Safeguarding Adult Review

Overview Report

Adult C

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1 LEGAL CONTEXT:

1.1.1 A Safeguarding Adult Review was commissioned by Lancashire Safeguarding Adult Board, following agreement at Lancashire Safeguarding Adult Review Sub Group in accordance with the Care Act (2015). Section 14 of the Care Act Guidance sets out the functions for LSABs. This includes the requirement for LSABs to undertake reviews of serious cases in specified circumstances.

1.1.2 The Care Act states a SAB 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:

- There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult and,
- One of the below:
  - Either the adult has died, and the SAB 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); *or*
  - the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect; *or*
  - We believe that there would significant value and learning from 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)

1.1.3 The Safeguarding Adult Review group agreed that the known facts in relation to this case met these criteria and this decision was supported by the Safeguarding Adult Board Independent chair.

Methodology

1.2.1 The methodology used was based on an adapted version of the Child Practice Review process.[1] This is a formal process that allows practitioners to reflect on cases in an informed and supportive way.

1.2.2 Reviewing the history of the adult and family is not the primary purpose of the review. Instead it is an effective learning tool for Safeguarding Adult Boards to use where it is more important to consider how agencies worked together. Because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice.

[1] Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012

1.2.3 The role of a Safeguarding Board is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These may be included in the final review report or in an action plan as appropriate.

1.2.4 Following notification of the circumstances of John in this case, and agreement by the chair of the Lancashire Safeguarding Adult Board to undertake a Safeguarding Adult Review, the Review Panel was established in accordance with guidance. This was Chaired by a Principal Social Worker Lancashire Adults Social Care and included representation from relevant organisations within Adult Social Care, Health, and the Police. Nicki Walker-Hall agreed to undertake the review with support from the Business Coordinator to the SAB.

1.2.5 Whilst the review was initiated as a result of the death of John, another care home resident caused John's injuries. For the purpose of this report he will be known as David. (NB. *Names of individuals have been changed to maintain anonymity)*

1.2.6 All relevant agencies reviewed their records and provided timelines of significant events and a brief analysis of their involvement. The agency timelines were merged and used to produce an interagency timeline. This was carefully analysed by the reviewer with the panel and informed the key focus areas for further exploration and consideration. Key practitioners were identified and required to attend a learning event in order to understand the detail of the single and interagency practice in this case.

1.2.7 The reviewer and the SAB Business Coordinator met with John's daughter to gain an understanding of the family's experiences of the services provided. Account was taken of the family's views when writing the report and making recommendations, and the reviewer is grateful for their contribution.

1.2.8 David's next of kin were contacted and invited to be involved in the review but declined, the reviewer respects their decision but acknowledges this may limit the learning.

1.2.9 The practitioner event was held in October 2017 and was attended by professionals who had direct involvement with either John or David. Not all those invited attended; some were spoken to at a later date. The reviewer facilitated the session assisted by the LSAB team. The learning event was organised in line with Welsh Government guidance[2] and minutes were recorded. A list of attendees' roles and the organisations they represent can be found at Appendix 3.

1.2.10 Following the learning event, the Reviewer collated and analysed the learning and developed a draft report. The draft report was provided to the panel in advance of a panel meeting in December 2017. This panel meeting provided an opportunity for

[2] Child Practice Reviews: Organising and Facilitating Learning Events, December 2012

organisations to conduct further analyses and draw up recommendations to address the learning points.

1.2.11 The reviewer and chair will offer to meet again with John's daughter to provide an opportunity to see a copy of the report when agreed by the Lancashire Safeguarding Adult Board. The reviewer and chair will seek to inform David's sisters of the outcomes of this review. Learning from the full report will only be made publically available after consideration by the Lancashire Safeguarding Adult Board.

Time Period for the Review

1.2.12 The review covers the timeframe from the 25/09/2014 until the 22/10/2015. This timeframe includes David's transitions between Care Homes and Hospitals when his risk could no longer be managed, until the death of John.

2 BRIEF OUTLINE OF THE CIRCUMSTANCES RESULTING IN THE REVIEW.

2.1.1 John (aged 86) and David (aged 76) resided in the same Care Home (Care Home 1) at the time of the significant incident; both had vascular dementia. John had been a resident in Care Home 1 throughout the timeframe under review, David had been a resident at Care Home 1 for just 10 weeks.

2.1.2 At the start of the review period David had been resident in Care Home 2. A member of staff used the Whistle blowing Policy to alert the appropriate agencies of concerns within Care Home 2. Part of the concern was that the owner had been threatening and abusive to David. A safeguarding alert was raised. The serious nature of this incident meant the Police and Adult Social Care conducted a joint investigation. No evidence of any criminal offences was found however issues were raised about certain standards of care that were shared with ASC and the CQC

2.1.3 David remained at Care Home 2 until February 2015 when, following an assault on a member of staff, and then an assault of a resident, David was admitted to hospital under Section 3 of the Mental Health Act (MHA) (1983) revised (2007). Care Home 2 liaised with Lancashire County Council (LCC) and served notice on David as they believed they were no longer able to safely manage David.

2.1.4 David was admitted to Care Home 3, an elderly mentally infirm home (EMI), in March 2015 accompanied by his CPN. Concerns arose immediately that this was an unsafe admission. David's CPN indicated that whilst it had been assessed that an EMI home could provide the right level of care, the layout of Care Home 3 would have made it difficult for staff to have David in sight at all times. Details of David's aggression towards residents had not been made clear prior to admission, and David's MAR had not been sent causing confusion over medication. Concerns arose that David may not have been receiving Lorazepam as prescribed.

2.1.5 Initially David exhibited some disturbed behaviours such as attempting to abscond, somehow locking his room door, and aggression to females. The Intermediate Support Team (IST) were to visit daily, and a referral was made to the Care Home Liaison Team to assist and support management. Applications for 1:1 funding were unsuccessful. David's CPN believed he might settle as he was exhibiting the same behaviours as he had on entry to Care Home 2.

2.1.6 In April 2015 David assaulted other residents in Care Home 3, safeguarding alerts were raised and David required Hospital treatment for a fracture in his hand caused by him punching.

2.1.7 Following a Psychiatric RIT team review David was to have a formal assessment of his Mental Health.

2.1.8 A week later a Multi-Disciplinary Team (MDT) meeting was held, Continuing Health Care (CHC) funding was agreed and a discussion as to whether David needed Hospital Admission rather than a new nursing home – those present concluded

David should not be allowed to go back to any care home, at that time, due his aggression and the level of danger he posed.

2.1.9 Four days later David had a Mental Health (MH) assessment and it was deemed he should be detained under Section 2 MHA – no bed was available for 3-4 days. On day 3 the RIT team contacted Lancashire Care Trust (LCT) who authorised 2:1 cover for David, however this could not be achieved due to staff shortages. A bed was found in the early hours of the following morning and David was conveyed to Hospital. David was then transferred nine days later to a specialist unit prior to transfer to a more local Hospital, where he was detained under Section 3 MHA. In total David spent two and a half months in Hospital settings. The discharging Hospital indicated that David had responded to de-escalation techniques.

2.1.10 Care Home 1 conducted a pre-admission assessment however, this was limited to what they gleaned from the Hospital records and discussions with ward staff, rather than the full information from Care Home 3, or indeed his family who were unaware of his move to Care Home 1 until 2 days after admission. The discharge letter noted "verbal aggress to other patients but responsive to verbal de-escalation" and "No physical incidents noted."

2.1.11 Within days David assaulted a fellow resident; in the first 8 days there were 4 incidents of aggression. Staff agreed to try and settle David. The family raised concerns as to whether David was at risk of absconding; they were reassured that he was monitored and the staff were aware of the risks. They also had concerns about the appropriateness of the placement as other residents were quite unwell; it was thought this would be similar in any placement.

2.1.12 On another occasion David was very agitated and threatening residents believing them to be in his own home and wanting them out. A DOLs application was submitted to LCC but no formal assessment, or provisioning was completed by LCC. No 1:1 contracts were issued and 1:1 observation was undertaken within the normal staffing complement. There is no documentation of an application for 1:1 funding from David's care co-ordinator although it is recorded this was refused.

2.1.13 Seven weeks after admission David was violent to another patient, a safeguarding investigation commenced and a review of his care and medications by his care co-ordinator, consultant, family and qualified nurse from Care Home 1. Notice was served to find an alternative placement able to meet David's very challenging and difficult behaviours.

2.1.14 Two weeks later David assaulted a member of staff; an incident report was completed and staff support put in place.

2.1.15 Five days later John was assaulted by David. The assault took place on an upper floor landing during staff handover and was unwitnessed by Care Home 1 staff. John sustained a scalp laceration, bruising to left cheekbone, bruising and swelling to both ears, swollen nose and bite marks. David had a cut lip and bruising to his knuckles.

2.1.16 John was immediately taken to Hospital where, as well as his injuries they also noted he had low oxygen levels and signs of a chest infection. John was admitted and treated for a Chest Infection. John was deemed fit for discharge 4 days after admission but remained in Hospital for a further week due to the Safeguarding concerns.

2.1.17 David was sectioned under the Mental Health Act (Section 3) and transferred to Hospital a week after the assault. In that time there were further acts of violence that led to safeguarding alerts, revisions of medication and daily involvement of the RIT team who were assessing the risks.

2.1.18 John returned to Care Home 1, where there was a deterioration in his physical health and he died a few days later.

2.1.19 The full facts of the case were presented to the Crown Prosecution service but no charges could be authorised due to the capacity of David. Both John and David were covered by Deprivation of Liberty Safeguards (DoLS).

2.1.20 Although John did not die from his injuries the coroner's verdict was that his death was due to "natural causes contributed to by injuries sustained during an altercation."

Subjects backgrounds

2.1.21 First and foremost, John was a family man who loved his wife and daughters. John had a long history of service, firstly in the Navy and then in the Police; he worked his way through the ranks and at retirement he was an Inspector. John liked structure and routine in his life; he could be stubborn. John gained a degree in history and liked to debate and socialise; he enjoyed travelling, having been to many countries, football and rugby.

2.1.22 David was a divorcee with no children; he had two sisters who doted on him. David was a hard working construction worker who had lived locally all his life. David had a dry sense of humour, was fit and agile; a real man's man, loving nothing more than banter down the pub and a local football club. David took on an alpha male type role, preferring the company of female staff. David was intolerant of people in his space and could be unpredictable with his temper. David had a lifelong disinhibition about resorting to violence.

3 PRACTICE AND ORGANISATIONAL LEARNING

3.1 Introduction

3.1.1 The following focus points were agreed by the panel following review of the summary timeline:

1. Transitions considering:
    a. Reasons for the moves
    b. Data shared at point of transfer
    c. Transparency
    d. Effect on individuals
    e. Pre-admission assessments
2. Management of John and David's physical and mental health
3. Service provision to manage John and David's holistic needs
4. Protocols for client on client assaults including notification of LA Safeguarding Team and the CQC

3.2 Transitions

3.2.1 As client's needs change it is recognised they may need to transfer from one care establishment to another. Managing those transfers is extremely important especially when moving elderly patients with dementia who can be greatly affected by any change in routine.

3.2.2 Throughout the period under review John remained in Care Home 1 with no transitions between Care Homes. John's daughter recounted the family's experience of transitioning firstly from an Acute Hospital to a Care Home and then from a Psychiatric Hospital to a Care Home. John's daughter stated they were given a list of Care Homes but were left to choose and gain entry into the Care Home which was daunting. There was no full assessment of John's needs and limited liaison between the ward and Care Home staff. The transition was not seamless and therefore stressful for John and the family. Practitioners indicated the current process is a "time consuming but in-depth process".

3.2.3 In contrast the family had a more positive experience when John transitioned from a Psychiatric Unit to the Care Home. The unit organised and managed the process. An assessment was completed and discussions had between the ward staff and the Care Home. As a result, the transition went smoothly and was calmer which ultimately proved beneficial for John and his family.

3.2.4 David had a number of transitions during the review period. The first was between Care Homes where there is evidence of reassessment by a Health Professional. The other moves were between Care Homes and Psychiatric Units, where there is evidence of reassessment by a Health Professional, and between Psychiatric Units and Care Homes where there is no evidence of reassessment either by a SW or a health professional.

3.2.5 The data shared at point of transfer is a key feature of this review. When patients had a period of detention under the MHA, between care establishments, this complicated the situation. On all occasions information crucial to pre-admission care assessments, on whether a proposed Care Home could meet David's needs, was omitted.

3.2.6 Pre-admission assessments provide an opportunity for services to be proactive and gain all the relevant information from those who know the client best. An incomplete assessment leads to a more reactive approach, as in this case.

3.2.7 Contact was limited to the current Hospital with no contact with the previous care home and those directly involved in David's continuing care. Medication information in the form of a MAR was not included on transfer and so there was confusion regarding David's medication dosage; this led to Care Home 3 immediately calling Care Home 2.

3.2.8 Within weeks of transfer Care Home 3 contacted the RIT team and advised they were giving David notice. They decided they could not meet David's needs after several safeguarding alerts had been raised and one to one funding had been refused.

3.2.9 It is clear that the pre-admission assessment was incomplete and lacked the level of data required to make a safe transition from one Care Home to another; there was a lack of transparency and information sharing. Practitioners report the professional assessments by the CCG are time consuming and cumbersome and this is impacting on the level of detail being shared. Care Home 2 indicated that they share information with the accepting care home on request.

3.2.10 Practitioners report communication issues, Care Home to Care Home, at times of transition – information may be withheld from practitioners, with reluctance to share all that is known about a resident for fear other Care Homes won't accept the client; managers are concerned they will be unable to move the client on.

3.2.11 This issue is compounded for the Care Home if they are not receiving sufficient support for the Local Authority or responsible Commissioning body to fund extra carers to manage the client's behaviours safely - this will be discussed further in section 3.5.

3.2.12 Prior to discharge from Care Home 3 there was a clear directive from those involved in the MDT meeting that David should not be allowed to go back to any Care Home due to his aggression and his dangerous presentation. On leaving Care Home 3 David was admitted under S2 of the Mental Health Act for assessment. Practitioners stated that when patients transfer between Care Home and Hospital they are sent with patient information but sometimes this will get lost or be seen as less significant

than the hospitals information, as appears to have happened in this case. SBAR[3] hand overs are completed in hospitals when patients are transferred between wards. There is confusion as to whether these are routinely completed.

3.2.13 Following this period of detention and despite the view that David should not be allowed to go back to any care Home, plans were put in place by the discharging unit for David to be transferred to Care Home 1. In discussion the lead reviewer learned that patients with dementia can have phases of aggression; it was purported that the treating medics may have believed David had moved on from his aggressive phase.

3.2.14 A pre-admission assessment was undertaken, however during David's assessment, no information was passed onto Care Home 1 from ACS Health or The Harbour about David's previous history of failed placements. CHC checklists were not completed. More specifically, during this initial assessment, there was no communication forwarded of David's prior history of safety issues with respect to his potentially aggressive interactions with other service users. David's pre-admission assessment was conducted on the ward at Hospital with no direct, or indirect communication between Care Home 1 and David's previous placement(s). The representative from Care Home 1 was given David's hospital notes to look through but practitioners identified it can be difficult to navigate the notes and some information can be lost. David's relatives were not consulted either.

3.2.15 The impact of multiple, successive transitions on clients is not receiving enough consideration.

Learning Point: Incomplete information is impacting on the quality of pre-admission assessments; there remains potential for clients to be placed in Care Homes unable to meet their needs leading to avoidable risk and multiple transitions.

3.3Management of health needs

3.3.1 There is evidence that professionals in the EMD[4] and EMI[5] homes John and David were resident in during the review period, and within primary care, were actively promoting, preventing and managing both John and David's existing health conditions and periods of physical ill health. John's daughter perceived her father's GP to be very responsive to call outs.

3.3.2 Both gentlemen were offered the seasonal influenza vaccination. Whilst John had his administered David declined his. What is not clear from records is whether David had capacity to understand the implications of the decision not to have his seasonal

[3] SBAR - Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.

[4] EMD - (Elderly Mental Dementia) which offers residential level support

[5] EMI - (Elderly Mentally Infirm) homes offering nursing level care

influenza vaccination. It would have been appropriate to contact his next of kin for discussion and carry out an assessment of David's mental capacity[6]using the two stage test. In a study[7], difficulties in obtaining informed consent from residents and where necessary their next of kin, was cited as one of the reported barriers to vaccination of residents. From a Public Health perspective vaccinations for vulnerable groups is a key priority.

3.3.3 David had a diagnosis of Cancer of the prostate and was under the care of a Consultant in secondary care. David attended regular monitoring appointments accompanied by both care staff and his relatives. The decision was to watch and wait. There was no change in this condition during the review period.

3.3.4 Aggression can be a sign that a person has a need that they are trying to communicate. It can be difficult for care staff to be clear what the need is. It is evident from records that staff were familiar with, and recognising changes in John's behaviour and their linkage to illness. Within days of an increase in agitation or aggression John was reviewed by his GP; on most occasions he was diagnosed with either a chest or urinary tract infection for which he was prescribed antibiotics.

3.3.5 It is apparent John had a fall, however there is no evidence this fall was assessed or recorded[8]. There should always be an assessment of any injuries as well as the cause of a fall and a plan to prevent further falls which should be recorded in residents and Care Homes records.

3.3.6 On one occasion medication for an eye infection was prescribed for John without the GP visiting. Whilst seeing a patient is currently thought best practice for GP's to safely prescribe for a patient, the GMC states "you may prescribe only when you have adequate knowledge of the patients health, and are satisfied that the medicines serve the patient's needs[9]. GP relying on care Homes for information, although GP's have the responsibility for the health of the person. Patients when they move Care Homes, move GP, so GPs can struggle to get relationships with patients however, I this case John's GP was familiar with his health needs. Care Homes reported they often struggle to get GPs to visit patients at the Care Home and that GP's have a lack of knowledge that the staff within the Care Homes are qualified nurses.

3.3.7 On one occasion when John was non-compliant with medication a DOL's assessment was completed however, there were occasions when this did not happen for John demonstrating an inconsistent approach. This was raised as a practice issue in a recent local SAB – Adult A.

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[6] Mental Capacity Act (2005)
[7] Flu and flu vaccination 2017/18 A toolkit for care Homes. Public Health England
[8] NICE (2013) Assessment and prevention of falls in older people.
[9] Good medical practice (2013)

Learning Point: There is an inconsistent use of the Mental Capacity Act and DOLS when patients with dementia refuse prescribed or advised treatments and interventions.

3.3.8 What appeared to be lacking for John, from primary care, was an end of life care plan. Thus when John's health declined in the days prior to his death he was taken to the local A&E department. The GP was somewhat understandably concerned this decline might be related to the recent assault, however John had undergone extensive investigations in Hospital which had demonstrated no specific brain injury.

3.3.9 In a recent study Dr K Sleeman from King's College said: 'Recognition of the need to improve end of life for people with dementia has been increasing. This includes enabling them to be cared for in their home or a care home.' However, results of the study showed an increase in the reliance on emergency care. They found 78.6 per cent of the patients ended up in A&E at least once in the last year of their lives with nearly half attending A&E in the last month of their lives and a fifth attending in their final week. NHS England have developed a Dementia and the End of Life Care Strategy[10] to try to address this Nationally.

3.3.10 Locally a "Liverpool care pathway" that included planning for end of life care disappeared several years ago and had not been replaced. An advanced care document has been created which includes end of life care, but this is not currently used.

Learning Point: All care home patients to have an end of life care plan that can be updated at points of decline.

3.3.11 John had routine, intermittent involvement with Mental Health Services throughout the review period. All input related to either refusal of medication, the need for medication review and changes in behaviours.

3.3.12 David was under the care of a Psychiatrist and the Intermediate Support Team. From February to April 2015 David had extensive contact with the RIT team. David had regular reviews of his medication at times when he was exhibiting challenging behaviours. Confusion regarding medication dose led to that medication being omitted. This could have been a reason for increased agitation.

3.3.13 When David assaulted a resident and needed to attend A&E, Care Home 3 staff asked for support from the Hospital Liaison team who were to meet David and staff in A&E with a view to handing him over to an acute Mental Health bed. Although this was agreed before David was transported to Hospital, when he arrived it did not transpire and Care Home 3 staff were left managing a potentially risky situation. The RIT team carried out three risk assessments in three months which demonstrated escalating risk leading to a plan for formal MHA assessment and admission.

[10] NHS England Actions for End of Life Care (2014-2016)

3.3.14 The AMHP service made a timely assessment. When it was deemed David needed to be detained under Section 2 MHA and no bed was available, the AMHP service had daily contact with the LCFT bed manager regarding bed availability.

3.4Service provision

3.4.1 There were two important system changes in the summer of 2015. Lancashire moved onto a new system called Liquid Logic. All case notes from the previous system ISSIS were transferred to the new system, but the assessments were not transferred. There is now limited access to the old system as over time passwords expired making access to the system more difficult. Practitioners were unaware this would happen before the system change, and this impacted on the fullness and quality of assessments.

3.4.2 The RIT team could not meet demand Monday-Friday so the service was extended to a 7 day a week service in 2011; the change was made without an increase in provision. In March-July 2015, following a period of consultation with staff and stakeholders, there was a restructure/redesign of the RIT team. The RIT team was a new team comprising of Care Home Liaison, Intensive Home Treatment and Single Point of Access. The benefit of having Care Home Liaison sat alongside Home Treatment was the reduction of duplicated assessments; it was developed as a proactive support mechanism. This meant that patients in crisis, within a care home setting, could be managed by the home treatment element of the RIT team working alongside the Care Home Liaison element, in order to maintain care home placements and avoid unnecessary hospital admissions. The model of the RIT team was designed to allow staff to flex between all elements, which also ensured staffing levels were higher to cover the 7 day 8-8 rotas.

3.4.3 There were a number of perceived negative consequences to these changes. The perception of some care home staff was that teams were lost. Care homes indicated a loss of professional relationships reducing the opportunities for communication. The Care Homes stated they used to have good positive working relationship with the care liaison team but with this change in service provision this reduced. Despite the consultation when the RIT team went into the new role after the restructure this was not known to some Care Home professionals.

3.4.4 Attendees from the RIT team indicated crisis referrals and gate keeping referrals took over as urgent and, planned Care Home visits often had to be cancelled, with no time period set for catch up.

3.4.5 The RIT team is now under new management and staff report an improvement in understanding of their role and their work load. A review has recently taken place, and as a result, a model of care home clinics has been developed. This is due to be showcased at the Quality improvement event.

Learning Point: The SAB and its partners need to ensure that as professionals are required to concentrate their efforts on one aspect of their role the negative consequences of doing do receive sufficient consideration.

3.4.6 There were additional resource issues. Systems set up to respond in times of crisis – CSU – were not effective. The system around applications for 1:1 support for funding when David required additional support were not robust.

3.4.7 1:1 care and its funding proved difficult on all occasions it was applied for. Local Authority commissioners indicate deciding who should fund such additional funding can be the subject of debate; there is no quick way of agreeing funding. The Local Authority and Health take a different stance currently, with the Local Authority generally being more pragmatic. The process is not simple and whilst funding can be split there is no joint funding; commissioners are reliant on Social Workers spending wisely.

3.4.8 1:1 funding was applied for within weeks of David's admission to Care Home 3, it was refused; however, David had settled after it had been applied for. On the second occasion David did not settle and within a week of applying for 1:1 funding, David had assaulted a resident sustaining a fracture to his hand. These two facts, coupled with difficulties contacting the RIT team and Safeguarding, and gaining support from the Hospital Mental Health Liaison, prompted Care Home 3 to give notice to David. A week later Care Home 2 still had no confirmation 1:1 funding had been agreed.

3.4.9 There was a lack of ownership of the application for 1:1 funding, and an adhoc approach to monitoring the progress of the application, leaving the Care Home reliant on others to inform them it had been turned down. This led to the Care Home picking up the shortfall in funding having had 1:1 in place for much of the week.

3.4.10 Following the assault of John, it appears there was confusion as to whether an application for 1:1 funding had been made, was required, and/or had been granted. Initially staff at Care Home 1 felt 1:1 might heighten David's agitation, however they were providing 1:1 close observation. Three days later, following further aggressive acts, the CPN made contact with Complex Package of Care (CPOC) to request a challenging behaviour unit place and 1-1 funding agreement.

3.4.11 Practitioners indicated that ownership over 1:1 funding is difficult and that 1:1 care was not working and difficult to put in place. An additional issue is Care establishments need to evidence the need for 1:1 funding and if they haven't kept adequate records the evidence is sometimes not there.

3.4.12 Currently Care Homes state they are making up the shortfall around funding 1:1 care at the same time as managing the increased risk. In discussions, the need to escalate concerns and challenge decisions if they do not seem appropriate appears underdeveloped in this area

Learning Point: The system, application and provision of 1:1 funding is not providing the support physically and financially to Care Homes at the point it is needed. In addition, the system does not include an adequate escalation and challenge process.

3.4.13 David received Mental Health Act assessments on two occasions during the review period. On both occasions the assessors agreed that David should be detained under the Mental Health Act (1983). On the first occasion detention under Section 2 was assessed as appropriate, and on the second occasion under Section 3.

3.4.14 On both occasions the lack of a suitable bed led to three-four day delay, thus delaying David from having the assessment/treatment his mental health required. The delays placed staff and other residents at potential risk during these times. On the first occasion 2:1 funding was agreed the day before admission by the Chief Executive from Lancashire Care Foundation Trust; it was proposed one of the two would be a RMN, however this was not possible as there were not enough available staff. This lack of physical support led to Care Home 3 being advised to turn to the police for help and support if required; Care Home 3 had already called the Police out earlier that day. What is not fully known is how frequently this contingency is being used to support Care Homes or how it's impacting on the Police.

Learning Point: Lack of Mental Health beds is impacting on patients but also impacting on none health agencies.

3.4.15 On the second occasion, there is greater evidence that additional physical support was put into the Home to assist in supporting David's challenging behaviours. However, on this occasion it is unclear how the concern with regards to the allocation of a bed had been escalated, and who it had been escalated to. The Mental Health Network have a HUB at the Harbour to manage beds, referrals etc. The Mental Health Network have a meeting for delayed discharges and bed management alongside the Commissioning Support Unit. Actions plans are completed. SITREPS, situational reports are completed on a daily basis to manage lack of beds and delayed discharge.

3.4.16 The social worker was in regular contact with the RIT team who were supporting Care Home 1 with daily visits and there is clear evidence that the AMHP service were in daily contact with the LCFT bed manager as per the Bed Management Protocol to gain an update on bed availability whilst awaiting a suitable bed. However, there appears to be a lack of strategic management of the situation. LCFT have had a very similar case in a neighbouring RIT team that went to coroner's court in October 2017. The coroner indicated the RIT team had done everything they could to support the patient and the care home. The coroners Regulation 28 report was sent to the health secretary, highlighting the lack of available MH beds in the country and the lack of challenging behaviour placements to manage patients with behavioural and psychological symptoms of dementia.

3.4.17 Lack of beds is not a local issue. In a recent study, researchers from Newcastle University warned Britain was facing a desperate shortage of care home places and predicted an extra 71,000 beds would be needed in England alone by 2025 – nearly a third more than were available in 2015. The study, published in the Lancet journal, warned people would need to spend more of their lives in care as life expectancy

increases[11]. There is also a national shortage of EMI beds which is leading to a blockage of challenging behaviour beds in hospitals. EMI homes offer the highest level of care that can be commissioned. Practitioners indicated specialised behaviour homes are needed for high risk individuals.

3.4.18 The Department of Health has published guidance [12]in a bid to ensure that everyone can be supported to be as independent as possible, and get the care and support they need, wherever they live. In the past, David would have been admitted to a mental health ward that no longer exists.

Learning Point: Patients who pose the greatest risk, living in environments where all residents are vulnerable, are waiting too long after they have been assessed as needing detention; thus leaving staff and patients at an unacceptably high risk of assault. Currently services are not future proofed.

3.5Protocols for client on client assault

3.5.1 Assaults within Care Home settings are not uncommon, management and consideration of safeguarding become of paramount importance for both victims and assailants. In this case appropriate alerts were made by Care Homes 1, 2 and 3 to adult safeguarding, the police, and social care following assaults. The response by the Police was swift and responsive.

3.5.2 The lack of Mental Health and Challenging Behaviour beds is impacting on moving clients, who have assaulted other clients, into the correct environment to keep everyone safe. The lack of such beds was a feature of another Safeguarding Adult Review in the region and is not only a local issue. Care home staff are trained to de-escalate situations but, are not currently trained in restraint and control.

Learning Point: If care homes are being required to care for aggressive/violent patients awaiting Mental Health beds the SAB need to be assured that care home staff are appropriately skilled to care for patients in the interim.

3.5.3 The response of the ASC and Safeguarding was variable. Whilst all alerts were considered the majority were swiftly closed down by MASH on learning that MDT meetings were arranged. On occasion, Care Home staff were advised to take actions they had already completed, or were not appropriate. There is no evidence that when safeguarding professionals learned this, they offered further advice or considered whether an escalation of the case was necessary. The role of safeguarding should not only be about sign posting and ensuring professionals are meeting to discuss the case, but to consider the effectiveness of care plans in lowering risks and promoting safety. Practitioners identified the process had its limitations at that time.

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[11] http://www.dailymail.co.uk/health/article-4811156/More-dementia-patients-E-lack-care-home-beds.html#ixzz50tI12mtI

[12] Department of Health (2016) Prime Minister's Challenge on Dementia 2020 implementation Plan

3.5.4 Whilst there is evidence of discussion regarding safeguarding at MDT meetings, there was only one occasion when a safeguarding alert led to a strategy meeting and that followed the serious assault on John. The reviewer believes there were occasions when David was resident in Care Home 3, when a strategy meeting should have been held. There was no challenge to the decisions of MASH and safeguarding professionals, and no escalation of the issues.

3.5.5 In April/ May 2017 new Safeguarding guidelines were approved by the SAB and rolled out across adult services. Those practitioners who had occasion to use them, indicated they were much improved and a useful guide, however some practitioners were unaware of these new guidelines.

Learning: Does the current remit of safeguarding team professionals adequately support professionals at the frontline?

3.5.6 What is of concern is the way alerts were recorded. The alert was recorded under the victim's name and not the assailant, making it difficult for the Safeguarding team to pick up when one assailant was responsible for a number of incidents. This is of particular concern when, as in this case, patients are moving between care establishments. This recording system makes it extremely difficult to identify those individuals how present a high risk of violence to others and take appropriate actions.

Learning point: The current recording system in the Safeguarding team is not able to identify assailants who pose a high risk to others.

4 PRACTICE ISSUES

Introduction

4.1.1 Practice issues were highlighted for individual organisations as a result of this review. These issues are generally not subject to separate recommendations as practice improvement and/or action is already in place or planned. The organisation's own governance arrangements will need to monitor that issues have been, or continue to be, resolved:

Practice issue – David was not supervised at the time of the incident. Supervision of clients in corridors during staff handovers has been addressed.

Services affected – Care Home 1

Practice issue – CHC checklists were not being completed on discharge from Hospital.

Services affected – Local hospitals

Practice issue – Videoing of clients

Services affected – Care home 2

Practice issue – Bed management – There is a lack of evidence of who escalated the case and how this was dealt with at strategic level.

Services affected – LCFT

5 GOOD PRACTICE IDENTIFIED

5.1.1 Some good practice, where professional commitment, persistence and professional curiosity resulted in an enhanced service was identified during the review, by the panel, by professionals at the learning event, and by John's daughter.

5.1.2 John's daughter reported the transition from the local Hospital to Care Home 1 was managed well – this is expected practice.

5.1.3 John's daughter indicated the GP was responsive to her father's health needs – this is expected practice.

5.1.4 On one occasion the RIT team, were responsive completing a risk assessment on the same day as referral.

5.1.5 Safeguarding were alerted following each assault – this is expected practice.

5.1.6 Dementia Care Mapping – Dementia Care Mapping is an established approach to achieving person centred care for people with dementia. This has been introduced locally and is used to form part of assessments and to plan care. Staff take the perspective of the person with dementia in assessing the quality of care that's being provided, it allows staff to engage in critical reflection in order to improve the quality of care for people living with Dementia, and also to educate staff. Two Practitioners within the Pennine Rapid Intervention and treatment team are trained in Dementia Care Mapping. The patient is observed in their environment using the Dementia Care Mapping Tool.

6 CONCLUSIONS

6.1 In this case the risk David posed was known. A clear directive from members of the community CHC team that David could not be cared for safely within a Care Home setting in April 2015, was not given adequate consideration when the decision was made to discharge David to a Care Home setting in July 2015.

6.2 David's family, whilst upset with the MDT's assessment at the time, expressed concerns regarding if and how Care Home 1 could manage the risks. They were not included in decisions at point of discharge from Hospital.

6.3 Had all agencies met and explored all of the information, and included the family in this process, they may have concluded that the unpredictable nature of David's violence meant transfer to a Care Home setting was not in David's, or other residents, best interests.

6.4 Setting up services and systems that are responsive to rapidly changing needs is fraught with difficulties and will always be challenging. At a time when LA's and the NHS are experiencing financial constraints, reductions in staff numbers and staff shortages compound those difficulties. The circumstances that presented in this case will present again and it is for that reason the system around managing crisis' and risk needs to be revised.

6.5 The risk of the current system is that the shortfalls in provision are leaving patients who pose the greatest risk, living in environments where all residents are vulnerable, for too long after they are assessed as needing detention; this is leaving staff and patients at an unacceptably high risk of assault.

6.6 Due to the significant period which has elapsed since the end of the timeframe, some systems and practice within organisations have now changed. Where this is the case no recommendation has been made.

GLOSSARY OF TERMS & ABBREVIATIONS

A&E	Accident and Emergency
AMHP	Approved Mental Health Professional
ASC	Adult Social Care
CHC	Continuing Health Care
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CPOC	Complex Package of Care
CQC	Care Quality Commission
DoLs	Deprivation of Liberty
EMD	Elderly Mental Dementia
EMI	Elderly Mentally Infirm
GMC	General Medical Council
GP	General Practitioner
IST	Intermediate Support Team
LA	Local Authority
LCC	Lancashire County Council
LCFT	Lancashire Care Foundation Trust
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
MHA	Mental Health Act
MHT	Mental Health Team
PRN	Pro Re Nata
RIT	Rapid Intervention Team
SAB	Safeguarding Adults Board

Appendix 1: Terms of reference Safeguarding Adult Review – John

Introduction
This Review has been commissioned by the Chair of Lancashire Local Safeguarding Adult Board (LSAB) in accordance with the Care Act (2014). The Safeguarding Adult Review will be undertaken as a concise Practice Review, utilising the principles of Child Practice Reviews in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

A multi-agency panel established by Lancashire LSAB will conduct the review and report progress to the Board through its Chair. Membership will include an independent Lead Reviewer and Chair and representatives from key agencies with involvement.

Role	Organisation
Independent Chair	Lancashire Adults Social Care
Independent Reviewer	Independent
Panel Member	East Lancashire Hospitals NHS Trust
Panel Member	East Lancashire CCG
Panel Member	Lancashire Constabulary
Panel Member	Care Quality Commission
Panel Member	Lancashire Care Foundation Trust
Panel Member	Lancashire Care Foundation Trust – RITT specialist
Panel Member	Lancashire County Council - ASC
Panel Member	Lancashire County Council – ASC Mental Health Specialist
Panel Member	Lancashire County Council – ASC SIAS Specialist
Panel Member	Mapleford Care Home
Business Coordinator	Lancashire Safeguarding Adult Board
Business Support Officer	Lancashire Safeguarding Adult Board
Panel Member (confirm on receipt of timeline)	Lancashire County Council - Safeguarding
Panel Member (confirm on receipt of timeline)	Dove Court Care Home

Timeframe for the review
The review will cover the timeframe of **25/09/2014** – **22/10/2015**. A summary of any significant incident/s relevant to the case which is prior to or post to the start or finish date of the above stated timeframe, should be included in the information completed by each agency.

Subject(s) of the review
John aged 86
David aged 76

Significant others

Not applicable

The purpose of the review is to:

1. Determine whether decisions and actions in the case comply with the policy and procedures of named services and the LSAB;
2. Examine inter-agency working and service provision for the adult and family;
3. Determine the extent to which decisions and actions were adult focused;
4. Examine the effectiveness of information sharing and working relationships between agencies and within agencies;
5. Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults;
6. Identify any actions required by the LSAB to promote learning to support and improve systems and practice.

Tasks specific to the review panel:

1. To set the time frame for the review, see above;

2. Agencies that have been involved with the adult and family will provide information of significant contacts by preparing an agency timeline with a focus on the purpose and scope of the review, see above;

3. Other agencies/services may be asked to provide a timeline following review of the information provided;

4. Agency timelines will include a brief analysis of relevant context, issues or events, and an indication of any conclusions reached. Information about action already undertaken or recommendations for future improvements in systems or practice may be included if appropriate. A case summary may include any relevant additional background information from significant events outside the timeframe for the review;

5. Agency timelines will be merged to create a composite timeline and used by the Panel to undertake an initial analysis of the case and form hypotheses of themes;

6. The Panel, through the Chair and Lead Reviewer will seek contributions to the review from appropriate family members and provide feedback to the relevant family members at the conclusion of the review process;

7. The Panel will plan with the Lead Reviewer a learning event for practitioners to include identifying attendees and the arrangements for preparing and supporting them prior to the learning event and feedback following the event;

8. The learning event will explore hypotheses, draw out themes, good practice and key learning from the case including any recommendations for the development or improvement to systems or practice;

9. The Panel will receive and consider the draft SCR report prepared by the Lead Reviewer, to ensure that the terms of reference for the review have been met, initial

hypotheses addressed and any additional learning is identified and included in the final report;

10. The Panel will agree conclusions from the review and an outline action plan and make arrangements with the Lead reviewer for presentation to the LSCB for consideration and agreement;

11. The Panel, through the Chair and Lead Reviewer will plan arrangements for feedback to the family following the conclusion of the review but before publication;

12. The Panel will make arrangements for feedback to the practitioners in attendance at the learning event and share the learning from the review;

13. The Panel will take account of any criminal investigations or proceedings related to the case;

14. The Chair of the LSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the SAR report for publication.

Key Focus points – To be revised as further information is received

1. Transitions considering:
   a. Reasons for the moves,
   b. Data shared at point of transfer,
   c. Transparency
   d. Effect on individuals
   e. Pre-admission assessments
2. Management of John and David's physical and mental health
3. Service provision to manage John and David's holistic needs
4. Protocols for client on client assaults including notification of LA Safeguarding Team and the CQC

Appendix 2: Practitioners event attendees

ATTENDEES	
Team Manager MASH	Lancashire County Council
	ACC
Senior Occupational Therapist	Pennine Rapid Intervention & Treatment Team LCFT
	Dove Court
Social Worker	Lancashire County Council
Business Co-ordinator	Lancashire SG Board
Deputy Team Manager	Pennine Rapid Intervention & Treatment Team LCFT
Team Manager ASC	Lancashire County Council
Detective Sergeant	Lancashire Constabulary
Manager	Mapleford
Business Support Officer	Lancashire SG Board
	ELHT
Senior Social Worker	Lancashire County Council
Community Mental Health Nurse	Pennine Rapid Intervention & Treatment Team LCFT
Care worker	Mapleford
Social Worker	Lancashire County Council
ABSENT	
Team Manager MASH	Lancashire County Council
Detective Inspector	Lancashire Constabulary
	Belverdere / unlimited care