Mrs VC
Appreciative Inquiry
Interactive Workshop

Gateshead Safeguarding Adults Board

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Safeguarding Adults
Board

Establishing the Inquiry

Safeguarding Adults Reviews (SARs):

- Are a statutory requirement for Safeguarding Adults Boards (SABs).
- Can improve safeguarding adult practice by identifying what is helping and what is hindering safeguarding work, in order to tackle barriers to good practice and protect adults from harm.
- SARs need to be of good quality and need to be able to be shared to maximise the value of their learning.

Establishing the Inquiry

Overall purpose of a SAR is to promote learning and improve practice, **not to re-investigate or to apportion blame**.

- lessons from how professionals and their agencies work together
- how effective are safeguarding procedures
- learning and good practice issues
- how to improve local inter-agency practice
- service improvement or development needs for one or more service or agency.

We are required to publish findings from SARs in our Annual Reports.

Establishing the Inquiry

A SAR must be carried out if:

- There is reasonable cause for concern about how the SAB, its members or other persons involved worked together to safeguard the adult; and
- The adult has died and it is known or suspected that the death resulted from abuse or neglect; or
- The adult is alive but it is known or suspected that they have experienced serious abuse or neglect.

NB It is irrelevant whether or not the adult is known to the local authority, or whether or not they are being provided with support or services to meet their care and support needs.

Establishing the Inquiry

Mrs VC SAR Referral:

- February 2017 the Gateshead Safeguarding Adults Review and Complex Cases (SARCC) Subgroup concluded that the case did not meet the criteria to progress to a statutory SAR:
  - No evidence to link neglect to the death of Mrs VC.
  - There was also no evidence to suggest that agencies had not worked together.
- March 2019 further information was submitted by Mrs VC's family to the SARCC.
- June 2019 it was agreed by the SARCC, that a discretionary Appreciative Inquiry should be undertaken.

Establishing the Inquiry

Discretionary Review

A discretionary review can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect, and can include exploring examples of good practice.

Appreciative Inquiry

Appreciative Inquiry is a method to help you analyse situations, make decisions and formulate action plans for change.

Establishing the Inquiry

The objectives of this AI are to determine good practice and areas for improvement for the following areas:

- Communication between partner agencies
- Communication with Mrs VC and family representatives
- Care and treatment (with a focus upon medication management, needs assessment, weight and nutrition)
- Managing concerns / complaints

Establishing the Inquiry

Stage 1 - Individual Management Reviews (IMR's) requested from all of those organisations involved in the care and support of Mrs VC.

Stage 2 - A joint chronology was produced using information submitted from the IMR's.

Stage 3 - Multi Agency Workshop

Stage 4 - Summary Report and Action Plan

Who was Mrs VC

- She was a nurse
- She was a wife, married for 62 years
- She was a mother of three children
- She worked as a nurse looking after a disabled child in a local mainstream school.
- She was a Grandmother
- She was very active and loved her family
- She loved to dance and sing.
- She developed dementia at the age of 82
- She was cared for by her husband
- She moved into Appletree Grange when her husband was no longer able to care for her

Background

February – March 2016:

- Mrs VC resided at home with her husband.
- A home care package was in place to support Mrs VC with her personal care, medication, continence care and light meals.
- Records indicate that it was becoming more difficult for the family to support Mrs VC to live within the family home as behaviour was becoming unmanageable due to progression of Alzheimer's.

March 2016:

- A sitting service was arranged by Durham County Council for one afternoon as Mrs VC's husband had a hospital appointment.

Background

April 2016 - Mrs VC was placed in Appletree Grange, Birtley (Owned by Barchester Healthcare Limited) for respite by Durham County Council (DCC) Adult Social Care.

- The CPN was involved in the assessment and review process with Adult Social Care.
- As per out of county placements, Durham contacted Gateshead Council commissioning team to ascertain that there were no issues preventing the placement.
- Mrs VC appeared to be fairly settled. Mrs VC enjoyed frequently going with her family and they visited mostly every day.
- DCC record a DoLs request was received from Appletree Grange, although the case remained awaiting allocation to a Best Interest Assessor.

The placement at Appletree Grange had been arranged in partnership with Mrs VC's family, due to an increase in care needs caused by the progression of Alzheimer's.

Background

May 2016

- Mrs VC's husband was no longer able to care for Mrs VC , agreed the placement should become permanent.

June 2016

- DCC undertook a review of Mrs VC, and it was noted that the Mrs VC and her family were happy with the placement.

Background

July 2016

- Following a number of incidents in relation to reported behaviours demonstrated by Mrs VC towards staff and other residents, a referral was made by Appletree Grange to the Community Challenging Behaviour Team.

August 2016

- The Community Challenging Behaviour Team visited and requested two weeks of behaviour monitoring charts.
- Records note refusal to take medication.
- Psychogeriatrician prescribed Olanzapine.

Background

September 2016

- Appletree Grange raise concerns about worsening behaviours as a result of new medication prescribed by Psychogeriatrician, and an alternative of Risperidone was suggested.
- Referral was made to the CPN within the Community Mental Health Team following deterioration and refusal to take medications.
- The GP and Urgent Care Team were called after Mrs VC presented with flu like symptoms and a chest infection and UTI were diagnosed.
- Antibiotics were prescribed, and Risperidone was put on hold until next GP visit.

Background

October 2016 – Several records indicate that Mrs VC's physical and mental health deteriorate.

October 26th, 2016:

- Appletree Grange contacted GP to state that blood glucose levels were high.
- Comprehensive GP notes from visit with Mrs VC, her two daughters and senior carer.
- Discussed several issues including continuing chest infection, reflux, problems swallowing, insulin, monitoring weight and increased analgesia.
- Planned SALT referral for swallowing and considered dietician.

Background

October 26th, 2016 (Continued):

- The GP practice contacted the ambulance service to book transport to convey Mrs VC to the Queen Elizabeth (QE) Hospital.
- The ambulance booking time frame requested was 1 to 2 hours.
- Due to significant demand on the service the ambulance arrived 6 hours and 4 minutes following the initial call.
- The ambulance was upgraded following additional information supplied by Mrs VC daughter.
- Mrs VC was admitted to the Queen Elizabeth (QE) Hospital with dehydration and unstable diabetes.

Background

October 26th, 2016 (Continued):

- The QE Hospital raised a Safeguarding Adults Concern on 31st October 2016 following complaints made by Mrs VC's two daughters.
- This Safeguarding Adults Concern alleged neglect, fabrication of fluid charts, pressure damage and poor risk management with respect to swallowing.

November 1st, 2016

- A Safeguarding Adults Concern was also raised by Durham County Council on 1st November 2016 due to concerns raised by the family of Mrs VC on 26th October 2016.

Background

November 25th, 2016:

- Mrs VC died in the QE Hospital.
- The cause of death was noted as I - (a) Hyperosmolar Hyperglycaemic State (HHS) and II - Alzheimer's Disease.
- 13th January 2017, a Safeguarding Adults Review referral was raised on by an officer within the Gateshead Council Safeguarding Adults team.

Good Practice

- Residential Care Home GP weekly ward round – GP records demonstrate timely, regular reviews by the GP practice which was facilitated by weekly ward rounds with the wider team looking after Mrs VC which usually included a Specialist Nurse, a member of staff from Appletree Grange and the GP.

- Swift arrangement of sitting service - Whilst Mrs VC was still living at home with her husband her daughter rang Durham County Council one morning to request a sitting service for Mrs VC that afternoon as she had to take her father to a hospital appointment. The service provision was arranged at short notice.

- Involvement of appropriate health partners - The Individual Management Reviews, joint chronology and practitioners workshop identified that the appropriate health professionals were involved in Mrs VC's care.

What do you think?

Imagine Mrs VC is from Gateshead and you are her allocated worker:

- Appletree Grange is registered to provide residential care and specialised dementia care.

In the situation as Catherine described what would be your practice?

Areas for Improvement

- Safeguarding adult concerns should be recorded separately - Gateshead Council received two separate safeguarding adult concerns for Mrs VC, one from Durham County Council and one from the Gateshead Queen Elizabeth Hospital.

- Review meeting records should accurately document care and support needs, and how these are being met

- Improvements to Multi-Disciplinary working - Whilst it was clear that the right health professionals were involved, it is not clear whether those professionals and the care home all had a shared understanding of the extent of Mrs VC's declining physical and mental health, or of what the plan of action should subsequently be.

Areas for Improvement

- Understand when to request a review of care and support needs-– Whilst health practitioner records and Appletree Grange records note a significant decline in the physical and mental health of Mrs VC from late September 2016, no request was made to Durham County Council Social Services by any partner for a review of Mrs VC's care and support needs.

- Communication with adult and family members - There should have been communication with Mrs VC and her family about significant changes to her medical, physical and mental health needs and this should have been accurately recorded. This was not always the case, and was a common theme across some partner records.

What do you think?

How do you know when a person needs to move from residential to nursing care?

Areas for Improvement

- Mental Capacity Act assessment and Best Interest recording – It was. acknowledged that there has been progress with respect to consideration of the practical application of the Mental Capacity Act, with clear evidence that capacity was considered. However, partners agreed that comprehensive documented recording, particularly in relation to best interest decisions, was lacking

- Swifter response to changes in weight and referral to SALT (Speech and Language Team) relating to swallowing issues - There was no documented evidence to suggest that Mrs VC was struggling to swallow her medication. There was a choking risk assessment carried out every month with the first being completed on 12 April 2016 and Mrs VC was assessed as being low risk. Mrs VC was re-assessed every month and on 16 October 2016 she was assessed as being medium risk and Mrs VC scored in a red trigger area.

Areas for Improvement

- Length of Ambulance waiting time - The ambulance took six hours and four minutes from initial call to arrival at Appletree Grange.

- Clarity about complaints process – The family of Mrs VC have made a number of individual complaints to the organisations involved the care and support of Mrs VC, and also to the Parliamentary and Health Service Ombudsman.

- Safeguarding Adults Review process initial information gathering – The initial decision making of the Safeguarding Adult Review and Complex Case Group not to progress was based upon the information known at the time.

Recommendations

- Gateshead Council Adult Social Care Direct will record all Safeguarding Adult Concerns separately
- The SAB Quality, Learning and Practice Group will lead on the development of guidance for front line staff to encourage hosting multi-disciplinary team meetings when a person's physical and / or mental health is declining
- The SAB Quality, Learning and Practice Group will undertake a multi-agency audit of practice to determine whether or not it is systemic that adults are not being referred soon enough for an unplanned review

Recommendations

- The SAB will review our Best Interest decision recording guidance and MCA training programme, within the context of the amended Mental Capacity Act code of practice
- The SAB will develop and implement ‘Making Safeguarding Personal’ training to enhance our approach to engaging / communicating with adults and their representatives
- The SAB will develop and implement an adult concern decision making tool to support practitioners to raise concerns utilising the most appropriate pathway

Recommendations

- The SAB Quality, Learning and Practice Group will work with our commissioners to produce a ‘Guide to complaints relating to commissioned providers’, which will adopt the ‘No Wrong Door to Complaints’ approach
- The Safeguarding Adult Review process is amended to ensure that the views of the family members are included at all stages of the process, including at the Rapid Review
- The SAB will facilitate a series of ‘Mrs VC’ learning briefings for front line practitioners

Any Questions