Dorset Safeguarding Adult Board

Safeguarding Adult Review

Highcliffe Nursing Home

Overview Report

Julie Foster 10th June 2016

1. Executive Summary

1.1 This Safeguarding Adult Review was commissioned by Dorset Safeguarding Adult Board after seven residents of the Highcliffe Nursing Home were found to have suffered serious harm and neglect. These incidents occurred between January 2014 and May 2015, between two external inspections by the Care Quality Commission, a period throughout which a considerable number of visits were made by health and social care practitioners but who did not identify and report concerns. It was agreed that the incidents met the criteria set out in the Care Act 2014 for carrying out a Safeguarding Adult Review.

1.2 The Review sought to understand how this situation developed, using the perspectives of residents, families and staff who were involved at the time. The aim was not to seek to apportion blame but to identify any learning to be used to improve systems and practice in order to protect people better in future.

1.3 The Review took into account the findings of the Whole Homes Investigation, the seven individual Safeguarding Adults Investigations and an enquiry conducted by Dorset Clinical Commissioning Group. Each organization provided a chronology of their involvement. In addition, a number of meetings were held with relatives of residents of this Home, with Home Managers and with practitioners from the health and care organisations involved.

1.4 Highcliffe Nursing Home states that it caters for people with specialist needs, including dementia and end of life conditions. During the period in question, the Home had residents with very severe and complex physical and mental health needs and it was evident from they were not able to meet all the needs of these individuals to an acceptable standard at this time. Relatives were keen to stress that, despite the problems, some good care was delivered. Even when they had concerns, they were reluctant to complain or to consider moving their loved ones, mainly due to a shortage of local alternatives and to previous experiences of poor services elsewhere. The Review found that relatives may not have a clear sense of the standards to be expected in a Care Home, nor how to raise concerns or complaints.

1.5 A lack of understanding about when and how to raise and escalate concerns was also identified amongst some practitioners, including GPs.

1.6 The Home failed to provide good care in many respects response but particularly significant was the lack of managing the mobility of some individuals with advanced dementia, resulting in contractures of the limb. Fortunately, with advice, greater care and the appropriate equipment, this has now been put right and is one of several improvements the Home has made.

1.7 There are several issues that contributed to the deterioration in care over this period. This included the lack of a registered manager since January 2011, a requirement of the Care Quality Commission with which compliance was not gained until 2016. This post is vital to ensure strong leadership and direction to the staff team, leading to a lack of routine and supervision. There was also a high turnover of staff and subsequent difficulties in maintaining skill levels, as well as communication inadequacies.

1.8 It is important to recognise that Care Homes are part of a wider system of health and care services for an individual, with a range of organisations working in

partnership in delivery. The Review found that this partnership was not always strong in that some practitioners tended to see all concerns as training issues internal to the Home rather than difficulties in a shared system of care. This system requires development in true partnership with Care Homes if proactive, personalised care is be provided to manage effectively the needs of people living in them.

1.9 This Review has also identified that the reductions in resources in health and social care are leading to a greater reliance on self assessment and a decrease in face to face work. This may not be appropriate for people with complex needs and communication difficulties and the safeguarding risks to this very vulnerable group are likely to increase if fewer practitioners make visits.

1.10 The main body of this report sets out the process and findings of the Review, ending with a set of recommendations for Dorset Safeguarding Adults Board. However, the overriding issue appears to be the prevailing culture of acceptance and tolerance of poor standards, by those delivering the care and by those who witness the care giving. Dorset is not alone in having this culture. It is a national issue which is reflected in the status and salaries of care givers and the scant regard paid to anything more aspirational than the basic care of older people.

1.11 Whilst there may be many factors contributing to this situation, it is essential that this matter is addressed at local level, from bottom up, and monitored in a robust way. Otherwise, residents of Care Homes will continue to be at risk.

2. Introduction

2.1 The Care Quality Commission (CQC) published an inspection report on Highcliffe Nursing Home (HNH) on 14 January 2014 which found it to be compliant in all aspects of care. However, following reported concerns, an unannounced inspection took place in May 2015 and a report published in August 2015 found significant failings in care provided, deeming to be 'inadequate' in 4 out 5 domains and placing it in 'special measures'.

2.2 During this period between external inspections, a high number of health and social care professionals visited the Home but did not identify that care was deteriorating, or did not act on or escalate these concerns.

2.3 As a result of this situation and the serious risks it presented to very vulnerable adults, Dorset Safeguarding Adults Board (DSAB) commissioned a Safeguarding Adult Review (SAR) under its' operating procedures. The Independent Chair of the Board took this decision on 25 August 2015 at the first SAR Panel Meeting. It was agreed that the circumstances of the case met with the following criteria as set out in the Care Act 2014.

'Safeguarding Adult Boards must arrange a Safeguarding Adult Review when an adult in its area dies as a result of abuse or neglect or has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced abuse.'

2.4 The main purpose of this Review is to understand how care at HNH deteriorated seriously between two external inspections and how external agencies did not recognize this or act sooner. The circumstances of neglect in this Home, and failure by several health and social professionals to identify concerns, led to seven

separate Safeguarding Adult Investigations, each substantiated, and where the individuals concerned were found to have suffered serious harm. A Whole Home Investigation was also held.

2.5 The nature and conduct of the Home over this period has been examined by CQC and a Whole Home Safeguarding Investigation. Detailed reviews have taken place which have identified the significant risks posed by the Home. As a result, steps have been taken to improve the safety and wellbeing of residents and improvement has taken place since this period.

2.6 The most recent, unannounced, CQC Inspection was carried out on 5 February 2016 and was published on 19 April 2016. This validates that significant work has been carried out; the overall rating shifting to being 'requires improvement'.

2.7 The SAR will consider, but does not seek to replicate or re examine work already carried out, in the process of understanding how such a situation developed and how the processes for reporting concerns worked. It aims to draw their findings together those of this Review to present a set of findings and recommendations for action to avoid such a situation occurring again.

2.8 The Terms of Reference (Appendix 1) set out the parameters, structure and purpose of the Review.

3. Methodology

3.1 This SAR follows the Care Act Guidance 2014 (14.137) and reflects the six safeguarding principles:

- Empowerment – People being supported and encouraged to make their own decisions and informed consent.
- Prevention – It is better to take action before harm occurs
- Proportionality – The least intrusive response appropriate to the risk presented
- Protection – Support and representation for those in greatest need
- Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability – Accountability and transparency in delivering safeguarding

3.2 The Care Act 2014 also states (14.138) that the following principles should be applied to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their

perspectives without fear of being blamed for actions they took in good faith; and

- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

3.3 A Safeguarding Adult Review Panel was set up to oversee progress and conduct the work. This was chaired by the Independent Chair of DSAB, and included was members from the key organisations involved, i.e. Dorset Clinical Commissioning Group, Dorset County Council, Bournemouth Borough Council, Dorset Health Care Trust and the Care Quality Commission. An Independent Overview Author was appointed to ensure transparency and provide an independent perspective.

3.4 The responsibilities of the Panel are as follows:

- The Review Panel is responsible to the Independent Chair of DSAB and any unresolved issues will be addressed via the Independent Chair.
- The role of the Independent Chair is to ensure that the right questions are asked and to oversee the development of the Overview Report. An Overview Report Writer will be commissioned by DSAB for this SAR. The recommendations and the report will be from the whole Review Panel.
- The report agreed by the Review Panel will be issued for 'sign off' by DSAB through its Chair. The DSAB will make arrangements to issue the draft Overview Report, Executive Summary, Action Plan and any other relevant documents. DSAB will arrange publication, including appropriate briefings of media, staff and stakeholders. Partner agencies will support this through their communication teams as required.
- The Review Panel is expected to operate collaboratively and reach agreed conclusions. Individual panel members are responsible for liaison with their agency during the review, briefing senior managers and individual staff as appropriate, and ensuring any IMR is delivered, maintaining confidentiality in line with guidance.
- All agencies involved in the review will bear the salary and expense costs of their own staff, meeting rooms etc. External expenditure necessarily incurred by the review, including payment of the Independent Chair and Overview Report Writer, will be met by the DSAB unless commissioned directly by another agency. Such expenditure will be agreed in advance between the Independent Chair and the DSAB SAR Chair.
- All agencies contributing information to the review have a responsibility to share evidence with any appointed police disclosure officer, if there are any criminal proceedings.

3.5 In terms of methodology for the SAR, it was determined that a hybrid model should be used to elicit greatest learning. Traditional chronologies from each organization would be provided initially. Key features of the systems approach, 'Learning Together', developed by the Social Care Institute for Excellence (SCIE), would also be used in order to engage people who were involved with the situation at the time and open up 'a window on the system' and counteract the dangers of hindsight bias.

3.6 Chronologies were received from the following organisations and merged into a single document:

- NHS Dorset Clinical Commissioning Group (CCG)

- Dorset County Council Adult Social Services (DCC)
- Dorset Health Care University NHS Foundation Trust Trust (DHC)
- Care Quality Commission (CQC)
- General Practitioners (GP)

3.7 Learning Together provided a set of principles to underpin the Review. It was particularly important to assure the case group (front line staff involved at the time) that no blame or criticism was intended and that the main aim was to understand what happened at the time in order to determine where learning could be identified to protect vulnerable people in future. This was done through a series of workshops and meetings.

3.8 An initial workshop was held for front line staff on 14 March 2016. 10 people attended, including community nurse, tissue viability nurse, dietician, speech and language therapist, occupational therapist, physiotherapist and social workers. A second, follow up workshop was held for the same group of staff on 13 April.

3.9 One workshop was held on 13 April 2016 for the managers of staff involved.

3.10 In order to get the views of the residents and families, the Author invited all concerned to meet with her at HNH on 15 March 2016, or to arrange a time to telephone. This resulted in five face to face conversations at HNH with family members and one telephone conversation. None of the residents expressed a wish to meet with the Author but this was not surprising as most residents were very disabled due to dementia or other serious conditions.

3.11 A meeting was held with the Locality Operational Manager, the Home Manager and her deputies at HNH on 15 March 2016.

3.12 Alongside the information gained directly from the chronologies, individual management reviews and specific events, this Safeguarding Adult Review will also consider the findings of other key investigations. This includes seven individual resident Safeguarding Adult Investigations, a Whole Homes Investigation and Care Quality Commission Inspection Reports.

4. The Care Setting

4.1 HNH is run by Althea Healthcare Properties Ltd under the overall brand of Kingsley Healthcare Ltd. This organization owns 15 Care Homes catering to a variety of health and care needs. It is a national organization operating across several counties with a head office in Norfolk. Kingsley Healthcare Ltd is an expanding organization, seeking new properties to add to the group.

4.2 HNH is registered with CQC as a privately owned care home with nursing which can take 46 residents, with 28 single rooms. The Home is described on its' website as providing *'specialist care in an idyllic coastal location… a very comfortable and friendly registered nursing home set in one of Dorset's most prestigious areas, Highcliffe-on-Sea. The home occupies an enviable position on one of the resort's quiet residential streets only a short distance from award-winning beaches and impressive cliff top views. The home offers high quality specialist nursing, residential, dementia and end of life care, with respite care also offered'.*

4.3 At 14 May 2015, HNH provided care for 36 residents. This included people who were self-funding, funded by Continuing Health Care (CCG) and those funded by Local Authorities of Dorset, Hampshire and Poole

4.4 HNH states that it specialises in caring for people over 65 with dementia, mental health conditions, old age and physical disability. The website state that it also offers diagnostic and screening procedures, treatment of disease, disorder or injury

4.5 The service comprises a ground and first floor providing accommodation. There are 46 bedrooms, 28 are single rooms of which 13 have en-suite facilities. Nine are double rooms of which four have en-suite facilities. The ground floor has two lounge areas one of which gives access into a secure garden area, a dining room and a conservatory. On the first floor there is a small dining room, which can accommodate four people, and a small lounge that can accommodate five people. There is a lift and staircases to the first floor. The service has specialist bathrooms, a kitchen, sluice and laundry facilities.

5. Care Quality Commission Inspection Reports

5.1 January 2014 (published April 2014). The service was inspected on the 14 January 2014 and found to be meeting the required standards.

5.2 Key points: There was no registered manager in post. The acting manager had been in post for three years.
Staff sought various ways to gain consent to their care and treatment from people and they treated them with respect and dignity. Where people had difficulties in making decisions the correct procedures for acting in people's best interests were put in place. Care records relating to people documented that people's wishes had been taken into account in planning their care, with the help of relatives if necessary. Care was delivered in a way that promoted people's independence. Although staffing levels were generally adequate there was no member of staff responsible for coordinating activities for people resulting in few activities for people to do. Whilst most staff were experienced, some had little formal knowledge about the terms "safeguarding" and "whistleblowing"; they had received training in this.

5.3 May 2015 (published August 2015). The service was placed into special measures as the overall rating of the service was inadequate.

5.4 Key points: People had not received safe or high quality care and the provider had not met a number of the fundamental standards. Improvements were needed in a variety of areas including staffing, management of medicines, management of risk, management of health and safety, staff training, management of people's legal rights, treating people as individuals, management of complaints, having a registered manager and notifying CQC of significant events.

5.5 February 2016 (published April 2016).This inspection was carried out AFTER the period of review but is included here to highlight the ongoing position. The service was rated as requiring further improvements , but significant improvements had been made.

5.6 Key points: Significant changes had been made. However, further improvements were needed in staffing, management of risk and safety, treating people as individuals and establishing a registered manager. It is a condition of registration with CQC that a home has a registered manager in place.

5.7 A significant concern has been the lack of a registered manager in post, a situation which had been ongoing since 24 January 2011. Although a manager has been in post since May 2015, their application for registration had not been submitted to CQC until November 2015. A registered manager is a legal requirement, a person who has registered with the Care Quality Commission to manage the service. This person has a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Given that effective and responsive leadership is a recurring theme throughout the recent inspection reports, as is the lack of staff direction, it is of great concern that Kingsley Healthcare Ltd permitted this situation to continue in one of its' establishments. It is also of concern that CQC were unable to enforce compliance. Effective leadership is perhaps the most important ingredient in ensuring safe, good care in a residential setting and the lack of it at HNH may have been the single most significant reason underlying the serious conditions during the review period.

6. The Whole Home Investigation

6.1 An Enquiry Planning Meeting was held on 29 May 2015 when it was agreed that eight of the alerts received by the Safeguarding Adult Team in respect of residents at HNH would progress to investigation under Section 42 of the Care Act 2014. It was also decided to hold a Whole Homes Investigation under the Dorset Multi Agency Safeguarding Adults Policy.

6.2 The focus of Whole Homes Investigation was, primarily, on the way in which care was delivered within the Home. Key areas were:

- Concerns about manual handling and management of contractures, which affected five residents
- Concerns about nutritional needs around fortified and special diets and recording of food provided
- Risks of malnutrition and recording of Malnutrition Universal Screening Tool (MUST) scores
- Inadequate care plans, risk assessments and case recording
- Risk of pressure sores
- Insufficient staff on duty to meet needs of the resident group

6.3 The Final Meeting Minutes document good attendance and engagement from both HNH managers and local organisations in investigating key areas. Robust plans were put in place in which local health and care professionals supported the Home in making the improvements necessary. For example, regarding manual handling, The Home reviewed and updated care plans for each resident and purchased and deployed the relevant equipment following assessment and guidance from Occupational Therapists from Dorset, Poole and Hampshire Local Authorities and NHS Dorset. Repositioning charts were implemented and the importance of monitoring these highlighted to any visiting inspector or health and social care professional.

6.4 A further report was made to the Investigation with respect to concerns raised about the standards of care provided by GPs. Following investigation, it was considered that their approach was reactive rather than proactive, record keeping could be improved in regard to clinical information and Safeguarding Adult training could be increased. However, it was found that the practice had not been negligent in their care. Recommendations about a more proactive approach to care, including the introduction of weekly 'ward rounds' were made and will be considered further later in this report.

6.5 The final meeting took place on 15 September 2015. The chairman concluded that the risks had been reduced significantly and that this was down to the team at HNH and professional support. He acknowledged that the situation that arose was extremely concerning and the impact this had on the residents, but that it had moved forward in a positive light. He noted that the safeguarding role would now be concluded.

7. Health Review

7.1 Dorset CCG carried out an Individual Management Review as part of this Safeguarding Adult Review, conducted by their Designated Safeguarding Manager (DASM) and a named doctor for Safeguarding Adults. This relates to the Safeguarding Adult issues raised at HNH between 14 January 2014 and 10 August 2015 and covers the activity in respect of the 7 named residents who were found to have suffered serious harm following Safeguarding Adult investigations under Section 42 of the Care Act 2014. Their review included detailed accounts of the issues for each patient and a survey of all GPs who had patients in the home during the agreed review timeframe to obtain information on the quality of the care that the home delivered. In addition, in order to review the quality of GP interactions and responsiveness to concerns, a random audit of medical records for all practices involved was conducted.

7.2 When the initial concern/enquiry was raised, Dorset CCG were commissioning 17 funded nursing care placements, 4 Continuing Health Care placements and 2 placements under Section 117 of the Mental Health Act.

7.3 Five GP Practices had a total of 67 patients resident at the Home during this period, the vast majority belonging to Highcliffe Medical Practice. This Practice recorded 741 contacts with 51 patients during this period. Information from the others was incomplete. Highcliffe Medical Practice also reported carrying out 69 over 65 checks on their patients there.

7.4 From the survey, GPs highlighted some areas of concern about the Home, including language and communication with some staff members and issues regarding the repeat prescription administration process and these were discussed with the Home. However, the overall view was that the 'culture was no different to any other care home that the GPs visited'. They considered that the Home sought advice appropriately, if prematurely at times, and that they kept to their policies and procedures regarding the wellbeing of very frail, elderly residents with complex needs. They had no major concerns and considered that residents' basic needs were being met.

7.5 A GP would review a resident in response to a concern from the Home and they reported that contractures made examination very difficult. The report provides examples of where the GP sought input from other health professionals about the

management of contractures. In one case, a specific chair and sleeping system was recommended but does not appear to have been used as the Home considered that the resident's behavior was too difficult to be managed if he was up and about. It is stated that the GP did not feel it was his responsibility to challenge this. This restriction of the residents' freedom to move constitutes a deprivation of his liberty and should have been assessed formally by a qualified person under the Mental Capacity Act/Deprivation of Liberty Safeguards legislation. This is a very serious issue and could have resulted in legal proceedings.

7.6 Over 75 checks were carried out proactively but they do not include a full medical examination and focused on specific issues.

7.7 The GPs stated that if they had concerns, they would report them to the clinical lead or to the registered manager at the Home. They suggested that they had no other route to report concerns, apart from Safeguarding. The GPs did discuss their concerns about HNC in their Vulnerable Patients Meeting but did not consider that they met the threshold for onward referral to Safeguarding Adults.

7.8 One GP had a patient in severe dental pain and appropriate pain management and treatment was required in his best interests. The resident lacked capacity to make this decision himself. A decision was therefore made on his behalf by his GP. However this was done without consulting his relatives, nor was it documented properly, thus not following the processes under the Mental Capacity Act 2005. The GP recognized this issue and sought additional guidance.

7.9 The Management review concluded with a set of five findings for the single agency. These were:

- Delays in CHC assessments being completed
- Lack of co-ordination of individual care between agencies and silo working
- GPs had concerns which they raised with the Home but did not seek outcomes
- GPs felt they had no avenue for onward reporting beyond clinical lead/registered manager if not safeguarding
- Consideration of initial assessment on arrival at Home and registration with new GP to ascertain care and minimize contractures.

7.10 A GP view on why the care deteriorated was that the Home had an unusually high number of residents with complex, end of life requirements and it was considered that this put exceptional strain on the staff and service. Others considered that HNH was known to take residents who other Homes would not and that there were no safeguards in place to ensure that the Home could manage the needs of these residents.

7.11 It is clear that the GPs had many contacts regarding their patients in this Home during the review period and provided treatment on a wide range of issues, including contractures. Despite this, seven residents were deemed to have suffered serious harm over this same period, caused by failure to manage their conditions effectively. Contributory factors in this may have been the lack of a proactive and holistic view of the patients' needs. There is some evidence that steps to identify and secure appropriate care were taken but that there was a lack of clarity as to who should be held to account to deliver that care when it did not materialize.

7.12 In terms of recommendations to be picked up in the SAR, Dorset CHC suggested that GP practices will need to consider offering a more proactive role to Homes, given they have received additional funding for their over 75 year old patients. This could be through weekly ward rounds which are in place in other Dorset practices to aid the building of good working relationships. It was also acknowledged as a learning outcome for the surgery, that their care plans and documentation could be more comprehensive in providing clinical information.

8. Individual and family experience

8.1 The Terms of Reference requires that the lived experience of the residents was a focus of this Review and the Care Act 2014 places emphasis on this. Unfortunately, it has not been possible to gain this at first hand as the majority of the residents concerned suffer from serious mental and physical conditions which impact significantly on memory and ability to communicate.

8.2 In order to gain some understanding of their experience, the chronologies and Safeguarding Adults Investigation records were considered. It speaks for itself that all seven investigations were substantiated with evidence of neglect. There are many accounts of situations in which residents would have experienced severe pain and distress. Examples include the limb contractures caused by incorrect positioning and care; the 'rotting teeth' and dental appointment delayed for two weeks whilst the resident was, according to the dentist, in considerable pain; the frequent falls experienced by some residents. Other than that, one can only assume that the poor care and lack of supervision in a Home containing several residents with 'behaviour that challenged' must have made it a very frightening and confusing environment in which to live.

8.3 The voice of the resident is heard, albeit at second hand, in one entry in the CQC Chronology dated 12 May 1014. This records a report to CQC from a visitor to the Home who said that two service users had told them that the Home was terrible and they wanted help to escape. Another said that they did not get proper meals.

8.4 In order to gain relatives' views letters were sent to all residents and their families or representatives inviting them to talk with the Author at HNH on 15th March or by other means. As a result, four relatives attended individual conversations with the Author; two following up with telephone calls or emails with further thoughts, and one was spoken with at length on the telephone. Of this five, only one had direct experience of the Safeguarding Adult process although the others were all aware of these, albeit without detail. Two people had been involved in moving their relatives from other Homes where the care provided was very poor. Despite the concerns at HNH, they both considered the care there was an improvement on what had gone before and that they would be reluctant to move their relatives unless they were forced to.

8.5 All relatives who attended the meetings or telephoned lived close to HNH, the location of the service being of prime importance to them as they could visit daily on foot. The wife of one resident visited at lunchtime each day and valued this opportunity to stay involved with her husband's care. Another expressed regret at not being able to care for her father at home herself but liked to call in regularly. Another expressed relief at not having to visit daily to check her fathers' welfare now that care had improved.

8.6 All relatives had noticed a change in the quality of care provided over the past six months. Comments included 'the care gets better and better'; 'communication and trust is better'; 'the carers work more as a team and are therefore more confident'; 'care is less rushed and chaotic';' no major issues'; 'brilliant'. One relative was delighted in the improvement in her mother's responsiveness. She had advanced dementia but the increased care and support from staff had enabled her to participate more in activities – 'a real bonus'.

8.7 One relative was angry about the quality of the care records as she considered that lack of written evidence about her fathers' needs had led to a refusal of Continuing Health Care (CHC) funding. She was concerned that, even now, records may not be accurate as staff are still under pressure and do not have time to carry out some care as required, although it is recorded as such. This person was concerned about fee levels, which she considered high, with two rises over the past eight months, and she wanted to see value for money.

8.8 One relative was concerned about the poor communication with the Home in the past, with treatment for his fathers' cancer having been started and stopped without informing him. He considers this is better now and he has developed a good relationship with the Manager. He said that he did not like to be seen as someone who complains a lot or grumbles unnecessarily.

8.9 This same relative whose father was subject of an individual Safeguarding investigation) commented that, in the past, his father was allowed to lay in bed in the dark all day. This has now changed and he is encouraged to get up with special equipment.

8.10 One relative had current concerns about the care, having discovered her father in bed covered only with a thin sheet with a window wide open in February 2016. He was admitted to hospital shortly after. This complaint was being investigated at the time.

8.11 In one case, the advice of a Speech and Language Therapist to thicken all liquids and food for his father was queried by a relative. Although he accepted that there was a risk of choking, he sat with his father whilst he ate slowly under his supervision. He considered this gave his father more dignity and questioned whether the required thickening of liquids was to help the care staff to save time rather than a true need. This matter was under discussion with the Home at the time. It raises the issue of making an informed choice, weighing up the benefits and disadvantages, or making a best interest decision on behalf of a person lacking capacity to take a risk. The son and the Home need access to the facts and professional opinion in order to reach a decision in his fathers' best interests.

8.12 When asked about the wider system of care of which HNH is part, relatives had few comments to make. They considered that GPs and other health and social care services were called and responded appropriately. One person considered the CHC assessors very harsh as they refused to consider verbal accounts from staff regarding her fathers' needs in the absence of written records. The son of the resident subject to a Safeguarding Adults Investigation said that he was unaware of the process until it was over. He regretted this as he said it was important, but did value a meeting with the social worker responsible who informed him of the conclusion and actions planned.

8.13 The chronologies were examined for further evidence about concerns from relatives, particularly those with residents directly involved with Safeguarding who

were under represented in the sample who made contact. There is some evidence of concerns being raised by relatives e.g. GP record on 'family wanting ears syringed urgently'; a call to CQC regarding 'couldn't be bothered' attitude of staff towards resident with dental pain. However, given the circumstances at the time, there are very few reported concerns from relatives.

8.14 The Review Overview Author is indebted to the relatives who took time to talk about their experiences. The views expressed about the Home were mostly positive and it was clear that they felt a need to present an alternative view to balance the negative perceptions which had given rise to the Review. These relatives wanted the Home to be seen as better than it was portrayed in the CQC Report and certainly improving. They had a vested interest in this Home being seen as successful. They relied on the Home to care for people with very high levels of need, for whom they were unable to care themselves, a service they knew was in short supply, with few, if any, local alternatives. They had chosen this Home for their relatives, so felt responsibility for placing them in the situation. They had also invested a great deal of emotion and trust in the Home, mixed with guilt in some cases that they could not look after their loved ones personally. Some said they felt 'part of the team'. Some had previous poor experience of Care Homes elsewhere and wanted to avoid the upheaval and distress of uprooting very vulnerable people to another Home which may not be any better and may be less conveniently placed for visiting.

8.15 It is also suggested that relatives may not express concerns as they are unaware of the standards of care that should be met. They may have had no other experience of care against which to judge it. It can also be said that the national culture regarding care of older people fosters low expectations and there is little aspiration to anything more than basic adequate care. Care workers are often perceived as having low status with low pay. This combines with the other factors raised previously to disempower the relatives of vulnerable people from insisting on better care.

8.16 This is a key issue to emerge from this Review and shows that there is not a reliable safety net in place for the extremely vulnerable people living in Care Homes. Their friends and relatives, who are likely to be their most frequent visitors, do not always identify concerns and risks and report them to the statutory organisations. A further factor is that statutory organisations have plans to reduce face to face contacts in many areas. This may place Care Home residents at much higher risk and requires addressing at the highest level.

9. The Work of the Organisations

9.1 Information about the work of the organisations during the period covered by the review was provided through the chronologies submitted and through the Independent Management Review completed by Dorset CCG. It was also the focus of workshops in which frontline staff and managers from all organisations participated. Key episodes and themes from their experience were identified. Twelve front line practitioners and ten of their managers attended 3 half day sessions. Feedback submitted after the event was very positive, with all participants who returned their forms stating that they 'agreed' or 'agreed strongly' that involvement in the process was very useful both personally and professionally and they had felt well briefed and supported to express their views and to participate.

9.2 The stated aim of the workshops was to gather information about 'the view from the tunnel' and to understand the experience of staff working with HNH at the time. A key aim was to hear first hand whether staff had concerns about care and, if so, what action, if any, had they taken. The use of 'Learning Together' methodology offers us a 'window on the system' and the opportunity to extrapolate wider, more general findings from the detailed focus on individual residents and cases. The multi-agency and multi-disciplinary staff group engaged well and were able to identify a range of issues which were of concern.

9.3 A long list of concerns about failings in care in the Home was collated, which the frontline staff group saw primarily as the responsibility of the Home and its' Management Company. This included concerns about the following:

- The care environment: cleanliness of bedding; residents left in bed; lack of infection control measures and dignity in shared rooms; a lack of care equipment and inadequate maintenance; no written information about special diets; poor security with door left unlocked and visitors allowed access without checking identification; falls alarms ignored.
- Staff and management: poor leadership and communication; language issues; referrals made en bloc to Speech and Language therapy and Dieticians when needed for records rather than individual needs; confused referrals and messages; a series of new managers adding chaos and no knowledge of residents; no link workers to residents.
- Training and awareness: lack of adherence to advice on use of equipment; poor awareness of wound care; failure to call appropriate help after fall; lack of insight into clinical signs of infection, tissue viability and wound care; poor understanding of contracture prevention and management; failure to understand thickening of fluids etc. despite training.
- Record keeping; paperwork incomplete or inaccurate; inadequate systems and equipment for records; lack of risk assessments, capacity assessments and best interests decisions.
- Responsibilities and proactivity about residents' welfare: lack of challenge over incorrect prescriptions or regarding GP actions.
- Supervision of residents: complex conditions and behavior that challenged; arguments between residents not managed; limited supervision of advanced needs and cognitive issues.

9.4 The majority of these issues have been acknowledged and managed within the CQC Inspection and follow up process and the Safeguarding Adult Whole Homes Investigation. It is included here to show the severity of the concerns arising during the Review period.

9.5 Particularly relevant to this Review are the concerns raised about the wider system.

- It was felt that referrals regarding people in care homes were often seen as less urgent than those received for people in their own home, both on an individual practitioner level in prioritizing workload and from the agency's allocation system. (E.g. seating referral received October 2014 but not allocated until January 2015).
- Requests made by health practitioners to GP for blood tests were not always done, nor were they chased up by the Home when they had a copy of the request. GPs did not always acting on letters of recommendations from health professionals.

- No statutory social care reviews had been carried out in HNH since 2012.
- Practitioners were doing what they should be doing as individual workers/agencies but records were all electronic and agency specific, with little sharing of information or multi-agency discussion.

9.6 Given this list of serious concerns, why did the practitioners involved not act on or escalate them sooner? Many of the practitioners involved at the time had concerns about the way the Home was working with them on the issues with which they were dealing. For example, speech and language therapists offered training in thickening fluids to reduce choking risks but the training was not assimilated; community and specialist nurses offered training and support with suture removal but the skill level of HNH nursing staff did not improve. Practitioners went to some lengths to follow up their training and advice and experienced some frustration, but **at the time**, they were unaware that their colleagues from other professions or agencies were experiencing similar problems as there was no clear means of doing so. They doubted whether the concern with which they were faced warranted referral to Safeguarding, which was the main means of escalating concerns open to them. They were unaware of any other process

9.7 The managers of the practitioners highlighted lack of awareness about the process of escalation although they were aware of the multi agency Safeguarding Adult Policy There was some difference in practice currently about trigger points for referral. Managers also felt that a new system to capture a range of information about Care Homes (RIFT) had potential to improve information sharing.

9.8 It was also identified that there is not a Care Pathway in place for Contractures. There is a lack of guidance on how to identify people at risk, when and to whom to refer for specialist input. A successful pathway is in place for falls.

10. Views of Highcliffe Nursing Home Management

10.1 The Author met with the Management Team on 15 March 2016 during a one day visit to the Home, when staff, residents and family were also invited to meet with her. The managers were positive about this visit from the start, offering a private room for the purpose and participating actively in identifying and encouraging people to attend both beforehand and on the day.

10.2 A new Local Operations Manager has been appointed in the past six months with a background in health and social care commissioning and contracting. This gives her a very useful perspective for the Home and the wider Kingsley Healthcare organization. Her role includes responsibility for HNH and one other Home in Dorset. The Home Manager came into post at this Home six months ago, but she had worked in other roles in Kingsley for 8 years previously. Her deputy has been in post in the Home for 8 years but in non-management roles, including administration. A restructure of management roles has taken place since the events under review with a further part time management post included to oversee buildings work and developments, removing this from the Local Operations Manager post. This was as a direct result of learning from the Investigation and increased the capacity of local managers to respond to local care issues.

10.3 The focus of the meeting was on the wider system of care, of which Highcliffe is part, rather than a reiteration of the issues which have been managed through the Whole Homes Investigation Action Plan and subsequent monitoring.

10.4 The managers participating in the conversation were open and transparent about the failings of the Home in the past. They were not defensive and made no excuses, although they were keen to provide their perspective on events. They described the set of circumstances which they believe contributed significantly to the issues. These included several changes in management and inconsistent leadership, high levels of vacancies and subsequent use of agency staff, inadequate recording systems and disruption from ongoing building work.

10.5 The local team in place at HNH at the time found the multi agency inspection in May 2015 a very stressful experience. In accordance with local Dorset practice where multiple concerns exist about a Home, a team of ten people from statutory organizations, including CQC, made an unannounced visit over 2 days. Although the reasons for the inspection are understood, the process was experienced as being particularly difficult due to a lack of co-ordination between the members of the inspection group, with nobody taking overall lead. This resulted in numerous demands for copies of documentation, duplicated for different members, and an apparent failure to recognize that staff had to provide ongoing care to residents as well as providing information and responding to the inspection group. Some members of the team were said to be rude and demanding. The acting manager was said to be overwhelmed and collapsed at the end of the day.

10.6 The management team stated that relationships with external organisations were improved greatly since the Safeguarding Adults processes. They find that they are all helpful and responsive, which they considered was not always the case previously.

10.7 Highcliffe managers are working to improve relationships with both external organisations and the local community. They hold Christmas and other local events to draw in local people but these are not well attended. A regular monthly Provider Forum has also been established at HNH to monitor the improvement plans in place, to which the wider group of health and social care organisations are invited. This is in its' early stages and is slow to develop. The Safeguarding Adults Team always sends a representative but other agencies may not.

10.8 The managers felt that they were reaching out to engage but there is not much response. They feel that others, especially the media, are quick to criticize but slow to recognize the improvements made and lessons learned. The Investigation has impacted severely on their business, with embargoes in place. Concern was expressed about the publication of this Review.

11. Findings and Themes

11.1 The following set of findings are taken from all the separate sources of information available to this Review and will provide the basis for the recommendations for action. It should be noted that this Review will not duplicate the work carried out by other investigations, although it will incorporate their findings, and will move from detailed to wider, more general themes.

11.2 Partnership with the Independent Sector. There is some evidence that the statutory organisations did not regard HNH, a non-statutory, independently run

service, as a genuine partner in care with them. Many frontline staff saw the failings of the Home as solely down to poor management, a reluctance to spend money, training and attitudes. Whilst there may some truth in this, it is not the whole picture as other organisations contribute to care, so it is vital that a greater sense of partnership working is achieved as the mixed economy of health and social care is part of national policy and here to stay. There is an onus on Care Homes to ensure that high standards are met in every respect so that the inspection and policing element of commissioning can be minimized and replaced by true partnerships i.e. they must be able to be relied upon.

11.3 Culture and expectations of older people's care services. There is anecdotal evidence that external agency staff, residents and families had low expectations of the quality of care that should be delivered to residents in HNH. This may be replicated nationally and locally as media frequently highlight negative matters whilst under reporting improvements and positive care. There may not be a clear understanding of 'what good looks like' throughout the system, resulting in poor standards being accepted as the norm, and a reluctance to challenge if there is no clarity about what is acceptable.

11.4 Personalisation of Care in residential settings. It is equally as important to offer an individualized service to residents of care homes and other multi-person settings as to people living in their own homes. There are examples of actions that HNH sent batches of referrals to the Speech and Language Therapy Team instead of referrals for individuals based on their needs. Statutory services staff also expressed the view that, with an increasing lack of funding, systems are being introduced which may undermine thorough assessments and reviews. The increase in telephone work planned in many services may lead to reviews becoming reduced to 'tick box' exercises. There is a backlog of statutory reviews and in future Residential homes may be given responsibility to carry out reviews for their residents and submit them to the statutory services. These changes will lessen the focus on the individual and may deny them the opportunity to participate if face to face involvement is not in place.

11.5 Increased Risk. Fewer visits to Homes by health and social care practitioners will also increase the Safeguarding risk to residents. CQC uses data and information from a variety of sources including visiting staff and public to help them plan their inspection activity. . In this case, CQC's continual monitoring of the service between inspections did not indicate a risk to people using the service as there were few concerns expressed. CQC target their resources where the highest risks are perceived.

11.6 Disempowerment and the need for resident advocacy. There is evidence to suggest that, although families and representatives of residents might be seen as well placed to raise concerns and advocate for their loved ones, their positions are seriously compromised by the lack of choice of placements and their anxieties about having to face a move. Further work to disseminate the findings of this, and other, Serious Case Reviews to front line staff is required.

11.7 Failures to escalate concerns. The lack of multi-agency working and communications contributed to the isolated way in which practitioners carried out their work, with little or no opportunity to share concerns. Different agencies may work to different policies with different trigger factors and with different reporting systems. There was a lack of awareness about an information sharing system that exists for concerns that do not reach the criteria for a Safeguarding Adult alert.

11.8 Lack of registered manager. Effective leadership was said to be lacking at the Home and there is plenty of evidence to state that this is essential for any successful service or team and could be perceived as a significant factor in this situation. It is suggested that the absence of a registered manager is challenged robustly by CQC and commissioners, with recourse to legal proceeding if necessary.

11.9 Proactive, timely, holistic care – health and social care agencies. Practitioners said that they considered a person in a residential setting to have needs of a less urgent nature than those in their own homes i.e. they were 'safe'. This Review has demonstrated that this is not true and that real harm can befall a resident if their needs are not met. This view may be reflected also in the office systems for prioritizing incoming referrals for allocation and longer waits for interventions may arise for people in care settings. (It is recognized that waiting times may be longer than desirable for many cases.) Once allocated, the practitioner would deal with the presenting need but may not have time to consider other issues. Added to this are the delays in completing CHC assessments/ reviews and delays in completing Social Services reviews.

11.10 Proactive, timely, holistic care –GPs. Residents at HNH have their own choice of GP, resulting in five different practices being involved. New residents from other areas are usually registered with one, which has the majority of registrations. This creates complexities in the implementation of potential responses, for example a link GP arrangement, or regular ward rounds. However, a more proactive system needs to be in place if residents are to receive comprehensive health care which safeguards them from harm. The Home itself needs to be part of designing a way of working with GPs to maximize the benefits. It may also be wise to review the format of the 'over 75 check' which may not include important issues relevant to safety and well being of older patients with complex conditions or at end of life. Practitioners also stated that information about the resident was often not clear on arrival, with a lack of notes and plans to hand.

11.9 Home as 'keyworker'. It has been stated previously that system of reviews may not be completed as planned, creating a potential hole in the safety net for the residents placed or funded through Social Services or CHC. It is unlikely that any resident will have a statutory services care manager or key worker in the long term. The position may be worse for individuals who fund themselves and who receive no monitoring from any statutory agency. For all residents, the Home is considered the keyworker in terms of coordinating their care, communicating and advocating and making referrals for specialist input where necessary. It is apparent that HNH did not always carry out this role effectively. This is of concern where other agencies do not have resources to be proactive and rely on referrals.

11.10 Mental Capacity and Advocacy. There was little reference to the mental capacity of residents during this Review, despite the fact that it was evident that a large number of individuals were lacking capacity around many decisions. However, in its' most recent report, CQC has stated that the service is working within the principles of the Mental Capacity Act 2005. Care plans included details of a person's ability to consent and where they were unable to best interest decisions had been made. The manager was aware of which people had a power of attorney in place and the decisions they could be involved in on behalf of their relative. A GP has also sought additional training. Where a person is considered to be Deprived of their Liberties formally, the legislation requires the appointment of a Relevant Persons' Representative and/or an Independent Mental Capacity Act Advocate. Where capacity is present but understanding not full, the Care Act 2014

requires consideration of the appointment of an appropriate advocate. These roles would be additional safeguards for residents, able to provide or support families or individuals to challenge.

11.11 Contractures. It is evident that there is a lack of knowledge and some misunderstanding about the early identification and management of contractures amongst most professions. It would be helpful to develop a care pathway, including information about equipment requirements and how these should be funded.

11.12 Equipment. There appeared to be a disconnect between contracting and front line staff from different agencies and home managers about the range of equipment that should be provided as standard in residential homes, particularly those registered to provide nursing care, and equipment for special needs over and above this. This is set out both in the Residential Care Home Contract and in a multi agency policy. A Single Equipment Store is also in place.

11.13 In conclusion, the overriding issue appears to be the acceptance and tolerance of poor standards, by those delivering the care and by those who witness the care giving. This finding has emerged in other Serious Case Reviews across the country and is not confined to Dorset. However, it needs to be managed at a local level so that residents and their relatives, front line staff, Care Home staff and the public understand what constitutes good care and empower them with information about what to do if they notice anything of concern.

11.14 There are many factors contributing to this situation as described in this report but unless this principle issue is addressed and monitored in a robust way, residents of Care Homes will continue to be at risk.

12 Recommendations				
No	Recommendation	Actions Agreed	Lead Responsibility	Timescale
1	Review the role of the residential home as part of an inclusive system of care delivering high quality, personalised care. To include: • A charter with clear standards for residents, families and visiting staff about what to expect and what to do if the Home does not meet them. • Self governance and self reporting mechanisms for risks and concerns – a safety thermometer. • Quality assurance measures to ensure the Home can meet the needs of its' whole population, especially where residents have behaviour that challenges. • Keyworker role of Home • Individual resident 'plan of care' shared with an inputted by visiting professionals • Relationships with other parts of the care system and their practitioners			
2	Ensure that the requirements of the Mental Capacity Act 2005 are embedded in practice across all agencies, including the appropriate use of advocacy			
3	Put in place a Care Pathway for the early identification and treatment of contractures		.	
4	Move towards greater integration between professions and organisations to shift away from 'silo working' and the risks of practitioners operating in isolation.		.	
5	Develop a proactive system to provide more comprehensive healthcare to residents of Care Homes. Review the areas considered in the Over 75 Check.		.	

6	Develop shared feedback mechanisms to capture low level intelligence on care home provision from visiting practitioners. Practitioners need to be aware and trained in the system. One pan Dorset harmonised system should be developed.			
7	There should be a greater role for care home registered owners. Staff with concerns should be able to speak to them, not just to managers. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 enforces a duty of candour on care home proprietors. This should be part of contractual arrangements.			
9	Ensure that changes in local policy and reduction in resources do not result in systems which compromise the safety of residents of Care Homes (e.g non-prioritisation of care home referrals; delayed reviews; telephone replacing face to face interventions.)			
10	The pan Dorset Safeguarding Adult Policy should be reviewed to include Escalation.			
11	a) Safeguarding training should stress to all professionals their duty of care and the need to be alert and vigilant to risks in all settings. b) Safeguarding training should stress the need to consult relatives or representatives from the start of any processes where the individual lacks capacity or has consented to sharing this information.			

Appendix 1 Terms of Reference

DORSET, BOURNEMOUTH & POOLE SAFEGUARDING ADULT SERIOUS CASE REVIEW

TERMS OF REFERENCE

Action Control Sheet 1 **SAR (*No.*)**

Subject: *Highcliffe Nursing Home* **dob N/A**

Alleged Abuser: *N/A* **dob N/A**

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1. Introduction

A CQC inspection report was published 14th January 2014 and the home was found to be compliant in all aspects of care. A joint contract monitoring meeting between Dorset County Council and Dorset Clinical Commissioning Group in March 2015 raised serious concerns about the home. An unannounced CQC inspection took place and a subsequent report published on 10th August 2015 which found significant failings in care provided and the home was deemed inadequate in 4 of the 5 domains and placed in "special measures".

Seven residents were subject to S.42 Safeguarding Investigations in May 2015 and were found to have suffered serious harm.

SAR Criteria

A request to hold an SAR was made to the DSAB Independent Chair on the 9th July 2015 and considered at the SAR panel meeting on 25th August where the Independent Chair took the decision to hold a Safeguarding Adults Review. On initial inspection this case fits the Safeguarding Adults Review criteria as follows:

Safeguarding Adult Boards must arrange a Safeguarding Adult Review when an adult in its area dies as a result of abuse or neglect or has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect.

2. Panel Membership

The Safeguarding Adults Review Panel
will comprise:
Jane Ashman (independent Chair)
Matt Wain Dorset Clinical Commissioning Group (deputy chair)
Sally Wernick Dorset County Council
Hayley Verrico Bournemouth Borough Council
Fiona Holder Dorset HealthCare Trust
Rian Gleave CQC (to be confirmed)

3. Time Parameters for Review

Each agency to submit a chronology of events and contacts with any or all of the 7 individuals and any general contacts with or about Highcliffe Nursing Home between 14.01.2014 and 10.08.2015. A standardised chronology format (attached) will be used.

4. Structure of Review

This review will be undertaken within a hybrid model of the systems methodology developed by SCIE and a traditional chronology of events. The independent reviewer will be expected to hold workshops with key frontline staff and first line managers, informed by the combined chronology to explore the circumstances and extrapolate the learning. A report will be drawn up with any recommendations for change.

The main purpose of the review is to understand how care at Highcliffe Nursing Home seriously deteriorated between two external inspections and external agencies did not recognise and/or act sooner.

The review will start with the experience of the seven named individuals and identify any themes leading to poor care. It will consider the agencies who worked with those individuals and any learning from that involvement. The review will also consider the wider interaction of agencies with HNH in general and comment on the efficacy of that interaction and whether improvements can be made.

For the Health element of the review, the CCG will use a mixed methodology of surveying all GPs who had patients in the home during the agreed review timeframe to ascertain information on the quality of the care that the home delivered. In order to review the quality of GP interactions and responsiveness to concerns the CCGs DASM and Named GP for safeguarding will conduct a random audit of medical records for all practices involved. The CCG will ensure that clinicians from the practices involved attend the learning sessions, in addition to the Named GP and DASM.

5. Commissioning of Independent Reviewer

An independent reviewer will be commissioned via the Dorset or Bournemouth & Poole Safeguarding Adults Boards.

Jane Ashman
Independent Chair of Review panel
02.12.2015