking for Michael Upward she returned to SC4 Worker SC4 stated worker MC told that they could not find Michael Upward. MC asks SC4 to phone	

Time	Care Home 1 Staff Statements	County Council Contract Officer Statements
	police. SC4 and CA8 went to look in immediate area and roads and return around 11.30/11.40	
11:15		11.15 - contract monitoring officers become aware that Michael Upward cannot be found by staff, they go to reception to find out what was happening, the visitors were just leaving, two care assistants noticed walking up the corridor asking where each other had They note that the door was not locked and there was no one else around and concluded that Michael Upward may have gone out through the front door while the receptionist was showing the visitors around.
11:20	CA8 states SC4 asked CA7 where Michael Upward was. CA7 did not know and SC4 went to look for Michael Upward	
11:25	Worker CA8 states she realised that Michael Upward could not be found and starts to search the building	
11:30	Worker MC states she was informed that staff were unable to locate Michael Upward. She and the 2 the County Council contract monitoring officers assist in search of the building and grounds	11.30 – Care Home 1 worker MC and staff appear very concerned. Monitoring officers advise that the Police need to be called. They help search immediate area outside then continued to search by car
11:30 – 12:00	Worker RD states Mr Guy Upward was contacted by telephone to inform him that Michael Upward was missing	
12:.00	Worker MC states that she and the County Council contract monitoring officers went off in their respective cars to look in the local area. She asked SC4 to contact the police Worker AD states that she returned to	12:12 Contract managers phone the home to check if there was any news. Care Home 1 worker R said Michael Upward was still missing and that she would phone the police now. Worker 35 said she must phone them straight away – by now Care Home 1 worker

Time	Care Home 1 Staff Statements	County Council Contract Officer Statements
	the home and was informed Michael Upward was missing	MC was also out in her car looking for Michael Upward (Worker 35 and WORKER 34 had met her by chance at the Upton Marina)
	SC4 calls the police at 12.02	
12:48		Monitoring officers return to the home, police present. Decide to continue their search
13:45		Monitoring officers return to home and then continue search
	Worker AD contacts Mr Guy Upward for contact details for Mrs Upward	
14:00	Worker AD contacts Worcestershire social services about the assessment they had provided	
14:30		Monitoring officer receive phone call from home suggesting monitoring officers search in Pershore
15:30		Monitoring officers see police officers in Pershore
15:50		Monitoring officers return to home
16:30		16.30 monitoring officers left home
17:30	Police inform staff they are widening search	

9.46 There were clearly extensive actions undertaken by the Care Home Provider staff and the County Council contract staff to search in the vicinity and as far as Upton and Pershore. There was no apparent co-ordination of this activity nor was there a single reference point in the establishment.

9.47 In any event a phone call reporting Michael Upward's disappearance was made to the Police at 12:02, one and a half hours after Michael Upward was last seen. This is confirmed by Police records where the narrative records the call at 12:03 and the statement:

"*We have lost a respite resident last seen at approximately 09.30 hours today (17th April 2015). Staff realised he was missing at 10.45 as we thought he was still in the*

garden". Michael Upward's name and date or birth was given and it was then stated that he has Alzheimer's.

9.48 In section 11 there will be a more detailed analysis of the information that was available to ensure a prompt search.

9.49 The policy and procedure that was in place at this time at Care Home 1 for dealing with missing persons will be dealt with at section 10.

10.0 Question 4: Policies and Procedures

Q4.1 Identify Care Home 1's policy and procedures for missing persons and their escalation procedures including how these are activated and how staff were made aware of them.

10.1 The policy that was in place on 17th April is at Appendix F. It has subsequently been revised (Appendix G) with clearer conditions and timescales:

- All relevant agencies are informed immediately if the resident has not been found after 30 minutes of being discovered missing
- Reference made to the Care Home Provider Group's Significant Incident Policy and Procedure and a definition of a significant incident has been included.
- Essential Standards of Quality and Safety have been replaced with the Fundamental Standards
- The missing persons flow chart is new and must be displayed in staff areas
- Section 2 (Assessment) is new and includes a missing person assessment and residential profile that must be completed for each new resident who potentially could leave the home unnoticed

Q4.2 What are standard working practices for residents with dementia and were they applied to Mr Upward.

10.2 The Care Home Provider have stated that *"In relation to caring for people living with dementia there are no separate 'dementia' policies, rather the policies refer to dementia where relevant and care planned and staff training will reflect the needs of the residents accommodated."*

10.3 This requires a more consolidated response. While it is important not to label individuals it is also important to support staff to understand complex need.

Learning and Development Point 18

Developing Specialist Skills and Knowledge

- **In any setting there will be different levels of skill, knowledge and experience.**

- **Care providers should demonstrate how skills are being developed specifically relevant to the stated purpose and objective at the home. This should be tailored to each level/group of staff. Commissioning could have a key role in supporting and evaluating this**

Q4.3 Are there multi-agency escalation policies and procedures in place by Worcestershire Safeguarding Adults Board for missing adults with care and support needs to ensure they are safeguarded.

10.4 No.

Q4.4 If they are in place, how have they been communicated to all agencies and providers.

10.5 Not applicable

Q4.5 What assurance was there that all agencies have relevant policies in place.

10.6 None of the IMRs have offered any evidence that any assurance was sought or given.

Q4.6 Has there been, or is there, an annual audit to seek assurance of the effectiveness of these policies.

10.7 No

10.8 To recap on the specific issues of the 17th April the various records/statements now record that Michael Upward was last seen in the building at 10:30 and noticed to be missing at 10:45 when an initial search of the building was carried out (instigated by workers SC4 and CA7).

11.0 Question 5: The search and subsequent discovery of Mr Upward's body:

Q5.1 What actions were taken by all agencies involved

11.1 This summary is taken from collation of various reports as part of preparing this SAR.

11.2 Michael Upward left Care Home 1 of his own accord during the morning of 17th April 2015. The Police note of the telephone call from Care Home 1 states that Michael Upward was not seen after 09:30. His disappearance was reported to the Police at 12:03 (according to the Police log)

11.3 Subsequent papers from Care Home 1 record that Michael Upward was seen in Care Home 1 at around 10:30am by workers AR and MC and also by both the County Council contract monitoring officers, that his absence was first noted at 10:45am and a search of the building and garden was initiated and that both staff from Care Home 1 and the County Council contract staff went further afield into

the locality in the direction of Pershore.

11.4 The Care Home 1 policy on reporting missing persons in place at that time states:

- Staff must inform the most senior person on duty immediately if a resident is discovered to be missing

- The senior person must check the care plan/risk assessment and signing out sheet to see if resident is out on a pre-arranged outing. If a resident is overdue in returning from a pre-arranged outing staff must make contact with the place/people they are visiting. Where contact cannot be made the duty manager must make a judgement as to whether the resident may be at risk then the police must be contacted

- If the resident is not on a pre-arranged visit the following procedure must be followed:
  - Alert all other staff and the registered manager immediately
  - Duty manager must have a structured plan to search the home and be confident the home and grounds have been systematically searched.
  - Ascertain who last saw the resident and any known plans for movements and try to discover the last time the resident was seen, where in the home, what they were wearing and how they appeared at the time
  - Where appropriate, tactfully ask other residents about the missing person's plans and movements
  - Co-ordinate a thorough search of all the rooms, locked or open, surrounding areas including grounds and immediate outside area. As each area is checked this must be confirmed on a checklist
  - If the resident is still missing a second check of the building/surrounding area must be carried out
  - Duty manager must at the earliest opportunity complete an incident report

11.5 In a separate section of the policy "Notifying Others" paragraph 3.2 says " *the senior person on duty must contact the police immediately*"

11.6 The initial search did not seem to have been co-ordinated nor does there appear to have been any collation of information about Michael Upward's relevant behaviour since his admission to Care Home 1. Such, that when the call to the police was made at 12:02 (Care Home 1 log) there was a reporting as follows "*we have lost a respite resident last seen at approx. 09.30 hours today (17th April 2015). Staff realised he was missing at 10.45 as we thought he was sat in the garden… he has Alzheimer's*". All of the previous information pointed to the fact that Michael would be searching for his wife, though the likelihood of him being able to have any chance of knowing the right directions towards Pershore and his home, which was a distance of around 8 miles, was extremely unlikely. Despite staff setting off here and there in their immediate search there was no map at the establishment to co-ordinate this in any way.

11.7 Subsequent Care Home 1 records would show that Michael Upward's son Guy Upward was phoned between 11:30 and 12:00 and told that his father was missing. A subsequent call to Guy Upward was made by AD, possibly at 14:00, to ask Guy Upward for Mrs Upward's mobile telephone number

11.8 This is surprising as on the pre-move in assessment form both Mrs Upward's mobile number is recorded and in a hand written note so is the name, address and phone number of the hotel (Marks Tey) where she was staying. So too is a list of Michael Upward's medication recorded by AD.

11.9 This has been explained by the Care Home Provider as follows:

"Mr Guy Upward was noted as the second contact in the event of an emergency as Primrose Upward was on holiday. However the respite admission form (which is different to the pre-admission assessment form that sits in the care file) could be seen as confusing as the layout and typing mixes up the main contact details (Primrose Upward) with the second contact details (Guy Upward). The telephone number first listed would be expected to be that of Primrose Upward, but was in fact Guy Upward's number. Primrose Upward's number was noted after Guy Upward's.

This seems to have been a typing and layout error and may offer explanation as to how Guy Upward was contacted first."

Q5.2 Was there adequate information to ensure prompt search.

11.10 The Police have recorded in the IMR that there was a lack of information known about Michael Upward by staff at Care Home 1 in order to provide accurate intelligence about Michael Upward's motivation for leaving the premises, along with intelligence as to how long he had been missing, how physically and mentally capable he was to look after his own safety, any local knowledge and the effect that any medication he had taken would have had on any of the above considerations.

11.11 The above information could have been in part provided by Michael Upward's wife who was on holiday in the Essex area and took a number of hours to trace and speak with "face to face"

11.12 The Police narrative confirms that there had not been any collation of material regarding Michael Upward by the Care Home Provider to report his disappearance. The first 2 members of police staff to attend were a safer neighbourhood team police officer and a police community support officer. The initial questions that were asked were:

- Has the premises been searched by staff
- When was Michael Upward last seen and by whom
- Physical description of Michael Upward and what clothes he was wearing
- Would he have been carrying anything or using a walking aid
- Questions concerning his mobility
- Whether he had any money
- Whether he had a mobile telephone
- How long he had been at Care Home 1 and whether he had stayed there previously

- Details of his family including contact details
- Would he know the area and would he be able to find his way home

11.13 The information that obtained as a result of these questions was:

- Michael Upward liked to be called Michael and was a respite patient. Michael Upward's wife was away for a short break in Essex. Michael Upward had only been there since Wednesday before he went missing (2 days) and the staff didn't know him that well. He had tried to leave the premises on the Thursday night to go home. Michael Upward had advanced Alzheimer's and wouldn't know where he was or how to get home. A full physical description was obtained including the clothing that he was last seen wearing. He didn't have any money or a mobile telephone. It appeared that Michael Upward had last been seen at about 0930 hours. A search of the premises had been carried out and members of staff were checking the local area. Michael Upward's family had not been contacted at that point.
- One of the police officers recalls that Essex and a short break were mentioned but no exact details were given as to the hotel

11.14 The Police are required put together a 16 point risk assessment which was used to create a compact record and this was done by 12:19.

11.15 At 12:21 front line officers went to the establishment. It became apparent that the care home was not in possession of relevant intelligence in relation to Michael Upward and there was very little tangible information to base the investigation and search parameters on.

11.16 At 12:26 Police advised that Michael Upward had tried to leave the home the previous night and had been persuaded to stay by members of staff at the care home

11.17 At this time Care Home 1 had in their possession or in the collective knowledge of

staff, significant relevant information including:

a) All the paper work completed dated 13th April 201that included:
    - Pre-move in assessment
    - Care Plan for Physical Care
    - Care Plan for Eating and Drinking Care
    - Moving and handling assessment
    - Physical dependency assessment
    - Waterlow assessment
    - Falls risk assessment
    - Continence assessment
    - Nutritional assessment
    - Risk assessment for medication

b) The knowledge from the previous day (16th) that Michael Upward had tried to leave the premises by the front door on 3 occasions, had been by the garden gate on 4 occasions, had previously been agitated and commented to the Contract Manager that he wanted to go and find his wife on the 16th. Further that he had said that he wanted leave associated with finding his wife as recently as 09:30 on that morning (17th), didn't fully comprehend that he was due to stay for some more days and uttered the words "*I'll be off then*".

c) The staff also knew the mobile phone number of Mrs Upward, the telephone number and address of the hotel where she was due to be staying

d) Had a complete list of his medication and details of his GP surgery

11.18 At 15:30 the police were told by staff at the Care Home Provider that Michael Upward was incontinent. This information was important as it might have been a reason for a member of the public to contact the police as well as enabling police officers to address the situation in a sensitive way if Michael Upward was found. This should have been available at the initial referral.

11.19 In their critical analysis the Police comment that "*while there was adequate information to start an initial search it would have been beneficial to the search and investigation if there had been clearer information in respect of the time that Michael Upward went missing and if the police had been notified at the earliest opportunity*" Better information would have enabled the investigation to be directed by his "*motivation for leaving the home and therefore his whereabouts*"

11.20 The events of the previous day and indeed at 09:30 on the day of his disappearance there had been a number of individual attempts by Michael Upward to leave Care Home 1 and an underlying thread that he wanted to "find his wife" and that he had not necessarily retained or could comprehended the information that he was due to stay at Care Home 1 for some days

11.21 This information was known to staff at Care Home 1 and in some part recorded in the hand over log on the evening of the 16th April (although this entry is not timed).

Learning and Development Point 19

Assembling information when reporting a serious incident

- **Where a Serious Incident is to be reported to the police, or other emergency services, it would be helpful, where possible, to assemble some of the important information about the individual and the circumstances so that a full report can be made.**

- **At the very least existing information should include names, addresses and telephone numbers. Those in the role of providing care should develop a simple front sheet on a file/record to support this**

11.22 The police log is detailed and comprehensive in terms of both the efforts to contact, and then speak with Mrs Upward, which were hampered somewhat by her presence on a coach excursion and was not directly contactable by her mobile phone.

11.23 The police should be commended for their thoughtful and sensitive approach to handling this.

11.24 Extensive police action and resources (uniformed police officers, road policing unit officers, dog unit, armed response officers, special constables, CID, scenes of crime, tasking team, National Police Air Support, and West Mercia Search and Rescue) were deployed in the search for Michael Upward who was from the outset designated as high priority.

11.25 Contact was maintained with the family, specifically Guy Upward who travelled from the London area to assist with the search.

11.26 The police then engaged in a number of their key activities including all local checks with local transport, taxis and ambulances, contact with local CCTV and contact with the duty PoISA.

11.27 Contact was finally made with Mrs Upward at 15.43. This contact confirms that Michael Upward does not wander off on a regular basis and that she described 2 occasions on which it had happened.

11.28 It is recorded that Michael Upward's son had travelled from the London area to assist with the search and is fully engaged by the Police.

11.29 During the hours of darkness in accordance with the advice of the PoISA coordinator direct searching was scaled down. Further searching was continued based on a number of potential sightings in the area. A number of these were eliminated

11.30 Other agencies confirmed that they were informed of the activities on the17th and then informed of Michael Upward's death on the 18th April.

11.31 Michael Upward's body was discovered by a West Mercia Search and Rescue volunteer at Ryall Court Farm at 19:07 on 18th April 2015, a distance of approximately 1 mile from Care Home1. By mutual agreement Michael's body was identified by Guy Upward at the scene

11.32 Subsequent search of CCTV footage placed Michael Upward at Ryall Court Farm at 11:09 on 17th April, which is about 750 metres from where his body was discovered. This was 50 minutes prior to the first contact from the Care Home Provider to the police to report him missing.

11.33 Throughout these events other agencies were informed

Q5.3 When and how were any family members informed of Mr Upward's disappearance.

11.34 Guy Upward was the first family member to be informed of Michael Upward's disappearance. This contact was made by staff at Care Home 1 between 11:30 and 12:00 on the 17th April. Guy Upward travelled to Worcestershire to assist the search and was in contact with the Police from 20:17 on the 17th. Guy Upward was the first family member to be informed as one of Care Home 1 records showed his telephone first even though Mrs Upward was identified clearly at the first contact.

11.35 As Mrs Upward was on a coach excursion direct contact with her was not possible. Mrs Upward was notified by the Police at 15:30 on the 17th April after the Police managed to contact the coach company and coach driver.

11.36 Following the discovery of Michael Upward on the 18th April at 19:07, Guy Upward identified the body at the scene at 20:16. It was Guy Upward who informed Mrs Upward of Michael's death.

Q5.4 What further communication and support was provided to Mr Upward's family during this critical period.

11.37 The Police were in constant contact with Guy Upward who was actively involved in assisting with the search and reviewing CCTV footage

11.38 The County Council tried to make contact with Guy Upward at 16:36 on the 17th April but had to leave a message asking him to ring back. A second attempt was made at 17:31 and a message giving him a telephone number to call if he felt that his father needed social care support over the weekend. A third attempt was made on 18th April at 09:38.

11.39 After hearing of Michael Upward's death the County Council made phone contact on 24th April with the family who confirmed that they would be involved in the safeguarding process. Mark Upward was agreed as the point of contact for the family.

11.40 On learning that Michael Upward had been found dead the Regional Director of the Care Home Provider telephoned Guy Upward at 21:13 on 18th April to offer his condolences to the family and to confirm that Mrs Upward had been informed.

11.41 The GP practice was informed of Michael's death by the Coroner on 20th April. The GP sent their condolences to Mrs Upward and the family.

11.42 The specialist home care provider service was notified of Michael's death by Mrs Upward on the 20th April.

Q5.5 Was there a designated officer representing all the agencies

11.43 There was not a designated officer representing all the agencies.

12.0 Predictability and Preventability

12.1 In addition to considering the questions set out in the scope, one of the purposes of this SAR was to consider whether or not Michael's death in the circumstances described could have been predicted or prevented.

12.2 It is important to remember that the purpose of an SAR is to ensure that lessons are learned and applied to future situations, and that this learning is used to improve local practice, procedures and services to minimise the possibility of a similar situations happening again.

12.3 However, for learning to be real and make a difference for future practice in the commissioning and delivery of services it is important to try and respond to these questions in the context of Michael's situation and what happened.

12.4 Predictability is not an exact science, rather, it is the balance of bringing together known factors and circumstances. For Michael Upward these are summarised as:

- That he was suffering from a progressive long term condition
- That wandering or walking is a very prevalent feature of people living with Alzheimer's[4]
- That new or stressful environments can increase the likelihood of wandering/walking[5]
- This was the first occasion that Michael Upward had been away from his family for respite care and that the whole environment including carers/other residents was completely new to him

[4] Robinson et al., 2007

[5] Advice from Professor Alistair Burns, Professor of Old Age Psychiatry and Vice Dean for the Faculty of Medical and Human Sciences at The University of Manchester, Honorary Consultant Old Age Psychiatrist in the Manchester Mental Health and Social Care Trust (MMHSCT) and National Clinical Director for Dementia, NHS England.

- The local authority assessment made it clear that he significantly underplayed his condition
- That during the first day at Care Home 1 he had shown some distress about where his wife was and had attempted to leave the premises on a number of occasions, the distress was also shown by an incontinence episode.
- That on the day that he walked out he had already been asking about his wife and where she was.

12.5 The predictability (likelihood) of Michael Upward's situation could have been enhanced by:

- Consideration of his needs in accordance with the Mental Capacity Act
- A fully updated and comprehensive assessment complied by the County Council
- A clear focus and risk management process during the pre-admission visit to Care Home 1
- Care Home 1 staff having considered the County Council assessment not withstanding its inadequacies
- A proper consideration of Michael Upward's first day at Care Home 1 and the potential degree of risk that this showed
- A clear unlocked door process and practice at Care Home 1

12.6 Given this combination of circumstances and Michael Upward's condition there was a high degree of predictability in this situation.

12.7 In considering preventability it is again important to remember the purpose of the SAR and its responsibility. However the whole basis of this SAR has been to review the events leading up to and including Michael Upward's respite care placement.

12.8 Prevention and risk were inevitably intertwined for Michael, and some of the elements outlined above in relation to predictability point to high risk areas that required good and consistent preventative practices.

12.9 The particular areas that would have supported a preventative approach should have started with a basis of understanding the risks to Michael Upward and someone in his situation. As with predictability some of these elements are the same.

12.10 There should have been:

- An updated and comprehensive assessment of Michael's needs
- Consideration of his needs in accordance with the Mental Capacity Act
- An engaging discussion during the pre-admission visit with Mrs Upward that supported her to talk about her husband's needs
- A clear process of communication within Care Home 1 for key care staff to know more about Michael and the key signs to look for
- Evidence of specific awareness of staff at Care Home 1 about Alzheimer's and its implications
- Evidence that events from Michael Upward's first day had been recognised, understood and acted on by the Care Home 1 staff. This should have included emphasis on the key signs regarding his levels of anxiety, demonstrated by his attempts to leave, and what this might mean in the context of his risks
- A clear policy and practice for managing an establishment without locked doors
- Handover notes within Care Home 1 available to all staff indicating that Michael had attempted to leave the premises to find his wife

12.11 Predictability and preventability cannot be entirely separated as they inevitably interact. Something being predictable does not of itself always mean that it can be prevented

12.12 Even in a more contained environment someone intent on leaving may still find a way and that may only lead to ever more restricted environments. Of itself, an open door policy was not a wrong setting for Michael. Care Home 1 refer to the morning

that Michael left via the front door as an unfortunate and unusual series of events. However, people coming and going and different day to day events happening together are a fact of life in many environments, including this one. The reality was that there was no open door policy in place. What was missing and should have been in place was clear staff guidance, training and processes that would have allowed them to take account of multiple events which were probably not entirely unusual or out of the ordinary.

12.13 The evidence throughout this SAR indicates that there were errors, omissions and many things that should have been done differently and better. There were nonetheless examples of good practice. Fundamentally there is inevitably a level of risk in many such placements and these may never be completely irradiated. However, in such settings it is everyone's responsibility to do everything possible to minimise risk and harm.

12.14 As indicated elsewhere in this report there are a significant number of things that should have been done. The net result of this would have been that on the morning when Michael Upward got up from the breakfast table and said "I'll be off then" this would have triggered a clear reaction at the establishment and alerted them to the fact that Michael's actions of the previous day were likely to reoccur. Namely, that he would again be attempting to leave the premises to find his wife, with all the risks that this entailed. As it was, there was a separate set of circumstances about the management of the front door that then tragically came into play. This is why preventative risk practices are vital.

12.15 None of this is presented with the benefit of hindsight but refers directly to the fact that:

1. There should have been up to date and comprehensive assessment of Michael's needs
2. Michael's mental capacity should have been assessed

1. The pre-admission visit should have gathered more information about risk
2. Information from Michael's first day should have been triangulated and shared

3. All the other factors likely to increase confabulation should have been built into the on the ground assessment and made real within the everyday tasks at the establishment

12.16 If that had been the case the predictability of Michael trying to leave the establishment would have been reduced. As stated at paragraph 12.12 if an individual is intent on leaving a setting that may be difficult to prevent. For Michael on that day the risk of harm was extremely high and given the nature of his placement and circumstances this level of risk should have been recognised.

13.0 Learning and Development – Draft for Future Development

13.1 There are some lessons and developments set out by agencies in their responses to the IMR reports (Appendix A) These will need to be cross-referenced as part of the leaning and development event and wherever possible used as a starting point. The action taken so far is also set out in Appendix A

13.2 It is preferable that these should be developed by the agencies concerned and by involvement at the learning event. This will engender a greater sense of engagement and ownership.

13.3 In light of the fact that the learning event may be delayed due to the Coroner's Inquest, there is nothing to prevent some work being initiated on any of these leaning areas.

13.4 A clear action plan should be drawn up by the key agencies so that progress can be assessed and followed up.

14.0 Summary

14.1 Information and Advice to Service Users and Carers Regarding Respite Care

- Carers/individuals and families should have access to clear information about respite care: the criteria, options and booking process should be set out at the start.

(Learning and Development Point 1)

14.2 Using electronic records

- The County Council should review its quality standards for assessment and case recording to ensure up to date and timely information.

- Where old information is used the date and origin of these noted should be clearly marked

(Learning and Development Point 2)

14.3 Reviews at Key Events

- Where planned respite takes place any assessment or care plan should be reviewed to ensure that the most up to date information is available, this should be comprehensively shared with the provider in good time so that it can be considered by the staff.

(Learning and Development Point 3)

14.4 Mental Capacity Assessments

- The application and use of the MCA should be reviewed recognising its use and its requirements are not just the responsibility of the County Council.
- The SAB should review current local guidance and where necessary revise it to ensure wide understanding of its requirements

- All providers should be supported and encouraged to review how they consider issues of capacity for individuals within the meaning of the Mental Capacity Act.

- A presumption of capacity should be tested and not simply be an assumption of capacity

(Learning and Development Points 4 and 10)

14.5 Use and issue of technology

- Information to individuals (and carers) who are supported with telecare should be reviewed, particularly where this has a direct impact on personal safety and is a part of managing risk.
- The eligibility for any item should be clearly set out and if removal is considered careful account should be taken of all known information and circumstances.

(Learning and Development Point 5)

14.6 Service User and Carer Assessments

- Assessment in care planning is the cornerstone of good practice in Social Care and Health. The Care Act 2014 requires joined up assessments that are appropriate and proportionate. They should also be relevant and timely. Old information may still be relevant but it should be noted as such.
- Care planning is more than the sum of assessment material. It draws in the skill and analysis of professional social care and health staff, not just a commentary on the information given. Contra-indicators or differing opinions should be drawn out. The County Council should refresh its staff development and requirements of supervision to bring a sharper focus on the skills required in assessment, analysis and subsequent care planning
- Carers' assessments are an integral part of supporting individuals. Carers now have a legal right to be assessed according to their own needs. All agencies, in the course of reviewing an individual's needs, should be aware of the needs of carers and the requirements of the Care Act 2014 in regard to the carer's right to an assessment and where eligibility is met the provision of services.

(Learning and Development Points 6, 8, 9 and 11)

14.7 Care Providers

- All specialist home care providers or other community support and residential, nursing or respite care should be asked to review their information requirements and ensure that the following is covered. Information should include:
  - Pre- Admission Role and Purpose: Be clear about purpose and how the information gathered is to be used
  - Information regarding individuals should be relevant and accessible to all staff
  - Risks should be considered for every individual
  - There should be clear arrangements for staff to access information at all times
  - Where the home has a practice of managing risk with unlocked doors there should be:

    (iii) A comprehensive policy that is known and understood by all staff

    (iv) For each individual a clear statement of how to mitigate any potential risks in light of that policy including an analysis of their illness or condition and any likely indicators or behaviours as a result of the new environment.
  - Developing specialist skills and knowledge. In any setting there will be different levels of skill, knowledge and experience. Care providers should demonstrate how skills are being developed specifically relevant to the stated purpose and objective at the home. This should be tailored to each level/group of staff. Commissioning could have a key role in supporting and evaluating this.

(Learning and Development Points 7, 10, 12, 15, 16, 17 and 18)

14.8 Sharing information and records

- Consideration should be given to determining what records need to be shared across agencies involved in the support of an individual. It is recognised that it would not necessarily be helpful to share all records all of the time and any information sharing protocol should focus on the sharing of material that is essential to manage risk or potential safeguarding issues.
- Consideration should be given to how relevant information from clinical assessments is shared with other agencies involved in the care and support of an individual, ensuring that this is done in a timely and appropriate way to make certain that key factors are included in assessments, risk analysis and care planning.

- One aspect of the learning event and subsequent action planning should be to ensure that any information sharing protocols are updated or developed to focus on

primary information that it is necessary to share where this covers risk and potential safeguarding issues

(Learning and Development Points 13 and 14)

14.9 Assembling information when reporting a serious incident

- Where a Serious Incident is to be reported to the police, or other emergency services, it would be helpful, where possible, to assemble some of the important information about the individual and the circumstances so that a full report can be made.
- At the very least existing information should include names, addresses and telephone numbers. Those in the role of providing care should develop a simple front sheet on a file/record to support this.

(Learning and Development Point 19)

15.0 Recommendations

That the Worcestershire Safeguarding Adults Board:

(1) Consider the action plans of the individual agency IMRs (see Appendix A) collectively and collate them into a work programme that partners are clearly accountable for completing. Where there is duplication or overlaps the SAB should seek to clarify who is responsible for what actions and in what timescale.

(2) Ensure that a learning and development event(s) is held with key professionals and practitioners to ensure real involvement and where necessary to develop and expand on the learning points. This will also improve ownership and engagement.

16.0 Appendix A – Single Agency Action Plans

West Mercia and Warwickshire Police

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	That there is clear identification and ownership of basic investigation tasks to be carried out by local policing areas, particularly prior to PolSA being contacted and once they have been deployed.	Clear identification and guidance for local policing staff of a number of basic investigative tasks that would be expected to have been completed prior to PolSA being contacted which will be incorporated into relevant working practice documents. Communication to relevant departments within the police as to the role of a PolSA and their capabilities to manage expectations.	Evidence from command and control logs that demonstrates completion and/or consideration of these tasks.	There should be an evident ownership of the 12 basic investigative tasks and clear communication of the outcomes between local policing and PolSA which in turn should ensure intelligence and investigation opportunities are maximised and in turn search parameters become appropriately targeted and prioritised.	PS S.B., Dog Unit, West Mercia and Warwickshire Police.	Work is already underway within West Mercia and Warwickshire Police. 12 key areas have been identified for completion in the initial stages of a missing person's investigation and have been partially communicated. Expected completion; end of 2015.
2	That there is a communications strategy/plan agreed with the most appropriate relative	Consideration and development of a clear communications strategy/plan with the most appropriate relative. Recording of this communications	Evidence from the relevant IT system of this being a pre-determined task.	Those relevant parties are kept up to date with key developments concerning the disappearance of their relative.	Supervisor Harm Assessment Unit North. West Mercia	April 2016 Work is currently underway to address this issue and changes to COMPACT are currently being explored. It has

		strategy/plan on the most appropriate IT system. Automated alerts when the plan is not completed to relevant members of staff.				been identified that Hampshire Police have a successful process of communication with relatives in missing person investigations. This is being developed to fit West Mercia & Warwickshire Police.

Worcestershire Health and Care Trust

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	WHCT should develop a Trust wide policy for the management and reporting of 'missing' patients from in-patient settings	Key lead in WHCT in-patient settings to be identified to undertake this task	Policy ratified	To ensure a consistent and robust approach Trust wide if patients in in-patient settings are 'missing.'	Tbc	Tbc

County Council – Social Work

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	No services should be arranged unless it is an identified need in a service users assessment.	• There needs to be a report so that cases where there has been any recording without a new work episode being created can be monitored • Review current assessment training and ensure that it is fit for purpose. • Staff must be mindful of the assessment policies • Staff must be mindful of the assessment policies • Review how respite is arranged and implement polices to guide staff. • Review assessment guidance • Review recording policy	• Respite policy • Assessment guidance • Recording policy • Detailed training material evidencing how assessment training is delivered • undertaken or achieved	• Improved outcomes for individuals/carers • Statutory requirements are met • Effective multi agency working	To be agreed	To be agreed

2	When staff are informed of a change in need then case records need to be updated to reflect this and consideration of whether a reassessment is required	• Staff need to be reminded that all new case intervention has to go via Triage • There needs to be a report so that cases where there has been any recording without a new work episode being created can be monitored • To specific and include this in any assessment policies • To include in recording policy • To review assessment and recording training	• Triage reports • Assessment guidance • Recording policy • Training materials	• Accurate records • Assessments completed at the right time • Statutory requirements are met	To be agreed	To be agreed
3	Information related to care needs is recorded in case notes rather than an episode. Case notes should only record events.	• Review recording policy	• Updated information within recording policy	• A cultural shift in working practice will be required to support staff • Improved outcomes for service users as services offered will be appropriate to meet their needs		
4	When information from previous assessments is pulled through into a new document then there needs to be a distinction between what is from the old assessment and what new information is.	• To include guidance in recording policy • To be included in assessment guidance • To review current training provided in relation to assessments	• Assessment guidance • Recording policy • Training materials • Evidence that HCPC Code of conduct has been discussed with	• HCPC requirements met • Statutory requirements met • Safe decision making based upon current information	To be agreed	To be agreed

		• Remind staff of the requirements of the HCPC Code of Conduct	Social Workers			
5	Staff need to research a home prior to arranging respite to ascertain if the service provider can meet the identified needs of the service user	• Review information held by teams • Utilise local knowledge of services • Regular meetings with contracts • Consultation with brokerage	• Contracts monitoring information • Quarterly summary of the information collated by CRT on the Quality and Contracts Monitoring Form	• Better outcomes for service users • Commissioning of quality services	To be agreed	To be agreed
6	When completing a review or closing a case the service user must always be communicated with.	• Social Workers must record in writing that they have had direct communication with the service user prior to closing a case • Review recording policy • Update assessment policy • Review training provided	• Case files • Detailed training report • Policies	• Better outcomes for service users and carers • Safeguards individuals	To be agreed	To be agreed
7	Uncompleted Current User Contact episodes need to be checked weekly to ascertain if action is required or that the action requested on the episode has been completed.	• Report to be run weekly.	• Reduction in uncompleted Current user Contacts • Guidance to staff	• Statutory requirements met • Safeguards individuals	To be agreed	To be agreed
8	Any change in accommodation for anybody who has a diagnosed mental illness needs to have a mental capacity	• Review MCA Training to ensure that it includes this • Report to be produced	• Training report • Analysis of report from Frameworki	• A shift in practice when providing respite care • Statutory requirements met	To be agreed	To be agreed

	assessment to support this change in accommodation	from Framework i to show adults whose primary need is mental health who has received any form of residential care and has no MCA		• Better outcomes for Service user		
8	No service should be provided or reviewed when there is not a protocol for the provision of the service	• All services provided need to be mapped • Review of protocols is required	• Report to Board	• Statutory requirements are met • Better outcomes for service users and carer's	To be agreed	To be agreed

Care Home Provider

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	All referrals for placement at Care Home 1 will be required to have an accurate assessment by Social Services. No less than 4 weeks prior to admission, This should contain any known risks or specific needs.	The home manager and deputy home manager (or senior care assistant) will check with the Local Authority Brokerage team that any information provided in the assessment is the most recent and up to date to within 6 weeks of the placement commencing. Referrals will not be accepted without an up to date and accurate Social Services assessment.	Evidenced through enquiry records kept at Care Home 1. Assessments dates and information checked and verified – enquiry log records this. Reason for refusals is logged including if assessments are not appropriate as above.	Assessment information will accurately reflect current care needs to assist Care Home 1 to make an informed decision on acceptance of a referral and to appropriately plan and deliver care and management of risk.	Registered Manager	Already implemented.
2	Review of front door security as well as other exits that may lead outside of secure garden area.	Key pad with code in place to all exits. Butterfly code information in place to egress for those capable of leaving as well as visitors, staff and others. Poster to remind visitors not to open the door for persons wishing to exit if they are unknown to them but to check with member of staff before exiting.	All exits secure. Notice regarding exit procedure for visitors.	Residents at risk of leaving the premises unsupervised are protected and safe.	, Registered Manager	Already actioned and in place.

3	Security of gates on the premises to be checked regularly, in particular if used for access.	Senior Care Assistant Change over Information and communication Record sheets to record date and time gates are checked to ensure are locked. Planned action to be taken in the event of gates being found unlocked.	Signatures in Senior Care Assistant Change over Information and Communication Record sheets	Gates remain locked and secure for residents' safety.	Home Manager	30 September 2015
4	Care Home Provider core documentation for respite residents admitted to Sanctuary Care Homes to be fully used for all respite admissions.	Respite care documentation will be prepared in advance to ensure it includes all relevant care plans and risk assessments. Sanctuary Care Respite care documentation to contain as a core mandatory care plan, 'comfort / anxiety'. Index to cross reference all documents required to be easily identified on Sanctuary internal intranet. Guidance to be included to remind staff to identify if is a first respite stay.	All core care plan documentation in place for respite residents. Generic risk assessment in place to assess risk of leaving the premises unnoticed.	Emotional aspects of care such as separation anxiety, disorientation, feelings of loss are included in care planning process. Risk of attempting to leave the premises is minimised and managed.	Policy Officer	31 August 2015
5	Review of Care Home Provider pre-move in assessment.	New Care Home Provider pre-move in assessment specifically references ask for and include information to	Pre-move in assessment form and resident care files.	Information on risk of leaving the premises informs care and management of any associated risk.	Director of Nursing, Quality and Care	Already actioned and implemented

		assess risk of residents leaving the home.	Risk assessments.			
6	Relatives to be requested to bring in a recent photograph on admission (or photograph to be taken at pre-assessment stage if placement accepted).	Current photograph to be available from point of admission. All staff to view photograph of new residents as part of each handover	Current photograph will be in care file and handover information	New respite and other residents will be identified to staff including those who may not have been present on shift at admission.	Home Manager	31 August 2015
7	Existing Dementia training content to be reviewed to cover identifying triggers in language and speech content as well as behaviours in order to provide appropriate and timely intervention and support.	Dementia training to be reviewed by Care Home Provider's Learning and Development team.	Care plans and risk assessments will contain details of potential triggers. Staff will demonstrate their understanding of triggers through questioning and observed practice.	Staff knowledge extends to identifying triggers in language and speech content as well as behaviours so they can support and reassure residents with appropriate intervention, management and reporting.	Learning and development Manager	30 September 2015
8	Improved handover information to staff	Detailed handover information to be recorded on handover sheets. All care staff to receive a full handover on commencement of shift.	Handover sheets will contain detailed information. Staff will sign to agree they have had full and detailed handover.	All staff will receive full information on all residents in order to provide appropriate and safe care.	Home Manager	31 August 2015
9	Staff to receive additional refresher training on completing daily records in residents' care files.	Training sessions for all staff on care planning to include additional practice and examples of what information is required to improve	Daily entries will be timed, detail observations, actions, outcomes and on-going action required where	Daily entries will be informative and contain all required information related to care plans and risk assessments.	Home Manager	30 September 2015

		daily entries.	necessary.			

Clinical Commissioning Group

There are no recommendations for the GP practice.

Specialist Home Care Provider Service

There are no recommendations

17.0 Appendix B- SARs – Statutory Duty

Safeguarding Adult Reviews - National Requirements

The Care Act 2014 came into effect from 1st April 2015. Under section 44:

(*1*) *A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if*

(a) there is reasonable cause for concern about how the Safeguarding Adults Board , members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if

(a) the adult has died, and

(b) the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if

(a) the adult is still alive, and

(b) the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

(4) A Safeguarding Adults Board may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the Safeguarding Adults Board must co-operate in and contribute to the carrying out of a review under this section with a view to

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases."

18.0 Appendix C- Membership of the Safeguarding Review Panel and Agency IMR Report Authors

Organisation	Name	Job Title	Role
Independent Chair	Ian Winter CBE	Independent Chair	Panel Member
Clinical Commissioning Group	Ellen Footman	Designated Nurse for Safeguarding	Panel member
Worcestershire Health and Care Trust	Karen Rees	Integrated Safeguarding Team Manager	Panel member
County Council	Rachel Fowler	Carer's Unit Manager	Panel member
West Mercia Police	Helen Kinrade (Away 1st Meeting)	Detective Inspector Strategic Child Safeguarding - PVP	Panel member
	Steve Tonks	Detective Chief Inspector	
	Jerry Reakes Williams (1st Meeting Only)		Panel member
Care Home Provider	Tom Parramore	Regional Director	Panel member
Clinical Commissioning Group	Joan Gowans	Independent Author	IMR Author
Worcestershire Health and Care Trust	Liz Wadley	Named Nurse for Safeguarding Adults	IMR Author
County Council	Andrea Cooke Pam Render	Area Social Work Manager Team Manager	IMR Authors
West Mercia Police	DC Nick Sanders	Detective Constable, Major Crime Review Unit	IMR Author
Care Home Provider	Jane Earl	Director of Nursing, Quality and Care	IMR Author

19.0 Appendix D - Key to Acronyms

- CCTV Closed Circuit Television
- CRT Central Reviewing Team
- DoLS Deprivation of Liberty Safeguards
- ECT Enhanced Care Team
- IMR Individual Management Review
- GP General Practitioner
- GPS Global Positioning Satellite
- MCA Mental Capacity Act
- MMSE Mini Mental State Examination
- SAB Safeguarding Adults Board
- SAR Safeguarding Adult Review
- WHCT Worcestershire Health Care Trust
- WSAB Worcestershire Safeguarding Adults Board

20.0 Appendix E - Chronology of Agency Involvement with Michael Upward

An overview chronology drawn from various sources.

Summarised to key elements

Date	WHCT	Social Care
2009	Initially known to ECT (formally OAMH Team). Standard Care Plan was in place	
June 2010	MU diagnosed with mild Alzheimer's. MMSE 25/30	
Aug-2011	11 Aug 2011 Visit to A&E, admitted to Medical Assessment Unit. Discharged the same day	
June 2012		28 June - Adult care referral
July 2012	MU discharged by ECT. Reference made to "no concerns about getting lost, some frustration noted"	1 July - Carers letter sent
	11 July referred to Admiral Nurses	2 July - care and support plan review
Nov-12	ECT medical notes record "small risk of wandering". Buddi recommended	
May 2013	7 May - OT visit to MU home to discuss Buddi. MU agrees to have a Buddi	
July	15 July - Buddi system taken to MU's home and set up with plan to review in	

2013	2-4 weeks	
	17 July - MU discharged back to GP from ECT. Letter to patient and carer re Buddi and copied to GP	
August 2013	14 August - Admiral Nurses notes records carers assessment declined	14 August - Adult Care Referral received and acknowledged. Phone contact with Mrs Upward attempted
	14 - 23 August - notes of interventions and contacts including Mental Capacity Assessment to consent to support with personal care (completed by social worker)	15 August - phone message left for Mrs Upward to get in touch
		21 August - home visit arranged for 23 August
Date	WHCT	Worcestershire Social Care
Aug 13		23 August - Personal Assessment carried out and MCA carried out regarding Client Charging and Assessment (CCA). Social worker seeks advice later in day re enduring power of attorney (POA) papers and whether they are registered in the Court of Protection.
		27 August - At office SAQ completed, Client Charging Notification (CCN) form and copy of POA received
September 2013		4 September - Mental Capacity Assessment (on financial matters)
		4 September - Carers Assessment - Mrs Upward capable of sustaining caring role
		5 September - Carers Support Plan - no further support required and case closed
		6 September - Client Charging and Assessment (CCA) requested

		10 September - Mrs Upward rang - she had bought a new shaver for MU and issues re shaving no longer an issue
		18 September - Further CCA assessment
		25 September - Carers Assessment and Carers Support Plan sent to Mrs Upward
		27 September - internal discussions between 2 social workers on what charges would be if services purchased
October 2013		1 October - Brokerage notified that if services purchased in future the maximum the client contribution would be £135.75 for a domiciliary service
		October - phone call with Mrs Upward . Records not clear what the purpose of the call was or why Mrs Upward decided to make private arrangements to support MU
Date	WHCT	Worcestershire Social Care
October 2013		4 October - Phone contact with Mrs Upward - says they have decided to make private arrangements for hair washing and therefore were not pursuing setting up the small care package. Access Centre number given should support/advice be required
	9 October - ECT note record reference to carers assessment having been completed and a private care package to start and access centre number issued to carer	9 October - closing summary on file re MU
		9 October - closing summary on file re carers assessment

Date	CCG	WHCT	Social Care
October 2013	12 October - Dementia Review		
			14 October - carers case closed

		17 October - MMSE 7/30 Case closed and MU discharged to GP. MU was stable at point of discharge	17 October - BAC team notified of case closure as no current services being provided. Review date removed.
Jan 2014	16 January - GP phone consultation with Mrs Upward. Sore wrist identified		
February 2014			2 February - phone call with Mrs Upward - wants personal assessment for support with personal care
			4 February - Adult Care Referral received - as support with personal care required now
			5 February - appointment for personal assessment made for 13th February. Mrs Upward confirms financial position not changed since previous financial assessment
			12th February - Home visit for personal assessment. Outcome is request for support with weekly shower visit
Date	CCG	WHCT	Social Care
February 2014	19 February - GP phone consultation. Increasing problems. No wandering and doesn't become lost. More awkward and verbally aggressive. Referred for review by Consultant Older People Psychiatrist		
		26 February - Letter received from GP requesting appointment for medication review in response to changing behaviour	

		27 February - screened by duty worker and offered appointment on 12 March	
March 2014	3 March - medical review by Consultant Older People Adult Psychiatrist		
			5 March - Care contributions assessment requested
			6 March - care and support plan
March 2014			7 March - Brokerage request for personal budget. Phone message left for Mrs Upward to update her that request made for Specialist Home Care Provider Service team to provide weekly shower visit. email sent internally about MU needing 3/4 hour visit on a Monday at 10.00am - advised to send it to Brokerage
	10 March - GP receives blood test request as MU refused to have bloods taken at clinic		10 March - Brokerage actions - request to purchase fully supported personal budget
	14 March - Dementia Review and bloods taken	12 March - seen in out patients . Noted that Mrs Upward now has Power of Attorney for finances. MMSE 7/30 but still functioning and risk of wandering mild. MU walking dog regularly	

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service
March 2014			17 March - level 1 risk assessment	17 March - Home visit for provider risk assessment
	19 March - Phone consultation blood results. Mild platelet disorder. Further blood tests and ECG requested			
			20 March - Home care assessment and home care service delivery plan	20 March - Home visit to do service delivery plan
			31 March - financial assessment revised	
April 2014	10 April - GP phone consultation with Mrs Upward. General aches and pains reported 11 April - general review - increased day time napping			
			17 April - services purchased	
	30 April - ultra sound of urinary tract - polycystic kidney disease identified		23 & 25 April - phone contact with Mrs Upward attempted	
Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service

May 2014			2 May - telephone contact. Mrs Upward reports MU accepting Specialist Home Care Provider Service team support. One call is sufficient at the moment. Reports cognitive difficulties seem to be deepening (can no longer be left alone to work independently and effectively) At present Mrs Upward feels able to leave MU . MU continues to go out and about in the town. Flexible break resource discussed as possible future step. Mrs Upward advised that if strain became too much to consider talking to MU's GP about a referral to Older Adults Mental Health Team	
			7 May - Phone call with Mark Upward	
			9 May - Care plan and support plan updated	
		12 May - Symptom profile completed by team re continence issues . MU did not meet criteria for pads. Strategies for managing issues discussed with Mrs Upward. Call made to Continence Service by Community Nurse		
Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service

May 2014	21 May - Dementia annual review		21 May - Transfer summary. Central Review Team screening. Updated support plan sent to Mrs Upward	
May 2014	23 May - review by Consultant to Older People Adult Psychiatrist - verbal aggression at times, able to walk to local shop but sometimes bought the wrong paper, safely walked his dog, occasional confusion about which day it is. Referral made to Admiral Nurses	23 May - Letter to GP on outcome of consultation on 12th March. Review planned for 2 months' time		
	30 May - GP phone consultation with Mrs Upward. Mobility slightly reduced		30 May - Mrs Upward reports Power of Attorney now registered. Asked about day opportunities	
June 2014	2 June - Attends GP surgery for steroid injection			
		MU seen in clinic. No changes. Review appointment offered of 28 October 2014	19 June - emails with Mark Upward. He is keen to understand options open for both his parents. Is concerned that Mrs Upward does not give the right information to assess the situation as she tends to play down the problems and thinks she should just be coping with the situation. Mark Upward's email discussed with supervisor	

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service
June 2014			23 June - Worker from Buddi rings to say that the Buddi has been lost. Last location recorded on 10 June. Replacement unit requested	
			25 June - Mrs Upward added as financial rep. Mrs Upward had requested correspondence is addressed to her.	
			25 June - holding email response sent to Mark Upward	
July 2014	7 July - GP phone consultation			
			10 July - letter sent to Mark Upward	
	17 July - Occupational Therapist review of Buddi. Shows MU walking safely and appropriately. Discharged from Enhanced Care Team			
August 2014			11 August - Social worker asked to contact Mrs Upward about request to increase shower visits to twice a week	11 August - increase in care requested from one to two visits a week via community social work team
	13 August - GP phone consultation. MU has developed episodes of		15 August - MU added to list of people to have the life line (Buddi) reviewed	

	incontinence associated with dementia			
Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service
Aug 2014			29 August - Specialist Home Care Provider Service confirm they are able to start twice weekly visits from 5 September	
September 2014			2 September - Brokerage actions	
			3 September - phone call with Mrs Upward. Confirm Specialist Home Care Provider Service visits. Asked about carers allowance	
	18 September - GP phone consultation. Painful knee 26 September - Injections of steroids to knee			5 September - Home visit - review of service delivery plan due to increase in service requested
	29 September - Consultant Older People Psychiatrist notes MU at moderate stage of Alzheimer's. MU continues to walk the dog sometimes by himself and does not get lost. Buddi lost and new one ordered			

Oct-14		MU did not attend appointment. New appointment of 26 March 2015 offered	16 October - Financial assessment revised. CCA notification to Brokerage	
November 2014			12 November - Financial Assessment. Enduring Power of Attorney, declaration and letter received.	
Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service
November 2014			13 November - services purchased	
			21 November - Phoned Mrs Upward re Buddi assessment . Arranged for 24 November	
			24 November - home visit for Buddi assessment (no formal eligibility criteria found) . Outcome of assessment was that MU did not meet eligibility criteria for continued funding for the Buddi. Mrs Upward left a list of GPS providers	
			26 November - care and support plan updated	
January 2015	15 January - MU arrives at GP surgery but unsure what he should be doing. Is sent home after being given directions. GP had phone consultation with Mrs		16 January - Phone update from Specialist Home Care Provider Service. No concerns with package. No reason for the SW to visit at the moment. Care and support plan	

	Upward		updated	
			23 January - Mrs Upward phones to request respite at Heathlands from 15 - 21 April. Also asked about costs doubling although circumstances have not altered. That there is no carers assessment was referred to manager for advice	
			28 January - Brokerage request for planned respite	
Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service
Jan 2014			30 January - Brokerage actions for planned respite care	30 January - Phone call from Brokerage to book respite care for MU. Assessment information requested
February 2015			2 February - Mrs Upward told Heathlands had declined but place at Beechwood identified. Discussed MU's care and that he wanted to go out more frequently, sometimes at night, increased continence problems. Advised on cost increases and appeal	

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider

February 2015			9 February - Latest review documents faxed to Care Home 1		9 February - assessment information received by fax and put in Respite Folder (assessment dated 16 January 2015)
			12 February - Phone call with Buddi staff. Told them MU was not eligible for continued funding. Financial assessment revised. Phone call with Mrs Upward querying MU's weekly charge. Different phone call with Mrs Upward about the Buddi and arrangements made to collect it on 18 February		
Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider
February 2015			17 February - Phone call from Mrs Upward asking if family members can visit Care Home 1 - advised to contact Care Home 1 direct		
			18 February - Buddi collected from home		
			23 February - Financial assessment		
		24 February - Letter sent to cancel appointment on 26 March and new appointment			26 February - assessment information requested again. Pre-admission visit

		on 23 April offered			booked for 19 March 2015
March 2015	6 March - review of painful wrist	6 March - referral to continence service by community nurse			
			11 March - Financial assessment revised		
			12 March - Brokerage selection for planned respite		
			13 March – Care Home 1 respite purchased		
			18 March - Mrs Upward has respite booking confirmed		
		19 March - discussion about management of incontinence			19 March - pre-admission assessment and visit cancelled due to D&V outbreak
Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider
March 2015		27 March - advice provided re alternative day care centre. Mrs Upward agreed to contact team again if required. Discharged from	27 March - Letter from Mrs Upward regarding increased care needs		

		service			
		30 March - MU visited at home by continence service. Bladder scan performed. samples provided. Mrs Upward called later to say samples were satisfactory and delivery set up to start in April			
April 2015			7 April - Phone call to another care home. Provisional booking had been made with them. Advised that MU was booked into Care Home 1		
			8 April - Phone call with Mrs Upward re respite care. MU increasingly resistant to help from her, needs prompting re dressing etc		
			9 April - Phone call with Care Home 1 to discuss the "above info re respite". Manager and Deputy Manager not available until 13th April		
Date	CCG	WHCT	Social Care	Specialist Home Care	Care Home Provider

				Provider Service	
April 2015			13 April - phoned Deputy Manager re pre-move in assessment visit. Staff aware that MU's dementia is progressing and the picture is different from at the point of the last review		13 April -11.00 pre-admission visit. Pre-admission assessment form completed during visit. MU's ability to consent to respite noted.13 April - Core Care Plans from respite suite of documents started and dated 13.4.15 (comprises 2 core care plans (physical care and eating and drinking) and 9 risk assessments)
		14 April - Out patient appointment for 23 April cancelled and new appointment of 25 June offered			14 April - AD reads the assessment information sent by Social Care
				15 April - service put on hold due to respite care	15 April - 15.00 MU and Mrs Upward arrive. Hand written note from Mrs Upward with details of MU's likes and dislikes and details of holiday and hotel address and contact numbers. Having been asked to bring in MUs medicines in their original packaging Mrs Upward returns to Care Home 1 to leave medicines. 2 hourly checks made on MU throughout night

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider
16th April 2015			2 contract monitoring officers start a 2 day planned monitoring visit at 09.30. Introduced to MU at breakfast. In the late morning MU stated that he wanted to go home and wanted to see his wife. This was repeated later in the day. After lunch MU observed becoming agitated and asked if he could go out of an exit door. Around 15.45 the monitoring officers asked staff to assist MU with personal care needs as he was distressed - in this instance staff were unable to find MU for 20 - 30 minutes. Concerns were fed back to the manager and deputy manager at 17.00		MU wakes at 06.45. Message left for Mrs Upward to bring in aspirin in original packaging for MU as unable to register with GP for a few days. SC1 thinks MU is a visitor on morning shift ▪ 14.00 CA3 thinks MU is a visitor - concludes he is a resident later by how he walked ▪ 14.00 MU asks if he can get out of the front door. Told no and MU goes into garden ▪ 14.20 MU tried the front door again asking if he could get out that way ▪ 14.30 SC2 doesn't realise MU is a resident until handover 14.45 MU tries the front door again. Maintenance man goes to open the door but is stopped by staff ▪ 15.30 CA5 thinks MU is a visitor. Later asks colleagues who he is because he looks a bit lost ▪ 16.15 - CA5 hears MU saying that he is going to look for his wife
Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider

16th April (cont)					18.00 - 18.15 - CA5 sees MU at garden gate and calls to SC2. CA5 recalls seeing MU at the gate several times up to 21.30 when the shift ended 18.10 CA3 hears shouting that MU is at the garden gate 18.30 CA4 sees MU at the garden gate 19.00 AD starts shift but no mention in handover that MU had tried to leave the building 20.00 SC2 records in the daily log that MU likes a walk and had tried the garden gate 21.45 MU declines to go to bed preferring to watch TV in the lounge 22.10 MU declines to go to bed again 23.00 MU fallen asleep in the lounge. On being woken declines again to go to bed 24.00 MU assisted to bed but returns to lounge 02.00 MU supported getting dressed for bed and gets into bed 03.45 daily care record records MU assisted to bed at 03.40

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider	Police

17th April 2015			Second day of planned monitoring visit 10.30 - MU seen at breakfast 10.45 - staff seen showing visitors around the home 11.15 - contract monitoring officers become aware that MU cannot be found by staff 11.30 - Manager and staff appear very concerned. Monitoring officers advise that the Police need to be called. They help search immediate area outside then continued to search by		Handover notes state MU had tried to get out of the garden gate on the 16th April 08.00 - MU assisted to dress and then went to breakfast 09.20 - MU prompted to take medicines. MU states "I'll be off then" 10.00 relatives of resident moving out arrive. SC4 involved in photocopying records 10.30 - MU seen at dining table by Manager and by Deputy Manager 10.45 - staff realise they do not know where MU is. 2 care workers look inside and outside the building 11.30 - Manager told that MU cannot be found - search of building and grounds carried out. 11.30 - 12.00 Guy Upward contacted to inform him that MU was missing to home following another task and is told MU is missing	

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider	Police

17th April 2015 (cont)			12.48 - monitoring officers return to the home, police present. Decide to		12.00 - Manager asks for the police to be called. Manager goes out in car to look for MU at same time the contract monitoring officers go in their car to look for MU 12.00 - Deputy Manger returns 12.02 - Police called time not recorded - Guy Upward phoned to get contact details for Mrs Upward time not recorded - WCC phoned by Deputy to speak about MU's assessment not being correct	12.03 MU reported missing. Identified as high risk. Resources deployed immediately. 12.21 Front line officers told to debrief staff 12.26 Checks with local taxi, buses and ambulances requested 12.27 staff confirm meds given at 09.15/ 09.30 12.32 told Mrs Upward not informed and efforts made to contact by phone 12.41 Clear there was a lack of intelligence on MU's condition or where he was likely to go 12.43 local CCTV made aware 12.49 Home checked

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider	Police

17th April 2015 (cont)			13.45 - monitoring officers return to home and then continue search 14.03 – Care Home 1 phoned to say MU had left the home, that police were involved. Asked for safeguarding number. Was told there was nothing in the support plan to suggest this might happen			13.10 Police Air Service 13.22 Social media release 13.23 Worcester Royal Hospital advised 13.31 Mrs Upwards neighbour advises she is on coach trip 13.41 Sighting at 10.30 on Ryall Road reported by local rev'd who knows MU 13.53 Coach details obtained 13.55 Dog unit requested

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider	Police

17th April 2015 (cont)			14.30 phone call from home suggesting monitoring officers search in Pershore 14.51 - phone call to Care Home 1. Informed that Police notified. Agreed to advise Safeguarding Team 15.30 monitoring officers see police officers in Pershore 15.50 monitoring officers return to home			14.12 All waterside pathways north & south confirmed searched 14.12 Permission to contact coach driver given 14.19 Dog unit report farm owners along Ryall Court Lane to Ryall Court Farm are checking outbuildings and other properties 14.20 Coach driver spoken to - Mrs Upward likely to be retuning at 16.00 14.29 Officers requested to go to coach location 15.00 Police and WCC identify places that MU like to visit 15.30 Informed the MU is incontinent 15.43 Mrs Upward spoken to by officers

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider	Police

17th April 2015 (cont)			16.20 Brokerage notified and bed identified at a different care home where doors are locked 16.30 monitoring officers left home 16.35 - message left asking Guy Upward to ring 17.51 - message left on Guy Upward's mobile . Specialist Home Care Provider Service put on standby to provide care over the weekend at home if MU goes home	16.26pm told MU missing by Community social work team. Advised MU may need support over weekend at home 16.45 - Police and staff continue their search of the immediate vicinity of home	17.30 informed by Police that search being extended and helicopter being used	16.07 incident log updated with info from intelligence from Mrs Upward 16.31 liaison with BBC Hereford and Worcester 16.55 Thorough search of care home and ground completed 16.58 mis-information of sighting on train - resources used to rule out

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider	Police

17th April 2015 (cont)						20.09 Police Air Search local area using thermal imaging as darkness falling 20.17 Contact with Guy Upward 21.12 False sighting on CCTV 21.26 up to date photo added 21.54 possible sighting at 13.00 reported 22.05 possible sighting at 19.30 reported - dog unit despatched 22.06 speak to staff that dealt with MU the previous evening 22.31 Guy Upward confirms CCTV not of MU

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider	Police

18th April 2015			00.31 Police advised who to contact when MU is found 09.19 Police contacted for update 09.38 message left on Guy Upward's mobile 10.39 update from Police 12.14 phone call from Care Home 1 seeking update			00.13 search aspect scaled down 00.52 Air search completed 01.52 direction to find and search Mrs Upwards vehicle 14.14 Witness says spoke to male matching MU's description at 17.15 walking north along Ryall Court Lane towards the farm 14.56 another reported sighting eliminated 14.56 - witness from 14.14 confirms very sure they saw MU but at 10.30 not 17.15

Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider	Police

8th April 2015			16.00 Police update on situation given 20.36 Call from Beechwood to advise that MU found deceased. Managers informed		20.30 staff informed that MU had been found deceased 21.30 - Condolences offered to Guy Upward	18.08 Air search again - no result 19.07 MU found deceased at Ryall Court Farm 20.16 Guy Upward identifies MU 20.20 Essex Police updated

19th April 2015			19 April - Safeguarding concerns reported			19 April 01.47 update that the officer has attended Ryall Court Farm and seized CCTV footage. It places MU at Ryall Court Farm at 11.09, 750m from where his body was found
Date	CCG	WHCT	Social Care	Specialist Home Care Provider Service	Care Home Provider	Police
20th April 2015	20 April - GP informed of MU's death by Coroner's office	Letter received from GP informing ECT of MU's death	20 April - care and support plan reviewed	20 April - Mrs Upward phones to notify Side by Side of the death.		
24th April 2015			24 April - Phone contact with MU's family. Family confirm they would be involved in the safeguarding process. Mark Upward agreed as point of contact			

21.0 Appendix F – Care Home Provider's Missing Persons Policy and Procedures at 17th April 2015

Subject/Title:	**Missing Person – Policy and Procedure**
Business Function:	**Registered Care & Nursing Homes**
Last Review Date:	**May 2014**
Next Review Date:	**May 2015**
Author(s):	**Policy Officer – Care**
Other Contributors:	**None**
Approved By:	**Executive Committee**

This document belongs in the Care Policies & Procedures Manual

CONTENT

A. General Information

1 Policy Statement

Sanctuary Care aims to ensure all registered care services are delivered to the highest standard, in line with the Care Quality Commission Essential Standards of Quality and Safety, current legislation/regulation and best practice.

Sanctuary Care ensures that measures are in place to ensure that regular checks are carried out on its residents in care homes, recognising their need for independence and mobility and balancing the freedom and dignity of residents against a possible requirement for close supervision. The well-being and safety of the resident is paramount.

In the event that a resident is missing, measures are in place to notify the relevant agencies, such as the police.

2 Objective of this Policy and Procedure

The objective of this policy is to outline the actions the Group takes when a resident is missing and the objective of the procedure is to provide guidance to staff on the actions they must take to find a resident.

3 Legislative/Regulatory Context

- Essential Standards of Health and Safety
- Health and Social Care Act 2012
- Mental Capacity Act 2005
- The Care Quality Commission (Registration) Regulations 2009

4 References and Sources

- Care Quality Commission

5 Responsibilities for Implementation

The Managing Director – Sanctuary Care is responsible for ensuring the overall adoption of and adherence to this procedure.

Registered Managers and staff with supervisory responsibility are responsible for ensuring adoption of and adherence to this procedure.

All staff working within registered care homes are responsible for adhering to this procedure.

6 What's New – What's Different?

An annual review has been undertaken and there are no changes.

7 Impact on Diversity

Sanctuary Care will seek to ensure that this policy is applied in a manner that is fair to all sections of the community regardless of age, disability, gender, marital status, nationality and any other characteristics.

8 Approval of this Procedure

This procedure is approved by the Executive Committee of Sanctuary Group.

9 Period of Review

This procedure will be reviewed annually in accordance with the requirements of the Essential Standards of Quality and Safety, unless:

- There are significant changes to legislation or regulation; or
- There are found to be deficiencies or failures in this procedure, as a result of complaints or findings from any independent organisations;

at which point the Managing Director – Sanctuary Care will initiate an immediate review.

Where appropriate, staff, key stakeholders, residents and interested parties will be consulted in any review of this procedure.

B. Detailed Procedures

Definitions

A&E	Abbreviation for Accident and Emergency department at the hospital.

1 Introduction

1.1 Many residents value their independence and mobility and spend many hours out in the community without raising concern. However, some residents are frail and limited in their mobility, some may become disorientated or be confused and, therefore, easily become lost. The balance of freedom and dignity against close supervision must always be considered.

1.2 Homes aim to prevent missing person incidents and false alarms by asking residents and family members to report to a staff member and signing in the IN/OUT log in the reception area. When a resident leaves the building, this must be documented in the resident's daily notes with an expected time of return and contact details.

1.3 Staff must remain vigilant and try to be aware of where residents are at any given time. Residents who are prone to leaving the home unnoticed or at risk of getting lost because of their mental capacity must have close observation and this must be identified in the resident's Care Plan with the level of risk identified.

2 In the Event of Discovering a Resident is Missing

If staff discover that a resident is missing, they must inform the most senior person on duty immediately.

2.1 The senior person on duty must check the Care Plan/Risk Assessment and signing out sheet to see if the resident had gone out on a pre-arranged outing. If the resident is out on an activity or walk, if they are overdue then staff must try to contact the resident/people/place they are visiting. Where contact cannot be made, the Duty Manager must make a judgement that the resident may be at risk then the police must be contacted and a suitable entry made in the resident's care notes.

Where a resident is not on a pre-arranged outing the following procedure must be carried out:

- Alert all other staff on duty and the Registered Manager immediately;
- The Duty Manager must have a structured plan to search the home and be confident the home and grounds have been systematically searched;
- Ascertain who last saw the resident and any known plans for movements and try to discover the last time the resident was seen, where in the home, what they were wearing and how they appeared at that time;

- Where appropriate tactfully ask other residents about the missing persons plans and movements;
- Residents in the home must never be allowed to involve themselves in the search;
- Co-ordinate a thorough search of all the rooms (including the missing resident's room), locked or open, and surrounding areas, including the grounds/garden and immediate outside area, for example, main road; as each area/room is checked this must be confirmed on a checklist;
- Where searches are outside and or in the dark, a supply of torches, a first aid kit and a space blanket must be available. Sufficient staff must remain in the home for the safety of other residents. The person(s) carry out the search of the grounds must have mobile telephone contact where possible to the home;
- If the resident is still missing, a second check of the building/surrounding area must be carried out. Consideration must be given in relation to where the missing resident may have gone, for example, an old home address or relative/friend's address;
- The duty manager must at the earliest opportunity complete an incident report including details of events with times, actions and decisions. The resident's notes must also be completed with an accurate record of events.

3 Notifying Others

It is important that when notifying others, that a contact name, date and time of the notification are noted.

3.1 Informing the Registered Manager

If the Registered Manager was not on duty at the time of the incident, they must be notified immediately and the Registered Manager must be kept up to date at all times.

3.2 Informing the Police

The senior person on duty must contact the local police immediately. The police must be notified of the following:

- The resident's name, date of birth and full description of the resident;
- A recent photograph of the resident;
- A description of the resident's well-being for example, state of mind, medical conditions, for example, diabetes, dementia;
- Details of what the resident was last known to be wearing;
- Details of resident's 'capabilities', for example, mobility/road crossing skills;
- If the resident is local or not, and details of where the resident may be heading for example, old home address;
- Details, address and telephone number of the care home; and
- The senior person on duty must agree with police, who (the home or the police) is going to contact other agencies, for example, hospital (A&E).

3.3 Informing the Relatives

Where, following a thorough search, the missing person has not been located, the senior person on duty must make arrangements to inform the resident's relatives, ensuring the family members are kept updated on a regular basis.

3.4 Informing the Regional Manager (Senior On Call Manager if out of hours)

Where following a thorough search, the missing person has not been located, the Regional Manager (Senior On Call Manager if out of hours) must also be informed as soon as possible.

3.5 Informing Care Quality Commission (CQC)

The senior person on duty must inform CQC. This must be initially carried out verbally by telephone and followed up by a Statutory Notification about a Person who Lives in a Care Home. Refer to the CQC Statutory Notifications – Policy and Procedure.

3.6 Informing Safeguarding

The senior person on duty must inform the local safeguarding authority of the incident.

4 When the Resident has been Found

4.1 When the resident has been found, the senior person on duty must ensure that all relevant parties are informed immediately:

- Relatives;
- Police;
- Registered Manager, Regional Managers and Director of Care;
- CQC;
- Hospital (A&E, if appropriate); and
- All other concerned parties.

4.2 An incident/accident form must be completed, as appropriate.

4.3 Staff must note the resident's well-being/condition. It may be necessary to seek advice/request a visit from the General Practitioner (GP). Staff must observe and monitor the resident closely.

4.4 Consideration must be given by the Registered Manager, after the event, to appropriate recording and assessment of future actions required to safeguard the resident, this may include setting up an urgent review. A Risk Assessment must also be completed (or reviewed if already in place) which staff must read and sign.

4.5 The well-being and safety of the resident is paramount. For some residents the experience of being lost can be distressing. However, it is important to remember that it can also be a difficult time for relatives and staff as well as the resident. It is

important to ensure that support, advice and encouragement to relatives and staff is also given during and after the event.

5 Record Keeping

5.1 A full account/record must be recorded in the resident's Care Plan and updated as events occur.

5.2 It is important that when speaking to external agencies, contact names are obtained for the record.

5.3 When the resident is found, a note of where the resident was found, the time and by whom must also be recorded on the resident's Care Plan.

For more information on record keeping, refer to the Record Keeping – Policy and Procedure.

6 The Press

If appropriate, the Regional Manager must contact the Public Relations (PR) Team, Worcester.

The PR Team must deal with any contact with the press and advise staff on what to do if the press contacts the care home for information.

22.0 Appendix G - Care Home Provider's Missing Persons Policy and Procedures revised July 2015

Sanctuary Care

Subject/Title: **Missing Person – Policy and Procedure**

Business Function: **Registered Care & Nursing Homes**

Author(s): **Policy Officer – Care**

Other Contributors: **Quality & Policy Working Group**

Approved By: **Executive Committee**

CONTENT

A. General Information

1 Policy Statement

Sanctuary Care aims to ensure all registered care services are delivered to the highest standard, in line with the Care Quality Commission's Fundamental Standards, current legislation/regulation and best practice.

Sanctuary Care ensures that measures are in place to ensure that regular checks are carried out on its residents in care homes, recognising their need for independence and mobility and balancing the freedom and dignity of residents against a possible requirement for close supervision. The well-being and safety of the resident is paramount.

In the event that a resident is missing, measures are in place to notify all the relevant agencies if the resident is not found within 1 hour of them being discovered missing.

2 Objective of this Policy and Procedure

The objective of this policy is to outline the actions the Group takes when a resident is missing and the objective of the procedure is to provide guidance to staff on the actions they must take to find a resident.

3 Legislative/Regulatory Context

- Care Act 2014
- Fundamental Standards
- Health and Social Care Act 2012
- Mental Capacity Act 2005
- The Care Quality Commission (Registration) Regulations 2009

4 References and Sources

- Care Quality Commission
- Significant Incident – Group Policy and Procedure

5 Responsibilities for Implementation

The Managing Director – Sanctuary Care is responsible for ensuring the overall adoption of and adherence to this procedure.

Registered Managers and staff with supervisory responsibility are responsible for ensuring adoption of and adherence to this procedure.

All staff working within registered care homes are responsible for adhering to this procedure.

6 What's New – What's Different?

An annual review has been undertaken and the following changes have been made:

- The policy has changed in that all relevant agencies are informed immediately if the resident has not been found after 30 minutes of being discovered missing.
- Reference made to the Group's Significant Incident Policy and Procedure and a definition of significant incident has been included. As a result of this, section 7 is also new.
- The Essential Standards of Quality and Safety have been replaced with the Fundamental Standards.
- The Missing Person Flowchart is new and must be displayed in staff areas.
- Section 2 is new and includes a new Missing Person Assessment & Profile (Appendix B) which must be completed for each resident who potentially could leave the home unnoticed.

7 Impact on Diversity

Sanctuary Care will seek to ensure that this policy is applied in a manner that is fair to all sections of the community regardless of age, disability, gender, marital status, nationality and any other characteristics.

8 Approval of this Procedure

This procedure is approved by the Executive Committee of Sanctuary Group.

9 Period of Review

Until a new policy is formally adopted this document will remain in force and operational. This policy will be reviewed in accordance with the programme agreed by the Executive Committee, unless:

- There are significant changes to legislation or regulation; or
- There are found to be deficiencies or failures in this procedure, as a result of complaints or findings from any independent organisations;

at which point the Managing Director – Sanctuary Care will initiate an immediate review.

Where appropriate, staff, key stakeholders, residents and interested parties will be consulted in any review of this procedure.

B. Detailed Procedures

Definitions

A&E	Abbreviation for Accident and Emergency department at the hospital.
Significant Incident	An adverse event or occurrence that arises as a result of the Group's operations and has the potential to have a significant adverse impact on the financial, operational or reputational status of the Group. (Source: Group Significant Incident Procedure)

A flowchart of the missing person process is available in Appendix A. A copy of the flowchart must be displayed in staff areas.

1 Introduction

1.1 Many residents value their independence and mobility and spend many hours out in the community without raising concern. However, some residents are frail and limited in their mobility, some may become disorientated or be confused and, therefore, easily become lost. The balance of freedom and dignity against close supervision must always be considered.

1.2 Residents and their family members are requested to sign in the IN/OUT log in the reception area. When a resident leaves the building, this must be documented in the resident's daily notes with an expected time of return and contact details. This will assist in reducing the numbers of false alarms in the event of a suspected missing person incident.

1.3 Staff must remain vigilant and try to be aware of where residents are at any given time. Residents who are at risk of leaving the home unnoticed or at risk of getting lost because of their mental capacity must have close observation and this must be identified in the resident's Care Plan with the level of risk identified.

2 Assessment

The Missing Person Assessment & Resident Profile (Appendix B) form must be completed for each resident who could potentially leave the home unnoticed. A copy of the completed form must be placed in the resident's care plan.

3 In the Event of Discovering a Resident is Missing

If staff discover that a resident is missing, they must inform the most senior person on duty immediately.

3.1 The senior person on duty must check the Care Plan/Risk Assessment and signing out sheet to see if the resident had gone out on a pre-arranged outing. If the resident is out on an activity or walk, if they are overdue then staff must try to contact the resident/people/place they are visiting. Where contact cannot be made, the senior person on duty must make a judgement that the resident may be at risk then the police must be contacted and a suitable entry made in the resident's care notes.

Where a resident is not on a pre-arranged outing the following procedure must be carried out:

- Alert all other staff on duty and the Registered Manager immediately;
- The senior person on duty must have a structured plan to search the home and be confident the home and grounds have been systematically searched;
- Ascertain who last saw the resident and any known plans for movements and try to discover the last time the resident was seen, where in the home, what they were wearing and how they appeared at that time;
- Where appropriate tactfully ask other residents about the missing persons plans and movements;
- Residents in the home must never be allowed to involve themselves in the search;
- Co-ordinate a thorough search of all the rooms (including the missing resident's room), locked or open, and surrounding areas, including the grounds/garden and immediate outside area, for example, main road; as each area/room is checked this must be confirmed on the Missing Person Checklist (see Appendix C);
- Where searches are outside and or in the dark, a supply of torches, a first aid kit and a space blanket must be available. Sufficient staff must remain in the home for the safety of other residents. The person(s) carrying out the search of the grounds must have mobile telephone contact where possible to the home;
- If the resident is still missing, a second check of the building/surrounding area must be carried out. Consideration must be given in relation to where the missing resident may have gone, for example, an old home address or relative/friend's address;
- The senior person on duty must at the earliest opportunity complete an incident report including details of events with times, actions and decisions. The resident's notes must also be completed with an accurate record of events.

4 Notifying Others

4.1 If after 30 minutes and the resident is not found, the following must be informed immediately.

- **Registered Manager** - If the Registered Manager was not on duty at the time of the incident, they must be notified immediately and kept up to date at all times.
- **Relatives** – the resident's relatives must be informed and kept updated on a regular basis.
- **Regional Manager** (Senior on Call Manager if out of hours)
- **Police** – the police must also be notified of the following:
    - The resident's name, date of birth and full description of the resident;
    - A recent photograph of the resident;
    - A description of the resident's well-being for example, state of mind, medical conditions, for example, diabetes, dementia;
    - Details of what the resident was last known to be wearing;
    - Details of resident's 'capabilities', for example, mobility/road crossing skills;
    - If the resident is local or not, and details of where the resident may be heading for example, old home address;
    - Details, address and telephone number of the care home; and
    - The senior person on duty must agree with police, who (the home or the police) is going to contact other agencies, for example, hospital (A&E).

4.2 A second search of the grounds must take place if the resident is not found within a further 30 minutes, the following must be informed:

- **Regional Director**
- **Care Quality Commission (CQC)** - The senior person on duty must inform CQC. This must be initially carried out verbally by telephone and followed up by a Statutory Notification about a Person who Lives in a Care Home. Refer to the CQC Statutory Notifications – Policy and Procedure.
- **Local Safeguarding** - The senior person on duty must inform the local authority (if out of hours, the duty social worker). The safeguarding team must also be informed of the incident.

4.3 If after the second search and the resident is still not found, the Senior Person on Duty must instigate a significant incident report – refer to Section 8.

4.4 It is important that when notifying others, that a contact name, date and time of the notification are noted.

5 When the Resident has been Found

5.1 When the resident has been found, the senior person on duty must ensure that all relevant parties listed in section 3 – Notifying Others are informed immediately.

5.2 An incident/accident form must be completed, as appropriate.

5.3 Staff must note the resident's well-being/condition. It may be necessary to seek advice/request a visit from the General Practitioner (GP). Staff must observe and monitor the resident closely.

5.4 Consideration must be given by the Registered Manager, after the event, to appropriate recording and assessment of future actions required to safeguard the resident, this may include setting up an urgent review. A Risk Assessment must also be completed (or reviewed if already in place) which staff must read and sign.

5.5 The well-being and safety of the resident is paramount. For some residents the experience of being lost can be distressing. However, it is important to remember that it can also be a difficult time for relatives and staff as well as the resident. It is important to ensure that support, advice and encouragement to relatives and staff is also given during and after the event.

6 Record Keeping

6.1 A full account/record must be recorded in the resident's Care Plan and updated as events occur.

6.2 It is important that when speaking to external agencies, contact names are obtained for the record.

6.3 When the resident is found, a note of where the resident was found, the time and by whom must also be recorded on the resident's Care Plan.

For more information on record keeping, refer to the Record Keeping – Policy and Procedure.

7 The Press

If appropriate, the Regional Manager must contact the Public Relations (PR) Team, Worcester.

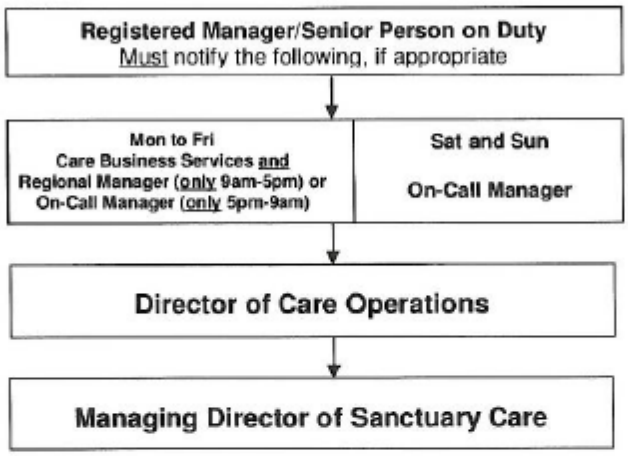
The PR Team must deal with any contact with the press and advise staff on what to do if the press contacts the care home for information.

8 Significant Incidents

8.1 In the event that a significant incident has occurred (please refer to definitions), staff must refer to the Group's Significant Incident Policy and Procedure.

8.2 Where a missing resident has not been found after the second search, a significant incident report must be instigated.

In the event of a significant incident, the following escalation process must be followed:



23.0 Appendix H – Biographical details of independent chair

Ian Winter CBE

Ian has over 40 years experience at local, regional, national and international level in health and social care. He was the Director of Adult and Children's Services in a large shire county, pioneering work on re-ablement, care management and integrating learning disability and mental health services.

Ian led an in-country assignment for the Royal Government of Cambodia, securing substantial World Bank funding over a 10 year period for healthcare.

He served for 6 years as senior civil servant in the Department of Health as regional director for London and other national projects.

Following this he worked on an integrated response to the Winterbourne View abuse scandal and researched and produced the national stocktake of progress which was used as the key bench mark for further action

Ian is the Board Chair at Croydon Care Solutions, a trading company providing innovative approaches in learning disability services and commissioning specialist support to daily living.

He currently is currently supporting a London Borough to implement the Care Act 2014 and a major project to reshape social care services.

He is the independent Chair of a Partnership and Transition Board for learning disability services for an authority in the Home Counties and an adviser to a private sector organisation in the provision of high quality care assessment services for adults.

Ian was awarded a CBE for services to social care in 2012.

October 2015

24.0 Appendix I – Dementia Information

What is Dementia

Dementia is an umbrella term for a set of symptoms including impaired thinking and memory. However, issues other than Alzheimer's can cause dementia such as. Huntington's Disease, Parkinson's Disease and Creutzfeldt-Jakob disease.

What is Alzheimer's Disease

Alzheimer's disease is a common cause of dementia causing as many as 50 to 70% of all dementia cases.

Alzheimer's is a very specific form of dementia. Symptoms include impaired thought, impaired speech, and confusion.

Alzheimer's disease causes nerve cell death and shrinkage in the brain. Tangles and plaques made up of abnormal proteins build up around nerves. This prevents communication and causes nerve cell death. When the cortex shrivels, your capacity to think, plan, and remember decreases.

Alzheimer's often severely damages the hippocampus, inhibiting your ability to form new memories. As the disease progresses, it impairs the areas of the brain involved in processing speech and spatial awareness.

How Are They Different

When a person is diagnosed with dementia, they are being diagnosed with a set of symptoms but not what is causing that particular symptom.

Another major difference between the two is that Alzheimer's is not a reversible disease. It is degenerative and incurable at this time, whereas some forms of dementia, such as a drug interaction or a vitamin deficiency, are actually reversible or

temporary.

Stages of Progression

Five stages of progressive dementia have been outlined. They are part of the Clinical Dementia Rating (CDR), which professionals use to evaluate the progression of symptoms in patients with dementia.

- Stage 1: CDR-0 or No Impairment

Stage one of the CDR represents no impairment in a person's abilities – a person is fully oriented in time and place, have normal judgment, can function out in the world, have a well-maintained home life, and are fully able to take care of their personal needs.

- Stage 2: CDR-0.5 or Questionable Impairment

A score of 0.5 on the CDR scale represents very slight impairments. A person may have minor memory inconsistencies. They might struggle to solve challenging problems and have trouble with timing. Additionally, they may be slipping at work or when engaging in social activities. At this stage, however, they can still manage their own personal care without any help.

- Stage 3: CDR-1 or Mild Impairment

At this stage a person is noticeably impaired in each area, but the changes are still mild. Short-term memory is suffering and disrupts some aspects of their day. They are starting to become disoriented geographically and may have trouble with directions and getting from one place to another.

They may start to have trouble functioning independently at events and activities outside the home. At home, chores may start to get neglected, and someone may

need to remind them when it is time to take care of personal hygiene.

- Stage 4: CDR-2 or Moderate Impairment

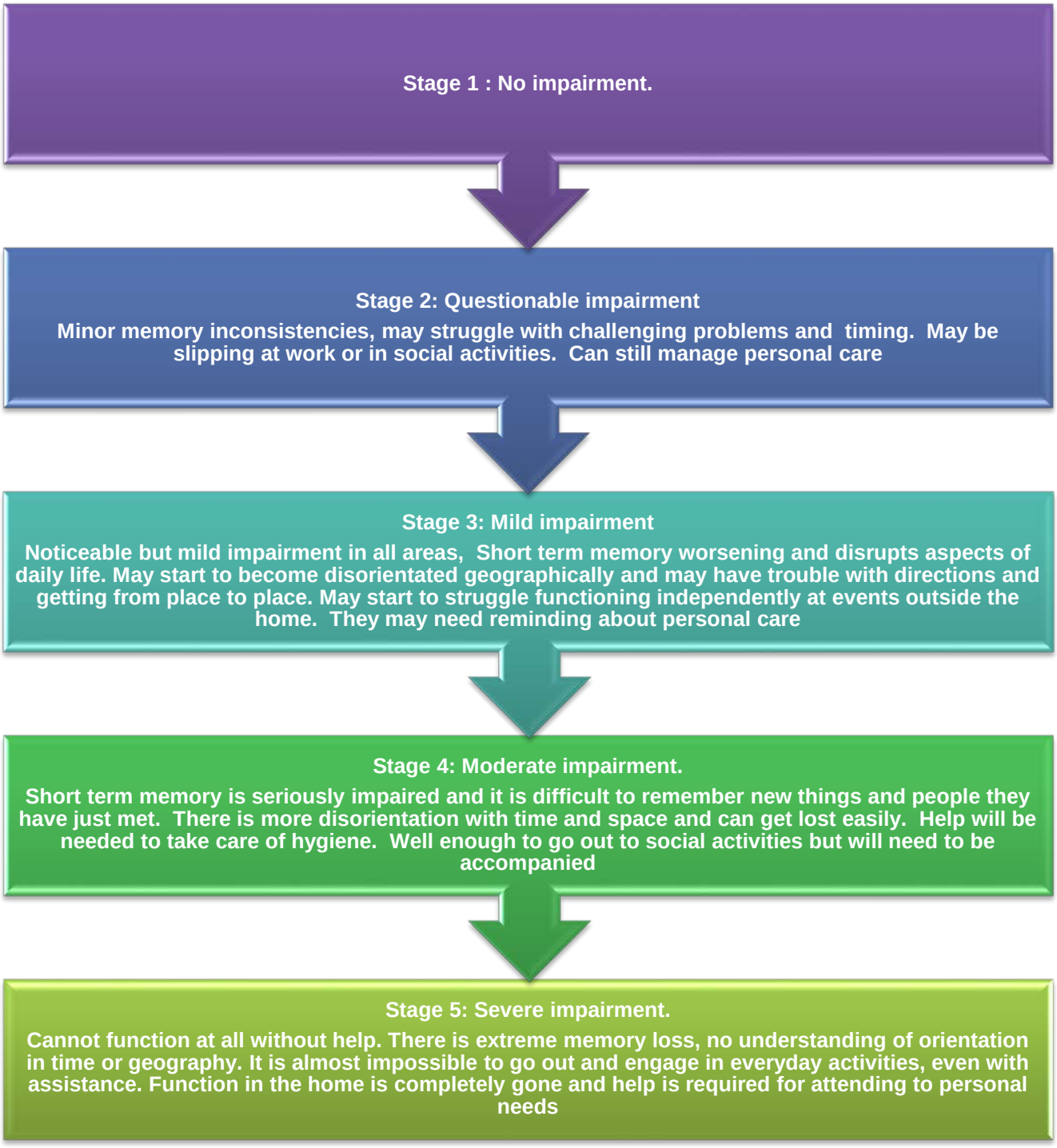
At this stage a person is moderately impaired. They now need help taking care of hygiene. Although well enough to go out to social activities or to do chores, they need to be accompanied.

At this stage there is more disorientation when it comes to time and space. They get lost easily and struggle to understand time relationships. Short-term memory is seriously impaired and it is difficult to remember anything new, including people they just met.

- Stage 5: CDR-3 or Severe Impairment

The fifth stage of dementia is the most severe. At this point a person cannot function at all without help. They have experienced extreme memory loss. Additionally, they have no understanding of orientation in time or geography. It is almost impossible to go out and engage in everyday activities, even with assistance. Function in the home is completely gone and help is required for attending to personal needs.

Stages of Dementia



25.0 Appendix J – Walking Safely

"Wandering" is one of the most dangerous behaviours associated with Alzheimer's disease. An Alzheimer's patient who is outside alone can easily become lost, confused, injured, or even die from exposure or other safety risks. It is estimated to occur in 15 - 60% of people with dementia (Robinson et al., 2007), although prevalence is difficult to assess. This can happen at any stage of the disease.

In the past it was common to refer to "wandering". The preferred term now is walking or safe walking as it reflects that "wandering" is not a term used by people with dementia who find the experience of walking enjoyable[6]

The Alzheimer' Society describe walking in a safe environment as a usually a positive experience that can provide physical and psychological benefits for a person with dementia. The motivation to walk is varied and usually represents a response to a need, such as boredom or discomfort, or may be from habit. However, some walking can be problematic, when it has associated risks.

One study found that the risk of getting lost was substantial, with about 40% of people with dementia getting lost outside their home. This sometimes resulted in increased confinement within the home and an increased chance of becoming permanently resident in an institution (McShane et al., 1998). Other associated risks include physical harm, emotional distress, and premature mortality (O'Connor et al., 1990; Ballard et al., 2001; Algase, 2005).

Interventions to assist safer walking should be encouraged, rather than to prevent wandering, in order to balance the need to minimise risk with the need for personal freedom (Coltharp et al., 1996; Cohen-Mansfield and Werner, 1998), and because of the benefits of walking.

Many people with dementia feel compelled to walk about and may leave their homes.

[6] (Dewing, 2006; Robinson *et al.,* 2007).

Walking is not a problem in itself – it can help to relieve stress and boredom and can provide exercise. However, it can be worrying for those around the person and may at times put the person in danger. It is important to find a solution that preserves the person's independence and dignity.

Why might people walk about?

There could be a number of reasons why a person with dementia walks around.

Possible reasons include:

- continuing a habit - If the person has enjoyed walking in the past, they will naturally want to continue doing this. You may find that they want to walk more at particular times of day, for example at times when they might have gone to work or collected children from school. Try to make this possible for as long as you can. If you are unable to accompany the person yourself, you may be able to enlist the help of relatives or friends
- relieving boredom
- using up energy
- relieving pain and discomfort
- responding to anxiety - Some people walk about if they are agitated, stressed or anxious.
- feeling lost - If the person has recently moved home, or if they are going to a new day centre or having residential respite care, they may feel uncertain about new surroundings. In this situation it may help to show the person familiar items, such as photographs or clothing, in order to indicate that they belong in a new place.
- memory loss - A person may set off with a specific goal, forget where they are going and then get lost
- searching for the past
- seeking fulfilment
- getting confused about the time.

Practical measures to reduce risk

Rowe (2003) emphasises the need to distinguish between *wandering* and *getting lost* in effective risk mitigation; 'people who wander may never become lost and those who never wander may become lost'. Analyses of instances where people with dementia have become lost highlight the need to alert emergency services as quickly as possible rather than wait and see if they return home (Rowe *et al.,* 2004).

Other ideas about how to help mitigate the risks of walking include risk assessment screening tools (UK Wandering Network, 2005-2009) to identify those who are at greater risk of coming to harm if they leave home and helpcards (Alzheimer's Society, 2010b) that can be carried so that if a person with dementia becomes lost, other people will realise that he or she has dementia. Safe walking technologies (Robinson *et al.,* 2007; Doughty & Dunk, 2009), such as exit monitors and global positioning systems (GPS), indicate when people have left a building or monitor their movements while out. Identity bracelets or mobile telephones can also be used (Walker *et al.,* 2006; Robinson *et al.,* 2007), although it is important to remember that some people with dementia may see such devices as intrusive (Robinson *et al.,* 2007) and so they should not be used without discussion or consideration of the ethical issues.

Care Providers

Care provides must take precautions to prevent people in their care from wandering away unnoticed. Good practice measures could include:

- At or before admission, staff familiarise themselves with the new person through an interview, assessment or lifestyle biography. This helps them to learn what that individual's behaviours are and what he or she has enjoyed in the past. Staff can then design individualized care plans with meaningful and appropriate activities that help residents remain focused and calm.
- Alarms on outside exits to alert staff if anyone leaves the building.

- High staffing ratios enable staff to participate in one-on-one activities and offer individualised attention.
- Taking extra care during turnover times, such as during shift changes or at pickup times in day programmes, when remaining participants might get the idea to leave and/or follow others out the door.
- Alzheimer's individuals tend to be more prone to wandering when they become agitated or upset. Listening to their favourite music through headphones can be soothing.

If a Person Goes Missing

Even with precautions, there is always a possibility that an individual with dementia may wander slip away unnoticed. They may be on foot or might have taken another form of transportation. If this happens, there are several things that may help find the missing person as quickly as possible.

- Notify the police. When a person with dementia goes missing, it needs to be treated as an emergency.
- Have several copies of a recent, close-up photograph of the person to give to police, neighbours, and anyone else who might be searching.
- Check with neighbours to see if anyone spotted the missing person.
- Keep a list (several copies) of the person's identifying features to share with search personnel. These would include age, sex, height, weight, and other physical features, as well as blood type, health conditions, medications, dental work, dietary needs, and other pertinent information.
- Provide an unwashed article of clothing that has been worn by the person and kept in a plastic bag, as this can assist police dogs in the search.
- Be aware of dangerous places in your neighbourhood that should be searched first, such as busy roads, bridges, streams, overpasses, drainage ditches, or steep terrain.
- Provide a list of places where the person likes to go, such as a shopping centre, place of worship, a park, an old job site, or former home.

- The more people in the community you inform about an individual with dementia and the risk of walking and becoming lost, the more help you can enlist to search for and locate the missing person.

26.0 Appendix K – Information provided by the Care Home Provider at the request of the author to outline their unlocked door approach

"Care Home 1 have managed their "open-door" policy by utilising standard door furniture in accordance with the County Council standards. Some residents would be able to exit the home voluntarily because they have the physical and mental capacity to do so. Where circumstances change, for example due to a reduction in mental capacity, care plans and risk assessments are updated, additional controls put in place (such as regular checks and risk assessment, and staff briefed accordingly). The reception, staff and managers offices are located so that during the day, there is high visibility of the entrance and car park and persons entering and exiting are generally well-observed. The front door has an external keypad to the door to protect the home from unwanted visitors and a normal turn lock to the inside. In addition an alarm was already in place on the front door which was activated at times outside reception managed times, although this was generally after 8pm when night staff commenced duty. The alarm was operated via a magnetic strip mechanism and became activated the moment the door was opened. After 8pm on a daily basis the door was locked at the turn lock (yale mechanism) and an additional bolt lock to the top of the door and the base of the door were engaged to maximise on safety.

After 5pm things begin to quieten down with residents having dinner, watching TV and going to bed etc, so residents are usually located together in known places and in front of staff. The care office is adjacent to the reception area, where senior care staff usually complete all care record information (and handovers from the afternoon shift to the night shift would start taking place around 7.30pm to 7.45pm when the night shift arrive for duty), so there are usually care and senior care staff in this area. Also, I would have thought that care assistants also are in and out of that

office and in and around the reception area. This office is generally in the proximity of the reception area so when administrative staff had left and it was unmanned senior care staff completing paperwork can clearly hear anyone in the reception area and if the front door was to be opened. Although the senior staff member does not have direct sight of the reception, they have direct view through a window to observe anyone that has left through the front door. If someone is in the office, the location of the window allows staff to clearly see anyone that leaves the premises through the front door without being observed.

Additionally, the staff room and Manager's office windows are also adjacent to reception area and therefore when someone is in these areas they would witness someone leaving the building via the front door or from the rear car park door. So there is always someone in and around the front area.

Management of this area was a local agreement that senior staff members initiated on a daily basis and dependent on any residents needs at the time. Anyone that the home were aware of who might be inclined to walk out of the home or were showing signs of repeated, determined attempts (staff have confirmed they did not think Michael Upward was making serious attempts to leave as he was not distressed / agitated and easily distracted and persuaded back from either the door or the garden gate) would be put on at least 30 minute observations, in addition to locking and alarming the door and closing the curtains as a distraction. These measures, and any necessary other controls, would normally be used once concerns regarding a resident wanting to leave were established, maybe due to a deterioration in that person's mental health needs or as a result of a change in their condition which has resulted in increased 'walking / wandering'."