Summary and Recommendations of a Significant Case Review (A)

December 2014

Glasgow City Adult Protection Committee Significant Case Review

1.0 Context

1.1 This significant case review was commissioned by the Glasgow Adult Protection Committee in the context of the Glasgow Adult Protection Significant Case Review Protocol. The purpose of the significant case review was to establish the following under the auspices of adult support and protection inter agency responsibilities:

- Whether lessons could be learned about the way local practitioners and agencies worked together, in the light of a situation where adults who had been part of the adult protection and/or other welfare systems, experienced significant harm.
- To identify what key lessons learned were, to recommend how best they be acted upon and what outcomes may be expected through change as a result.
- To provide a framework for improvement in inter-agency working towards the better support and protection for adults seen to be at risk of harm within Glasgow City.

The SCR Team identified a number of themes to focus on during the review process. The recommendations from the review are listed under these themes.

2.0 Background

2.1 A number of allegations were made about a series of ASP incidents regarding a privately owned nursing home within the Glasgow area that provided nursing care for older people within both frail elderly and dementia units. The home had been performing poorly with low grades awarded by the former Care Commission. This had contributed to improvement notices being put in place which were subsequently lifted when the grading improved.

3.0 Summary of the case

3.1 A series of alleged ASP incidents towards a number of frail elderly residents were reported by a staff member whistle-blowing within the unit. These were reported by the provider to Social Work Services. The allegations included verbal and physical harm, rough handling and force feeding of some of the care home residents.

3.2 This led to a number of staff members being suspended. A voluntary moratorium on admissions was agreed between Social Work Services and the Provider as a result of the Adult Support and Protection allegations.

3.3 Adult Support and Protection investigations were subsequently carried out regarding the allegations of harm.

3.4 A combination of the various responses from Social Work Services, the then Care Commission and the Police supported the Provider's response to the

allegations within the care home. The Provider's response was to acknowledge the allegation issues and focus on tackling them to improve the care of the residents. Some of the staff members that had been suspended were subsequently dismissed. The Police investigation concluded that no criminal charges could be brought.

4.0 Conclusions and Recommendations

4.1 The significant case review concluded that lessons could be learned by most of the agencies involved in relation to the application of procedures and joint working practices. The conclusions and recommendations were as follows:

5.0 SCR Panel Conclusions

5.1 The need for competent and qualified staff in care homes is paramount.

5.2 Poor communication was evidenced within the Provider's organisation, both within the home and from the care home to external managers. This had a significant effect on the quality of care within the home.

5.3 Good and regular communication was evidenced between the Care Commission and Social Work Services Contract Management Team.

5.4 NHS staff that provide services in care homes need to discuss with other agencies i.e. Social Work Services or the Care Inspectorate, when they experience concerns regarding the care being provided within any care home.

5.5 All agencies need to be able to evidence that their staff have accessed training on Adult Support and Protection procedures and in particular there is a need to ensure that interagency Adult Support and Protection training is provided for NHS staff regularly going in to care homes.

5.6 Improved communication between NHS, Social Work Services and Care Inspectorate, needs to continue and needs to be managed in a more disciplined manner.

5.7 Inspections by the Care Inspectorate should continue to take place in care homes during evening and weekends as well as daytime.

5.8 Social Work Services reviews of residents in care homes need to look at support needs over a 24 hour period.

5.9 Social Work Services care management reviews of residents should include consultation with relatives to identify if they have any concerns with the care being provided.

5.10 Care home residents' rights should be embedded in the delivery of care and in the process of inspections and care reviews. – Care Managers should also take cognisance of the role of the Mental Welfare Commission.

5.11 Access to independent advocacy support for residents in care homes should be facilitated by Social Work Services and embedded into work with care homes.

5.12 Multi agency meetings to review failing care homes should be put in place and chaired by a Social Work Services Service Manager.

5.13 Multi agency meetings to review alleged Adult Support and Protection incidents should be convened and chaired by Social Work Services staff, in line with Adult Support and Protection procedure.

5.14 There is a need for an updated MOU that covers Social Work Services, Care inspectorate and Care Home Services Team staff who provide services to care homes, e.g. GPs, nurses, mental health staff etc

5.15 Procedures for flagging up concerns across agencies need to be tightened up.

5.16 A list of indicators of poor culture within a care home should be made and shared across agencies.

6.0 Recommendations for action

6.1 The ASP investigation recommendations

6.2 Social Work Services need to ensure that in any future ASP investigations SWS take the lead as per ASP guidance.

6.3 When convening the ASP investigation, and /or any multi agency meeting regarding the welfare of care home residents, there is a need to ensure that all agencies involved in the monitoring of residents' care and care home standards, including the NHS, are invited to participate in any multi agency reviews, conferences and investigations.

7.0 Advocacy, rights issues recommendations

7.1 Adults affected by mental incapacity and unable to ask for support should be referred for advocacy by the lead agency. Where a proxy is present the referral should still be made and the proxy informed.

7.2 Systems need to be put in place to ensure that social care providers demonstrate that they have trained their staff group on the rights of residents with mental incapacity.

7.3 There should be an assessment of rights issues at the commencement of the ASP intervention and formal contact established with the local independent advocacy provider.

7.4 Consideration of advocacy should be a standard part of review preparation and any reason for non involvement of advocacy noted in the review minute.

7.5 Awareness of the principles of the legislation should be embedded into the induction and training of care home staff and include AWI guidance on the care of residents.

7.6 Advocacy training for SWS should be examined to ensure that the following aspects are covered:

7.7 Human rights and equalities best practice in formal care settings.

7.8 Awareness raising of the availability of independent advocacy and its benefits.

7.9 Managing & supporting disclosure of harm in an AS&P context.

7.10 Promoting the benefits of engagement and involvement of adults and carers in care settings.

8.0 Communication recommendations

8.1 Any identified deficiencies of care in care homes should be communicated across all agencies, i.e. Social Work Services, Care Inspectorate and the NHS staff by the identifying agency.

8.2 In the event of potential Adult Support and Protection situations affecting more than one resident in the same care home, Social Work Services should appoint a Team Leader to coordinate all individual care reviews and link closely with the Social Work Services link Contract Officer.

8.3 Multi disciplinary contingency planning meetings, involving Social Work Services, the Care Inspectorate and the NHS should be convened when there are serious deficits in care home service provision.

8.4 Social Work Services should seek to involve relevant NHS staff in any care reviews or multi agency meetings.

8.5 Care home providers must ensure that care home staff are competent, knowledgeable and able to communicate effectively internally and with other agencies' staff.

9.0 Joint Working recommendations

9.1 The Memorandum of Understanding (MOU) between the Care Inspectorate and local authorities and health boards is updated and implemented.

9.2 The updated MOU should include a reference to the need to share learning from any SCRs across all agencies.

9.3 There should be greater recognition of the need for referrals to the Mental Welfare Commission and this should be part of joint working between agencies.

9.4 All statutory agencies should re-issue guidance to staff on the circumstances when the Mental Welfare Commission should be notified of incidents within care homes.

9.5 Staff who provide services to care home residents should be advised to share any concerns regarding the quality of care with Social Work Services staff and/or the care inspector for the home.

10.0 Triggers and Red Flags recommendations

10.1 The NHS GGC Care Homes Services Team fully implements its new procedures for nurses and GPs to raise any concerns about the care of residents in care homes.

10.2 The Care Inspectorate continues to implement its new Adult Protection Procedures and increased notifications system for providers.

11.0 Assessment and Review Processes recommendations

11.1 Social Work Services Care Managers should be issued with guidance advising on the need to discuss with relatives of care home residents that they report back any concerns regarding the care of their relative.

11.2 Review minutes should be recorded in detail using an agreed template which should be available as E forms on Care first 6 and should inform the overall care plan of the resident.

11.3 Social Work Services should consider a specific role for Social Work Services Assistant Service Managers (ASMs) in the governance and managing of performance in care home reviews

11.4 Social Work Services should automatically notify advocacy services when there is concern about systemic failings in a care home impacting on the rights of residents.

11.5 Advocacy services information should be available in all care home settings, both independent and local authority.

11.6 Social Work Services should review its approach to monitoring and reviewing care home residents as more regular review will assist in the identification of issues of concern re quality of care.

11.7 Social Work Services should amend its assessment and review guidance to incorporate the need to explore care arrangements over a 24 hour period.

11.8 Social Work Services should ensure explicit discussion on legal status and powers at both assessment and review stages.

11.9 Protocols to be developed to ensure that NHS staff are included in the communication and activities of those agencies involved in inspecting and monitoring the performance of care homes.

11.10 All agencies, including the NHS and providers, need to ensure that staff going into care homes are trained in Adult Support and Protection Procedures and have a responsibility to report any concerns.

12.0 Quality of staffing and management recommendations

12.1 All care home providers should review staff's understanding of Adult Support and Protection procedures and the effectiveness of associated training

12.2 This should be reinforced by managers through supervision / support sessions with individual care home staff.

12.3 All agencies should increase their monitoring and review activity in situations where care homes are graded two or below.

12.4 SWS contract monitoring staff should explore with the care home what staff supervision and support arrangements are in place when a care home is graded two or below for quality of staffing and management.

12.5 Whilst the care home liaison staff have now all been trained, the NHS should review the extent to which care home liaison staff understand their role in relation to Adult Support and Protection procedures.

13.0 The role of the NHS recommendations

13.1 The NHS should explore with Social Work Services whether there is scope to merge and share the residents' reviews so that information on the individual's social care and medical needs are in the one document.

14.0 Culture recommendations

14.1 A list of indicators of poor culture in care settings should be developed and shared with all agencies for dissemination to staff going in to care homes.