Safeguarding Adults Review

Executive Summary and Recommendations

A Report commissioned by Norfolk Safeguarding Adults Board into the cases of Ms F and Mr G, two unrelated residents at the same care home in Norfolk.

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Executive Summaries

1. Executive Summary: Safeguarding Adult Review Overview

1.1. This executive summary presents the findings of a Safeguarding Adults Review (SAR) concerning the cases of two elderly residents of XYZ Care Home in Norfolk, identified in the present report as Ms F and Mr G. The full report contains further detail regarding the chronology, experience and learning in relation to the two residents involved. This current executive summary includes an overview of each case followed by the detailed recommendations arising out of the SAR process.

1.2. Neither resident knew each other and both residents died in separate circumstances. There was evidence of both residents experiencing, or being placed at risk of experiencing, abuse and/or neglect.[1]

1.3. It is noted that the circumstances of Ms F significantly overlap with another service user, who will be referred to as Mr Z in this report. He had been aggressive and violent towards Ms F, as well as other service users and members of staff at the home.

1.4. For Ms F, the scope of the SAR runs from **June 2017**, which was approximately when Mr Z was admitted to the care home, and her death in **January 2018**.
For Mr G, the scope of the SAR runs from **June 2017** to his death in **November 2017**.

1.5. The two Safeguarding Adults Reviews (SARs) considered in the present report were commissioned by Norfolk Safeguarding Adults Board (NSAB). This report is the final output from two SARs which relate to service users who had both received care from the same care home in Norfolk (referred to as XYZ Care Home).

1.6. The two residents were not related to each other in any way, and their cases are quite different. However, there are overlaps in a number of the learning themes, and the Safeguarding Adults Board (SAB) agreed it would be beneficial for both cases to be reported in a joint report.

1.7. The primary purpose of a SAR is to learn lessons so that professionals can work more effectively to improve care and prevent abuse in future cases. The criteria used to decide whether a SAR is conducted is outlined in s.44 of the Care Act 2014, which is not further expanded on here. However, broadly, the aim of this SAR is to try to improve the response of services to other people with similar needs, and to make practical recommendations for future service development. The aim is not to hold practitioners or organisations to account, or to attribute blame. Other processes exist to do this, and it is recognised that the analysis in this report may contribute to such decisions. However, to generate meaningful learning, the report does need to address and consider concerns and failings in practice, including at the level of individual organisations.

1.8. This SAR included two whole-day Learning Events in which practitioners, managers and commissioners – who had either directly worked with Ms F or Mr G, or who were professionally involved in service management or commissioning of services – were invited to develop a wider understanding of the events that had led up to the deaths of Ms F and Mr G, and to consider lessons for future practice.

[1] I note that although the report does not attribute the cause of this to a specific agency, the care home involved in the care of both residents objects to this view.

2. Executive Summary: SAR F

2.1. Ms F was an elderly lady with dementia, who at the time of her death was a resident at XYZ Care Home in Norfolk. She had been in this care home for a number of years.

2.2. The focus of the SAR begins in **June 2017** after another male resident, Mr Z, was admitted to the same care home. Mr Z was admitted as a private resident, meaning that statutory services were not involved in the process of his admission.

2.3. Soon after Mr Z's admission, Mr Z began to demonstrate challenging behaviour. This took a variety of forms, including resistance to personal care, shouting and verbal aggression. Relatively soon after admission, this developed to include violence towards staff members, and after this, other residents. Violent behaviour included hitting or punching residents in the face/head.

2.4. The care home described Mr Z's violent behaviour as unpredictable. However, analysis of the process by which violent incidents were recorded and analysed leads to a question of whether these incidents could have been better understood and more effectively responded to. The home explained that they did not commonly look after residents demonstrating violent behaviour and the staff team agreed that Mr Z's needs exceeded their capacity throughout much of the admission.

2.5. There was some evidence for an escalation in behaviours in **August 2017**, with the Dementia Intensive Support Team (DIST)(the local acute/intensive support service from the mental health trust) being involved from the beginning of July. The role taken by DIST appears to largely monitor Mr Z and provide medication, which appears to be in Mr Z's case of limited effectiveness, and concerns about the care home's ability to safely manage Mr Z do not appear to be escalated by DIST. DIST close the case at the **end of August 2017** without referring on for ongoing support by the community team.

2.6. By the **middle of December 2017**, there had been a series of violent incidents, including at least nine occasions where residents were hit or punched in the head/face area by Mr Z. Many of these incidents had the potential to cause more serious physical injury than that which occurred, and it is noted that the 'index' incident towards Ms F, on the **19th December 2017**, did not appear fundamentally dissimilar to these previous incidents, apart from circumstantial changes which led to a more serious outcome. This is in addition to a greater series of more minor but still challenging behavioural presentations, as well as violence directed towards staff.

2.7. The 'index' incident on the **19th December** appears to be the fourth time that Ms F was assaulted by Mr Z. It appears that Mr Z pushed Ms F towards the ground, leading her to hit her head as she fell, and leading to her sustaining a fractured neck of femur. This required her to be admitted to a local acute hospital for surgery, where she remained over the Christmas period. Consequent to this incident, Mr Z was detained under the Mental Health Act 1983, with the process here bringing severe challenges, ultimately requiring four separate ambulances to attend before Mr Z was conveyed.

2.8. Ms F was then admitted back to XYZ home in **January 2018**. By this stage, the incident and subsequent surgery seems to set in motion a chain of deterioration in Ms F's physical and emotional health. Whilst it is not for the report to consider causation of Ms F's death, it appears important to note Ms F's death then occurred some weeks afterwards at XYZ Care Home on the **31st January 2018**.

2.9. The most severe incidents of violence towards residents were generally reported by the home to the local authority safeguarding team. However, the wider context of this violence in terms of its frequency and breadth did not seem to be understood, and steps that may have been taken to more effectively manage the risk (e.g. considering an alternative placement; detention under the Mental Health Act) did not appear to be considered by statutory services until too late. This may be for several factors, including an over-reliance on assurances given by the home about the ability of risk management plans (broadly enhanced observations) to manage the risk, some apparent inconsistency in the message given by the home about their ability to care for Mr Z, poor communication between professional agencies, Mr Z's status as a private resident, some potential concerns with the electronic recording system in the safeguarding team, and a lack of professional curiosity (e.g. in reporting or requesting details about the wider history and in particular the wider range of attacks towards staff).

2.10. The SAR was commissioned given concerns expressed, particularly, about the extent to which Ms F and other residents had been protected from harm including through the management of Mr Z by the care home. Questions around the process of interagency working and communication are also considered within the wider analysis of the SAR. More broadly, the process of the SAR also revealed questions in practice around the assessment of Mental Capacity, the process by which detentions under the MHA are made (and particularly conveyance under the MHA by a secure ambulance), and the way in which challenging behaviour is assessed and managed in a residential home context in what appeared to be a largely 'medication first' way. The SAR concludes with a number of recommendations relating to these factors, and these recommendations are presented in the context that their implementation may work to prevent other residents in care settings experiencing abuse or neglect as a consequence of another resident's violent behaviour.

2.11. It is right that the Executive Summary acknowledges the concerns expressed by the family about the care of their mother in this case, and it is certainly hard not to empathise with their broad analysis of events, which is as follows:

> *'Our mother was physically fit and healthy on the 18th December, weighing in at approx. 78+kg, singing, humming, laughing, chatting and dancing, and coming to the café with us for tea and cakes.*
>
> *On the 19th December she was viciously attacked, knocked to the ground and never recovered from surgery. Not only did mother suffer a broken hip but had a large bump on her head and several contusions on her right harm[2] giving evidence of the ferocity of the attack.*
>
> *She subsequently passed away on 31 January after several seriously painful weeks, a skeletal lady weighing approx. 50 kilos suffering from painful bed sores'*

3. Executive Summary: SAR G

3.1. Mr G was an elderly man with dementia and a range of other health conditions. At the time of his death on the **22nd November 2017**, he was an inpatient at GHI Hospital, a local acute hospital in Norfolk. He had been admitted to GHI hospital from XYZ Care Home, where he had been a resident from the **10th – 19th November 2017**.

[2] This has not been verified

3.2. The scope of the SAR in relation to Mr G begins in **June 2017**. He had been admitted to GHI Hospital following an incident in a previous care home which led to him falling and sustaining an injury (not a fracture). Whilst in hospital, as well as staff managing the physical aspects of Mr G's behaviour, there are reported a number of concerns about the behavioural elements of Mr G's presentation.

3.3. Ultimately, concerns about Mr G's behaviour are serious enough to warrant Mr G being detained under the Mental Health Act 1983, and subsequent to this he is admitted to a psychiatric hospital (DEF Hospital) that is outside Mr G's commissioned area. This is discussed in the SAR report as reflecting a potential resourcing issue, as the local mental health trust did not have sufficient beds to admit Mr G to one of their own units more local to Mr G's family. The SAR report also considers concerns around the process of assessment, with family members and the Nearest Relative indicating that they believed they were not involved as they should have been.

3.4. Mr G was admitted to DEF hospital on the **15th July 2017**, and shortly after this he was admitted to this hospital's local acute hospital with a suspected infection and dehydration. It appears that fluid treatment and treatment of Mr G's infection led to a rapid improvement in the behavioural elements of Mr G's presentation, leading one to ask the question of whether this infection was also the cause of the challenging behaviour previously observed at GHI Hospital. After this point, the behavioural elements at Mr G's presentation appear of significantly reduced acuity. Overall, despite being an out of area placement, Mr G appears to have a relatively positive experience of care at DEF hospital and the SAR report comments on the positive aspects of practice observed.

3.5. From DEF Hospital, arrangements are made to transfer Mr G to a more local psychiatric hospital operated by the local mental health trust. This transfer occurred on the **14th August 2017**. By this time Mr G's section under the MHA had ended and so this transfer is conducted informally, and it does not appear that there is any formal process of consideration of Mr G's best interests in this process. Despite the potential for disruption caused by this move, it is noted that Mr G's experience of JKL hospital, in Norfolk, also appeared broadly positive, with staff from this team seeming to understand well Mr G's care needs and demonstrate an ability to develop and implement an appropriate plan for managing Mr G's physical health and behaviour.

3.6. Mr G was discharged from JKL hospital and admitted to XYZ Care Home on the **10th November 2017**. There are a number of concerns about the process by which Mr G was transferred. Most prominently, these relate the fact that the local commissioning group allocated this placement under the 'Discharge to Assess' pathway (DTA) which provides 28 days of funding to assess clients in a less restrictive environment. However, JKL psychiatric hospital indicated that this process did not apply to patients detained or admitted to their hospital or indeed any mental health hospital. Consequently, they held Mr G's bed open which would have allowed him to return at any point if necessary (the bed was held open originally for 7 days but this was then increased to 14). The care home, believing that Mr G was discharged under the DTA process, reported that they were not aware of the option to return Mr G to the psychiatric hospital (although several occasions where such information was conveyed to XYZ are noted). The SAR considers how this might have occurred, and further considers the basic suitability of the DTA process when applied to patients in a psychiatric hospital such as Mr G.

3.7. Unfortunately, XYZ had significant difficulties in effectively managing Mr G and providing him with adequate care. Personal care was often refused, or delivered under challenging conditions.

The specifics of the behavioural elements of his presentation are less clear as care records from XYZ over this time are relatively limited. The DIST service, who remained in contact with Mr G during his admission to XYZ, noted concerns about the ability of XYZ to safely manage Mr G, although this is not flagged as a safeguarding referral. Concerns raised by the care home about the family's behaviours interfering with effective care delivery also do not appear to be translated into a safeguarding referral.

3.8. Despite their concerns, three days later, the DIST service propose to discharge Mr G to the care of his GP based on apparent improvement in his presentation. This does not ultimately occur. However, it is possible that DIST's assessment of Mr G's needs and risks at this point was compromised by the lack of records noted above and, perhaps, an over focus on his presentation on the day in question. Certainly, the decision-making around this issue seems to lack detailed inquiry or professional curiosity, which is reflected on more widely in the wider SAR. Later the same day, during a family visit, the family are concerned enough about Mr G's physical state and lack of attention to his care needs that they request the home escalate medical assessment and intervention for Mr G. This brings its own concerns, as the family, unhappy with the care home's response, communicate directly with the GP and arrange for Mr G to be prescribed antibiotics without clinical assessment. The care home shared a number of difficulties in working with the family members which are expanded on in the body of the SAR report.

3.9. Mr G's condition is reported as deteriorating the following day, and there is evidence suggesting significant difficulties in the delivery of his care. Ultimately, there is significant concern for Mr G's physical health and a paramedic is called who arranges for Mr G to be admitted back to GHI hospital, with a query of sepsis. The ambulance crew who admit Mr G to hospital, however, were so concerned about Mr G's physical state that they made a safeguarding referral, querying the possibility that Mr G had experienced neglect at XYZ care home. The care home has disputed the concerns documented by the ambulance service, stating that these concerns were simply those relayed by the family. Therefore, to provide greatest clarity of this incident, the records taken by the ambulance crew members in the Patient Care Record state the following:

> *'Pt has been in care home for approximately 10/7 [10 days].*
> - *Family are concerned that pt has not been out of bed and now has bed sores, staff uninformed of pt hx [patient history]*
> - *Also concerned pt is not being hydrated properly (current UTI), had meds residue behind mouth ? effectively medicating, was faeces on his table, has not been given appropriate care (top not changed, no evidence of cleaning, new bruising on upper limbs ??origin'*

3.10. These concerns were then relayed by the ambulance service in a safeguarding referral, which is then summarised verbatim below:

> *'An ambulance crew were called on 19/11/2017 at 17:15 and arrived to find [Mr G] in bed conscious but not fully alert. His family were present and they told the ambulance crew they were concerned as [Mr G] (who has dementia) had been in the home for 10 days and is currently being treated for a UTI since last Tuesday and he looked worse than he did yesterday (he had become pale, clammy and agitated/unsettled). Ambulance crew were told by family he had not been out of bed since being admitted.*[3]

[3] The latter sentence does not appear to be correct.

Care home staff were said to have little information and records shown were minimal.

There was evidence of not being hydrated properly (dry lips) and he had developed bed sores. There was residue of medication around his neck and he smelt (body odour) and he did not appear to have had his upper clothing changed for some time.

Bruises were on upper limbs and family had stated they were unable to find out how these had occurred. Faecal matter was located on his bed side table and family stated they had cleaned some off his face.'

3.11. Unfortunately, Mr G died in GHI Hospital on the **22nd November 2017**.

3.12. As well as consideration of the points already noted, the SAR developed learning in relation to the process of assessment and response to mental capacity, inter-agency working and communication between professionals and organisations, as well as the process by which care needs are assessed in a hospital environment. Recommendations are then drawn from this learning, which would seek to prevent other residents from experiencing abuse or neglect in care settings in future.

Practice Recommendations (presented in full as in the main report)

4. Presentation of Recommendations

4.1. Norfolk Safeguarding Adults Board have adopted a framework for thematic learning during Safeguarding Adult Reviews, with recommendations being presented in one of five categories:

- Professional Curiosity (no specific recommendations are drawn from here, though this is integrated in many of the other recommendations
- Fora for Discussion and Information Sharing
- Ownership and Accountability: Management Grip
- Collaborative Working and Decision Making
- Manging Risk, Uncertainty and Mental Capacity [this is a theme which underpins all the above themes but specific learning against this theme is derived below]

4.2. In order to ensure that implementation of recommendations can be appropriately prioritised, each recommendation has been reviewed by the Independent Author in line with the following table:

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	Moderately (months)	Quickly (Days or weeks)

4.3. Please note, these ratings are not intended to be definitive or rigid, but are provided only to assist the Safeguarding Board with prioritisation of implementation plans.

Recommendations with more ratings on the right-hand side would tend to be considered the highest priority for implementation.

5. Recommendations Already Enacted

5.1. Throughout the process of the SAR, there was some feedback that practice changes were implemented directly. Although these recommendations have not been reviewed by the Independent Author, they are noted here:

Recommendation 1

5.2. XYZ Care Home reported that they had updated and revised their admission template to improve this and ensure that appropriate historical information was always collected. This is positive. This process should be reviewed by the SAB to ensure that:

- The assessment form is improved to allow greater breadth of clinical information, including more details about past and present risk, previous admissions, other historical factors, daily functioning, and cognitive functioning.
- Processes are in place to clarify how the assessment should be completed and provide a 'bare minimum' in terms of sources of information. This should include an interview with the patient, and interview with any involved staff and family members, GP records, and any relevant hospital and social care records.
- Audit processes are then completed to check compliance against the standards, which could then be reviewed by the QA Team in Social Care, or potentially by the regulator the CQC.

Recommendation 1: Reviewing XYZ Admission Processes and Paperwork

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

5.3. In addition, the Head of Service for safeguarding has advised that evidence where individuals deviated from practice recommendations about recording safeguarding incidents against both a victim and a perpetrator will be followed up with an appropriate line manager.

5.4. Whilst not a deliberately enacted recommendation, it is noted that concerns about the safeguarding records system (LAS/CareFirst) have been reduced through the passage of time.

6. Recommendations: Fora for Discussion and Information Sharing

Recommendation 2

6.1. Norfolk County Council's Adult Social Care should set out 'minimum standards for assessment' for admissions to care homes, applying the principles in Recommendation 1 more generally across the county.

6.2. This should include a question to check whether a carer's assessment is offered to involved family members, particularly for privately funded clients, who otherwise may not have a formal means of connection to statutory services

Recommendation 2: 'Minimum Assessment Standards' for admissions to care homes

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 3

6.3. The care experience of both Ms F and Mr G would have been improved had there been a central person coordinating their care. The SAB should meet with commissioners to review whether this is possible within existing frameworks or whether this needs further resources, funding, or new processes.

6.4. It is acknowledged that meeting this recommendation will be difficult or even impossible if a person is not receiving care from statutory services.

Recommendation 3: Care Coordination

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	**Slowly (years)**	Moderately (months)	Quickly (Days or weeks)

7. Recommendations: Ownership and Accountability: Management Grip

Recommendation 4

7.1. The SAB should request evidence that the practice in regards to the involvement of the Nearest Relative by the AMHP in Mr G's detention is reviewed by the appropriate line manager.

Recommendation 4: AMHP Involvement of Nearest Relative (Mr G)

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	**Narrow scope**	Moderate scope	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	Moderate effort	**Low effort**
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	Moderately (months)	**Quickly (Days or weeks)**

Recommendation 5

7.2 The SAB should request that the appropriate line manager reviews practice in regards to the AMHP's apparent failure to leave an AMHP(3) form at the XYZ care home for the secure ambulance service, thus resulting in the secure ambulance provider not having the necessary authority to transfer Mr Z to JKL hospital. NSAB should have requested confirmation of this practice review within **3 months** of acceptance of the report. This recommendation could further be generalised to learning for AMHPs across the county on the process and local paperwork.

Recommendation 5: AMHP Paperwork Process (Mr Z)

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	**Narrow scope**	Moderate scope	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	Moderate effort	**Low effort**
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	Moderately (months)	**Quickly (Days or weeks)**

8. Recommendations: Collaborative Working and Decision Making

Recommendation 6

8.1. XYZ themselves suggested that one potential improvement would be for the care home to take up a shadowing or observation opportunity alongside staff within the discharging hospital prior to admission. Whilst this cannot replace the need for the detailed assessment above, this is an excellent suggestion, and in turn allows the patient an opportunity to familiarise themselves with care staff in their new home.

8.2. For care home placements funded by the local authority or CHC where complex care needs are identified, this could be implemented through amending the funding contract to set a requirement for staff from the receiving care home to spend time shadowing or observing staff in the discharging hospital prior to admission. Evidence of this action is recorded in the admission paperwork. For care home placements funded privately, this could be implemented through a wider quality standard for care homes set by the QA Team in the Local Authority, or made as a strong recommendation to care homes.

Recommendation 6: 'Shadowing/observation' of care prior to admission

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 7

8.3. Norfolk's Clinical Commissioning Groups, the Norfolk Continuing Care Partnership, and Local Authority including leads within NCC Adult Social Services should consider ways to develop understanding and knowledge of the Continuing Healthcare process, particularly within psychiatric hospitals. This communication process should also highlight the requirement of multi-agency best-interests meetings occurring prior to discharge under Continuing Healthcare, for clients who lack capacity to make decisions about their residence, as well as the non-applicability of the DTA process in the psychiatric setting.

8.4. It is noted that feedback from the CCG as part of the SARP was that practice changes had already taken place which would reduce the likelihood of clients inappropriately being assigned to the DTA pathway.

Recommendation 7: Review Process for Continuing Healthcare and application of DTA process

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 8

8.5. DIST should consider setting up meetings or forums with Care Homes where it has regular working relationships, and particularly in cases where those relationships could be improved. DIST may consider other possibilities for developing more effective relationships with care homes, for instance through 'link workers' that are identified with a particular 'set' or group of homes. The purpose of these meetings should be to build relationships, clarify expectations about DIST service provision, review and discuss the use and purpose of the MHA, as well as clarify methods of communication. A specific recommendation is made for a meeting or forum between XYZ and DIST, which could also incorporate wider involvement from Continuing Healthcare.

Recommendation 8: Meeting or Forum between Care Homes and DIST

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	**Moderate scope**	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 9

8.6 The local mental health trust should review why DIST did not discharge or plan to discharge Mr Z to the CMHT, and instead planned to discharge him to the GP. This issue may need to be discussed at a more strategic level, either with senior trust management, CCGs, or the STP. The review should include a focus on why DIST did not make other agencies aware of their decision and rationale for discharge.

8.7 The SARP reflected that an important component of this relates to the broader process for discharging clients, ensuring a clear rationale is always provided, and risk is considered and documented in a transparent way.

Recommendation 9: Discharge from DIST to the CMHT

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	**Narrow scope**	Moderate scope	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	Moderate effort	**Low effort***
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	Moderately (months)	**Quickly (Days or weeks)***

* The review could be carried out quickly but actions from this review may require more time or more effort.

9. Recommendations: Managing Risk, Uncertainty and Mental Capacity (Training Needs and Knowledge Gaps)

Recommendation 10

9.1 The present review acknowledges that there were widespread gaps in practice in applying principles of the Mental Capacity Act. Yet, it is acknowledged that training in the MCA is a core legal requirement for all care homes. Thus, there is a need to review the effectiveness of training provided to ensure that learning and knowledge development is appropriately translated into practice. This should ensure that all Norfolk Care Homes are delivering training in the MCA which considers, as a minimum:

- Awareness of professional responsibilities to make decisions for and on behalf of patients who lack capacity to make those decisions
- How capacity is to be assessed in relation to those decisions
- How to assess Best Interests
- How an LPA allows the deputy to make decisions for and on behalf of the person, and why it is important to know which residents have an LPA.
- That family members without an LPA cannot make decisions for and on behalf of a patient or resident who lacks capacity.

Recommendation 10: MCA Training in Care Homes

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	**Moderate effort***	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)***	Quickly (Days or weeks)

* The complexity of implementing this recommendation depends upon the extent to which such training is already provided.

Recommendation 11

9.2 The CCG in partnership with Norfolk Adult Social Care and other involved agencies should review the ability of the wider clinical and care system to respond to guidance that challenging behaviour should be understood primarily through a behavioural/functional/psychological approach. This should include consideration of recommendations which have de-emphasised the role of using psychotropic medication as a first-line approach to the management of challenging behaviour. This will mean that services will need to be supported in the development and use of data, which is meaningfully recorded, but also the development of tailored, comprehensive management plans which are rigorously followed within the care team. It also requires appropriate training of staff in wider skills such as de-escalation, as well as relevant additional specialist workplace resource to support this process.

9.3 It may be possible for this recommendation to be included in wider work in the county which is developing in this area, for instance wider developments in NCC to implement principles of Positive Behaviour Support (PBS) in Learning Disability services.

Recommendation 11: Moving away from a 'medication-first' approach to challenging behaviour

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 12

9.4 NSAB should seek assurance from the local authority on average response times from the AMHP service to determine if these typically fall within the requirements of the Code of Practice. This may require the local AMHP policies to develop specific standards about expected response times. A wider lack of AMHPs may have resourcing implications which would then need to be separately explored.

9.5 It must be acknowledged that this issue relates to wider issues including an acknowledged national shortage of AMHPs and also s.12 doctors. This national shortage is reflected regionally. If staffing is not sufficient, then it may be that the focus of this recommendation should be to set and manage expectations of professionals and public in regards to the timeliness of the AMHP response.

Recommendation 12: AMHP Resourcing and Response Time Review

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood***
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	**Moderate scope**	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	**Moderate effort**	**Low effort***
Speed: How quickly could this recommendation be implemented realistically?	**Slowly (years)**	**Moderately (months)**	**Quickly (Days or weeks)***

* The complexity of implementing this recommendation depends upon whether a resource issue with provision of AMHPs is identified. If it is, this will necessarily increase cost and complexity.

Recommendation 13

9.6 There is a need for care homes such as XYZ to improve their knowledge and skills in working clinically with dementia. The QA Team at Norfolk Adult Social Care should review provision of training and use of clinical models in Norfolk Care Homes for dementia. It should be a basic expectation that dementia care homes are appropriately skilled in the management and care of clients with dementia. Specific models such as Dementia Care Mapping may be considered for adoption.

9.7 It is acknowledged that appropriate training and skills in this area already forms part of core commissioning requirements for care homes. It may be, therefore, that the first task is to review the existing knowledge base in care homes and identify gaps in learning.

Recommendation 13: Dementia Training and Specialist Dementia Care Models

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

10. Recommendations: Managing Risk, Uncertainty and Mental Capacity (Practice Recommendations)

Recommendation 14

10.1. The SAB should request evidence, **within a timescale of no more than six months from the acceptance of this report**, from the relevant partners that a review is conducted of provision for secure ambulances across Norfolk. Having a non-contractual arrangement where ambulance provision is requested on an ad-hoc basis means that the AMHP service is inherently at risk departures from expected MHA Code of Practice standards without 'cogent reasons'. This is because the secure ambulance service can refuse conveyance without leaving the AMHP any recourse to an alternative arrangement. If AMHPs expect secure ambulances to be unavailable, it may also mean that AMHPs are more likely to request a non-secure ambulance for a situation that requires secure conveyance.

10.2. Block contracts with specific providers may resolve this problem. If ad-hoc commissioning continues to be used, the CCG or Local Authority should ensure that potential providers agree to a set of 'minimum standards' regarding response times and agreed practice requirements. Audit mechanisms should mean that providers who fail to meet these standards are no longer used.

10.3. The SARP wished to acknowledge the practical difficulties in implementing this recommendation, including the significant costs and resources that would be associated with its implementation. However, for the reasons above, it is stressed that analysis of demand to understand this need must be more complex than simply reviewing current usage.

Recommendation 14: Review of Secure Ambulance Provision

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 15

10.4. **Within a timescale of no more than six months from the acceptance of this report**, the relevant NHS Provider, CCG and STP (Sustainability and Transformation Partnership) should urgently review strategies to reduce out-of-area admissions. This report is then to be shared with the Norfolk Safeguarding Adults Board. It is common public knowledge that the involved NHS provider organisation has experienced long-term significant adverse media attention already about this matter. Mr G's case is a tragic reminder of the human impact of the inability to identify long-term solutions to this problem.

10.5. The SARP wished to acknowledge recent news that additional bed capacity was being developed in Norfolk following additional central government funding. This is positive. The SARP wished to recommend however that the capacity specifically for older adult psychiatric care and, in conjunction with Recommendation 16, older adult low-secure psychiatric care, was reviewed.

Recommendation 15: Reducing Out of Area Placements under MHA

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort***	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	**Slowly (years)***	**Moderately (months)**	Quickly (Days or weeks)

* Whilst resourcing may well take a long time to develop, a strategy to solve it should be developed much sooner.

Recommendation 16

10.6. NSAB should engage with NHS England / Improvement (NHSE/I) about the intentions to develop provision for low-secure beds for patients with neurodegenerative conditions. NSAB should seek the support of the STP and/or CCGs in developing a system-wide perspective to be raised with NHSE/I.

Recommendation 16: Secure Beds for people with neurodegenerative conditions

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort***	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	**Slowly (years)***	**Moderately (months)**	Quickly (Days or weeks)

* Whilst the resourcing may well take a long time to develop, a review of the demand/need should and could be completed much sooner.

Recommendation 17

10.7. All Norfolk Inpatient hospitals, **and any private hospitals outside the region used by local commissioners (specifically including JKL and GHI hospitals in the present case),** should review their policies for carrying out Best Interest Assessment meetings at the point of discharge. For patients placed out of area, the decision to move a patient back to the local region can be seen as the 'default' plan, and whilst this may usually be a decision in a patient's best interests, it is not necessarily so. In all such cases, if a patient lacks capacity to make decisions about their residence, a Best Interests meeting should be carried out to consider how best to make this decision for and on behalf of the patient. All such hospitals included in the scope of this recommendation should provide evidence of their review and any actions taken back to the CCG Safeguarding Adults team. The CCG Safeguarding Adults team should then provide assurance back to NSAB.

Recommendation 17: Best Interest Decision meetings at the point of discharge

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort*	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)*	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 18

10.8. NCC Adult Social Care Safeguarding team in conjunction with other teams should review the processes and practice for making and responding to safeguarding referrals in Norfolk care homes. This should include consideration of the following questions:

- Can improvements be made to ensure that relevant historical information is always captured when a violent incident is reported? (to avoid incidents being incorrectly captured as 'one off')
- Can improvements be made to the process to ensure that it is clear which agencies are involved, and automated processes for updating involved agencies considered?
- Can safeguarding processes automatically trigger a referral to ASC if a previously unknown patient (e.g. a privately funded client) is referred as the subject of a safeguarding referral?
- Can processes be improved such that the police are able to appropriately record all incidents which are crimes? This process may need to be reviewed alongside the volume of incidents occurring in a given context, as well as the potential reluctance of clinicians to report behaviour as a formal crime.
- Are safeguarding practitioners adequately considering the extent to which a risk management plan will mitigate risk? (e.g. 1:1 observations, as considered in the present report)
- Is there value in a standardised written form be used for making safeguarding referrals?

10.9. The emphasis on the above should be about ensuring that appropriate contextual information about safeguarding incidents is readily available to the safeguarding team when incidents are reported.

Recommendation 18: Review of safeguarding processes to ensure availability of contextual information

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort*	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)*	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 19

10.10. The DIST team within the local mental health trust should review their safeguarding practice in relation to expression of concerns that a care home cannot safely manage a patient. If DIST do form such a view, this should be followed up with a safeguarding referral.

Recommendation 19: DIST Review of Safeguarding Reporting Processes

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	**Narrow scope**	Moderate scope	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort*	Moderate effort	**Low effort**
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)*	Moderately (months)	**Quickly (Days or weeks)**

Recommendation 20

10.11. Norfolk County Council QA Team must ensure that XYZ Care Home review their processes for recording incidents of violence. This must consider not only whether such incidents are routinely recorded, but also the quality of information (in regards to antecedents and consequences) that is included. The review must also consider the extent to which such data is meaningfully used in incidents where challenging behaviour is present. XYZ must provide the QA Team with assurance explaining how it has achieved this and implemented this into practice. The SAB may wish to review whether the this can be applied more widely to other care homes in the county, region or country.

10.12. XYZ wished to note that they had already made improvements in this regard, and so this recommendation may already be judged as being met following review by the QA Team.

Recommendation 20: Improving XYZ Processes for Incident Reporting and Use of Recorded Information

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	**Moderate scope**	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort*	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)*	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 21

10.13. The QA Team should ensure that XYZ leads a review into its processes in regards to clinical risk assessment. This review should consider whether the currently established processes are able to satisfactorily and comprehensively assess risks, including the risk of violence. The policy should ensure that risk assessments are appropriately updated, both in regards to important trigger incidents and at regular intervals subsequently. The complexity of the risk assessment should reflect the nature of the potential risks being assessed. Assurance should be provided to the SAB (which may be delegated via the QA team) as to how this has been achieved. Subsequently, XYZ Care Home should then review compliance with the completion of these risk assessments through retrospective audit and provide assurance to the QA team on a regular basis.

10.14. XYZ Care home reported that this recommendation was already enacted and so may simply require further review by the QA Team for assurance.

Recommendation 21: Improving XYZ Processes for Clinical Risk Assessment

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	**Moderate scope**	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort*	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)*	**Moderately (months)**	Quickly (Days or weeks)

Report written by:

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Abbreviations Used in this report:

ABC Charts – Antecedent, Behaviour, Consequence Charts

AMHP – Approved Mental Health Professional

CCG – Clinical Commissioning Group

CHC – Continuing Healthcare

CMHT – Community Mental Health Team

CQC – Care Quality Commission

DIST – Dementia Intensive Support Team

DOLS – Deprivation of Liberty Safeguards

DST – Decision Support Tool

DTA – Discharge to Assess

EMI – Elderly Mentally Infirm

LPA – Lasting Power of Attorney

MASH – Multi Agency Safeguarding Hub

MCA – Mental Capacity Act 2005

MHA – Mental Health Act 1983

MHAA – Mental Health Act Assessment

NCC – Norfolk County Council

NICE – National Institute for Health and Care Excellence

NSAB – Norfolk Safeguarding Adults Board

QA Team – Quality Assurance Team

SAR – Safeguarding Adult Review

SARP – Safeguarding Adult Review Panel

UTI – Urinary Tract Infection

Fractured Neck of Femur (Broken Hip)

[Information taken from Plymouth Hospitals NHS trust information leaflet: https://www.plymouthhospitals.nhs.uk/what-is-a-fracture-neck-of-femur]

Fractured neck of femur (broken hip) is a serious injury, especially in older people. It is likely to be life changing and for some people life threatening. It occurs when the top part of the femur (leg bone) is broken, just below the ball and socket joint.

There are two main types of hip fracture, intracapsular and extracapsular.

Intracapsular Fracture

In this injury the ball on the top of the femur has broken off at its junction with the neck of the upper thigh bone, within the hip joint.

Occasionally, it is possible to re-attach the ball, but it is usually removed and replaced with half a hip replacement (called a hip hemiarthroplasty) or a total hip replacement, if appropriate.

Extracapsular Fracture

This break is further down the femur, outside the hip joint and is fixed using metal work. The surgeon will explain which type of fracture you have.

Sepsis

[Information taken from NICE Guidance 'What is Sepsis' https://www.nice.org.uk/guidance/ng51/ifp/chapter/What-is-sepsis]

Sepsis is a rare but serious reaction to an infection. If you get an infection, your body's immune system responds by trying to fight it. Sepsis is when this immune system response becomes overactive and starts to cause damage to the body itself.

It can be hard to tell if you have sepsis. You might not even have a fever or high temperature, you may just feel very unwell.

Sepsis needs to be treated urgently because it can quickly get worse and lead to septic shock. Septic shock is very serious, as it can cause organ failure and death.

Anyone with an infection can get sepsis. But some people have a higher chance of getting it than others.

Discharge to Assess (DTA Process/Pathway)

The Discharge to Assess (DTA) process has been developed to address the problem of assessing long-term care needs within an acute setting. It is recognised that assessing people outside a familiar or safe community environment (e.g. the person's home, or another residential or community setting), and specifically in an acute hospital, is likely to contribute to poor decision making around long-term care needs. The DTA pathway therefore provides 28 days of funding for a person with potential long-term care needs to be discharged to a community setting and consequently have their care needs fully assessed in a more familiar and less restrictive environment.