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Shared Learning Bulletin

**INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF RESIDENT A FROM THE INITIAL DIAGNOSIS OF PROBABLE ALZHEIMER’S DEMENTIA TO THEIR TRANSFER TO AN INPATIENT MENTAL HEALTH UNIT.**

**INTRODUCTION**

This document provides an overview of findings from an independent investigation into the care and treatment of Resident A in relation to a violent incident, where Resident A struck Resident B in a Residential Home and Resident B passed away from these injuries. The investigation was undertaken to support a Safeguarding Adult Review.

**AUDIENCE**

* Mental health and dementia specialist teams, who may benefit from the insights into risk management and the escalation of challenging behaviours.
* Residential care staff, who are responsible for the day-to-day management of residents with dementia and ensuring that safeguarding protocols are followed.
* Adult social care professionals involved in care planning, risk assessment, and the coordination of multidisciplinary responses to safeguarding incidents in those with dementia.
* Integrated Care Boards (ICBs) and Safeguarding Boards, responsible for regional oversight and ensuring that care systems work together effectively to manage risk in those with dementia.
* Police and safeguarding leads, particularly those involved in managing incidents related to residents with dementia and mental capacity issues.

**CASE BACKGROUND**

Resident A, had been diagnosed with Alzheimer’s dementia. He had shown a history of changing behaviours and was a resident in a Residential Home at the time of the incident. Despite receiving care from various specialist dementia services, his behaviours were challenging for those who were involved in his care. This included verbal aggression and inappropriate behaviour to others, raising significant concerns among his family, care staff, the GP, specialist dementia services and adult social care.

Resident A’s condition included medication reviews, safeguarding referrals, and discussions with Adult Social Care. On occasion, the police had been involved. Despite these measures, there was a lack of coherent risk management and escalation planning.

**IMPACT OF THE COVID-19 PANDEMIC**

This incident occurred during the COVID-19 pandemic, a time when systems were under immense pressure due to limited resources and significant workforce shortages. The pandemic impacted the timely access to critical services, including mental health and dementia care, impacting on decision-making and risk management. This context is essential in understanding the challenges faced by all organisations in responding to Resident A’s escalating behaviour.

**KEY FINDINGS:**

1. Inconsistent Risk Management: All organisations were inconsistent in their approach to risk assessment and incident management, particularly in response to Resident A's escalating behaviours.
2. Lack of Expertise in Relation to Escalating Behaviours: The access to appropriate specialist expertise to assess and manage changing behavioural needs and risks was not available to the Residential Home.
3. Delayed Mental Health Act Assessment: Despite Resident A’s deteriorating mental status, there was a delay in arranging a Mental Health Act assessment after the incident, which led to the Residential Home and

local teams having inadequate support for a short period.



**AREAS OF GOOD PRACTICE**

* Adherence to NICE guidelines in diagnosing Alzheimer’s disease and prescribing regimes.
* Resident A was seen by the correct specialist dementia services as per local policy.
* Once Resident A was assessed under the Mental Health Act, compliance with appropriate detention and hospital transfer resulted.

**AREAS FOR IMPROVEMENT**

* Lack of advanced care planning and person-centred care plans.
* Inconsistent application of risk assessments and poor documentation of incidents.
* Possible missed opportunities for early intervention, particularly in response to inappropriate

behaviour.

* Reactive crisis-orientated response although on the backdrop of COVID-19.

**KEY LEARNING POINTS**

1. **Holistic and Dynamic Behavioural Risk Assessments** – A person-centred approach is required when assessing individuals with dementia, particularly in relation to inappropriate behaviours. Care plans should integrate personal histories, preferences, and underlying factors to better understand and manage behaviours. Staff need to be supported to conduct dynamic, ongoing risk assessments that adapt to emerging behaviours. The CQC's guidance on "Relationships and Sexuality in Social Care" is not well known, and raising awareness of this could aid in managing these challenges. Additionally, third-sector resources like Alzheimer’s Society’s guidance on sexual behaviour in dementia and the Perth & Kinross Council's "The Last Taboo: Guide to Dementia and Sexuality" provide valuable insights that could support the development of more effective behavioural management strategies.
2. **Collaborative Decision-Making When Resources Are Absent** - This case highlighted the challenges of resource limitations. When care homes, mental health services, or safeguarding teams escalate cases due to emerging risks, there is often a lack of available resources such as specialist placements or staff. A whole-systems approach involving Integrated Care Boards (ICBs) and Safeguarding Boards could strengthen collaborative decision-making when local policies cannot be followed.

**FOUR QUADRANTS OF LEARNING**

1. **Individual Practice**
	* How can life story and changing behaviours be consistently integrated into advanced care plans, care plans, and risk assessment?
	* What steps should staff take when requested support is not available, and escalation pathways do not result in action?
2. **Organisational Governance**
	* Are systems in place to ensure risk assessments are properly documented?
	* Is there a clear process for escalating cases when additional resources are stated as unavailable?
	* How are incidents related to inappropriate behaviour documented?
3. **Organisational Assurance**
	* How does the organisation ensure that risk assessments and care plans meet required standards?
	* Is the organisation confident that lessons learned from incidents related to inappropriate behaviour are being implemented effectively?
4. **System Learning**
	* Development of cross-organisational response when resources are stretched or absent, ensuring effective pathways to emerging needs preventing gaps in care.
	* Review strategic policy in light of national guidance in relation to intimacy, inappropriate behaviours, and risk management.