SAR D – Practice Brief Overview: Dave's Story

What is the WSAB?

Warrington Safeguarding Adults Board is the local strategic partnership responsible for:

"Warrington's Safeguarding Adults Board will oversee local arrangements to ensure that safeguarding adults at risk is prioritised and coordinated effectively. We are committed to continuous improvement, learning from experience and enabling adults at risk of neglect and abuse to have a voice".

Shirley Williams, Independent Chair WSAB

What is a Safeguarding Adults review?

The SAB, as part of its Learning and Improvement process, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult; or
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

The SAB also has the freedom to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to practice to prevent similar harm occurring again.

Cases can be referred to WSAB for consideration by completing the SAR referral form in the professionals area of the WSAB website - www.warrington.gov.uk/wsab

Anyone can refer a case for consideration.

What is this document?

This is a briefing sheet that WSAB have decided to use to cascade lessons learnt either from screening cases or conducting SARs. It contains information that we think front line practitioners need to know alongside useful links to practice guidance that might support you in dealing with complex cases.

What should I do with this?

We are asking all practitioners and team managers to reflect on the information in these briefings. We need everyone to consider how they relate to their practice and what they may need to do differently. You will find a feedback sheet at the end of the document to send back to us to evidence how you have used this information.

Alongside producing briefing SARs we also offer lunchtime workshops so that you can come along and hear about findings from a range of cases and audit processes. You can receive details of these sessions by emailing - wsabadministrator@warrington.gov.uk

How Can *YOU* make a difference?

By reading this document and considering your own practice, or arranging to discuss this in a team meeting, you are helping the WSAB share lessons learnt. You are also ensuring that these translate into meaningful changes in practice.

You might also identify other issues or needs that arise from the briefing and raise these with us. For example, you might identify a training or service gap that we want to hear about.

Further Reading:

1. https://www.gov.uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities/swallowing-difficulties-dysphagia
2. https://www.guidelines.co.uk/WPG/Dysphagia-with-learning-disability/236036.article#.Vi9ZarfNzIU

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The Case Summary

In 2016 Dave[1], an inpatient at an independent mental health hospital was admitted to hospital following a choking incident. Sadly, as a result of his injuries from oxygen starvation due to the blockage in his air way, he died. The case was referred into the Council safeguarding team as professionals were concerned that Dave may had experienced neglectful care. A safeguarding investigation identified that the risk of choking was known and that a specialist SALT assessment had resulted in a specific care plan for his meals. There was evidence to suggest that this had not been followed by staff on the day of the incident and that this may have played a part in his death.

What happened Next?

As a result the case was referred to the SAB for a Safeguarding Adult Review (SAR) to be considered. The Independent Chair requested that a screening panel be created. This is a selection of senior managers from the agencies represented on the Board such as health, local authority, police and the third sector. Agencies involved were asked to provide a chronology of their involvement with Dave and their understanding of his care and support needs.

The Screening panel then met and reviewed the submitted information before interviewing the key practitioners involved in Dave's care provision. This process allows them to understand what Dave's support needs were and how professionals were working together to meet them. From this process and the information gathered they were able to ascertain that the concerns were primarily single agency issues and propose to the Independent Chair that a full Statutory SAR was not required because of this. However it was agreed that there was learning that had been identified and that it would be useful for all frontline practitioners to be aware of.

This document represents a concise SAR that shares the key lessons learnt around Dave's journey with guidance and proposals for professionals to consider in their practice moving forward.

Dave had Autism, a Learning Disability and Schizo-Effective disorder which meant that he had been receiving inpatient based care for most of his life. He had behaviours that challenged staff and it was difficult to identify a suitable community based placement for him. He had moved to his current hospital placement as a stepping stone to a community placement. The Clinical Commissioning Group (CCG) were planning to work with the hospital to revise Dave's care approach to prepare him for a more home-like environment in the local community. Whilst Dave's care and support needs were complex, in line with the transforming care agenda, it was recognised as important for him to have the opportunity to live within a community based setting.

At the hospital Dave required skilled staff to understand how to interact with him and meet his needs without exacerbating his behavior.

Key Learning Point 1: It is sometimes difficult to balance the need to manage risk against the human rights of the person to dignity and privacy.

Dave had moved into the hospital 7 months earlier and the staff providing his care had needed to learn how best to support and enable him including supporting him to eat his meals safely. A specific care plan around eating had been implemented due to Dave having swallowing difficulties and being at risk of choking when he ate. This was because he rushed his food and would overload his fork and mouth. This meant all of his food should be prepared in small pieces to reduce the risk of

[1] **Dave is a pseudonym and not the real name**

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choking. The plan also emphasized that he should be observed at meal times and given positive reinforcement when he swallowed. However staff had also identified that Dave could become very agitated when they observed him, therefore they observed him from outside of the room rather than sitting with him. This meant that the precaution of verbal encouragement was no longer in place.

Dave had received a full speech and language assessment when he was in a previous NHS based hospital. This had outlined the key aspects of his care plan around meals and snacks and included positive encouragement. When he moved into the new hospital this was not reviewed and he did not receive any further speech and language assessments. As a result the staff in the hospital were not receiving ongoing professional guidance and advice in terms of personalising Dave's nutritional support needs and best practice responses to the challenges posed by his reactions.

When individuals have potential capacity issues around decision making it is important that needs are reviewed, and that options are considered using their communication methods about diet. For example, if a patient regularly does not eat something they should not need to be able to state they do not enjoy it for professionals providing care to recognise this. In Dave's case he could not state what he wanted but he could demonstrate what his wishes and feelings were. These should have been considered in regular reviews around his diet care plan.

Key Learning point 2: Not all professionals are aware that private hospitals are not covered by community Speech and Language Teams (SALT) and need to buy in their own service.

The private hospital that were caring for Dave had been open for 7 months, however it had not yet been inspected by CQC. The oversight o of Dave's care was the responsibility of the CCG in this case. They had identified the placement and were responsible for ensuring it was meeting his needs. They were working with social care from the Local Authority who were involved to conduct section 117 reviews. As the Local Authority had not commissioned the placement they were not responsible for care arrangements or reviews. Their role was confirmed as focused on planning towards a community placement.

The hospital was a new one which had not yet been inspected by CQC. The Commissioners had made assumptions about the overall reliability of the service based on CQC registration. They had placed Dave there on the understanding that it was able to meet his needs and had conducted reviews that suggested it was. The commissioner's view was that Dave was more settled than in previous placements and appeared to be doing well. However the CCG had not undertaken any monitoring at an organisational level. For example, looking at training, organisational polices, recruitment practices, risk and incident management and other processes.

Alongside the CCG, the Council social worker was also supporting Dave but believed the CCG were ensuring the management of the care itself was suitable. It transpired that neither social worker nor commissioner recognised a gap in SALT support for the staff at the hospital as they both believed they were accessing the local service. This appeared to have happened as both agencies believed the other to be monitoring arrangements for day to day care.

Further Reading:

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SAR D – Practice Brief Overview: Dave's Story

Key Learning point 3: Assumptions are sometimes made in practice without the full facts and can lead to professionals mistakenly being assured. For example, assuming CQC registration means all staff are appropriately trained or that social workers are always responsible for monitoring day to day care.

After Dave's death a whistleblower had come forward at the hospital to CQC to report issues around staff training and policies and procedures. When CQC visited they identified significant gaps in the organisations risk and incident management, policies, procedures and training in areas such as CPR. The service was placed in Special Measures. The led to a multi-agency high level risk summit and action plan led by NHS England until the service improved.

When the panel reviewed the information commissioners, social workers and other frontline practitioners had in relation to Dave the following emerged:

- assurances had been taken based on assumptions rather than facts; particularly in relation to robustness of the checks that came with CQC registration processes & SALT input
- professionals had expectations about how they were each working with Dave but did not state their roles clearly to each other – whilst this was not inherent to the actions on the day of the incident this is a practice issue to note
- Good practice around SALT processes is perhaps not clearly available to frontline practitioners particularly in cases where capacity may be factor and individuals may prefer to eat at risk
- There was a failure by a range of agencies to initially recognise this incident as requiring a safeguarding referral. This seemed to be because it was evident that the staff cared about Dave, had not intended harm and were very upset by what had happened. Because of this, basic questions were not asked when the incident was first reported that would have identified some of the concerns. This was addressed a few days after the incident by the Local Authority safeguarding team.

Key Learning point 4: SALT processes and good practice in this area may not be as easily available to frontline practitioners.

Key Identified actions:

After screening this case the panel identified the following as key actions to take forward:

1. Write to CQC to explore whether there is any learning from this case, or any other relevant plans in relation to the processes for registration and inspection of new hospitals.
2. Escalate to NHS England (Cheshire and Merseyside) the potential risks that were identified as a result of the absence of a clear framework around the lack of accountability for monitoring and oversight of independent hospitals and to request feedback regarding how NHS England is starting to develop framework guidance
3. Share briefing of key lessons from the panel to include:
    - ensuring appropriate SALT provision is in place in private independent hospitals when placing a patient
    - good practice around implementing effective SALT processes with clarity when service users are objecting to care plans and choosing to eat at risk
    - recognising when neglect becomes a safeguarding concern and the questions to ask
    - ensuring partners clarify each other's expectations when working together on case management.

Messages for practice:

Do not assume what role and action another agency is taking in relation to a person's care provision – ***always clarify with each other how you will contribute to care***

Further Reading:

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SALT provision is not available to private hospitals – therefore ***always check that the service has arranged for SALT services to attend their site***

Whenever an adult experiences or is at risk of possible abuse and neglect safeguarding referrals should be made to the Local Authority via 01925 444239 – ***don't assume someone else will make the referral***

Do not assume that CQC registration or inspection is sufficient to indicate a care provider is fit for purpose. ***When placing service users you must be assured that adequate training, procedures and policies are in place. UPDATE -*** In Cheshire and Merseyside, NHS England have now clarified the arrangements for monitoring independent hospitals where there is a local commissioner and in all cases where there are concerns. This document.

Where there is a risk of choking mental capacity assessments should be standard practice. If there are challenges in following advice, then professional guidance should be sought and ***where decisions are made by capacitated service users to "eat at risk" these must be documented and reviewed regularly***

Staff should refer to the following practice guidance note around choking risks and consider their own practice against the good practice criteria identified

Further Reading:

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Practice Guidance and Further Reading

In response to a number of choking incidents which resulted in the death or serious harm of Adults, Devon's Safeguarding Adults Board published guidance[2] for health, social care staff and unpaid Carers on how to identify those at risk and prevent serious injury and possibly death from choking for people with swallowing difficulties.

Whilst people with a diagnosis of a Learning Disability are well known to be at higher risk of choking than other people; it also emphasises that this risk also extends to other adults with care and support needs including people with dementia related illness and those with a severe physical disability, such as stroke victims. Below are some of the key messages for practice.

Adults with the capacity to decide have the right to eat at risk should they choose to do so. It is not uncommon for people with choking risks to choose to eat at risk to improve their quality of life. Sometimes this is because food is a significant remaining pleasure or aspect they have control over. Therefore, it is important that practitioners and carers discuss and consider what the individual's wishes and feelings are in this area.

Where someone has capacity to make the decision to "eat at risk" this should be properly documented and all those working with the service user made aware. Records should clearly indicate that capacity is not in question, the service user's views and informed consent and any actions taken to mitigate the risks. For example, modifying how the diet is prepared or the types of food consumed. It is also important to involve speech and language therapists (SALT) professionals who can offer advice and guidance on options and alternatives. A key part of this approach will be ensuring a clear care plan is in place that includes actions to take if aspiration occurs. However it is important that plans are reviewed and updated regularly to ensure the best options and approaches are in place.

When someone has been assessed as not having the capacity to make this decision it is important to balance the desire to reduce the risks with other considerations about their wellbeing within a plan made in their best interests. For example, tube feeding may be an option but consideration must be given to the risks it brings, the persons response to it and the appropriateness of prolonging life if there is suffering being experienced. Practitoners and carers can find it difficult to identify the balance between risk and quality of life. This is where the persons own views become paramount in helping guide us to make decisions.

There are occasions where we may not recognise that dysphagia[3] has become an issue. The guidance suggests the following as signs and symptoms to be alert for:

- Coughing / spluttering / gurgling / throat clearing
- Change in breathing pattern
- Change of colour
- Excessive sweating
- Dehydration
- Weight loss
- Persistent chest infections
- Changes in eating patterns

[2] Prevention of Choking Risk: For adults in receipt of health and social care. Guidance to support health and social care staff and carers. November 2016. Available at: http://docplayer.net/30214284-Prevention-of-choking-risk-for-adults-in-receipt-of-health-and-social-care-1-purpose-setting-the-scene-national-context.html

[3] Dysphagia is difficulty with eating, drinking and swallowing.

Further Reading:

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Sometimes there will also be additional symptoms that are directly caused by a medical condition. For example people with dementia may develop challenging behavior around feeding or people with a Learning Disability may have difficulties with chewing and eating food slowly enough for it to be safe. This is why it is important for a SALT assessment to occur and offer guidance on how best to support people to eat safely.

Some of the options SALT can advise on are:

- Altering eating positions to reduce risk
- Altering volume of food / drink given
- Suggestions on consistency & texture
- Specialist aids
- Environmental distractions
- Training needs for family / carers / practitioners

Staff working to support adults with risk of choking must record all incidents whether or not there are serious consequences, so that steps can be taken to reduce the risk of it happening again.

Choking incidents should be reported to the adult's General Practitioner/healthcare team so that a health assessment can be carried out and referrals made to the appropriate health and social care professional.

Incidents where the individual suffers significant harm should be reported for screening as a safeguarding concern to the Local Authority. In addition, if the incident occurs within an NHS setting or is receiving NHS funding, this should also be reported as a Serious Incident.

Death or significant harm of a person in a regulated care setting must be reported to the Care Quality Commission (CQC). In cases of death the police will also need to be notified. They will liaise with the coroner who will seek to find the cause of death but is not looking to apportion blame.

Key Practice points:

1. Always be alert for potential signs of dysphagia in a service user
2. Always assess and record capacity to choose to eat at risk
3. Always attempt to identify the persons wishes and feelings in relation to food and fluids
4. Always ensure a clear care plan is in place and known to all with clear details of actions to be taken when/if aspiration occurs
5. Always seek SALT input to ensure all options and mitigation for risk has been explored
6. Always review the care plan regularly to ensure adjustments are made when needed, especially when medication changes or deterioration in presentation occurs
7. Ensure all incidents of choking are appropriately reported

If you are regularly working with those at risk of choking then training should be accessed around the Mental Capacity Act and supporting safe nutrition and hydration to enable you to support service users effectively. This should include training in relation to basic first aid for choking incidents.

You can also access further guidance and tools to support you to assess swallowing difficulties and choking risks designed by the National Patient Safety Agency. Their website is designed for individuals with a Learning Disability due to the increased risk often experienced. However, the tools can be adapted to support practice with other patient groups. Their resources can be accessed here: http://www.nrls.npsa.nhs.uk/resources/?entryid45=59823

Further Reading:

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SAR D – Practice Brief Overview: Dave's Story

Learning Lessons - Feedback Sheet

Please return completed feedback to: wsabAdministrator@warrington.gov.uk

Your Name	
Agency	
Date	
This briefing was cascaded to:	(e.g. District nurses, duty social workers etc.)
This briefing was used in:	(e.g. supervision, team meeting with X number of staff etc.)
Action taken as a result of the learning:	
Other feedback or discussion points:	

Further Reading:

1. https://www.gov.uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities/swallowing-difficulties-dysphagia
2. https://www.guidelines.co.uk/WPG/Dysphagia-with-learning-disability/236036.article#.Vi9ZarfNzIU