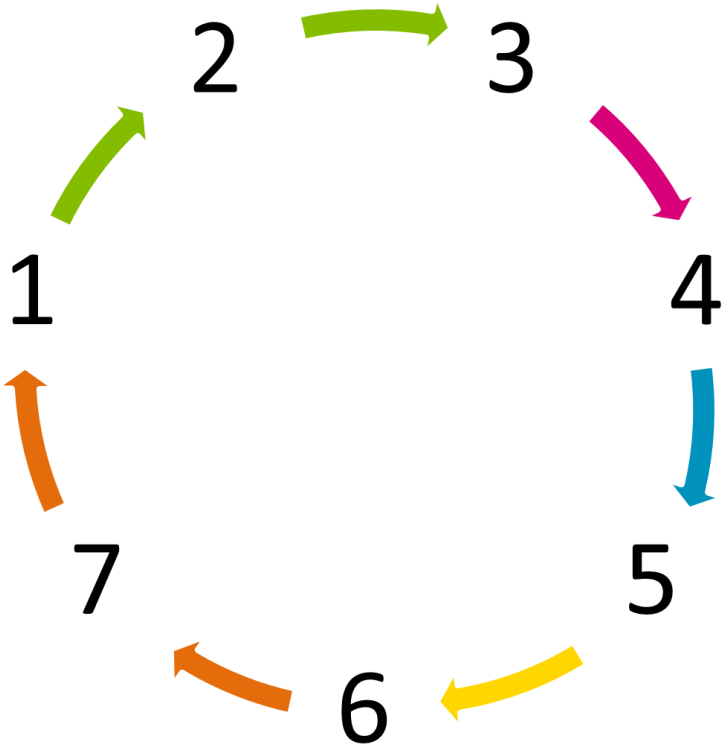


7 Minute Briefing: SAR Adult 27

Safeguarding Adult Review (SAR): AP

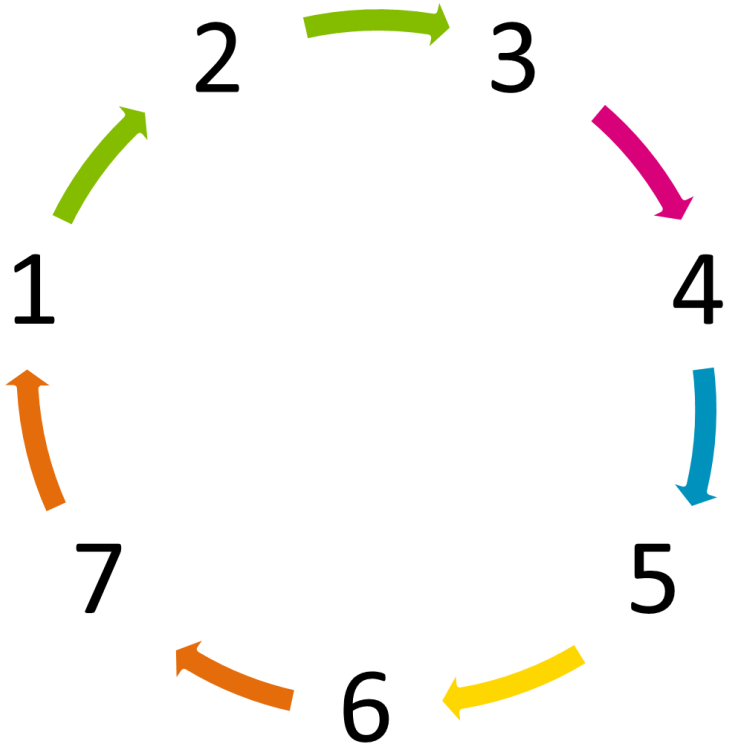
Wigan Safeguarding Adults Board

Methodology

The Adult's Independent Chair is consulted on the methodology utilised in any given SAR, and mandates the approach.

The WSAB used a 'Systems Learning' approach in the review of **Adult 27**. This is a model that was introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011. This approach sets out to study the whole system and look closely at what influenced professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice in a more in depth way. The process seeks to be a collaborative process with professionals being actively involved in the review from the outset. The approach promotes reflective thinking as a system to identify the causal factors that influenced practice for which improvements can be made upon.

Background



Background

AP was a gentleman residing in a mental health care home who refused medical treatment. It was unclear if he had the capacity to make this decision due to lack of mental capacity assessment, which in addition to a lack of best interests meeting led to an uncoordinated treatment plan and poor outcomes at end of life care pathway.

The main themes within the case are:

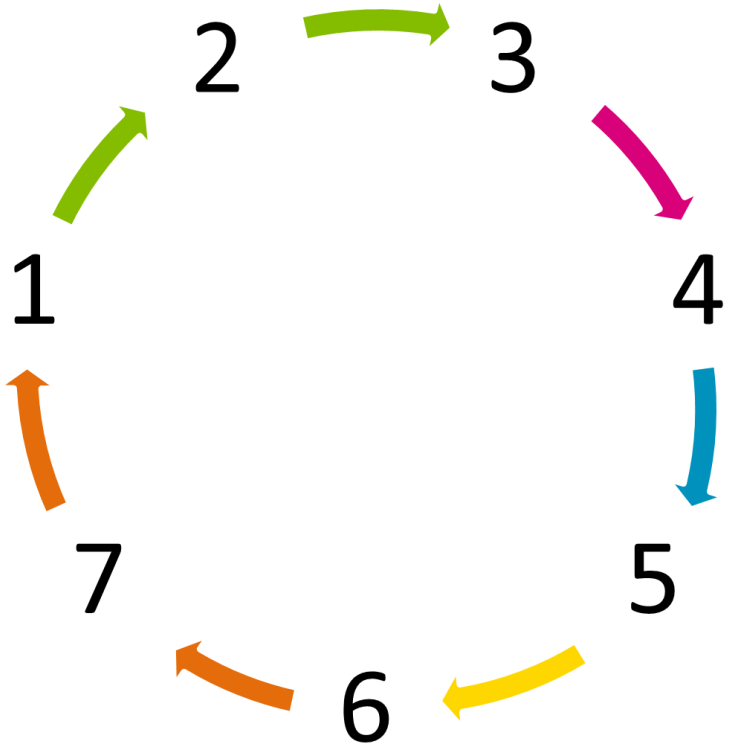
- Medical Self-Neglect
- Mental Capacity Assessment
- Neglect and Acts of Omission

The main learning themes from the review are captured within Key Lines of Enquiry and in this case include:

1. Mental Capacity Assessment
2. Medical Self-Neglect

Learning points were identified through the case review, highlighting areas of learning and improvement.

1. Mental Capacity Assessment



Mental Capacity Assessment

There were missed opportunities to identify and respond to medical self-neglect and to assess mental capacity in relation to Adult 27 refusal to medical treatments, both for physical and mental health treatments:

- AP stopped taking anti-psychotic medication despite having a diagnosis of schizophrenia; there was no Mental Capacity Assessment in relation to this recorded, and no clinical oversight.
- AP refused medication for high cholesterol treatment; there was no Mental Capacity Assessment in relation to this recorded, and no clinical oversight.
- AP missed some medical appointments and this was on his initial admission, these were recorded by services as "DNA" (Did Not Attend). Once an in person ward round was established with the GP attending Care Home AP engaged appropriately and was happy to discuss his health needs.
- There was a missed opportunity when AP saw a vascular consultant regarding the treatment of his leg for the consultant to assess AP's mental capacity, to document this, and to share the information with AP's care providers in the community.

- Whilst in the community, there were frequent attempts to engage the GP in relation to AP's care and treatment in regards to his refusal to treatment, however the GP could not be engaged.
- There was a record within AP's medical records from the GP surgery that a Mental Capacity Assessment had taken place, however, it was not documented formally and therefore unclear if the 2-stage test had been applied. Furthermore, the Care Home were not aware this had taken place and the outcome of the assessment was not shared outside of primary care. It was recorded that AP did not have capacity at this time. It did not appear that any further action followed this assessment in relation to treatment plans for AP, and a missed opportunity to initiate a best interests pathway.
- The care home where AP resided referred AP to mental health services following a deterioration in his mental health presentation. GMMH assessed AP as having a relapse and an MDT was held to agree a treatment plan. It was discussed that AP may required hospitalisation for treatment to stabilise his condition, however it was agreed that the least restrictive option to treat in community would be trialled first, with an option to provide medication covertly if required. AP refused treatment, however it was determined that there was no legal framework in place to treat with covert medication. There was no Mental Capacity Assessment completed, and there was no further mental health treatment.
- A further referral to Mental Health Services was made, however GMMH determined that AP did not have capacity and his needs were for social care and not for mental health services.
- Over time Adult 27 settled and was accepting of his placement, support and treatment and as such the DoLS was rescinded.
- At the time the family of Adult 27 could not advocate on his behalf due to being estranged, however the referral process to Independent Mental Capacity Advocate (IMCA) service was not formalised by practitioners requesting IMCA involvement. Legally, IMCAs cannot act on behalf of an individual without formal instruction and full mental capacity assessment indicating a lack of capacity.

The British Medical Association states that where consent to medical treatment is required, the health professional proposing the treatment has the responsibility of ensuring that capacity is assessed.

SCIE best practice advises that the level of detail recorded in relation to Mental Capacity Assessments should be directly related to the seriousness of the decision in question. For complex decisions, or those that have potentially serious consequences, it is advisable that the record should include direct references to what was actually said by the assessor and the actual answers given by the individual and refer to what led the assessor to come to a certain determination.

Making a difference:

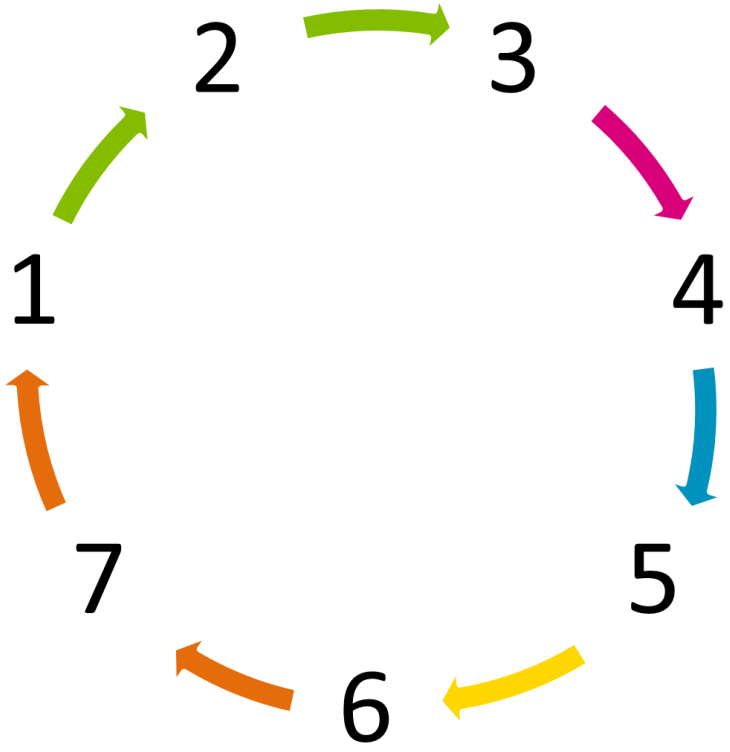
> WWL DNA policy has been updated to a 'was not brought' policy (missed medical appointments in children, now updated to include adults)

> GMMH DNA policy to be reviewed for reasonable adjustments, particularly in relation to LD and links to the self-neglect policy

> Implementation of a Quality Assurance Framework across the partnership to provide assurance of MCA training competencies and impact

> Communication of the IMCA referral process to be shared across the health and social care partners

2. Medical Self-Neglect



Medical Self-Neglect

There was a lack of clarity and coordination in relation to the care and treatment of AP due to a lack of lead professional taking responsibility for AP. There is no shared pathway across the Health and Social Care partnership for medical self-neglect; this has been identified as a gap and, without an agreed pathway in place, there are limitations to effective escalation and resolution protocols.

Numerous attempts were made by professionals caring for AP to engage the GP in care planning. Despite continued efforts, there was a lack of communication from the GP causing delays to robust care planning for AP. A lack of knowledge in the absence of a medical self-neglect pathway and escalation policy, and without the clarity of whether AP had capacity or not and a lack of response resulted in a referral to Adult Safeguarding to support an escalation of the case.

The Safeguarding Section 42 process held a strategy meeting which was also regarded by some as a Best Interests meeting, this perhaps demonstrates the lack of legal literacy at this point in the case. The strategy meeting succeeded in expediting a Mental Capacity Assessment for AP, which was completed by what was the CCG at the time.

Following this, the safeguarding enquiry was closed assuming that the Mental Capacity Assessment would enable progression in the care of AP, however the progress was subject to drift without a lead professional responsible for the care coordination for AP. This resulted in the care plans for AP, who was on an end-of-life pathway, not being in place, and poor outcomes for AP during this time. The Section 42 strategy meeting agreed a future date for an Multi-disciplinary Team meeting, however AP died before this took place.

As part of the Section 42 process, Adult Social Care wrote to the GP in relation to the care of AP being medically led and requiring clinical oversight. Furthermore, the District Nurses involved in the care of AP requested reviews specifically from the GP. The weekly reviews were completed by the Advanced Nurse Practitioner, which was felt adequate by the practice despite repeated requests for GP input.

The Adult Social Care Locality Team leading on the Section 42 Safeguarding enquiry sought advice from the Adult Social Care Safeguarding Team.

As it was eventually deemed that AP had capacity to refuse medical treatment, there should have been the following risk management in place:

- A robust plan for conservative treatment in relation to the ongoing health concerns for AP, detailing the plans for any acute treatment required for reversible health problems that may arise
- At least 2 documented Mental Capacity Assessments that confirmed AP's ability to weigh up the risk associated with medical self-neglect
- A DNA CPR
- A Statement of Intent
- Anticipatory medication for end-of-life

AP did not have any of the above in place as part of his care or treatment plan.

Making a Difference:

> The development of a partnership pathway that clarifies the roles and responsibilities of agencies in respect of medical self-neglect

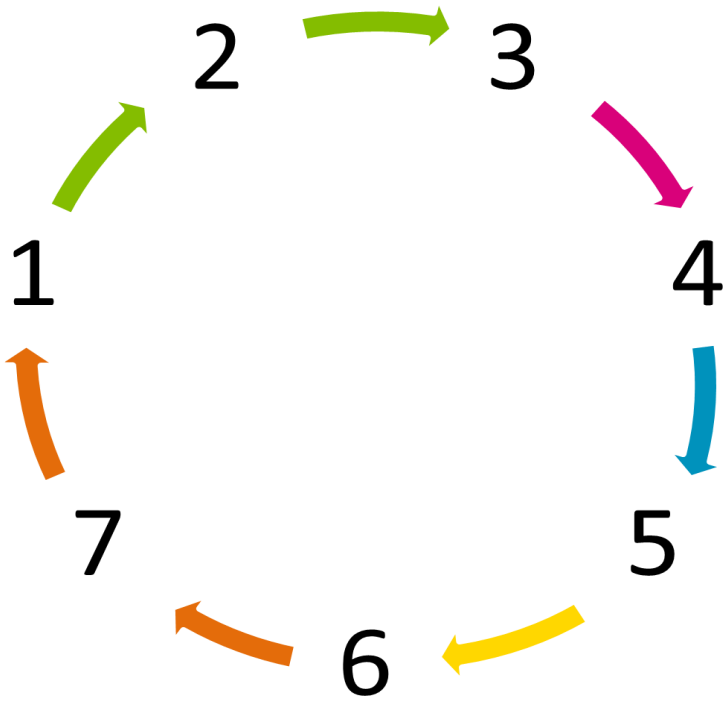
This should include:

- *Defined approach to Mental Capacity Assessment, with consideration to standardised documentation and practice standards*

- *Expectations of recording and documenting of Mental Capacity Assessment, the decision making and outcome*
- *Advocacy / IMCA referral*
- *Robust Care Plan via Best Interests / Court of Protection*
- *Clarity of lead professional (primary care in community and consultant clinicians in acute hospital / mental health settings)*
- *Clarity of pathway when an individual is deemed to have capacity*

> Review intra- and inter- agency escalation protocols, ensuring that they are in place, have expected resolution timeframes, and are communicated / promoted to practitioners across the partnership

Practitioner questions to consider



1. Do you consider self-neglect in relation to refusal for medical treatment?

2. Do you consider Mental Capacity Assessments in relation to refusal for medical treatment?

3. Do you feel confident in your assessment of Mental Capacity? Including assessment of Functional Capacity versus Executive Capacity to demonstrate an individual's application of their understanding?

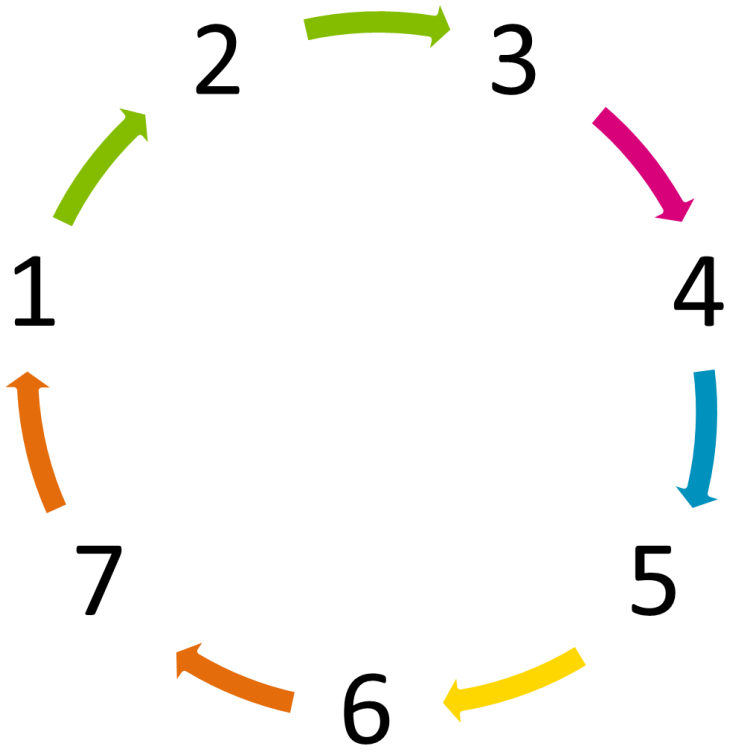
4. Have you fully documented the Mental Capacity Assessment and outcome within a service users records?

5. Are you aware that WWL Safeguarding Team has an MCA / DoLS lead that can support with policy and processes in relation to capacity?

6. Are you aware of the local resolution policy to escalate any barriers to delivering care?

7. Do you approach presentations of self-neglect using trauma informed practice?

Want to learn more?



Evidence Led Practice:

https://www.nice.org.uk/guidance/ng108/chapter/Recommendations#assessment-of-mental-capacity

cbc-mca-practice-guidance.pdf (scie.org.uk)

Practice guidelines:

Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)

Mental Capacity Act toolkit (bma.org.uk)

63caa0bbe44b78caaf7729a0_BetterHiringToolkit-Care_v8.pdf (webflow.com) **SCIE Training**

E-Learning - MCA: Mental Capacity Act (MCA): e-Learning course | SCIE **WSAB Training:**

WSAB Training Brochure 2021 (wigan.gov.uk)