INTERAGENCY CARE PLAN

In strictest confidence

SERVICE USER DETAILS			
INITIALS:	Anil MAISURIA	AGE:	78
RELIGION:	Hindu	ETHNICORIGIN:	From India
FIRST/PREF LANG	Gujarati (understands some Hindi)	INTERPRETER REQ'D:	?

OTHER PEOPLE INVOLVED IN THE ASSESSMENT/ WHO ELSE DID YOU SPEAK TOO?

NAME	*RELATIONSHIP TO SERVICE USER*	*TELEPHONE NUMBER*
Mrs Sumi Maisuria	Wife	0116 252 3773

1. USERS VIEWS / WISHES

- Mr M was unable to express his views and wishes due to his mental illness.
- It was observed that Mr M seemed easily distracted, losing his concentration after short periods. Therefore, a more detailed profile needs to be collated over a longer period of time. His wife pointed out that he was quite sleepy and not really in the mood to answer my questions. When asked when he was most receptive, she was unsure, reporting he was drowsy most of the day
- Mr M seemed tearful at some points during my assessment. Whilst he didn't express anything verbally, he appeared to be unsettled, expressing a non verbal emotional response.
- When asked if he liked sitting in the recliner chair Mr M seemed slightly agitated. He didn't express if he liked, or disliked it. His wife emphasised it helped to keep him safe from falls.

- An interpreter was invaluable in trying to capture Mr M's point of view. He was able to express some choices and preferences around short simple questions. These included: he only likes to eat food cooked by his wife; he likes going out of the house; he likes to watch TV sometimes; he doesn't like sitting down all day; he doesn't like talking to unfamiliar people; he doesn't enjoy visitors coming round to see him.
- Mr M looked rather bored. When questioned, he did not express specific requests of what he might like to do during the day. In his presence, it was discussed with his wife whether the environment could be enriched, e.g. with some music or the option to watch TV. She agreed to discuss this with her daughter and to consider if changes could be made; she raised concerns that Mr M might break the appliances.
- Mr M seemed slightly agitated regarding his use of the recliner chair. As his wife has raised an issue of his safety, a referral was made for an OT assessment to explore this and any other relevant issues around improving and maintaining a safe environment.
- It was possible to establish from his wife that Mr M had been an active man who liked the outdoors. It is worth exploring if he might be a candidate to join one of the local groups, for Asian elders, to see if he enjoys some of their organised outings.

Source of information: Service User interview.

2. CARERS VIEWS / WISHES

A separate assessment of the carers needs can be completed

- She can't speak very good English.
- Mrs M definitely wants her husband to remain at home with her.
- Mrs M doesn't seem to want any further help or services, as she says she is coping, however, she did acknowledged his need for care was increasing & the degree of care required was heavy and time consuming to deliver. She is providing all care concerning his personal hygiene, toileting and watching over him.
- When asked what time they get up & go to bed, Mrs M suggested it varied as she relied on her daughter & son-in-law to get Mr M in & out of bed – typically he got up at about 8am & was put to bed at 6pm.
- When asked about the routine during the night Mrs M admitted that she never gets her husband out of bed during the night, as he is too heavy when she's on her own. Occasionally, he does manage to get out of bed himself and on these occasions she has to lock him in the bedroom to ensure he is contained, as she fears he will fall down the stairs.

- For the purposes of this initial assessment an interpreter was used to ensure Mrs M could fully express her views.
- Mr M has a bath once a week when the son-in-law is available to help at the weekend. During the week Mrs M tries to give him a shower, on alternate days, but Mr M frequently refuses, as he hates getting wet and cold. Mr M regularly has to have washes and a change of clothes, in between times, due to his incontinence.
- Mrs M reports spending most of the day either delivering care, or supervising her husband's safety. She gets two short breaks each day when her daughter and/or son-in-law pop in to help get Mr M get in or out of bed – usually about 8.00am and 6.00pm.
- When asked how toileting was managed over-night, Mrs M said her husband was usually alright. She and her daughter dealt with any accidents the next morning.
- Mrs M reported she felt very tired and worried all the time, so much so, she struggles to sleep at night. She has a painful lower back, pains in her neck and arms, and regularly has an acidy feeling in her stomach. She admits to feeling sad most of the time, as she just wants things to go back to the way they were when her husband was fit and healthy.
- Mrs M insists she doesn't need help from outside carers because it is her duty to care for her husband. She also expressed concerns that this would be the first step to putting him in a residential home. She is reassured that this is not the case. However, a referral is being made to Social Services for a Carer's Assessment because we are concerned about her well-being. She is further reassured that all decisions will be discussed with her.

Source of information: Spoke to Mrs M.

3. CURRENT SUPPORT NETWORK

- Mrs M is living with Mr M & is the primary carer.
- Daughter visits X2 per day on her way to & from work.
- Son in law assists his wife when possible with 'heavy' tasks, like getting Mr M up in the morning & putting him to bed at night.
- Mr & Mrs M have another daughter – she maintains contact over the phone, but lives too far away to visit on a regular basis.
- Mrs M believes using family members as carers is more beneficial to her husband, as he knows who these people are and they provide a familiar routine for him.

- Mr and Mrs M have a small support network of immediate family. Their eldest daughter and her husband live locally and visit twice a day to assist with Mr M's care. The other daughter lives a long way away and only visits 3 or 4 times per year.

- Mrs M admitted that none of the family involved in Mr M's care had received any form of training or advice e.g. moving and handling, or reducing the risk of infection during toilet duties. When asked if they ever struggled to work out how to approach a care problem e.g. improving her husband's continence, she had to admit that such help would be very welcome.

- Mrs M admitted the family did not often take Mr M out, as he could be embarrassing in some situations; she hated the thought that some people might be staring at them and talking, in derogatory terms, about her husband. She implied her community would be quick to pass judgement on why Mr M had been 'struck' with this illness.

- Options of expanding their social network were discussed, such as eliciting help from friends, neighbours, a dementia support group, Age Concern, or other worshippers from their temple. Mrs M is to consider these possibilities with her family.

Source of information: From wife & initial referral letter.

4. MENTAL HEALTH

- ?? dementia.
- Mr M seemed a bit confused during the assessment visit
- Mr & Mrs M used to do a lot of things together outside of the home. Up until 8 months ago they were still going out shopping together.
- Mrs M described a gradual deterioration of her husband's memory over the past 3 to 4 years. First she noticed that he started to forget recent information and then he began forgetting important dates e.g. the grand-children's birthdays.
- Mr M's appetite is not very good and he has lost weight.

- Mr M and his wife were seen with an interpreter.
- About 8 months ago Mr M started to wonder out of his house. He would say that he would need to go to work and could be adamant to leave. He also started to dismantle the tv and put the cooker on. In discussion with the family it was decided that it would be better to keep Mr M in his chair for his own safety and that of others.
- She describes that he was always a cheerful person, but that over the past few months he is not happy and often gets angry. He hardly seems to enjoy anything.
- He sleeps on and of in the daytime and is often awake at night.
- He is often tearful 'for no reason'.
- He often states that no-one wants to help him. At other times he is pleased to see his wife. He used to smile at her, but that hardly happens nowadays. There is no evidence of a perceptional abnormality. (Such as hallucinations).
- Mr M gets angry and lashes out when the family look after his personal care.
- When the interpreter speaks to Mr M, she explained that Mr M did not find it easy to express himself.
- Mr M knows his name and he recognises his wife as being his wife. He knows he is in England in Leicester, but he doesn't know the address. He scores 10 out of a possible 30 on the MMSE. He does not co-operate with all the items.
- He says that he is not happy, but cannot explain why. He doesn't smile and there is little change in facial expression. He does not respond to questions such as if he trusts people or that he believes he is victimised. He also does not respond to questions about his personal circumstances and what he wants to happen and how he could be helped. He just looks ahead. After a while he stops responding to questions altogether and turns away.

Source of information: Observation of Mr M during initial visit.

5. OTHER SIGNIFICANT FACTORS

- Slight bruising noted: probably due to a minor 'knock' whilst mobilising.
- Visually, there were circular bruises around the upper arms.

- Some new and older bruises noted on Mr M's upper arms. Not obviously causing any pain or discomfort.

- Bruises are circular around upper arms and around waist. Caused by belt being used to restrain him on arm chair to prevent him from getting up and walking

- Arms sometimes tied to arm rests when family need to attend to personal care as he has been hitting out, bruising around wrists.

- Some finger point bruising to arms where family have been lifting him in and out of the bath, and from restraining him when agitated.

- Also at night he is restrained otherwise he is up at night, preventing his wife from sleeping. Family are restraining him, because they believe it is in his best interests. They are worried he might fall, or leave the house.

Mental Capacity Act 2005:

a) *Introduced a new criminal offence of ill treatment or wilful neglect of a person lacking capacity.*

b) *Independent Mental Capacity Advocate – a new role; a statutory safeguard to support people lacking in capacity. Main duty focus on people subject to adult protection proceeding.*

Source of information: Observation of Mr M during initial visit.

6. RISK FACTORS

- Mr M has been known to 'lash out' at wife as he is sometimes resistive to the care he receives.
- Mr M also struggles to accept physical care from his daughter and son-in-law, although he has never 'lashed out' at either of them; he has, however, used verbally abusive language with them and has clenched his fist in response to their input.
- He needs constant supervision at home, as tends to engage in unsafe activities e.g. moving the furniture around, or turning the gas cooker on.
- He has been known to wander out of the house & into the street at night.

- To-date he has not physically struck her and he has not used weapons. Mr M's 'lashing out' tends to occur when his wife is providing him with physical care and/or immediately following the removal of physical restraints.
- Although Mr M dislikes the fact that his family provide complete physical care for him, they believe it is essential and are sceptical that he could perform certain tasks with only moderate input from them.
- The family also have concerns regarding the integrity of his skin around the sacral area.
- Mr M's family lead busy lives and would find it difficult to allow Mr M the time he needs to carry out certain physical/self care tasks independently. Mrs M in particular is struggling with the demands of providing complete physical care for her husband (she is often tearful and can become frustrated with Mr M) but cannot see any other way of ensuring he is toileted, clean and dressed adequately.
- The family report that Mr M is less inclined to 'lash out' and more inclined to accept their assistance with physical care approx 30 minutes after taking diazepam, during the day time and/or after having slept.
- SOS pendant or bracelet might be an option if Mr M were to wander away from the family home and get lost.
- The family report that both Mr M's mimicking behaviour and his wandering are less evident if he is engaged in practical tasks. However, the family have not made the connection between his old routines and his current behaviour and do not have any strategies to occupy Mr M in meaningful and safe activities.

Source of information: From wife.

- Atrial fibrillation.
- Hypertension.
- Hypercholesterolemia.
- Old stroke (right sided weakness).
- The family need to give Mr M his medication which he often refuses to address this they hide it in his food.
- Has fallen at home several times recently

- On medication for blood pressure and high cholesterol. Takes Bendroflumethiazide 2.5mg daily, Simvastatin 20mg at night, Aspirin 75mg daily.

- GP has prescribed Diazepam 5mg when needed recently.

- Atrial Fibrillation in the past. Several factors increasing the risk of cerebrovascular events. Has had a stroke in 2004 with some residual right sided weakness. But had been walking and self caring after this.

- Has become increasingly confused since that time.

- Has fallen at home several times recently, perhaps a combination of old CVA, and the diazepam prescribed by the GP.

- *Is the diazepam causing an increase in confusion, agitation, and leading to reduced mobility and increased falls risk ?*

- *Does hiding medication in food raise ethical dilemmas ?*

Source of information: Initial referral letter from GP.

8. PERSONAL CARE / SELF CARE

- Mr M is reasonably mobile.
- He needs assistance with all personal care e.g. to get in & out of bed, to get dressed, to go to the toilet.
- He can feed himself, if food is left in front of him.
- Mr M's family report that he is doubly incontinent. However, this incontinence usually occurs when Mr M has been restrained for his safety. At other times he makes attempts to reach the toilet. Mr M's family try to manage his incontinence by taking him to the toilet as often as they can.

- Mr M's gait is unsteady but he is able to transfer from chair to standing (and vice versa) and between chair and bed (and vice versa) with minimal assistance.
- He is also able to walk short distances, although negotiating stairs is a problem.
- He is able to use a walking frame, but he does not like to use it.

1. The toilet is upstairs;
2. Mr M is resistive to their efforts to help him;
3. The family have limited time to provide for his needs (this can mean Mr M is given food and drink and then left for long periods of time restrained in his chair). During more lucid moments, Mr M is able to describe where the toilet is in the house and he is able to recognise the symbol for 'toilet' when shown.

- However, without assistance, Mr M is not able to mobilise well enough to manage the stairs in the house and would not be able to undress or dress himself adequately prior to using the toilet or afterwards, as he finds the fastening and unfastening of buttons and zips very difficult.

Source of information: From wife.

9. DOMESTIC TASKS

- Mr M has never had responsibility for domestic tasks at home.
- He continues to be supported by wife & extended family members.
- Mr M's daughter and son-in-law currently manage all the finances. They keep Mr M fully inform of the decisions they make around household expenditure. Mrs M admits her husband's views are not sought, as the family believe conversations around finances would be stressful for him and they do not believe he could make a meaningful contribution to such conversations.

- Until recently, he did attend to the garden and the general maintenance of the house.
- He was responsible for paying household bills.
- However, Mr M does tend to ruminate over bills and household expenditure generally.
- Mr M has not done any work in the garden for several months and neither has he had much access to it.

Source of information: From wife.

10. CULTURAL, RELIGIOUS & DIETARY NEEDS

- Mr M has lots of cultural needs as he is an Asian Hindu who doesn't speak any English.
- Mr M will only eat food prepared by his wife, as she knows exactly what he likes and dislikes. The family is vegetarian. Mr M has lost a bit of weight recently; his wife reports that he often doesn't finish a meal, as he loses interest in it after a few minutes. Sometimes she has to feed him; he tends to get angry and spits the food out, as he prefers to feed himself.

- Prior to Mr M deteriorating he and his wife used to visit the local temple everyday for 'arti' or evening prayers. This allowed Mrs M a chance to talk to members of the community and it also gave her a break for constantly having to supervise him, since there were lots of people at the temple.

- Mr and Mrs M are devout Hindu's and strongly believe in reincarnation. Mrs M sometimes feels her husband's illness is as a result of something bad that she must have done in her past life and she is paying back God in this life.

- Mr and Mrs M always celebrate Diwali. It came and went this year and neither was able to go and join in the celebrations, as Mr M is not really safe outside of the home, especially when not strapped in his 'secure' chair.

Source of information: Observation during initial assessment.

11. RECREATIONAL / EDUCATIONAL / EMPLOYMENT NEEDS

- Not applicable at the moment as not going out
- Mr M used to enjoy watching cricket.
- Retired from hosiery industry 13 years ago.
- It was observed that Mr M was sitting in a room with the curtains drawn; Mrs M reports it is to stop people looking in through the window whilst her husband is unwell.

- Mr M used to enjoy watching cricket, listening to music and watching TV.
- He used to take a long walk each morning.
- Every morning Mr M tries to get up to get out of the house, as part of an old established routine. The family are locking the door to prevent him getting out.
- He is often agitated in the morning, banging on doors and windows if not restrained. On several occasions he has managed to abscond from the house and family have had search for him.
- Due to reduced mobility Mr M can no longer manage to travel very far.
- He sits in a room with no TV.
- The curtains are usually drawn to prevent people from looking in at him.
- Mr M often sleeps during the day and is wakeful at night.
- Family time is mainly taken up with managing his personal hygiene, rather than positive interaction with him.
- His wife usually sits in back room to watch TV on her own.

Source of information: From wife & initial referral letter.

12. ACCOMMODATION & ENVIRONMENT

- Mr M lives in small terraced house in the Highfields area.
- He owns the house.
- The living room seems to be the main care environment: it is somewhat cluttered & unkempt.
- Mr M is cared for in a 'special' recliner chair.
- There is no downstairs toilet.

- Mr M requires an immediate home assessment from an OT to recommend some quick strategies to create a safer environment, as safety is such a prominent theme in the minds of the family members e.g. removing trip hazards e.g. a loose rug; or ornaments that could cause injury if accidently broken e.g. a glass vase; or fixtures and fittings that are sharp or hot e.g. a radiator that could be covered.
- Some of the work associated with caring for Mr M may be reduced with the use of relevant equipment which can be given on loan from the OT. A commode and urinary bottle to ease the work involved in toileting him. Storage boxes to discreetly put away care items, like toilet rolls, or flannel, as this may encourage the family to invite friends back to the house. A profiling bed should help with some of the moving and handling issues and concerns about bed sores. An alternative armchair for Mr M could still seek to promote his safety and initiate discussions around the ethics of restraint.
- During the OT visit the viability of renovating the house to better meet Mr M's longer term care needs could be established. Minor work would include installing grab rails or safety features to 'danger zones' such as the front door, fires, electrical sockets, cooker etc. Major work might include building a downstairs toilet or bathroom.
- Mr M is believed to be the sole owner of the family home. Social Services need to explore general finances to advise Mr & Mrs M e.g. does he want to put his wife's name on the deeds. If Mr M's capacity was felt to be an issue any changes to such a legal document could be problematic.
- *An approved mental health worker (from any profession) has to make an important assessment about the precise use of the reclining chair: is it simply a convenient and comfortable place to sit, or is it being used to restrain and effectively 'imprison' Mr M? If the latter were thought to be true, the professional is required to recognise it as potential abuse and must make a decision about whether to take further action to initiate procedures to safeguard a vulnerable adult.*
- *If such work was authorised, there would be a delay in starting major work, whilst funding and finance arrangements are being agreed. Depending on his savings, Mr M could be liable to make a financial contribution towards this.*

Source of information: From wife & initial assessment.

13. FINANCIAL

- Mr M is in receipt of a State pension.
- Money was always managed by Mr M; he has some savings, but his wife is unaware of the amount as she has never played any part in the family's financial dealings. She doesn't even know if she receives a pension.
- The daughter & son in law have had to manage Mr M's finances for about the last 3 months as he no longer has any interest in such matters.

- Mr M did not respond or show any interest in questions about his finances.
- Mrs M is uncertain about how much pension they each receive per week, or how much money they have in their savings account.
- The daughter and son-in-law have unofficially taken over the management of the household finances. They have suggested Mr M is no longer capable of making informed decisions and Mrs M has never had any involvement in matters relating to money and doesn't want this new role forced upon her now. Social services need to explore these circumstances further and formalise any financial arrangements.
- Mr M's (financial) capacity needs to be verified, ideally by his own Dr, before any decisions are made about his future.
- *Are there risks of potential financial abuse? Can this be protected against?*
- *At this stage family members do not have 'Lasting Power of Attorney' in any official capacity. (Covered in MCA)*
- *Court of Protection and Deputies (MCA) – a new Court and new public official, to protect people who lack capacity and to supervise those making decisions on their behalf.*
- *Public Guardian (MCA) – an appointed guardian protects a person lacking capacity from abuse. A register of guardians is kept and they are supervised.*

Source of information: From wife.

14. INFORMATION GIVEN ABOUT SERVICES

- Specialist medical care being received: GP manages/monitors health issues.
- No social care services are being received, as wife has declined any assistance.
- Respite care was discussed – wife has also declined this service.
- Family to explore contacting their local pharmacist to have Mr M's repeat prescriptions automatically collected from the GP & dispensed.

- Mr and Mrs M have been introduced to the Interpreting Services. They have been strongly advised to request this service when significant discussions are taking place.
- Mrs M has been advised to see the GP concerning her own musculo-skeletal pain, gastric symptoms, chronic fatigue and low mood.
- Mr M has already received a full psychiatric assessment. The Consultant will continue to monitor his symptoms and review treatment, initially on a 3 monthly basis, in the out patient clinic. The family have full contact details.
- The Consultant referred Mr M to the day hospital. Transport is being arranged. Initially, for 2 mornings per week, to provide Mrs M with a break. If successful this could be increased. It is hoped staff will promote positive and enduring routines to improve daily care e.g. encouraging better bladder and bowel control; developing incontinence management strategies; promoting independence at meal times; providing interesting activities to enhance concentration and mental agility; increasing mobilisation; and initiating improved patterns of wakefulness, rest and sleep.
- The OT referral: for a full home assessment and loan of equipment. Mr M's on-going needs and funding for longer term adaptations will be explored. The OT will also advise on stimulating activities Mr M could enjoy safely at home.
- Mrs M has been put in touch with a local charity who can give her a second hand TV to provide Mr M with some stimulation in the sitting room.
- Social Services: The carer's assessment is complete; Mrs M is considering if she will accept regular support carers and occasional respite care. A financial assessment and advice is pending. Contact details of local support group for Asian Elders, the Dementia Society and Age Concern have been provided; a Hindu support worker is investigating if the temple offers any domiciliary services.
- The community pharmacist has been asked to undertake a medicines use review. The over-use of diazepam was identified as a significant risk factor and this information was fed-back to the GP. A suggestion was also made to consider dispensing medicines in a liquid form, as this could help with administration/swallowing problems.
- An Approved Mental Health Worker (AMHW is supporting the family to reduce the risk of bruising to Mr M due to poor moving and handling techniques. The family are waiting to hear about a local training course run by a community physiotherapist. Mr M's status is being carefully monitored as he remains a vulnerable adult. A lot of work with the family is being facilitated by the AMHW, the OT and the day hospital to educate them about not restraining Mr M and the use of alternative strategies to manage his moods and behaviour.

Source of information: From wife & initial assessment.

15. ASSESSMENT CONCLUSION

- Consider a carer's assessment for wife.
- Consider ethnic issues.
- GP to follow up on management of medical care & incontinence issues.
- Recommend wife should liaise with GP should Mr M's health or social situation change. This will include any request for future referrals or assessment.
- No specific additional services required at this time.

The original care plan (student version) hints at some valuable steps forward, but its main weakness is the absence of any assertive action. The assessment appears as if it was completed in haste: hence it is superficial in all areas it appraised; at times assumptions are made based on flimsy evidence; it missed some worrying signs; and key people were not appropriately engaged to obtain a full and accurate history.

- Action Points Included In Revised Plan:
  - Using an interpreter to ensure the accuracy of the information; also to obtain clear feedback, from the family, about their cultural and spiritual needs.
  - Referral to a psychiatrist to undertake an appropriate medical assessment and to provide an informed diagnosis and future management plan, including attendance at a Day Hospital.
  - Referral to social services for a carer's assessment; immediate financial monitoring and welfare rights advice; and to review the care package, which now will include some extra services, such as, additional carers, respite care and referral to certain outside agencies to expand support networks.
  - A range of OT assessments to improve safety, assess the home environment, provide equipment and engage Mr M in more meaningful activities.
  - A medication review to evaluate the drug regimen and improve compliance.
  - Relevant training of the relatives involved in Mr M's caring to develop better strategies to manage his on-going needs and improve Mr M's quality of life.
  - Allocation of a key worker, who could belong to any of the professional groups involved in Mr M's care (Dr, nurse, OT, social worker etc).
  - Once a more effective therapeutic relationship is established with a range of professionals, they can all make a vital contribution to on-going preventative work, such as educating the family about Mr M's condition and care needs.