Executive summary of a Serious Case Review into alleged abuse in a nursing home

1.0 Context, Scope and Methodology

1.1 This is an executive summary of the Overview Report of a Serious Case Review conducted by Torbay Safeguarding Adults Board. The Serious Case Review was commissioned to consider historical safeguarding adults concerns dating back to 2007 regarding the possible abuse of residents in a nursing home.

1.2 The scope of the review included the following:

- The response made by the home's management to complaints and concerns raised
- The effectiveness of the safeguarding adults processes in response to concerns raised and whether practice complied with guidance and standards at the time
- The role and process applied by the regulator and commissioners
- Evidence of good practice within the nursing home and agencies involved

1.3 In terms of methodology, a Serious Case Review Panel was convened to oversee the work. All agencies involved provided an Individual Management Review, including chronologies and lessons learned, which were amalgamated into an overview report written by an independent author with an action plan. This was presented to the Torbay Safeguarding Board in July 2013.

1.4 The Review looked at the evidence for alleged poor or abusive practice. Records were found to be incomplete, with inconsistencies between records held by different agencies of safeguarding activity, which made it difficult to gain a full picture of the concerns, action taken and outcomes. The concerns led to 21 safeguarding strategy meetings and the majority of these were followed by one or more case conferences. On four occasions the concerns raised were substantiated but further action was taken in only two cases.

1.5 It was not possible to be certain about whether any abuse was suffered by residents of the nursing home during the review period, or about the standard of care or management of the home at that time. Investigation of these matters at the time was inconclusive and subsequent enquiries have been similarly inconclusive. However, during the review period there were persistent and significant concerns that residents may have been subject to abuse, evidenced by the number of complaints and safeguarding alerts made by residents, relatives, staff and visiting professionals and the associated safeguarding activity. A Whole Home Investigation was held due to the large number of safeguarding concerns to consider the risks to all the residents in the home. This Whole Home Investigation lasted for more than two years and failed to reach a conclusion.

1.6 The Review does not draw conclusions about whether or not abuse occurred but identifies areas for improvement in the management of the safeguarding adult process and the involvement of different agencies in that process in use at the time. The lack of conclusions about the safety, or otherwise, of residents raises important issues about the effectiveness of the safeguarding process at the time, despite evidence of considerable activity. The activity seemed to focus on process rather than outcome.

2.0 Findings and recommendations

2.1 Significant improvements in safeguarding adults in Torbay and Southern Devon Health and Care NHS Trust have been implemented since an independent audit was commissioned in 2009. Following this, governance of systems and processes was improved with an effective case management tracking system and other improvements that have addressed many of the concerns identified in this review.

2.2 The Safeguarding Adult Board is participating in the Association of Directors of Adult Social Services Peer Review in autumn 2013 with a specific focus on safeguarding adults from a multi-agency perspective. The Peer Review will consider progress made on issues arising from this review.

2.3 There was little direct communication with residents, relatives or staff at the Nursing Home by safeguarding adult investigators. The opportunity to gain a fuller picture of life at the home was missed. There was also little evidence of consideration of the mental capacity of the residents involved. It is acknowledged that there is much greater awareness and clarity about the requirements of the Mental Capacity Act 2005 across the country since the events considered by this Review.

2.4 The Safeguarding Adult Board should ensure that practice conforms to the Social Care Institute of Excellence (SCIE) guidance requiring consideration of an appointment of an Independent Mental Capacity Advocate.

2.5 Many different professionals visited the home during the review period, but there was very little sharing of information or concerns between these professionals. There was no single record of all the professionals involved with any one resident, nor lead responsibility for, or oversight of, a care plan.

2.6 The Safeguarding Adults Board should seek to ensure that all visiting professionals and the managers of homes are able to access and contribute to a shared record

2.7 Most of the safeguarding investigations were led by the Police. Following safeguarding alerts the police conducted seven safeguarding investigations and investigated five other deaths, all recorded as non-suspicious. There does not appear to have been acknowledgement that the purpose of a police investigation is to detect crime, thus requiring a higher level of proof than an investigation into the safety of an individual.

2.8 The Safeguarding Adults Board should ensure that investigation training makes it clear that action to protect adults can be taken in cases where there is insufficient evidence to justify a criminal prosecution.

2.9 The Whole Home Investigation lasted nearly two years and failed to reach a definitive conclusion as to whether the Nursing Home was, or was not, a safe place for residents. This impacted on the morale of management and staff at the nursing home and on reputation of the establishment. A new policy for Whole Home Investigations has recently been introduced and should address some of the shortfalls highlighted in this review. The implications for resources to conduct such an Investigation are considerable.

2.10 The Safeguarding Adult Board should ensure that a decision to undertake a Whole Home Investigation is taken at a senior level with due consideration and that the Investigation has clear leadership, management oversight and is adequately resourced so that the work can be carried out within a reasonable timescale.

2.11 Safeguarding processes were not aligned with the contracts and commissioning processes and did not feature in commissioning or contract monitoring guidance.

2.12 The Safeguarding Adults Policy should be reviewed by the Board to ensure that the relationships between the commissioning, contract monitoring and safeguarding are clearly specified and that safeguarding matters must have primacy in decisions about commissioning and contracting.

2.13 Although a contracts officer had responsibility for monitoring the nursing home, decision making in relation to contracts did not have the benefit of any mechanism to enable 'soft intelligence' gathered by front line staff to be incorporated into any performance assessment of the home. A Quality Assurance Framework with a care home check list is being developed, which should improve the capacity to assess performance.

2.14 The Torbay Safeguarding Adults Board should ensure that their Policy reflects the need to make sure that any local staff visiting are aware that the Home is subject to the Whole Homes Investigation process.

2.15 Considerable work has been undertaken to improve practice in safeguarding adults in Torbay. This has included revisions to training modules. However the review did not see any evaluation of the delivery and effectiveness of training programmes.

2.16 The review recommends that contracts, commissioning and regulatory staff will need to have a means of monitoring the take-up and delivery and impact of training modules for staff at all levels in the NHS and the independent sector.

2.17 The review identified a lack of engagement by GPs in the safeguarding process. It is known that some GPs had concerns about the standards of care in the home, but in the main these concerns were not formalised. Faced with significant time constraints, GPs were not always able to take a holistic view beyond their patients' clinical needs. This is understandable in terms of the demands placed on GPs, but falls short of best practice and is of some concern given the complex medical needs of some residents.

2.18 The report identifies a need to review the arrangements for the provision of health care to residential and nursing homes to make the most effective use of a limited resource and ensure as far as possible continuity of healthcare to residents.

2.19 Fully integrated healthcare should be provided to all residential and nursing homes with close clinical oversight and support to home managers. Opportunities should be explored for linking GP practices to Care Homes. Care, nursing and treatment plans must be fully aligned. The Safeguarding Adult Board should ensure the development of multi-agency action plan to implement this.

2.20 Regionally and nationally it is advised that GPs put their medical notes into the Care Home notes as well as their own surgery notes. It is recommended that Torbay Safeguarding Adult Board consider this.

2.21 The submission by the Care Quality Commission (CQC) to the review acknowledges weaknesses in the follow up of concerns received and accounts for these in terms of operational difficulties within CQC and the adoption of new inspection and review methodologies. The CQC states that a number of improvements have already been implemented to tackle these weaknesses, but acknowledges that some risks remain, particularly in relation to securing safeguarding information from local authorities.

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