

A Report into the care and treatment of Adult A

Safeguarding Adults Review

Gateshead Safeguarding Board

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# Introduction

This report concerns the death of an 81-year-old lady, Adult A. She lived alone and died on 17th February 2015 in Queen Elizabeth Hospital (QEH). The cause of death was identified as cardiac failure, sepsis and extensive pressure sores due to immobility. Adult A’s health was declining over the period before her death, she refused Hospital admission on a number of occasions. At times, Adult A also refused care and treatment at home. There were a number of agencies involved with Adult A and the Adult Safeguarding Board made the decision to refer Adult A for a Safeguarding Adults Review to learn the lessons from her unfortunate death.

The Adult Safeguarding Board would like to express their thanks to everyone who participated in the review of Adult A’s death. We have not been able to contact Adult A’s daughter but would like to express our condolences to her family and friends.

# Terms of Reference

Safeguarding Adults Boards were set up as statutory bodies under Section 43 of the Care Act 2014. The Act places the responsibility on local authorities to establish such Boards in order to help and protect adults in their respective areas where the local authority has reasonable cause to suspect that an adult in its area -

*(a) has needs for care and support (whether or not the authority is meeting any of those needs);*

*(b) is experiencing, or is at risk of, abuse or neglect, and*

*(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

The statutory bodies comprising Gateshead’s Safeguarding Adults Board are:

* Gateshead Council;
* Northumbria Police; and
* Newcastle Gateshead Clinical Commissioning Group.

Safeguarding Adults Reviews were established on a statutory basis under section 44 of the Care Act 2014. The Act imposes a duty upon Safeguarding Adults Boards to arrange for there to be a review of a case when certain criteria are met. This criterion is set out in detail in Section 44 of the Act.

Adult A was referred by Newcastle Gateshead Clinical Commissioning Group. The Safeguarding Adults Board considered the circumstances of this case against the criteria set out in the Care Act 2014 and agreed to undertake a Safeguarding Adults Review (SAR).

# The Purpose of the SAR

The purpose of a SAR is to scrutinise the case in question in detail to identify any lessons to be learned, which could be applied to future cases to prevent further incidents of abuse or neglect.

# Local terms of reference

The Safeguarding Adults Review Panel has also proposed a series of local objectives to be considered throughout the course of the SAR:

* To request and review information from North East Ambulance Service;
* To liaise with Adult Social Care Direct regarding conversations and information exchange between Council officers and Adult A’s GP;
* To consider how agencies involved in the case worked together and whether this multi-agency working could have been more effective;
* To consider why a safeguarding alert was not raised following the fire in Adult A’s home;
* To request information from the care provider, particularly following information received relating to the fact that the carers involved with the client were struggling to deal with her needs;
* To consider the inconsistencies in relation to understanding of mental capacity across all agencies involved in the case, with particular reference to partners from health; and the application of the Mental Capacity Act 2005;
* To consider how Adult A appeared to fall between gaps in services between January and February 2015;
* To consider whether the matter was considered as urgently as it should have been by agencies and to further consider why a revised care package was not considered sooner;
* Given the lack of supporting evidence, to consider why no meaningful conversation took place with Adult A which outlined, in simple terms, the gravity of her health situation and the options that were available to her at that time;
* To consider the delay in making an application for Continuing Health Care involvement to address Adult A’s increased needs;
* To consider whether agencies should have come together sooner to discuss the Adult A’s case in detail; and
* To consider why Adult A consistently refused to engage with most services, and to reflect on how engagement with the client could have been improved.

# Membership of the Board

The members of the Safeguarding Adults Review Panel was:

Independent Chair;

Newcastle Gateshead Clinical Commissioning Group;

Northumbria Police

Gateshead Council;

South Tyneside NHS Health Foundation Trust;

Gateshead NHS Health Foundation Trust;

North East Ambulance Service; and

The Gateshead Housing Company.

# Involvement of family

Gateshead Council had a contact telephone number and address for Adult A’s daughter who had involvement in her care. A letter was sent to this address and there was no reply. The telephone number was rung but the number did not connect. The District Nurses had the same telephone number and address but a different house number and therefore a second letter was sent with no reply. Adult A’s daughter lived in the South of the Country.

During the Appreciative Workshop, information was shared about other siblings which not all the agencies were aware of, the panel had no contact details for these family members.

Contact with families is essential for any review, both in terms of keeping family members involved with the process but also any information they can provide. It is disappointing that the panel were not able to make contact with family members.

The information shared at the Appreciative Workshop was that family members did not always have a good relationship with each other or Adult A.

# Methodology

## Scope of the review

The agencies involved with Adult A were asked to provide written chronologies from 02.04.2014 to 17.02.2015. Any relevant information prior to this timeframe was submitted as a summary.

## Agencies who provided chronologies

Chronologies were provided by the following agencies:

* North East Ambulance Service NHS Foundation Trust (NEAS)
* South Tyneside NHS Foundation Trust – District Nursing Service (STNHSFT)
* Gateshead Council Adult Social Care – Care Management
* Gateshead Council Adult Social Care – Safeguarding
* Gateshead Clinical Commissioning Group
* TGHC – Gateshead Housing Company
* Queen Elizabeth Hospital

## Other information shared with the Review

The author of the Review has seen the Coroner’s report and a letter from a Consultant Psychiatrist.

## Information not available

The Review was not able to receive information from the care provider as this agency had been decommissioned. Letters were sent to the provider and they were contacted a number of times but declined to be involved. The care provider had significant involvement with Adult A and would have been able to offer valuable information.

## Appreciative Workshop

The decision was made by the Safeguarding Adults Board to hold an Appreciative Workshop as a means of gathering and analysing information rather than request Independent Management Reports (IMRs) from each agency. This approach and the information is discussed later in the report.

# Timeline taken from the chronologies

This is a summary of the information provided by the agencies who submitted chronologies.

Adult A lived in her accommodation since 11th March 2008. This was general needs accommodation and there were no incidents of note. The Caretaker recorded difficulty gaining entry to do small repairs because Adult A was very hard of hearing and therefore he went in when the carers were present in the afternoon. There is reference to a fire within the home but on closer scrutiny this was only smoke and therefore no safeguarding alert was raised.

In 2008, Adult A had her left leg amputated below the knee due to poor circulation but she was able to mobilise using a scooter. There were concerns about Adult A’s self-care, she was taking off her own dressings, refusing to let the District Nurse dress her wound and at times the dressings would not be intact. Following this period, Adult A was seen regularly by the District Nursing Service.

District Nursing became involved in September 2013 because of a wound to Adult A’s right foot and ankle.

Adult A was referred to the Vascular Clinic and her first appointment was 9th December 2013. Within the chronologies, there were references to indicate the Vascular Service was involved throughout with Adult A and they were aware of the issues of her non-compliance with care and treatment.

In June 2014, there was evidence that Adult A was not taking her medication correctly and blister packs were ordered because of concerns about her memory. 22nd June 2014, the District Nurse completed a Mini Mental Test for dementia screening. The score was 21 out of 30 which suggested an increased likelihood of dementia, although 21 was a borderline score.

On 1st July 2014, Adult A complained about the carers’ attitude and put in a safeguarding alert, this alert was not progressed to a referral and therefore the episode was not investigated. Adult A complained that the night time carer had told her that she ‘would have to get ready by herself’. When the same carer attended the following night, Adult A refused her access and slept in her wheelchair. The Manager of care provider said that sometimes Adult A would refuse to allow certain carers in. Also some individual carers refused to work with her because of the way that she spoke to them. On 14th July 2014, the Social Worker reviewed the care plan with Adult A’s daughter present. Adult A said she was not happy with care provider and wanted to change to another company. She was later visited by the Manager and she agreed to retain them. This was not progressed to Safeguarding and the outcome was recorded as ‘no further action’

10th July 2014, antibiotics prescribed because Adult A’s wound was infected.

13th July 2014, Adult A’s daughter was visiting and changed her dressings, she was advised that this should be done by the District Nurse to reduce infection.

In July 2014 there were concerns regarding Adult A’s confusion. On 3rd July 2014 GP 3 completed a Mini Mental State Examination and Adult A scored 21/30. A score of 19 – 24 is considered a mild range of confusion. Adult A did not hear or see the ‘call through’, the system used to alert patients to go into see the GP for the appointment. The GP referred Adult A for an assessment by Old Age Psychiatry.

Letter from Old Age Psychiatry detailed the outcome of the assessment completed on 21st July 2014. Adult A was diagnosed with possible Vascular Dementia but the history was also consistent with Alzheimer’s. Adult A refused a scan or Occupational Therapy and the plan was to review her in 6 months, 12th February 2015, but by this time Adult A was in Hospital.

29th July 2014, Adult A attended for a GP Consultation, she presented with slight confusion. She remembered the year and month but could not recall the date however she checked the date on her appointment card which was the previous day.

August 2014, Adult A fell from her scooter because the belt was not secure. The paramedics were called but Adult A had sustained no physical injuries.

3rd September 2014 the neighbour informed the District Nurse that there had been a fire over the weekend. Adult A could not initially recall this but remembered she left her cooker on with her grabber stick on the hob which was melting, causing alarms to go off. On further scrutiny this was only smoke and not flames.

15th September 2014, the District Nurse spoke to Adult A’s daughter about concerns about her mother’s memory. It was agreed that the daughter was going to speak to the carers about overseeing her taking medication because of problems with Adult A’s memory.

On 17th September 2014, Adult A’s daughter was concerned about her mother’s low mood and weight loss. She had a previous diagnosis of depression. Adult A was seen at the surgery on 19th September 2014, she denied low mood and said that she had only lost a small amount of weight.

17th September 2014 Adult A complained about not being able to swallow paracetamol but could manage other medication. Her paracetamol was changed to caplets.

During September/October/November 2014 there was evidence that Adult A was not taking her medication correctly. She had some stashed in a drawer; she had difficulty swallowing tablets; there was a deterioration in her ulcers and a grade 2 sore on her heel. Adult A was not compliant with her dressings and applying ‘Fiery Jack’ to her wounds which was not helping. Adult A already had a pressure relieving mattress in situ. The District Nurses continued to visit, carers were visiting 4 x day and the GP prescribed antibiotics to treat the wound. Adult A initially mislaid the antibiotics.

1st October 2014, Adult A was seen at the GP Surgery and she was prescribed antibiotics for ulcers on foot. Adult A said she was struggling with the pain relief – she had difficulty swallowing the paracetamol and manipulating the small codeine tablets and she requested soluble pain relief. She had Osteoarthritis and her knee was painful.

4th November 2014, Adult A had 3 ulcers to her foot which were infected and antibiotics prescribed. On 11th November 2014, Adult A requested a repeat dose of co-codamol effervescent but the GP prescribed tablets because her sodium levels were high and the effervescent is high in sodium.

15th November 2014 Adult A was admitted to Queen Elizabeth Hospital (QEH) following a fall where she sustained a fractured tibia.

17th November 2014, Adult Social Care spoke to Adult A and her daughter because of her admission to Hospital and pending discharge. Adult A said she was happy with the level of care she was receiving and did not want an increase.

On 21st November 2014 was discharged home. She was not able to weight bear and was nursed in bed. Adult A had a Hospital bed and air flow mattress to help with her skin integrity. The District Nurses recorded that she was incontinent of faeces and urine. It was difficult treating the sores on her heel and leg because she had a back slab for her leg which had to be removed to allow the wound treatment.

By 25th November 2014, an additional visit from the carers had been added at 6pm to provide support with toileting and a medication prompt.

On 26th November 2014 the Care Workers reported that Adult A had a break on her sacrum. The District Nurses visited daily to treat the wound. Also on this day, Adult A rang the GP Surgery to request an increase in her pain relief for when the Nurses do the dressings. The GP added in Codeine 30mgs x 4 for the carers to prompt.

1st December 2014, the District Nurse gave advice regarding pressure relief and high protein diet and Adult A was referred to the Dietitian.

3rd December 2014, the District Nurse said the wound to the top of her foot was much improved but it was difficult to assess the heel because of the position of the wound. The Care Worker said they were expecting a new wheelchair.

Between the 10th and 15th December 2014, the District Nurses described Adult A as ‘well and chatty’.

16th December 2014, the District Nurse was concerned about rapid weight loss, grade 3 ulcers had developed on her sacrum and there were multiple breaks. When the Nurse dressed the wounds, Adult A was screaming in pain. Later that day there was a joint visit by GP 4 and the District Nurse. The GP recorded: Adult A ‘looks dreadful, lying in her own faeces, new pressure ulcer over sacrum. In pain with ammonia smell. Needs admission for pressure care and possible amputation of lower leg’. The District Nurse reported that the carers were struggling to cope, there was increased confusion and Adult A appeared to be suffering from hallucinations.

Adult A was admitted to Queen Elizabeth Hospital with limb problems, gangrene in her leg and sacral sores.

On 23rd December 2014 there was a referral from the Ward to Adult Social Care and a conversation between the Ward Sister and the Adult Social Care Assessing Officer about Adult A’s level of care needs, Adult A wanted to return home but the Doctor felt that she needed a care setting until her cast could be removed. There was a discussion with Adult A and the Manager of the care provider, and it was agreed that the care provider could manage her care needs because they had cared for her previously when she had a broken leg. The referral was closed 29th December 2014 because there were already carers in place.

Adult A was discharged home from Hospital on 31st December 2014 against the advice of the District Nurses. The Hospital staff also had concerns about the discharge but it was clear that Adult A wanted to go home and would have discharged herself from Hospital.

The discharge letter from Queen Elizabeth Hospital. recorded that Adult A had the following health conditions: dementia; her right leg was in a cast and she was not to weight bear for 3 months; she had a category 4 damage to her sacrum and her general condition had deteriorated. Adult A refused to have right leg amputated, whilst in Hospital she had completed course of antibiotics. Adult A refused to have an increase in her package of care from 4 x calls daily. Her daughter was visiting over the weekend and therefore she would be able to prompt with fluids and positional changes. The plans on discharge were: District Nurse to speak to Social Worker to ensure the care package is adequate, Occupational Therapy for advice on seating, referrals to the Tissue Viability Nurse and the Dietitian.

On 1st January 2014 the District Nurse contacted the out of hour’s team requesting an increased package of care. An Officer from Adult Social Care Direct (ASCD) telephoned Adult A who said she did not want an increase in her care. The ASCD officer felt that her more pressing needs was for more suitable seating than her wheelchair and arranged for the Occupational Therapist Assistant to visit.

On 2nd January 2015, the District Nurse referred Adult A for an urgent Social Work assessment and re-referred to the Dietitian because she missed the appointment whilst in Hospital.

5th January 2015, the District Nurse completed a home visit and planned to request GP home visit to review pain and chesty cough. The District Nurse also shared concerns with Social Workers over the care workers not administering medication on that day.

The Urgent Care Team visited on 5th January 2015 to assess for chest infection, Adult A refused an assessment. The notes indicate that a capacity assessment was undertaken and Adult A was deemed to have capacity to refuse treatment. It is not clear if this was a recorded capacity assessment.

On 6th January 2015, the Tissue Viability visited and assessed Adult A’s wound, she recommended that Adult A be nursed in bed but she did not want this therefore a referral was made for a seating assessment.

GP attempted to complete a home visit but could not get in because Adult A was not able to hear the Doctor. He returned later with the District Nurse. The Doctor believed the situation to be ‘untenable’.

A Continuing Healthcare Checklist (CHC) was completed and was in the District Nurse records, the following was recorded under the different domains:

* ‘cognition’: problems with short term memory;
* ‘psychological / emotional’ - periods of distress;
* ‘communication’ - unable to reliably communicate their needs;
* ‘mobility’ - completely unable to weight bear;
* ‘nutrition’ - nutritional status at risk may be due to unintended weight loss;
* ‘continence’ - continence care is routine;
* ‘skin integrity’ - pressure damage or open wounds responding to treatment;
* ‘breathing’ - normal;
* ‘drug therapy / medication’ - requires assistance’.

On 9th January 2015, Adult A had a further category grade 3 pressure sore to her right foot. She also has chronic vascular ulcers on the same foot. The District Nurses encouraged the Care Workers to re-position on every visit with the recognition that Adult A may often refuse and she refused overnight carers.

Between 10 – 14th January 2015, the District Nurses reported that Adult A was not eating and she said she was not hungry. Also she had run out of pain relief over the weekend.

On 13th January 2015 there was a home visit by GP. Adult A’s breakfast was at the side of the bed. District Nurse said sacral sore was improving and the plan was to continue with the treatment. There was concern about the situation.

On 15th January 2015 the Urgent Care Team visited and Adult A refused treatment. They recommended admission to Hospital due to the potential for dehydration but Adult A refused to consider this. The Urgent Care Team completed a ‘Refusal of Treatment Form’ stated that Adult A was able to process information and able to retain and recall information around risk and therefore on this basis was judged to have capacity to refuse admission to Hospital.

On 16th January 2015, Adult A was asking the District Nurses to leave her alone. The District Nurses were concerned about her fluid and dietary intake. Adult A refused Hospital admission or an intermediate care bed. Social Care Duty Worker contacted the Intermediate Care Manager who said an Intermediate Care Bed was not appropriate because Adult A could not weight bear and suggested signposting to the GP. The Duty Worker contacted the District Nurse who was going to contact the GP. The outcome of the contact with Adult Social Care was ‘no further action’.

Later that day, the GP visited after Surgery and recorded the following: *‘a very difficult situation. Adult A acknowledges her difficulties, but, is adamant that she will not go to hospital (and I note her unsuitability for an intermediate care bed). Adult A says that she likes her home because ‘it’s nice and quiet’, but, does admit that she feels low because of her overall situation (which is understandable). Adult A states that she is pain free at present, her breathing is a lot better since starting the antibiotics*.’ The GP commented that he felt that Adult A had capacity at present to make decisions about her care and treatment.

On 19th January 2015 Adult A’s bed was soaked in urine. The District Nurse notes indicate that the manager of care provider said they were finding it difficult to meet Adult A’s needs and Adult A had refused to an increase the services or to be allocated a Social Worker. There was a telephone call between the Manager of the care provider and ASCD, the Manager of the care provider said it was difficult to provide personal hygiene care and positional changes because Adult A refused. The notes indicated that the Manager of the care provider said that Adult A did not have a ‘mental disability’ and therefore had the capacity to refuse care. ASCD said care could not be increased without Adult A’s consent. Information from ASCD was that advice was sought from the team and the opinion was that because Adult A had capacity and, was aware of the consequences, it was her choice to refuse or accept additional care. It was said that they could not increase services or visit against her will. The advice was for the care provider to continue to coax her to accept treatment and positional changes. ASCD recorded ‘No further action’ as an outcome at this stage.

There was a telephone call from the GP to ASCD requesting additional support and this appeared a difficult conversation. ASCD contacted the District Nurse for an update and was informed that Adult A was refusing all care but that a GP had visited on 16th January 2015 and deemed her to have capacity. The ASCD Officer rang Adult A and asked if a Duty Worker could visit, Adult A refused. The ASCD Officer requested that the capacity assessment from the 16th January be shared with ASCD. When this was discussed with the GP, he said a formal capacity assessment had not been completed and that it was difficult to say if Adult A ‘does or does not have capacity’. It seems that the ASCD Officer asked for a capacity assessment to be completed and the GP said ‘not by them’. It would have to be referred to Old Age Psychiatry (OAP) but this could take months. The ASCD contacted the District Nurse to arrange a request for an OAP Psychiatrist to complete a capacity assessment as soon as possible. Outcome for Adult Social Care at this time ‘no further action’.

On 19th January 2015 the District Nurse raised concerns with the Adult Safeguarding Advisor South Tyneside NHS Foundation Trust (STNHSFT). She was concerned that Adult A had discharged herself against professional advice, she had grade 4 pressure damage and was refusing to let care workers give her personal care and medication. The notes from the District Nurse chronology stated that Adult A ‘does have mild dementia but has full capacity to understand the risk she poses if she does not engage with care and treatment’. There was a discussion about possible depression and the GP had considered increasing her medication but currently she was not taking any. The agreed plan was: to raise a Safeguarding Alert, to discuss the need for a risk management/information sharing meeting to discuss risks and how these may be minimised. Also consideration to be given to the Trust Legal representatives attending the meeting. The Clinical Operational Manager to contact Social Care to see whether or not a Social Worker would attend the risk management meeting.

On 20th January 2015, the District Nurse notes indicated that the District Nurse discussed Adult A with the ASCD Officer at Gateshead Adult Social Care. The ASCD said that a Duty Worker could not visit Adult A because she had declined a visit and she had capacity to make this decision. There appeared to be agreement that a capacity assessment needed to be undertaken to determine the next steps. It was questioned whether or not any of the District Nurse had completed the Mental Capacity Act Champion Training and would be therefore able to assess Adult A’s capacity. The ASCD Officer said that a Social Worker would attend a risk management meeting.

There was evidence that the District Nurse Service escalated concerns upward to Senior Managers. Two root cause analysis were undertaken and the concerns regarding one GP’s understanding of mental capacity were discussed. The Safeguarding Lead for the Clinical Commissioning Group (CCG) contacted the ASCD Officer and suggested that a Social Worker should visit and not take no for an answer. The Duty Worker said that they would not be able to gain access and because Adult A had said no, this would be trespassing. The District Nurse Manager agreed to go out the next day with the case worker to do a capacity assessment.

Also on 20th January 2015, the Occupational Therapy Assistant (OTA) visited and assessed Adult A for her seating requirements. The notes indicated that ‘Adult A was very pleasant and co-operative regarding having a pressure reclining chair to sit in’ and following this visit the chair was ordered.

On 21st January 2015, there was an update within the District Nurse service. The District Nurse Manager had visited and found Adult A’s capacity to be fluctuating but that she had capacity. The Consultant Psychiatrist from Old Age Psychiatry, was to visit on 22nd January 2015 to complete a further capacity assessment. The District Nurse raised a Safeguarding Concern because it appears that the carers were not spending the full time with Adult A and there were out of date food in the fridge. The District Nurse reported that when she was there, Adult A ate a bowl of Frosties and can do this with persuasion. Also concerns about how her money was being managed because she could no longer get out on her scooter. The Manager of care provider wanted to put in a safeguarding alert because of self-neglect but was advised this was not a category therefore this was not progressed to Safeguarding.

22nd January 2015, the District Nurse attended and Adult A refused to swallow antibiotics because of the size and it was arranged for it to be given in suspension format. 29th January 2015, the District Nurse recorded that Adult A refused to be re-positioned which meant that she had not changed her position for 16 hours. In addition, the carer had not turned up that morning and this was reported to the care agency.

The District Nurse records noted a letter from the GP on 29th January 2015, the GP recorded that Adult A felt reasonably well, she was eating and sleeping and happy for the carers to visit. There was no evidence of depression. Her score on the Mini Mental State Examination (MMSE) was 15/30 with 5/10 for orientation and 1/3 for recall. The MMSE is a useful tool to test for cognition and memory loss. The GP explored capacity in relation to accommodation and Adult A was aware of the difference of living in care and her own home. She did not want to go into care and would prefer to ‘die in her own home’. He recorded that it was ‘doubtful she could weigh up information regarding her health and welfare fully in making a decision about her future accommodation’. What came across was that Adult A was ‘adamant that she wanted to stay at home.’ The GP recorded that on the balance of probably she probably did have capacity to make a decision regarding her future.

The District Nurse reported to the GP that there was a momentary speech problem 29th January 2015 when Adult A was being moved. She was unable to say anything for a few seconds, then the odd word was uttered that did not make sense; lasted seconds, then as soon as she was made comfortable, reverted to normal speech. No facial / limb weakness noted and Care Staff report that there was a similar incident yesterday. They also informed the District Nurse that they have noticed that the fingers on her left hand are contracted, this is a new sign. Adult A may require a speech therapy assessment / swallowing assessment.

29th January 2015, a Safeguarding Alert was raised by the District Nurse about the care workers not spending the allocated hours with Adult A. Also about who was managing her finances as she was no longer able to go out on her mobility scooter.

30th January 2015, the District Nurse reported that Adult A had a wound on her left shoulder. There were on-going problems with re-positioning and personal care because of discomfort and her oral intake was also very poor.

30th January 2015, there was a home visit by GP. Adult A reported that she felt better because the plaster had been removed from her leg. She said she was not in pain, was eating a bit more and was adamant that she wanted to remain in her own home. GP agreed with OAP Psychiatrist and previous GP that Adult A has limited capacity but able to make decisions that affect her.

1st February 2015, Adult A refused a wash and pad change by carers.

3rd February 2015, joint visit from District Nurse and Tissue Viability Nurse. Adult A refusing overnight care and did not like the supplementary drinks.

4th February 2015, the District Nurse visited and was concerned that there was a soiled pad on the floor, Adult A was in a wet bed and her breakfast was out of reach. Care workers had visited for 40 minutes, not 60. Adult A declined to be moved. District Nurse contacted the care agency and discussed concern with Adult Social Care. District Nurse informed that the decision from the Safeguarding Alert was that a Social Worker would become involved.

Later that day, the South Tyneside Foundation Trust Safeguarding Advisor spoke to the Safeguarding Adult Co-ordination Team to discuss why the safeguarding alert was not progressed. Was told the alert was open and information should be sent to the Social Worker.

5th February 2015, the District Nurse observed the care worker carry out care whilst wearing her outdoor coat. She refused to take it off and she had no apron or gloves. These concerns were raised with care provider and the manager agreed to do a spot check.

Also on 5th February 2015, the District Nurse telephoned ASCD and said that Adult A continuing to refuse care from carers. Advised that a Social Worker had been allocated to Adult A and this information would be passed to her.

On 6th February 2015, District Nurse attended to provide wound care and found Adult A in soiled pads. The care workers were contacted and they said they were ‘stuck in traffic’.

On 6th February 2015 there was a Safeguarding concern generated by Commissioning as a Whistle-blower had contacted them. The person gave details about Adult A and her health and care needs and said that she had arrived at her house to care for her but the other carer did not turn up. The carer provided the care herself. This was not progressed to Safeguarding because the inadequacies in the care led to no discomfort or harm.

8th February 2015, Adult A’s daughter was present and it appears she remained there until 10th February 2015 and her granddaughter was to visit over the weekend.

10th February 2015, the Social Worker spoke to Adult A’s daughter and fed back concerns and the need for overnight support but also the outcome of the capacity assessment and the belief that Adult A had capacity. Adult A’s daughter said she would talk to her mother about a Nursing Home but anticipated a refusal.

On 10th February 2015, call to 111 from daughter. She gave Adult A’s medical history and deterioration in health from Christmas. Adult A was not taking any food but was taking energy drinks. She experiences pain when the carers move her but was settled at the time of the call. The advice from 111 was to monitor and continue with pain relief.

10th February 2015, the GP chronology indicates that Adult A may have clostridium difficile.

11th February 2015 the District Nurse visited with the GP and was concerned about infection. At this time, the concerns about her health indicated Hospital admission. The ambulance service received a 999 call on behalf of Adult A. It was said that Adult A was in pain and her condition had worsened. An urgent vehicle was dispatched but Adult A refused to get in. The GP was called out and Adult A refused to get in a second time following which the GP prescribed antibiotics for a query infection and Oramorph for general pain.

The GP rang the Social Worker and updated her and said that in his view Adult A needed to be in Hospital but there was the issue about capacity. The GP recorded the following in the notes: ‘Adult A stated that she will not go to hospital as she *‘hates the place, didn’t like the way they treated me’.* Further discussion was held about the consequences of not going into hospital and the possible outcome of this decision, in particular that her safety was at risk and that she could die if the infection form her bed sores became systemic. The GP took a basic capacity assessment as per the MCA1 form (scanned in the records) and concluded (as did Psychiatrist 1 on 22.01.2015) that, for the specific purpose of understanding what was being suggested, that is, admission to Hospital, and the consequences of refusing this, that is, she could die, then at this moment I think she does, just, have capacity.

The GP notes that the following plans were put in place:

* Started treatment with erythromycin liquid for the infection – written notes left for Carers and Nursing team.
* Prescribed oramorph liquid which can be used for pain control as needed, again, instructions left for the Carers.
* Informed the District Nurse team that Adult A has not been admitted to hospital and also noted that her Carers are aware so she will continue to receive her care package. In addition, informed the Queen Elizabeth Hospital that she was not coming in for now.
* Discussed the case with GP Lead for Adult Safeguarding, Newcastle Gateshead CCG, who suggested:
* an urgent multi-disciplinary team review meeting
* seek an opinion from ‘Plastics’ team regarding the possible options for treatment of the pressure ulcers.
* Re-assess Adult A’s capacity to make this decision - will be done on Friday when GP 3 is next in the surgery.
* Discussion with Psychiatrist 1 – who confirmed that we could make a revised determination of capacity if we felt there had been a significant deterioration. We could overrule his findings without the need to involve him in the decision making process.

On 12th February 2015, 999 was contacted again. When the ambulance arrived, Adult A was lying propped up in bed and conscious. She was agitated and wanted the crew to leave, she initially refused to go to Hospital because she said she was frightened. Adult A said she was in pain and thirsty. She was de-hydrated but refused to be cannulated. She eventually agreed to go into Hospital and was transported to Queen Elizabeth Hospital.

The Hospital noted that Adult A was admitted with sepsis and dehydration. She was started on Intravenous antibiotics and referred to the tissue viability nurse. She was assessed as lacking capacity to consent to her care and treatment and MCA 1 and 2 were completed.

17th February 2015, a safeguarding alert was put in by the Hospital because Adult A had a grade 4 pressure sore. There was a conversation between Adult Social Care and the CCG Safeguarding Lead and agreement that because the sore was caused by Adult A refusing care and not neglect that this should not proceed to safeguarding at this time but on discharge hold a risk management meeting.

17th February 2015 – Adult A died in Hospital and her death was referred to the Coroner.

# Appreciative Workshop

The decision was made to hold an Appreciative Workshop day for practitioners to attend and share their experiences of working with Adult A. The Appreciative Workshop was based on the Social Care Institute for Excellence training and guidelines on how to conduct an inquiry. This is a systems approach looking at what actions, inactions and decisions where taken at the time.

The questions asked on the day were:

1. Recollection (Emotional Responses)

* What do you remember about the case?
* How did you feel about working with the individual?
* How did the individual feel about their involvement with you?
* How did the case affect you?

1. Conversations (Discovery)

* What were your thoughts about how agencies worked together on this case?
* Which agency did you feel offered the most support to you on this case?
* What are the things that you appreciated about the processes that were followed and the actions that were taken?

1. Reflections

* Given what was known and knowable at the time is there anything that you think should/could have been done differently?
* Identification of key themes
* Anything in addition to the learning already identified?

1. Identifying the learning (Defining)

* Considering the information gathered from all agencies, do you think this case should have been handled differently?
* Would you change your own personal practice based on the information that has been shared today?
* Would you recommend any changes to be implemented within your own organisation based on what you have learned today?

1. Addressing the learning (Designing)

* Are there any changes that you think need to be made to partnership arrangements?
* What would the consequences of doing nothing be?

## Information from the Appreciative Workshop

Professionals shared their views of Adult A, she was described as a determined lady who wanted to maintain her independence as much as possible. She was described as being able to assert her rights. She used the television as a distraction as she was mainly housebound. Adult A needed assistance with moving from the bedroom to the living room. She had limited contact with her daughter who lived away from Gateshead. There were some references to Adult A’s family members, including her granddaughter, but little was known about other family members.

Health staff described the extent of Adult A’s health problems, she was a poorly lady with severely restricted circulation. The blood was not getting to her extremities and the description was that Adult A was dying from the ‘inside out’.

The GP was not available for the Appreciative Workshop, he was due to attend but unfortunately was not able to for understandable reasons. The GP had strong views that Adult A was neglected by the Care Agency.

The following are notes of the information shared on the day of the Appreciative Workshop:

## Task 1 – Recollection Responses

When talking about working with Adult A, staff said that they felt ‘frustrated’ because they could see the need for care and treatment but she was very clear that she did not want to go into Hospital, nor did she want an increase in the carers. Professionals also felt frustrated by the lack of working together between agencies and some professional groups felt that their concerns were not listened to.

## Task 2 – Conversations

It was agreed that there was insufficient information sharing and issues about how information was shared e.g. not all agencies were aware of the diagnosis of dementia although this information had been shared.

There was a lack of understanding about the roles and responsibilities of different professionals and the limitations of their roles and it was clear that there was some tension between different professional groups.

It was agreed that there was a lack of coordination and planning between different agencies and departments e.g. at the time of Adult A’s discharge from Hospital. Adult A insisted on going home and therefore the Hospital staff felt that they had no choice but to discharge her but the community services were concerned about her non-compliance with care at home and possible deterioration in her health. There was a lot of work done in relation to Adult A and a number of agencies involved but it was agreed that the work would have been more effective if it had been coordinated, and this was in relation to all involvement not just Hospital discharge.

Adult A’s mental capacity was assessed in relation to decisions about her care and treatment but it was recognised that there was a lack of understanding and training around completing capacity assessments. She was a described as a person who had strong views about what she wanted and this may have impacted on the capacity assessments that were undertaken.

## Task 3 – Reflections

Information was shared in July 2014 regarding Adult A’s diagnosis of potential vascular dementia, query Alzheimer’s. It was stated that she had a mild to moderate dementia consistent with Alzheimer’s but had refused a CT scan. She was offered Occupational Therapy (OT) support but refused. Adult A said she had a poor memory but denied that she was forgetful. It would appear that the diagnosis of dementia did not appear to influence any change in the care or treatment of Adult A.

The letter confirming the diagnosis of dementia was sent to Adult Social Care but it would appear that whilst this was recorded on the client electronic database it was not easily visible and therefore was not known to the social care workers involved with Adult A.

The District Nurses stated that they had not been formally told of the dementia diagnosis and the system used also did not flag that Adult A had received a dementia diagnosis.

The group discussed the role of the named GP for people over 75 years and questioned whether or not there was guidance about this role and the responsibilities. This may have provided more medical consistency for Adult A.

There was limited understanding about Adult A’s family, the one daughter that some professionals had contact with lived away and therefore had limited visits to her mother.

In terms of Adult A’s care in Hospital when she broke her leg, she was treated ‘conservatively’ and this was appropriate as she would have been unlikely to survive an operation to repair the damage to her leg. It was agreed that there was some confusion around discharge information and that there could have been more communication between Hospital and Community Nurses. Adult A did not want an increase in her package of care and this was believed to be because of cost, albeit the care package was increased due to her not managing. It was agreed that her general health deteriorated following this injury to her leg.

## Task 4 – identifying the learning

The following were identified as issues:

* the lack of ‘joined up’ working and the use of inappropriate pathways to try to identify a resolution to Adult A’s difficulties
* The lack of understanding about the Mental Capacity Act 2005 and concerns about application.
* Concerns about the care provider and the response when concerns were raised
* The role of the named GP for over 75 year old people.
* The confidence of professional workers to be able to challenge decision making.

# Analysis of information and lessons Learnt

## Adult A’s health

Adult A was a poorly lady with severe health problems, she had a history of vascular disease and blood and oxygen were not getting to her extremities. She had a previous amputation to her left leg above the knee. Adult A broke her right leg and became immobile and developed pressure sores and her general health appeared to deteriorate following this and she developed repeated infections from her wounds. Adult A was not terminally ill but she was not going to get better from her illness.

Adult A had care at home and nursing from the District Nurses. She would often refuse to be re-positioned and there were times that she was laying in her own urine for a number of hours. Adult A would also refuse food and drink. Adult A refused Hospital admission on a number of occasions, saying that she ‘hates the place, doesn’t like the way they treat you’. She also refused residential/nursing care. Adult A was described as a ‘strong willed, independent lady’ who knew what she wanted. She made it clear that she did not want to go into Hospital and she wanted to stay in her own flat.

There was evidence that those working with Adult A felt frustrated and sad that they could not do more to make her more comfortable and meet her health needs. It was not clear whether or not the GP had discussed Adult A’s prognosis with her, she was not going to recover from this illness. Her care was not considered to be ‘palliative care’ but if it had been a clearer end of life pathway may have been put in place. The ‘Deciding Right’ Initiative is a Northern England Strategic Clinical Networks strategy to enable people to make decisions about their care and treatment should they lose capacity to make decisions for themselves. There was no evidence that this was applied, if it had been Adult A may have had the opportunity to make clearer plans for her care and treatment.

Adult A was diagnosed with dementia and this will be discussed later on in the report.

## Self-neglect

There was clear evidence that Adult A was neglecting herself, she refused to be re-positioned, take medication, would refuse food and drink and to have her soiled pads changed. From the Appreciative Workshop there was a sense that Adult A was in significant pain and re-positioning hurt and that she could not ‘be bothered’ because it was too difficult. There was no sense that Adult A was deliberately taking her own life by not allowing her day to day needs to be met. Rather she was too poorly and in pain to be troubled by being moved, eating etc. During the time that Adult A was being cared for, self-neglect was not a category under Adult Safeguarding procedures.

## Pain management and medication

Adult A requested pain relief be given in soluble form because she was not able to swallow. The information from the District Nurses was that it took a long time to change from tablet form to soluble pain relief and this was another obstacle in the care of Adult A. There was one entry on the timeline, 4th November 2014, when Adult A requested soluble pain relied but was prescribed tablets because her sodium levels were high. There appeared no capacity assessment to assess whether or not Adult A would prefer soluble pain relief despite the effects on her sodium levels.

There was evidence that Adult A was struggling to take her medication effectively and would misplace medication and the decision was made for the Carers to prompt with medication. However, there were concerns expressed by the District Nurses that they were not doing this consistently. Adult A would also refuse medication.

## Diagnosis of dementia

Adult A was diagnosed with dementia but not all agencies were aware of this. The District Nurses did not have sight of the letter from the Old Age Psychiatrist confirming the diagnosis. The letter from the Old Age Psychiatrist was sent to ASCD and recorded on their care record but not ‘flagged’ and therefore was not picked up by those involved in making decisions about her care. Because this diagnosis was not seen by Social Workers and Duty Workers in ASCD it would not have been passed onto the care providers.

The lack of awareness about the diagnosis of dementia is an important issue in relation to assessments and discussions about Adult A’s capacity to make decisions and about her care and treatment. Clearly, the diagnosis of dementia does not mean that the person lacks capacity to make decisions when they need to be made. However there would be an expectation that this would be taken into consideration. The lack of awareness about the diagnosis meant that there was no discussion about the possible impact of dementia on Adult A’s ability to make decisions. The diagnosis may also have impacted on Adult A’s day to day care and her understanding of what the carers and District Nurses were trying to do.

The issue appears one of recording of this information to ensure that all those involved in Adult A’s care knew about the diagnosis and possible impact.

## Working together

From the information gathered, it would appear that individual agencies worked in isolation. There is no question that some agencies worked very hard to provide a quality service for Adult A and that a lot of time was spent with this lady by all agencies. However, there lacked a co-ordinated approach. For example, there was no multi-disciplinary team meeting, one was talked about February 2015 but there would have been a benefit of a joint approach much sooner, particularly as all agencies had concerns about Adult A.

Not only was there a lack of working together, there was also evidence of conflict between some agencies e.g. 19th January 2015 there was a difficult telephone conversation between one GP and the Duty Worker from ASCD. This appeared to be difficult and unproductive and was not helpful to Adult A.

It was felt that there was a lack of consistent working together between in-patient Nursing Services and the Community Nurses. For example, there was a lack of consultation with the District Nurses on Adult A’s discharge from Hospital.

During the Appreciative Workshop, some agencies felt that they were unsupported by colleagues in other agencies.

There was also evidence that some agencies were not aware of concerns e.g. Housing, and how they may have been able to contribute to Adult A’s care.

As Adult A’s health deteriorated, there was a sense that agencies were ‘blaming others’ rather than working together.

## Professional challenge and ownership

There is evidence that the District Nurses escalated their concerns to Senior Managers and felt supported by Senior Staff. There is evidence that some agencies challenged others e.g. GP challenged ASCD, District Nurses were critical of care provider however what was lacking was professional ownership and individual agencies taking control of the situation. Any agency could have convened a Multi-disciplinary Team (MDT) meeting and proposed a joint approach to what was a very difficult situation. An MDT meeting was suggested in February 2015 but this should have been done earlier. The lack of professional leadership may be due to lack of confidence and confusion about roles and responsibilities.

## Understanding pathways

There appeared to be a lack of understanding of care pathways and how systems and processes could be used to help Adult A. As her health deteriorated in early 2015, there were a number of referrals into Adult Safeguarding. This was pre the implementation of the Care Act 2014 when self-neglect became a category under Adult Safeguarding. There was a sense that Adult Safeguarding was being used as a process to bring agencies together whereas this could be achieved through one agency calling a MDT meeting. There were safeguarding issues in relation to the Care provider and these will be discussed further in the report. However, it felt that the intention was to bring people together to address concerns but this did not happen.

## Care provider

There were concerns expressed by the District Nurses that the care providers, were not providing the care that they were commissioned to provide and therefore Adult A was left without adequate care and support. The District Nurses raised concerns that they were not spending the agreed time with Adult A, they were not ensuring that she received the care and they did not take into account her individual needs. The Care Provider was commissioned to provide 3 x 60 minute calls and this was increased to 4 calls daily. There were times when the District Nurses visited and the Carers were leaving before the end of the 60 minutes. They were not assertive in providing care e.g. there was one occasion when Adult A had refused to eat breakfast from the carers but took it from the District Nurses. There did not appear to be effective engagement with Adult A e.g. the District Nurses knew that Adult A liked a cooked breakfast e.g. egg but was being offered corn flakes. This was a lady who was refusing food and there appeared to be no attempts to offer her a choice of meal or understand what she liked to eat. Adult A herself previously complained about the Care provider but was persuaded to continue with them. There was also a whistle-blower who raised concerns about the service.

Concerns about the Care provider were shared with ASCD and Adult Safeguarding Alerts were put in. Initially, the decision was to share the concerns with Commissioning and there appeared no ‘joined up approach’ identifying that Adult A was a lady who was self-neglecting and that this was not just an issue about contract compliance but about whether or not Adult A was receiving the appropriate care and treatment. Eventually the concerns were accepted into Adult Safeguarding and the decision was made to manage the concerns through the allocation of a Social Worker but action should have been taken earlier.

There was also evidence that the Care provider over stepped their role e.g. negotiating with Adult A when she asked for a change in Care provider and making a decision about her capacity. From the Appreciative Workshop there was a feeling that the provider was not well managed. The Service has been de-commissioned and therefore were not available to comment on the role they played in Adult A’s care.

There were clear concerns about the Care provider but they are a commissioned service, there should have been greater oversight from ASC particularly as there were clear concerns about Adult A’s health and welfare.

## Appropriateness of the care and resources available

The District Nurses talked about persuading Adult A to go into Intermediate Care, this took a lot of persuasion and Adult A finally agreed only to be told that she did not meet the criteria because she was not mobile. There was no other similar service available for her.

The District Nurses completed the Continuing Healthcare Assessment which indicated that a ‘referral for full assessment for NHS continuing healthcare is necessary’. A meeting was planned for March but unfortunately Adult had passed away by this time.

The District Nurse team considered a referral to the Community Matron Service, due to the role they play in the management of long term conditions. However, on review of Adult A’s needs (complex pressure area care, continence care, non- compliance and dietary advice), it was decided at the time that her needs would be best managed and co-ordinated by the District Nurse team.

## The role of the Named GP

All patients over 75 years old have a named GP. Adult A appeared to be seen by a number of different GPs in crisis situations. It is not clear what the role of the Named GP is but this needs to be considered in the recommendations.

## The role of the Social Worker

The decision was made to allocate a Social Worker to re-assess Adult A’s care. There appeared some delay in this decision and any activity undertaken by the Social Worker. The Social Worker then made telephone contact with Adult A, who refused a visit. The decision was made that Adult A had capacity to make this decision. This raises a number of issues: firstly, capacity was assumed and not properly assessed and secondly, Adult A was a poorly lady and there were concerns about her care and treatment it would have been appropriate to take some action even though Adult A may have refused a visit e.g. call a MDT meeting, liaise with other agencies, review the Care Package. Social Care were commissioning a service that was clearly not meeting her needs and this was not reviewed in a timely manner.

At the same time, Adult A refused a visit from a Social Worker she was seen by the Occupational Therapy Assistant for a seating assessment. Adult A may have accepted this visit because she liked to be out of bed and sat in a chair but it may have been a different approach that worked more effectively with her.

## Mental Capacity Act 2005

There were significant issues in implementing the MCA, by all agencies:

* The MCA appeared to be applied when Adult A was in a crisis situation and a specific decision needed to be made e.g. Hospital admission. There appeared to be no routine implementation of the MCA which would have been suggested by her diagnosis, repeated infections and at times she was said to be confused. For example, (1) there was no routine capacity assessment regarding her medication, both prescription and dispensing, although she appeared forgetful and confused about her medication. (2) There appeared no capacity assessment or discussion about capacity when she refused an increase in her care package even though her needs indicated this.
* There were references to the presumption of capacity. The first principle of the MCA says the starting point is the presumption of capacity and Adult A may have had capacity to make certain decisions, including unwise decisions. However, this raises two issues: firstly, given Adult A’s diagnosis and level of risk it would have been better practice to have completed capacity assessments and then to have found that she had capacity to make decisions. The outcome of a capacity assessment should not be pre-determined and only be done when there is the presumption that the person lacks capacity. It is a process to determine capacity and there was sufficient information to suggest that Adult A’s capacity to make certain decisions may have been impaired given that she had a diagnosis of dementia and repeated infections. Secondly, the presumption of capacity does not mean that no action is taken. Clearly if a person has capacity then it is about negotiation rather than doing things for them in best interests. What appeared to be happening was that a decision needed to be made e.g. Hospital admission and when Adult A refused and was presumed to have capacity then no alternative plan was put in place to minimise the risk e.g. convene an MDT meeting.
* There was clearly confusion about who should be the person to assess capacity. All agencies appeared unsure about this element of the process. The person who assesses capacity should be the person who needs the decision to be made e.g. prescribing and admission to Hospital is the GP, day to day wound care is the District Nurse, day to day care including meals, fluids, personal care is the Social Worker and Carers and so on. Given this, there should have been a number of capacity assessments. However, there appeared to be a lack of understanding and willingness for agencies to undertake assessment. An example of this confusion was the discussion between the GP and the ASCD Duty Worker 19th January 2015. This was in the context of deteriorating health and Adult A was refusing care. The ASCD Duty Worker asked about capacity, the GP said an assessment was done on 16th January 2015 but he was not sure if it was recorded and that he would not be doing one and there should be one completed by the Old Age Psychiatrist but this would take months. This was not helpful to the situation and showed a lack of understanding about capacity assessments. At no point was there an agreement about the different decisions to be made and therefore who the appropriate people to complete the capacity assessments were. Adult A was refusing her day to day care and therefore that capacity assessment should have been completed by Social Care. Her health was deteriorating and there was consideration of Hospital admission and she was refusing medication, that capacity assessment is therefore the responsibility of the GP.
* There may be times when a complex situation requires an MDT to discuss capacity or it is appropriate to ask a specialist such as a Consultant Psychiatrist to complete a capacity assessment. In respect of Adult A, the request for the OAP Psychiatrist to complete the assessment was because of the confusion about whose role it was to complete the assessment and potentially unwillingness and/or lack of confidence. The OAP Psychiatrist completed the capacity assessment on 22nd January 2015. He assessed capacity around Adult A’s ability to make a decision about her accommodation e.g. staying at home or going into residential care. The Psychiatrist concluded that Adult A understood the difference between care and being at home but was not able to ‘weigh up information about her regarding her health and welfare fully in making a decision about her future accommodation’. He concluded ‘on the balance of probability, at the time I saw her, I felt she probably did have capacity to make a decision regarding her future even though she does have limited understanding of her risks’. This capacity assessment is unclear, the Psychiatrist suggests that Adult A has capacity but she fails the third step of being able to weigh up the information therefore I would question, on reflection, whether or not she did have capacity to make a decision about her accommodation. What appeared to have happened was that the assessor was ‘swayed’ by Adult A’s persuasive wish to remain at home. I think capacity was confused with wishes and feelings.
* The MCA best interest checklist states that one of the factors we have to take into consideration is a person’s wishes and feelings. Adult A’s clear wish was to remain at home. She was adamant and described as a ‘stubborn lady’ and persuasive. It is difficult to say with hindsight but her wish to remain at home may have been mistaken for a capacitated decision because she was so strong willed. There was no consideration that the MCA allows for wishes and feelings to be considered as part of best interest decisions. Therefore, if a person lacks the capacity to make a decision such as remaining at home rather than going into Hospital or care, this decision can be made in their best interests even though there may be risks e.g. in the case of Adult A she was going to die because of degree of her illness. If this decision was made, other capacity assessments and best interests decisions could have been made to make staying at home more less risky in terms of her health and care. For example, Adult A’s capacity could have been assessed in relation to her refusal to increase the carers or ability to decide whether or not to pay for this service. If Adult A lacked capacity in these areas decision could be made in her best interests to increase the care.
* There was no evidence of consultation with family as required by the MCA or an Independent Mental Capacity Advocate (IMCA) in certain situations when there is no family to consult. Clearly there were assessments completed in urgent situations e.g. admission to Hospital. Other assessments would have allowed sufficient time for proper consultation e.g. the assessment completed by the OAP Psychiatrist. Adult A’s daughter lived away but the District Nurses were in contact with her. Given that he was assessing for a change in accommodation e.g. residential care an IMCA should have been considered if family were not available to consult.
* There was evidence of a lack of training and confidence in applying the MCA, this was particularly highlighted in the District Nurse Service.

To conclude, there were serious gaps in the understanding and application of the MCA across all agencies.

## Evidence of Good Practice

There was evidence that the District Nurses went to great lengths to provide a service for Adult A. It was reported that Adult A would often be in conflict with the Carers and complain about them. She refused a visit from a Social Worker but Adult A never refused access to the District Nurses. The District Nurse Service ensured that Adult A was seen by a Senior Nurse, they went beyond their role e.g. at times feeding her and spending more time with her than allocated.

# Review of local terms of reference

The Safeguarding Adults Board agreed a set of local terms of reference. The majority of these have been addressed in the body of the report and it is not the intention to go through each point for consideration separately. However, the issue about the fire and why a safeguarding alert has not been addressed and this was because the incident was not significant enough, it was smoke rather than an actual fire.

# Recommendations

The recommendations will be considered by the Review Panel, however the following areas should be considered:

1. Implementation to the MCA

Proposed actions: Training of all staff, ensuring that policies are up to date and disseminated and that the MCA is implemented across all agencies.

1. Working together

Proposed actions: this should improve given the framework of Adult Safeguarding now that self-neglect is a category but there is a need for all professional groups to be able to challenge decision making and take responsibility for problem solving difficult situations.

1. The role of the named GP

Proposed actions: there needs to be further clarity about this role e.g. consistency of care, lead for MCA assessments, attendance at MDTs etc.

1. How to work effectively with people who self-neglect

Proposed actions: Social Care are undergoing a review and the new model will create efficiencies and effectively will free up Social Worker’s time to be able to spend whatever time is needed with service users especially those with complex needs.

1. Ensuring that care providers are able to meet individual peoples’ complex needs. Caring for an aging population is a challenge for all agencies due to the rising numbers of older people and the complexity of their health and social care needs. Alongside this, is the drive to avoid unnecessary Hospital admissions and delay admission to residential care. Most people want to be cared for at home, however this provides a challenge for care providers. It is recognised that caring is low paid employment with many being paid the minimum wage, but expected to care for people with complex needs.

Proposed actions: to review the process of responding to complaints and concerns about the effectiveness of care providers and the ability of Commissioners to have assurance that care is provided to an adequate standard.

# Glossary of Terms

ASCD – Adult Social Care Direct

CHC – Continuing Health Care

CCG – Clinical Commissioning Group

IMCA – Independent Mental Capacity Act Advocate

MCA – Mental Capacity

MDT – Multi-disciplinary Team

MMSE – Mini Mental State Examination

OAP – Old Age Psychiatry

QEH – Queen Elizabeth Hospital

SW – Social Worker