# Norfolk Safeguarding Adults Board

## Safeguarding Adult Review

## MRS BB

## SUMMARY OF REPORT

## 09 December 2016

## Case Summary

Mrs BB had been diagnosed as having dementia, probably due to Alzheimers in October 2012, and lived alone from February 2013 after her husband was admitted into residential care nearby. Mrs BB had four children who provided fluctuating levels of support. She received twice daily home care visits but quite often was not at home because she made frequent trips to town or to visit her husband. There were concerns about Mrs BB's safety when she went out, with reports of her becoming lost, disorientated, anxious, and approaching strangers for help or lifts. During the two months prior to her death, these risks increased, because the frequency, and pattern, of her trips out became more erratic.

Following a Mental Capacity Act assessment in late November 2014, a Best Interests Decision was made with the family to look for a residential placement, in the south of England near one of her daughters, preferably for Mr and Mrs BB to be placed together. In the interim, two hours additional support was commenced to take her to have lunch with her husband. However, Mrs BB often continued to make her way there on her own. Therefore, in mid-December, an alternative home care agency was commissioned to provide nine hours support each day to keep her safe when out, and engage her in social activities. Initially this was provided between 09:00 to 18:00 but quickly changed to 08:00 to 17:00 because Mrs BB had sometimes gone out when the carer arrived.

From mid-January 2015, Mrs BB's behaviour became increasingly agitated, and police assistance was required when she made an evening visit to her husband's care home. On 20 January 2015, the carer arranged an urgent late afternoon GP appointment because of a further escalation of her agitated and erratic behaviour. This hampered the GP's ability to carry out a full examination. The GP decided that Mrs BB should be taken to A&E where she would be in a place of safety, and further investigations could be carried out. However, the carer did not pick up the need for Mrs BB to be in a place of safety that evening so she was not left alone.

On leaving the surgery Mrs BB continued to be agitated, and refused to go to hospital. After discussion with his manager, the carer returned Mrs BB home, and contacted one of the daughters who was unable to visit that evening to assist in taking to her hospital. The manager, who was unaware of the GP's view about the need for a place of safety, and believed that the A&E plan was about further tests, instructed the carer to ensure Mrs BB was settled, and he would visit the next morning to collect a urine sample and proceed to hospital if the carer could not get her there that evening.

When the carer visited in the morning, Mrs BB was missing. It appears that Mrs BB had left her home at some point the previous evening. The body of Mrs BB was found lying in a ditch by the side of the road by a member of the public.

## MULTI AGENCY RECOMMENDATIONS

### Introduction

The recommendations to implement the learning from this review are organised within the following priority themes which address the areas of greatest concern:-

- Risk assessment and management;
- Joint working and information sharing;
- Mental Capacity Assessment processes;
- Home care provider roles and working practices
- Agency systems

***Risk Assessment and Management***

1. *NSAB should request all agencies to update their procedures, guidance, training and supervision arrangements to incorporate the learning from this SAR to ensure staff have the skills and tools to recognise risk and take appropriate action. Agencies should remind staff that in cases of high risk, care plans should include consideration of alternative contingency courses of action, and there is a shared understanding of when, and how, these might be triggered.*

2. *NSAB should request a report from the police on how effectively the Athena system is affecting practice in reporting incidents of concern in respect of adults at risk, and on the potential for, and resource implications of, the MASH to research their systems to share the full picture of risks known to the police.*

3. *NSAB should request Norfolk County Council to draw up a plan for the ongoing dissemination of information about what assistive technology solutions are available and may be useful in reducing risks in respect of people with dementia, and particularly those living alone.*

***Joint Working and Information Sharing***

4. *NSAB should request member agencies to agree inter-agency arrangements for joint working in cases where people with dementia are considered to be at risk. These should include:-*

   *(i) forums within each locality where local agencies and care providers can share information and co-ordinate multi-agency support;*

   *(ii) a process for escalating concerns in cases of high risk, including the convening of high level multi agency meetings where plans have not, or cannot be agreed locally;*

   *(iii) practice guidance which describes:-*

      *- factors and behaviours which may constitute high risk;*

- *thresholds for information sharing;*

- *the need for co-production in formulating a co-ordinated multi-agency response;*

- *the factors which need to be taken into account when deciding how to implement a decision that a service user who is displaying agitated behaviour, needs to be taken to a place of safety, including the arrangements for informing the family. .*

5. *Social Care and the Clinical Commissioning Groups should review how effectively the role of the Integrated Care Co-ordinators is building links between Primary Care and Social Care, and explore how liaison and joint working can be developed further.*

***Mental Capacity***

6. *NSAB should request all agencies to assess how effectively the requirements of the Mental Capacity Act are being adhered to, and report back to NSAB on action taken to revise their policies, procedures and training to assure the Board that:-*

   *(i) all staff develop the necessary level of knowledge and skills to identify potential issues around mental capacity, and take the appropriate action.*

   *(ii) the outcome of MCA assessments, and implications of any best interest decision reached, are communicated clearly, particularly where responsibility for implementing the decision is being transferred to another agency.*

***Home Care Provider Roles and Working Practices***

7. *NSAB should request that Social Care commissioners take steps to organise a series of learning events to share the learning from this Review with home care providers, and monitor providers' progress in implementing the following:-*

   *(i) updating policies and procedures on risk assessment, and the maintenance of a risk register of all service users with dementia;*

   *(ii) an escalation policy to be applied when there is evidence of deterioration, and / or an increase in the number of incidents of concern;*

   *(iii) procedures for maintaining support and seeking assistance when it has been deemed that it is not safe for a service user to be left alone.*

   *(iv) guidance for home carers when attending medical appointments which includes insisting on being given written confirmation from the medical practitioner of any action which is agreed will be undertaken by the carer following the consultation.*

(v) *procedures for safe rostering which ensures a carer is not required to work single handed with a service user with dementia for extended periods without breaks during the day, and the working week.*

***Agency Systems***

8. *NSAB should request all agencies to ensure that where a service user / patient is known to have dementia:-*

   (i) *a "flag" is placed on the patient record to this effect;*

   (ii) *the agency has up to date information, and contact details, of the primary family carer who is to the first point of contact;*

   (iii) *arrangements are discussed and agreed with the patient / service user, and the family as appropriate, on who will receive correspondence from the agency about appointments or other matters.*

   (iv) *client record systems are effective in ensuring dates are logged for assessments and reviews, and enable managers to spot quickly when these are overdue.*

9. *NSAB takes the necessary action to publicise to GP practices the need to maintain on patient records, appropriate, and up to date, information about relatives or others who the patient would wish to be informed of any new diagnosis and / or significant steps the GP decides are necessary to respond to the patient's presentation.*

10. *Social Care reviews its supervision arrangements to ensure that these enable managers to check the progress, and quality, of case management.*

# Safeguarding Adults Review
# CASE Mrs BB
# Multi Agency Action Plan

Norfolk Safeguarding Adults Board
12-9-2016

# Safeguarding Adults Review CASE Mrs BB – Multi Agency Action Plan – (Themed)

| **Theme 1**<br><br>Ensure appropriate planning when dealing with people with dementia, including system flagging to identify patients with this condition | | | | |
|---|---|---|---|---|
| **Linked to recommendations:**<br>8(a), 8(b), 8(c), 8(d) | | | | |
| **Action** | **Evidence** | **Owner** | **Timescale** | **Completed** |
| 1. NSAB (LIP) to design policy and practice guidance to advise agencies of the process for escalating concerns and coordinating activity around complex cases, including dementia, at a locality level. | Complex case guidance completed. | SARG | March 2017 | |
| 2. NSAB (LIP) in consultation with Norfolk Dementia Strategic Implementation Board and other relevant agencies, to develop and promote a range of learning events which include a focus on cumulative risk and risk escalation in relation to dementia cases. | Delivery of learning events. | NSAB LIP | November 2017 | |
| 3. To raise awareness of the coding facility within GP record systems and how to use it. | Assurance from GP surgeries that the flag is being used appropriately on patient records thereby ensuring relevant reviews. | NHS England | March 2017 | |

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|---|---|---|---|---|
| **Theme 1**<br><br>Ensure appropriate planning when dealing with people with dementia, including system flagging to identify patients with this condition | | | | |
| **Linked to recommendations:**<br>8(a), 8(b), 8(c), 8(d) | | | | |
| 4. NSAB and partners to raise awareness of the importance of maintaining up-to-date information about family and contact details, especially the primary point of contact. | Publicity material. | NSAB Comms Group | March 2017 | |
| 5. NSAB Chair to raise with Healthwatch and at the Norfolk Public Protection Forum (PPF) the need for collaborative action to promote awareness in this area. | Meeting minutes. | NSAB Chair, Healthwatch & PPF | March 2017 | |
| 6. NSAB Chair to formally write to all GP practices in Norfolk to advise them of the learning outcome of this SAR in regards to importance of up to date patient records | Letter from NSAB Chair. | NSAB Chair | End of January 2017 | |

**Theme 2**

Appropriate reporting of risk, contingency planning and supervision.

**Linked to recommendations:**
1, 4, 7(iii), 10

| Action | Evidence | Owner | Timescale | Completed |
|---|---|---|---|---|
| 1. Adult social care supervisors to ensure that staff members' updated caseload lists are available and used at each supervision session. | Records audit. | NCC Q&A team | Immediately, with audit March 2017 | |
| 2. NSAB to request all Board partners and relevant agencies to review their current procedures, guidance, training and supervision arrangements in relation to risk and update as necessary | Formal letter from chair of NSAB.<br><br>Board partners and relevant agencies to provide NSAB with short reports detailing their actions. | NSAB Chair and NSAB Business Manager | December 2016<br><br>March 2017 | |
| 3. NSAB (LIP) to disseminate guidance on practice in care planning (including risk identification, contingency planning in high-risk cases and understanding of when and how these plans might be triggered) to all partners. | Publication and dissemination of guidance. | NSAB LIP | April 2017 | |

**Theme 3**

Joint working between agencies, notably in relation to integrated care coordinators and when home care staff attend medical appointments

**Linked to recommendations:**
5, 7(iv)

| Action | Evidence | Owner | Timescale | Completed |
|---|---|---|---|---|
| 1) NSAB partners to audit the existing function | Report to NSAB. | Director of Adult Operations and Integration | March 2017 | |
| 2) NSAB to request a report detailing joint working arrangements for integrated care coordinators across the county | Formal report to NSAB. | Director of Social Care and Chair of Chief Officers CCG Group | May 2017 | |
| 3) NSAB LIP, in consultation with all relevant partners, to design policy and practice guidance to advise agencies on the role and responsibility of home care staff who attend medical appointments in support of service users | Publication and dissemination of guidance. | NSAB LIP | May 2017 | |

| **Theme 4**<br><br>Awareness raising in relation to the MCA and notably in relation to managing people / responding to people with dementia | | | | |
|---|---|---|---|---|
| **Linked to recommendations:**<br>6 | | | | |
| **Action** | **Evidence** | **Owner** | **Timescale** | **Completed** |
| 1) NSAB chair to meet with the MCA / DoLS and LIP sub group chairs to agree terms of reference for an audit of current practice which is to include training delivery and skill development. | Terms of reference and timetable for the work agreed. | SAB Chair | End of January 2017 | |
| 2) NSAB to request reports from lead statutory partners, including on behalf of primary care, as per the recommendation. | Reports available from each partner agency. | NSAB Chair and NSAB partners | May 2017 | |

| **Theme 5**<br><br>Dissemination of the learning from this review to all agencies but, in particular, home care providers, to avoid future recurrence of the same. | | | | |
|---|---|---|---|---|
| **Linked to recommendations:**<br>1, 7 | | | | |
| **Action** | **Evidence** | **Owner** | **Timescale** | **Completed** |
| 1) The report to be shared with all NSAB Board partners and relevant agencies with a formal request for them to disseminate within their own organisations. | NSAB agenda and minutes. | NSAB Business Manager | November 2016 Board | |

**Theme 5**

Dissemination of the learning from this review to all agencies but, in particular, home care providers, to avoid future recurrence of the same.

**Linked to recommendations:**
1, 7

| Action | Evidence | Owner | Timescale | Completed |
|---|---|---|---|---|
| 2) Report to be presented to the Norfolk Public Protection Forum for wider county awareness. | PPF agenda and minutes. | NSAB CHAIR | November/ December 2016 Board | |
| 3) Publication of Report and Action Plan on NSAB website with associated email alert. | Existence on NSAB website. | NSAB Business Manager | November 2016 | |
| 4) Report and Action Plan to be shared with the Care Quality Commission with a request for dissemination to all relevant services. | Confirmation received from CQC this action has been completed. | NSAB Business Manager & Quality Assurance Manager NCC | November 2016 | |
| 5) Develop and deliver, in consultation with Norfolk and Suffolk Dementia Alliance and other relevant agencies, a range of learning events which include a focus on cumulative risk and risk escalation in relation to dementia. | Development and delivery of events. | NSAB LIP & LSAPs | November 2017 | |

## Single Agency Recommendations

| ***2. NSAB should request a report from the police on how effectively the Athena system is affecting practice in reporting incidents of concern in respect of adults at risk, and on the potential for, and resource implications of, the MASH to research their systems to share the full picture of risks known to the police.*** | | | | |
|---|---|---|---|---|
| **ACTIONS** | **Evidence** | **Owner** | **Timescales** | **Complete** |
| 1) Raise awareness of the existence of the API on Athena through the vulnerability training.<br><br>2) Complete a report that includes how effectively the Athena system is affecting practice and the resource implications for MASH in respect of these referrals. | Increased submissions on the Athena system to be included in the report received.<br><br>Dissemination of the vulnerability training package. | Head of Safeguarding Norfolk Constabulary | November 2017 | |

| ***3. NSAB should request Norfolk County Council to draw up a plan for the ongoing dissemination of information about what assistive technology solutions are available and may be useful in reducing risks in respect of people with dementia, and particularly those living alone.*** | | | | |
|---|---|---|---|---|
| **ACTIONS** | **Evidence** | **Owner** | **Timescales** | **Complete** |
| 1) NSAB to make a request in accordance with the recommendation. | A plan is produced | Assistant Director (Social Work) NCC | March 2017 | |

| ***9. NSAB takes the necessary action to publicise to GP practices the need to maintain on patient records, appropriate, and up to date, information about relatives or others who the patient would wish to be informed of any new diagnosis and / or significant steps the GP decides are necessary to respond to the patient's presentation.*** | | | | |
|---|---|---|---|---|
| **ACTIONS** | **Evidence** | **Owner** | **Timescales** | **Complete** |
| 1. NSAB Chair formally writes to all GP practices in Norfolk to advise them of the learning outcome of this SAR in regards to importance of up to date patient records | Letter from NSAB Chair. | NSAB Chair | End of January 2017 | |

## Glossary

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|---|---|---|---|
| CCGs | Clinical Commissioning Groups | NSAB Coms Sub Grp | Norfolk Safeguarding Adults Board Communication Sub Group |
| CPA | Care Programme Approach | NSAB LIP | Norfolk Safeguarding Adults Board, Learning, Improvement and Policy Sub Group |
| GP | General Practitioner | NSFT | Norfolk and Suffolk NHS Foundation Trust |
| JPUH | James Paget University Hospitals NHS Foundation Trust | QEH | Queen Elizabeth Hospital |
| LSAP | Locality Safeguarding Adults Partnership | SAB | Safeguarding Adults Board |
| LD | Learning Disabilities | SN | Self-neglect |
| NCC | Norfolk County Council | SNH | Self neglect and hoarding |
| NNUH | Norfolk and Norwich University Hospital | ToR | Terms of Reference |
| NSAB | Norfolk Safeguarding Adults Board | | |