**12.3**

**How will you ensure that the practice of advocates is appropriate, safe and supervised when undertaking non-instructed advocacy work? Please provide supporting evidence that includes a case study to support your answer. (550 words, not including additional evidence requested)**

J is an elderly man with dementia who lives at home with his family. A decision had to be made about whether J should be moved to different accommodation and there was conflict between J's family and the decision maker, so an IMCA referral was made. J was not able to communicate his wishes so the IMCA took a non-instructed approach.

It was known that J could behave in a volatile manner and that there were safety issues at home, so a case planning meeting was called to review the risks and put in place measures to ensure both the IMCA's and J's safety. It was decided to put in place lone working procedures for the IMCA so that his colleagues were aware of the times and location of visits and were alerted by text both at the start and end of visits. J's family were consulted to enable the IMCA to understand what triggered J's volatile outbursts and they were able to advise on what tone to take and language to use in conversation with J and to avoid direct eye contact. IMCA staff also received 'breakaway' training to equip them to deal with any dangerous behaviour. The risks involved with working with J were also flagged on VoiceAbility's database to ensure that note was taken.

Due to the conflict between J's family and the decision maker the family were initially suspicious of the IMCA but once it had been explained that the IMCA process would involve ascertaining and reporting their views they engaged well with the service. They supported the IMCA, calming J when he became agitated and enabling the IMCA to carry out his work. Although J had very limited communication, the IMCA was able to ascertain some views through simple yes/no questions and pictures. The IMCA was also able to observe how J reacted with his family, and how he reacted to other people. The IMCA debriefed to his manager after each meeting to see if any additional measures needed to be taken to work safely and appropriately – this was also recorded on the database.

This work led to richer information being available for the decision maker who felt more confident about J's wish to remain with his family and to explore further efforts to support J to do so that didn't place as much caring responsibility on the family.

**12.4**

**Please describe the key relationships through which the service will ensure that good outcomes are delivered for service users. Please provide supporting evidence in the form of case studies that demonstrates examples of each in relation to Serious Medical Treatment (SMT), changes to accommodation, Deprivation of Liberty Safeguards (DOLS) , safeguarding and care reviews. (550 words, not including additional evidence requested)**

*Case Study – Serious Medical Treatment*

O, a young man with learning and physical disabilities was admitted to hospital for a decision regarding PEG feeding. During discussions between the consultant, O and O's father, O appeared agitated and distressed. The Learning Disability Nurse picked up on this, and

through speaking separately with O, identified that he did not want his father to be involved in the decision. The nurse flagged this to the consultant, stating that the IMCA service needs to be involved. The nurse was able to identify this as the IMCA service worked closely with her through the hospital's working groups.

After seeking some guidance from the IMCA service, a referral was made by the nurse, who also made the IMCA aware of O's communication needs – that O has a communication book that has been developed by Speech and Language Therapists (SALT) that work closely with O. After the IMCA met with O, it was identified that O was desperate to communicate his views but struggled to through his communication book. Through the symbols in the book, O named his SALT. The IMCA contacted the SALT and explained the situation, where he received advice on how additional symbols need to be produced to be consistent with O's manner of communication. After speaking with the consultant and the nurse to ascertain further details about the treatment options and impacts, the IMCA met with O again with more symbols and pictures that could be used. The IMCA presented the risks and quality of life associated with not having the PEG. O presented that he really enjoyed the taste of food, particularly chocolate, and did not want to lose that, but at the same time he didn't like the risks or impact with the other options. This then led to O agreeing on the option of having a PEG, but that he continues to eat some foods, and these can be risk assessed.

*Case Study – Changes to accommodation*

B has profound learning disabilities and epilepsy. He currently lives in supported accommodation. An IMCA was appointed due to the breakdown in relations between B's mother and the Social Worker when the Social Worker proposed a change of accommodation for B. B's mother refused to countenance this. It was deemed that there was no-one 'appropriate to consult' on B's best interests. The IMCA felt that there was no value in challenging this decision as B's best interests were likely to be served by the IMCA process which would allow for everyone's input into the best interests decision.

The IMCA met B on four occasions. B communicated through his actions, but could not communicate verbally. The IMCA was told by B's key-workers that since moving into his current accommodation B was not displaying signs of anxiety. In his previous accommodation B had used to hit himself and shout out loudly. B's key-workers had known and worked with him for over ten years – they told the IMCA that B's health had not deteriorated seriously. He was still capable of enjoying life. They went with B to the pub, to social clubs and out shopping.

It was clear from speaking to other carers at B's accommodation that opinions about his health and long term care were divided. Those in management positions appeared to favour B being moved, for health and safety reasons.

The IMCA spoke to B's mother, who is 90 years old. She explained the IMCAs role and how it was very important that B's mother's opinion was put forward. She agreed. After much discussion she said she would like to attend any future meeting where B's accommodation was to be discussed.

The IMCA also contacted B's GP to seek his opinion. He was adamant that B's needs were not so serious as to require nursing or residential care. He felt passionately that B should not be moved from his current home. He was concerned that no one had discussed this with him previously. He said he would like to attend any future meeting regarding B's accommodation.

The IMCA spoke with the Social Worker about the evidence she had collated. The IMCA suggested a Best Interests meeting would be the best forum for everyone to put forward their opinions. The Social Worker agreed. An evening meeting was arranged to allow B's GP to be available to attend. The IMCA spoke to B's mother, who also agreed to attend.

At the meeting B's mother and his GP expressed their opinions clearly and strongly. It was agreed that it was in B's best interests for him to stay in his current accommodation. This was the least restrictive option. It was also agreed that a hoist would be installed, and sensors placed by B's bed, should he have a fall.

*Case Study – Safeguarding*

D was taken to respite care after concerns from Social Services regarding the quality of care provided by family members, who, due to deterioration of their own needs, were struggling to safely care for their son. Due to D's vulnerability, the risks for him to return home were high, especially as the family was reticent to accept extra help. As the family was engaging positively, a referral to the IMCA service was not considered. However, a safeguarding lead involved in this case raised it at the IMCA awareness session with the staff, and through discussion with the IMCA, identified that an IMCA would enable an independent and client focused view on the person. This resulted in a referral to the service and an IMCA shortly meeting with D. Through the use of simple closed questions, D, over a few sessions, consistently communicated that he wished to return home and being away from home was making him unhappy. The IMCA also consulted with the family to provide some context for D's views, that culturally it was very important for the family to be together and some difficult experiences with care staff in the past resulted in the family taking over the caring responsibilities.

The IMCA discussed with the decision maker and included in her report that articles 5 (right to liberty) and 8 (right to private and family life), as well as the state's limited power in such situations without sanction of the court (Hillingdon v Neary & Anor [2011]), and the balance between risk and happiness. This enabled the area of consideration to shift more towards working with the family to address risks to enable D to return home, which was the ultimate conclusion.

*Case Study – DOLS*

A is a deaf Somali woman with severe learning disabilities. She communicates using informal sign based on BSL which is understood by people who know her. Whilst she was living with her family, a carer made an allegation that she witnessed her being physically abused by a relative.

The subsequent safeguarding investigation resulted in her being moved against her wishes to a mental health inpatients unit (locked ward) pending decisions on her future care. This decision was taken on the basis that she was assessed as lacking the mental capacity to make this and other related decisions. Although there was a record of her having a previous diagnosis of a mental health issue, there was no evidence that such she required treatment in relation to a contemporary mental health issue.

The hospital sought a DOLS authorisation and made 2 consecutive DOLS urgent authorisations as the measures that were necessary to protect her were likely to amount to a deprivation of liberty. A particular factor was that A indicated through her behaviour that she would be likely to leave the ward and would need to be prevented from doing so. The safeguarding authority also perceived a risk of relatives seeking to remove her from the placement.

On admission to the above service A made further allegations of serious physical abuse by carers. These allegations were facilitated by A's carers who understood her and had been made partially available to support her during her admission.

An IMCA was instructed in relation the DOLS authorisation process. The IMCA accompanied A on the ward and when she visited a day service. Based on this and wider enquiry the IMCA made the following observations:

- As the signing carers referred to above were rarely present on the wards, A was unable to communicate her wishes for substantial periods of time.
- A was able to be more independent whilst at her day service. She could communicate more freely, for instance when buying food.
- The DOLS authorisation requests were for a duration driven by meeting dates that were administratively convenient for statutory services, rather than A's health or social care needs.

The key outcomes of IMCA representations were:

- The IMCA gained agreement for BSL relay interpretation to be made available to support A around her care planning, including at key meetings. The IMCA also made practical proposals around the way in which key meetings were conducted to support A's involvement- e.g by asking for the number of attending professionals to be reduced from a large group to a smaller less intimidating group. This substantially improved A's ability to direct her care and support.
- The IMCA questioned the appropriateness of a mental health admission being made for a person without any treatable mental health diagnosis., prompting a consensus that alternative placements should be sought.
- The IMCA gained agreement for the authorisation time frame to be determined with reference to A's support needs, leading to a move to a more empowering community placement within days rather than weeks.

**12.5**

**How will you evidence that you are supporting empowerment and independence of service users with learning disabilities and dementia? Please provide case studies to support your answer. (550 words, not including additional evidence requested)**

An older man with learning disabilities, R had strong ties with the community that he spent most of his life in. However as he got older and his needs increased, he moved to a residential home. Initially R enjoyed the care and security that he received at the home, but over time he became increasingly vocal about wanting to return to his community. At this point a referral was made to the IMCA service as the Social Worker, being made aware of R's changing attitude, needed to review that the home continued to be in R's best interest. When the IMCA met with R, R verbalized his fond memories with his community, and expressed how much he wanted to live there again. However, through consultations from the home staff, his keyworker and home manager expressed how R has very particular needs and that the home is very good to him, and that he won't receive the same quality of service elsewhere. The Social Worker also expressed that there wasn't any appropriate accommodation available in the community that R wishes to return to. The IMCA discussed her approach with her manager, concerned that the risk or possible failure of the move overshadows the likely impact of R not moving. It was agreed that R needs to be central to the solutions, and this can only happen by making him aware of some of the concerns and bringing him into the best interest meeting.

The IMCA took this information back to R, presented some of the challenges and explored whether R would wish to visit his community more often (it was only a short trip away and staff could regularly take him). However R refused stating that he would rather live in a placement in his community that was 'less good', and that remaining where he is was making him miserable. The IMCA noted these findings in her report, which was checked by

her manager, before it went to the Social Worker prior the best interest meeting. The Social Worker also agreed to R attending the meeting, thus the IMCA supported him to present his views, which were earlier discussed. The message was strong and clear at the best interest meeting, that R's unhappiness with his current placement could amount to a deprivation of liberty, and that R was willing to explore and trial arrangements. This led to discussions including arranging more visits (including overnights) to his community while monitoring views, exploring accommodation that may be more restrictive (i.e. fewer staff available per person) but would potentially enable R to be happier, and whether a flat and a fulltime carer would be feasible through a personal budget. This also enabled R to proceed in manner that was not all or nothing, but that he was willing to accept intermediate steps of increasing his time in his community, and having overnights in identified placements to ensure his views remain the same before a longer-term decision was made regarding accommodation. A best interest decision was made to proceed in this manner and it was agreed that if changes arose to what was agreed, the IMCA service would be contacted as this may require a further eligible best interest decision. The outcome was discussed with the service manager and the information was recorded on the database, which shows that he received the outcome that he wanted