7 MINUTE LEARNING

01 Introduction

The Safeguarding Adults Review was commissioned by the Safeguarding Adults Board after 7 residents in a nursing home in Dorset * were found to have suffered serious harm and neglect between 2014 and 2016. The Review examined how this situation occurred, seeking views of residents, family and staff who were involved at the time. The incidents occurred between 2 external inspections however visits were made between these times by health and social care practitioners.

02 Learning: 'What does good look like?

Settings need to be clear that external agency staff, residents and families are aware of the quality of care that should be delivered to residents. Systems need to promote 'good quality care' and people need to feel comfortable to 'challenge' where they feel standards are not acceptable.
It was felt that national and local media highlight negative matters , whilst under reporting of good news resulted in this standard being considered the 'norm.'

03 Learning: Personalisation of care

Residents of care homes are entitled to the same personalisation of care as if they were living in their own home. Assessments and reviews should be equally thorough and not a 'tick-box' exercise to save time.

04 Learning: Escalation of concerns

Lack of multi-agency working and communications contributed to the isolated way practitioners worked, with little or no opportunity to raise concerns. This resulted in failures to escalate concerns. An awareness of information sharing systems could help ensure future concerns are raised.

05 Learning: Identifying and managing contractures

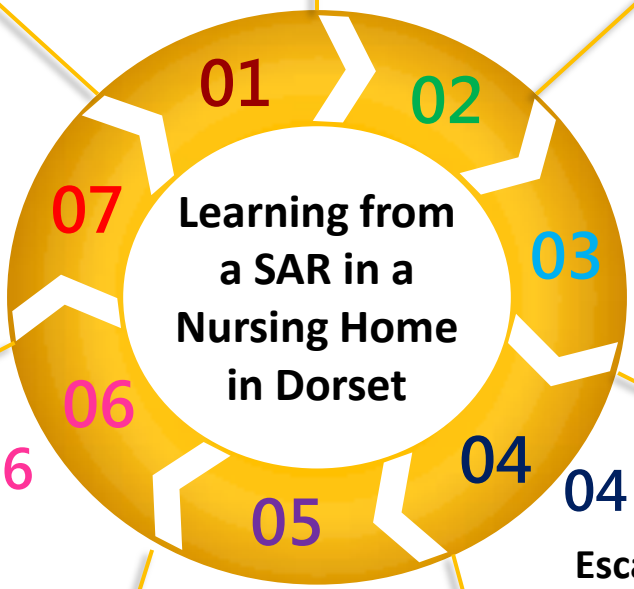
Professionals need to be able to identify and manage contractures. A care pathway should be developed to include equipment and training requirements

06 Learning: Impact of proactive, timely and holistic care

Health and care agencies and GP's should ensure that residents' needs in a care home are seen as just as important as those living independently. Homes should be proactive in designing a way to work with GP's to maximise benefits.

07 What to do next

Discuss these learning points within your teams and examine if systems are in place that would support these outcomes. Additional information on policies and procedures is available on the Safeguarding Adults Boards' websites.



Dorset and Bournemouth & Poole Safeguarding Adults Boards

*Full report available at https://www.dorsetforyou.gov.uk/dorsetsafeguardingadultsboard

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