Transition to Care Home Nursing

Section B - Working in the Care Home with Nursing Setting

Chapter 7 - Working with Adults at Risk

A resource in the QNI's 'Transition' series, designed for registered nurses with an interest in working in a care home with nursing and for those who are already in this area of practice, who would like an update on current practice and approaches.

Section B - Working in the Care Home Setting

Chapter 7 - Working with Adults at Risk

Completing this chapter will enable you to:

- Define an adult at risk
- Identify what constitutes abuse and your role in safeguarding adults
- Describe how the Mental Capacity Act supports people in making their own decisions and process we use to make a decision in a person's own interest when they lack capacity.
- Define Deprivation of Liberties Safeguard.

Introduction

Whilst working in a care home you may be exposed, to potential 'risks of harm' to patients how you are able to understand and work with risk will evolve as you become more experienced. Older people in care homes are particularly at risk due to their dependencies related to cognitive and/or functional self-care challenges. Although many care homes provide good care, maltreatment and abuse of older people can and does occur (CQC (2017)). Neglect, which is a form of abuse in a care home setting could be due to chronic under staffing or lack of specialist knowledge or because of poor management.

This Chapter will describe your role in protecting the residents that you support and what type of treatment or behaviour that might constitutes abuse. It will also outline some of the law and processes in place to protect adults at risk when raising concerns.

Duty of Care

The law imposes a duty of care on practitioners, whether they are support workers, students, registered nurses, doctors or others, when it is "reasonably foreseeable" that they might cause harm to patients through their actions or their failure to act (Cox, 2010). All nurses under the NMC Code (2015) have a duty of care to protect people at risk of harm.

It is your responsibility as a health care professional to act promptly if you have any concerns. Duty of care may include:

- acting in the resident's best interest and in the least restrictive way if they do not have capacity to make the decision at that time.
- acting to protect the adult at risk from harm or abuse
- dealing with immediate needs, as far as possible, central to the decision making process
- report and follow up your concerns.
- get support to make referrals where needed.
- talk concerns through with your line manager.
- contact the local safeguarding lead for advice. They will advise if police involvement is necessary if you think a criminal act is involved.
- accurately record the incident.

However, if a resident has capacity to make their own decision then we have a duty of care to follow their wishes, even if this is an unwise decision.

Who is an 'Adult at Risk'?

The Care Act (2014) defines an adult at risk, and therefore safeguarding duties apply to an adult who:
'Has needs for care and support (whether or not the local authority is meeting those needs) and is experiencing, or at risk of abuse or neglect and as a result of those care needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.'

What is Abuse?

Abuse is a violation of an individual's human or civil rights and includes all forms of harm, mistreatment and neglect. It can be a single act or repeated act or a failure to act, which usually occurs within a relationship in which there is an expectation of trust. Abuse concerns the misuse of power, control and/ or authority. It can be perpetrated by an individual, group or organisation. It may be intentional or unintentional."

The Care Act (2014) identifies 10 types of abuse:
This is not intended to be an exhaustive list, but an illustrative guide as to the sort of behaviour which could give rise to a safeguarding concern. What constitutes abuse or neglect can take many forms and the circumstances of the individual case should always be considered.

Figure 7.1 Different types of abuse

Physical abuse	including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.
Domestic abuse	including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.
Sexual abuse	including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure, sexual exploitation and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.
Psychological abuse	including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, Verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
Financial or material abuse	including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
Modern slavery	encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
Discriminatory abuse	including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.
Organisational abuse	including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.
Neglect and acts of omission	including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
Self-neglect	this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

> “ Abuse is a violation of an individual’s human or civil rights and includes all forms of harm, mistreatment and neglect.

Safeguarding Adults

The Care Act (2014) defines safeguarding as:
‘…protecting an adult’s right to live in safety, free from abuse and neglect… It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action… This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.’

Safeguarding is about acting in the best interest of people who are receiving care in health and social care domains. Remember, the NMC Code 2015 states: *‘Professional standards of practice and behaviour for nurses and midwives requires you to ‘raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection’.*

It is of paramount importance that you are aware of both national and local policies and have attended mandatory safeguarding training.

Consent

Residents must give their permission for medical tests, examinations and treatment other than in some select circumstances. These circumstances are if the resident:

- lacks capacity to consent to treatment of their mental health (for example, in cases of dementia)
- requires hospital treatment for a severe mental health condition
- is a risk to public health (for example due to ebola, cholera, tuberculosis)
- is severely ill or infirm and living in unhygienic conditions
- needs an additional emergency procedure during an operation
- if the resident requires life-saving treatment and they are unconscious[2].

Collaborative Approach to Risk

A serious case review of Winterbourne View care home exposed by the BBC Panorama programme in 2011, shocked the nation regarding institutional abuse and the failures of staff working in the home. Whilst this was deemed as an extreme case, the approach to adult safeguarding is for collaboration and partnership between patients, adults and incidents of abuse in health and social care settings appear in the media all too frequently.

The Francis Report, a review following the Mid-Staffordshire incidents, raised further questions in relation to adults at risk. Among many recommendations, it stated that:
‘Patients must be the first priority in all of what the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture, and protected from avoidable harm and any deprivation of their basic rights[1].’

Although the Francis report focused on NHS, the findings and recommendations should also be followed in care homes.

Activity:

- Have a look at your organisation’s safeguarding adult policy.
- Make sure you know your responsibilities if a safeguarding concern is observed or reported to you, and who you have to report the concern to, including their contact details

Mental Capacity Act (MCA) 2005

Mental Capacity is the ability to make a decision, however big or small, for example the ability to choose what to wear today, whether to take prescribed medication to where you want to live or consenting to medical treatment.

A person lacking capacity *‘means they lack the capacity to make a particular decision or take particular action themselves at the time the decision or action needs to be taken.’* (MCA Code of Practice 2005)

The five principles of the Mental Capacity Act aim to protect people who lack capacity & help them take part as much as possible in decisions that affect them.

Figure 7.2 The five principles of the Mental Capacity Act

1	An adult must be assumed to have capacity unless there is proof that they lack capacity.
2	A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3	Don’t assume a person lacks capacity to decide just because they make an unwise decision.
4	If you have to make a decision for a person who lacks capacity to decide themselves this must be in their best interests.
5	You must decide on least restrictive way to meet their needs.

To help determine if a person lacks capacity to make particular decisions, the Act sets out a two-stage test of capacity.

Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?
This may include:

- conditions associated with some forms of mental illness
- dementia
- significant learning disabilities
- the long-term effects of brain damage
- physical or medical conditions that cause confusion, drowsiness or
- loss of consciousness (for example diabetes, epilepsy or infection)
- delirium
- concussion following a head injury, and
- the symptoms of alcohol or drug use.

Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?
A person is unable to make a decision if they cannot:

1. understand information about the decision to be made
2. retain that information in their mind
3. use or weigh that information as part of the decision-making process, or
4. communicate their decision (by talking, using sign language or any other means).

Only when we have tried everything to support the resident to make their own decision, do we act in their best interest.

Your organisation will offer MCA Awareness training; this will give you the opportunity to explore the five principles of MCA and how you put these into practice.

Best Interest Decisions

The NMC Code (2015) states that as a registered nurse we must act in the residents best interest at all times, this includes balancing the need to act with the requirement to respect a person's right to accept or refuse treatment, ensure informed consent is gained and documented, and you keep to the Mental Capacity Act.

The Mental Capacity Code of Practice describes the best interest principle as: *'An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.'*

However, we must always start with the first principle of the Act that people must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack it. That means that working out a person's best interests is only relevant when that person has been assessed as lacking, or is reasonably believed to lack capacity to make the decision in question or give consent to an act being done at the time of assessment.

People with capacity are able to decide for themselves what they want to do. When they do this, they might choose an option that other people don't think is in their best interests. That is their choice and does not, in itself, mean that they lack capacity to make those decisions.

There are two circumstances when the best interests principle will not apply. The first is where someone has previously made an advance decision to refuse treatment while they had the capacity to do so. Their advance decision should be respected when they lack capacity, even if others think that the decision to refuse treatment is not in their best interests. The second concerns the involvement in research, in certain circumstances, of someone lacking capacity to consent.

> “ Only when we have tried everything to support the resident to make their own decision, do we act in their best interest.

Figure 7.3 When acting in someone's best interest you should consider the following:

• Do not make assumptions about capacity based on age, appearance or medical condition
• Encourage the person to participate as fully as possible
• Consider whether the person will in the future have capacity in relation to the decision to be made and if the decision can wait until they have regained capacity.
• Consider the person's past and present beliefs, values, wishes and feelings
• Take into account the views of others ie carers, relatives, friends and advocates
• Consider the least restrictive options

Who is the Decision Maker?

For the small everyday decisions, for example what to wear or what/ when to eat or drink that will be you or the support staff you are on duty with.

For the bigger decisions for example where to live then this decision will be made through best interest decision meeting.

Activity:

- Think about and list all the decisions you support your residents to make and the practicable steps you take to help them make the decision themselves.
- You could do this activity independently as a CPD activity, or could form discussion in your 1:1 supervision session, or you could do this activity as a group in a team meeting.

The Best Interest Decision Meeting

This meeting should be a multidisciplinary meeting and be documented on a best interest decision form.

As well as professionals involved in the decision attending the meeting the resident should be involved as much as they are able to, any family and/or friends that are involved in the residents care and an independent advocate may need to be invited.

All the options should be considered, including the resident's wishes, feelings, beliefs and values when s/ he had capacity to make this decision. The pros & cons should also be discussed.

The final decision and how this was made should be documented including any follow on work that may be required.

If a final decision cannot be decided by all involved even after any follow on work, in extreme cases this may need to be referred to the Court of Protection.

If you will be involved in best interest decision making and meetings, you may need to attend local authority training, your manager should discuss this with you.

Activity:

- A Best Interests checklist will be available in your organisations Mental Capacity policy or as part of local authority policy and procedure that your organisation will follow.
- Have a look at your residents records that have had a best interest meeting in order for best interest decision to be made (for example about living in your care home or decisions about do not attempt resuscitation) this will help you understand the best interest process and how the decision was made.

Case Scenario:

Bill has been diagnosed with Dementia and Prostate Cancer and currently lives with Ethel his wife of over forty years. Bill currently comes into the care home every six weeks for respite care and has done so for the last two years. When Bill is at home he has a care package consisting of two homecare visits a day to assist with washing and dressing, Ethel provides all other care that is required including eating and drinking and support with going to toilet and changing continence pads.

The care home nurse has assessed and observed that Bill is deteriorating in terms of his care needs and requires all help with washing, dressing and eating. He seems more confused, is very restless, and is constantly wandering. Hence the reason for calling the meeting.

At Bills last hospital visit for his prostate cancer the Consultant prescribed Morphine Sulphate tablets for his back pain, which was diagnosed as bone secondaries. He was also started on a laxative as a precaution. The Consultant made a referral to the palliative care team as he now thinks that Bill is at the end stage of his cancer.

Ethel has said that she cannot cope with Bill at home anymore as he keeps wandering off in the middle of the night and on the last occasion had to be bought back by the police. She has her own health problems and finds it very upsetting that Bill doesn't know who she is any more.

Bill's social worker visited him at home to assess his capacity to make the decision to move permanently to a care home. Bills social worker also invited an independent advocate Independent Mental Capacity Advocate (IMCA)

to ensure Bill's wishes, feelings, beliefs and values were also considered as part of the decision making process.

At the time of the social workers visit she assessed that Bill did not have the capacity to make the decision about where to live because he didn't have an understanding of his diagnosis of cancer and increased care needs, he also couldn't remember regular visits by the community palliative care team and previous conversations with them and his wife about moving to a care home.

The IMCA spoke to his wife and family about Bill, they informed the advocate that Bill has always been an independent gentleman and when he was diagnosed with dementia he didn't want to become a burden on his family and would prefer to live in a care home and retain his relationships with his wife and family rather than them becoming his 'carers'. Bill's GP of more than 20 years also confirmed this as he had conversations about his future care early in his diagnosis as this troubled Bill.

The IMCA also spoke to the care home staff, who confirmed that during Bill's respite stays although he was more confused and wandering, he is settled doesn't try to leave or gets anxious about going home or seeing his wife and family.

The best interest meeting discussion focuses on the best place for Bill to be cared for. There is a lengthy discussion around 'preferred place of death' and where Bill would be best looked after. The care home nurse feels that there is the capacity, expertise and relationship with Bill for him to be admitted permanently for his end of life care.

After opinion is sought from all those involved in Bill's care including Bill's opinion when he did have capacity, the least restrictive option for Bill would be to move into the care home both him and his family know.

Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberties Safeguards are described by SCIE as '*A procedure prescribed in law when it is necessary to deprive of their liberty a person who lacks capacity to consent to their care or treatment in order to keep them safe from harm.'*

The Mental Capacity Act (2005) allows:

- Restraint & restrictions to be used only when if they are in a person's best interest,
- Extra safeguards are needed if the restrictions and restraint used will deprive someone of their liberty.
- Care homes & hospitals must ask the local authority if they can deprive someone of their liberty

Restraints and restrictions include:

- Frequent use of medication/ sedatives to control behaviour
- Use of bed rails without person having the capacity to consent
- Use of covert medication without the person having the capacity to consent
- Restricting contact with other people
- Physically stopping the person doing something that could cause them harm
- Holding the person to give care or treatment
- Not allowing a person to leave your care home.

The Law Commission published a set of recommendations in March 2017 to replace Deprivation of Liberties Safeguards with Liberty Protection Safeguards. The Government published interim response in October 2017, confirming that final response to these recommendations would be published in Spring 2018.

> “ You notice that every time a resident’s relatives visit afterwards she presents as very unsettled, withdrawn and tearful.

If you are required to complete DoLS requests you should attend local authority training.

Activity:

- Do you have any residents that have a DoLS authority?
- Have a look at the completed documentation this will help you understand the process and how the decision to deprive them of their liberty was made

Reflection trigger point – what would you do if…?

These reflection triggers are for you to get together with your mentor and if appropriate other team members to debate possible solutions. They could be used as a basis for a discussion or even a teaching session. We are aware that the solutions to these triggers may vary from Care Home to Care Home according to local policy and procedure. We are also aware that there may be no ‘right or wrong’ answers to how certain situations might be tackled and therefore it will be for you as a qualified nurse to apply your thinking within the parameters of your own professional practice.

- You notice that every time a resident’s relatives visit afterwards she presents as very unsettled, withdrawn and tearful.
- **Discussion Points:** can your resident tell you why she is so upset? Is she upset after each visit or is this a ‘one off’. Does she have capacity to know where/ why she is living in the care home? What relationship does she have with her family? Are there concerns of abuse/harm? What actions should be taken and by whom? What is your role as registered nurse on duty?

- You work in a care home supporting people with dementia, one of your residents hits another resident, and this is not the first time that this has happened.
- **Discussion Points:** Does either resident have capacity to know what has happened and why? What steps have been taken to reduce the risk of the resident hitting other residents, and are these being followed? If the steps to reduce risk haven’t been followed or not working, what else can you do? Has the resident caused harm? Is this a safeguarding concern? What actions need to be taken? What are your responsibilities as registered nurse on duty?

- A resident has a wound on his sacrum, you last dressed this wound a week ago and documented that this wound needs to be redressed every other day, today, you have noticed that the wound is deteriorating and the patient is in pain during the procedure. You look at the residents notes and nothing has been recorded about the wound since you last dressed it.
- **Discussion Points:** What actions are you going to take? Is this a safeguarding concern? What are your responsibilities as registered nurse on duty?

- The support staff report to you that one of your residents are refusing to have a bath.
- **Discussion Points:** Has support staff assessed her capacity to make decision to refuse? What practicable steps has support staff taken/ discussed with you to enable the resident to make the decision herself. If she has been assessed as not having capacity at that time what would be in her best interest and least restrictive way? What actions should be taken and by whom? What is your role as registered nurse on duty?

- A resident in your care home has diabetes and dementia, they are prescribed medication for diabetes but recently has been refusing to take their medication. You have had a discussion with the GP about this as you are concerned her diabetes is becoming unstable, the GP has advised you that he wants staff administering medication to hide her medication in food.
- **Discussion Points:** Where does our duty of care lie? Should we be following GP directions without justification of actions? Does she have capacity to refuse medication? What’s in her best interest? Is this a deprivation of her liberty? What actions should be taken and by whom? What are your responsibilities as a registered nurse?

Summary

This chapter focused on the complexity of working with adults at risk and some of the issues you may encounter whilst working with this group and raises awareness of a professionals' safeguarding responsibility when caring for people at risk of harm. It has discussed some of the legalities of mental capacity, best interest decision making and deprivation of liberties safeguards.

It has also suggested ideas of how you may report or raise your concerns when protecting the people and relatives you may encounter in your role. This topic is complex and specialist and all professionals need to keep updated with regular training and need to work collaboratively so that any risk of harm is managed effectively.

References

1. DH (2012) Transforming care: A national response to Winterbourne View Hospital: https://www.local.gov.uk/sites/default/files/documents/transforming-care-report-47f.pdf

2. NHS Choices, 2016, Consent to Treatment. [online] Available at: <http://www.nhs.uk/Conditions/Consent-to-treatment/Pages/Introduction.aspx> [Accessed on: 19 December 2016].

Further Resources

- The Care Act (2014) Care & Support statutory guidance Care Act 2014 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

- Cox (2010) Legal Responsibility & Accountability, Nursing Management 17:3 18-20

- NMC Code (2015) https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
- Mental Capacity Act (2005) Code of Practice https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

- SCIE Deprivation of Liberties Safeguards at a glance https://www.scie.org.uk/mca/dols/at-a-glance

- http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/

- Social Care Institute for Excellence (SCIE) www.scie.org.uk

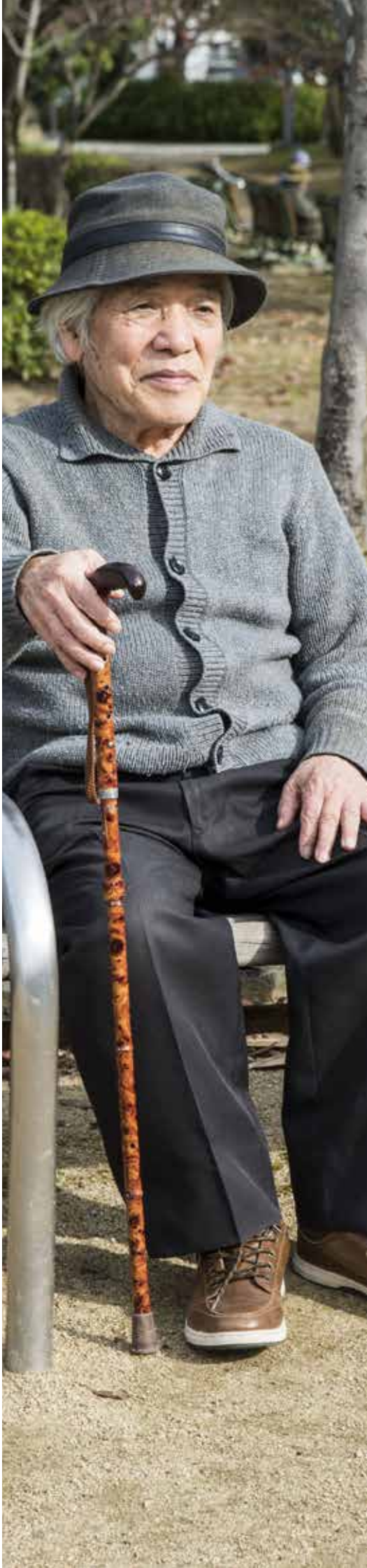
- Resource for safeguarding adults, mental capacity & deprivation of liberties safeguards.

- RCN resource on safeguarding adults in nursing. https://www.rcn.org.uk/clinical topics/safeguarding

- NHS England – Pocket principles of Protection – The health professional's safeguarding pocket guide

- Department of Health (2011) Safeguarding Adults: The role of Health Service Practitioners London The Stationary Office

- Department of Health (2013) Statement of Government Policy on Adult Safeguarding London The Stationary Office



“ One of your residents hits another resident, and this is not the first time that this has happened. What do you do?

- CQC (2017) The State of Adult Social Care Services Findings from CQC's initial programme of comprehensive inspections in adult social care http://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf
- Skills for Care: A guide to Adult Safeguarding for Social Care Providers http://www.skillsforcare.org.uk/Documents/Topics/Safeguarding/A-guide-to-adult-safeguarding-for-social-care-providers.pdf
- Office of the Public Guardian: Mental Capacity Act: Making Decisions https://www.gov.uk/government/collections/mental-capacity-act-making-decisions
- 39 Essex Chambers http://www.39essex.com/category/articles/#resources
- Court of Protection https://www.gov.uk/courts-tribunals/court-of-protection
- Best interest assessment http://www.scie.org.uk/publications/mca/bestinterests.asp
- The Money Advice Service - if you or someone you care for lacks mental capacity https://www.moneyadviceservice.org.uk/en/articles/help-manage-the-money-of-someone-youre-caring-for
- https://www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards
- The Law Society (2015) – Identifying a deprivation of liberty: a practical guide- the care home setting file:///C:/Users/user/Downloads/deprivation-of-liberty-chapter-6-the-care-home-setting.pdf
- Centre for Policy on Ageing www.cpa.org.uk
- Care Quality Commission www.cqc.org.uk
- Joseph Rowntree Foundation www.jrf.org.uk
- Safeguarding Adults at Risk Information hub www.saarih.com
- Action on Elder Abuse www.elderabuse.org.uk
- Nursing Home Abuse www.nursinghomeabuse.net
- Age UK https://www.ageuk.org.uk/
- British Institute of Human Rights: https://www.bihr.org.uk

Notes on the chapter