Wolverhampton Safeguarding Adults Board (WSAB) Learning Lessons Briefing – Adult Z

The Review

This Learning Lessons briefing is created as the result of a Safeguarding Adults Review Committee (SARC) learning review, into the death of Adult Z in Spring 2016.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Background Summary

Adult Z had been resident in a local care home, in Wolverhampton, on a self-funding basis, for some time and was visited regularly by family. Adult Z had several long-term health conditions, including Dementia.

On the day prior to an admission to hospital, it is believed that Adult Z fell at the care home. Adult Z was admitted to the hospital due to vomiting and having difficulty breathing. Following investigations, Adult Z was found to have a fractured hip and pneumonia. Due to underlying health conditions little could be done, and Adult Z sadly died some five days later.

Areas of Good Practice

- The regularity of visits made to Adult Z by the District Nursing Service was exemplary in dealing with the presenting nursing needs
- The Practice Nurse provided an excellent service to Adult Z, with support from the GP
- The Multi-Agency Safeguarding Hub (MASH) were responsive when the safeguarding referral was made

- The Wolverhampton Clinical Commissioning Groups' Quality Nursing Service provided a much-needed service to support the work carried out in this home. (This service supports and drives excellent practice in nursing homes but no longer supports residential care homes in this way). However, the model is one that should perhaps be considered by all Clinical Commissioning Group's (CCGs)
- When Adult Z was admitted to hospital, staff immediately noticed a painful hip that was externally rotated and shortened, and they also identified that Adult Z was not swallowing safely

Key learning themes arising from the review

1. Implementation and embedding of advice

One year prior to Adult Z's death, the Quality Assurance and Compliance Team from the Local Authority (LA) suggested improvements to the care home but these were not fully actioned. Shortly afterwards, a full inspection of the home was undertaken by the Care Quality Commission (CQC) which rated the care home as 'Good'. This rating may have may have distracted the Local Authority from following up the improvements they had previously recommended.

While Adult Z's care and mobility needs and falls risk were regularly assessed by the care home, the necessary actions arising from those assessments were neither taken or implemented, respectively.

What has changed?

The LA and CCG have implemented a rolling programme of quality visits to care and nursing homes; they involve other agencies in visits, where appropriate. The focus is no longer on homes of concern, but all homes.

During visits, risk assessments are reviewed, and questions asked to ensure the implementation of recommendations/findings.

The CCG has introduced a series of quarterly quality review meetings for all commissioned nursing homes where action plans are reviewed.

If a provider is not proactively improving upon the quality concerns identified from monitoring activities, the lead Quality Assurance and Compliance Officer (QACO) from the Local Authority will discuss the concerns and/or share monitoring reports with the LA Commissioner. If appropriate the lead QACO will escalate the concerns to CQC.

Concerns can also be shared at the bi-monthly CQC Information Sharing Meetings. If necessary, the Council's Care Provider Procedures can also be instigated.

2. Escalation Processes

During the review period it was concerning that no escalation process for the sharing of key information between the various quality assurance bodies was in place. Although a CQC Information Sharing Meeting took place, this was only held bi-monthly.

Information held by the Local Authority (LA) Quality Assurance and Compliance (QAC) Team was not robustly shared with adult social work teams or safeguarding service. Information sharing of this nature may have triggered a social work review of LA funded residents which, in turn, could have led to the identification of necessary actions to improve care and services at the home.

The care home records show that Adult Z suffered 9 witnessed falls and 23 unwitnessed falls: a total of 32 falls in the last four months of residing there. None of the falls were reported as safeguarding concerns. It is known that other residents also suffered falls in the period under consideration but few, if any, of these falls resulted in a formal safeguarding concern being raised or a review/multi-agency meeting being convened.

What has changed?

The CQC Information Sharing Meeting has introduced robust governance processes which ensure information is recorded, shared and actioned appropriately.

Where the LA or CCG identify potential safeguarding concerns during their visits, a safeguarding referral is raised via the Multi-Agency Safeguarding Hub (MASH). As a result, information-sharing is swifter, and expectations are clearer; ultimately residents are safer.

As part of the structured quality monitoring visits, the LA and/or CCG consider incident logs and resident records, and should unusual patterns be noted, they are escalated.

The West Midlands Regional Safeguarding Adults Policy and Procedure is actively promoted within the Wolverhampton Care Home Provider Forum and providers are aware of their responsibilities for escalating safeguarding concerns. Care homes have been provided with training via the CCG and the LA and they can seek support from the MASH.

Wolverhampton has introduced a quality improvement initiative (SPACE project) supported by the Patient Safety Collaboration which has provided intensive support to care homes, including falls prevention. The dementia care plan within GP electronic systems has been reviewed to include a section on ‘Falls Risk discussion’. This is part of a wider programme of learning across the health economy that includes primary care, community and care home staff.

3. Silo Working

During the review period, various professionals visited the care home and Adult Z was seen on numerous occasions. There was a tendency for visiting professionals to focus on the presenting issue at that time and not consider the wider context.

It was not until after Adult Z's fatal fall that regulating agencies took definitive action about the care home. It should have been identified earlier that the care home had been demonstrating areas of poor practice in the delivery of care for some considerable time.

What has changed?

Local professional training has been reviewed and incorporates training to address the negative impact of silo working, promoting professional curiosity and multi-agency approaches.

Suitability of Employees

Concerns were raised regarding staff employed within the care home who did not have appropriate contracts of employment, were unable to give their own personal details and therefore could not be signed up to essential training. There were also concerns that checks with the Disclosure and Barring Service and with the Border Agency were not being completed. The CQC addressed matters with the provider at the time and recorded that these issues would be followed up at the next planned inspection. There was no meaningful follow up, by any agency, to check on the employment and immigration status of all staff at the home.

As a result, employees did not access all appropriate training which in turn, may have negatively impacted on their delivery of quality care and support.

What has changed?

The rolling programme of visits by the LA or CCG to care and nursing homes looks at employee records and verifies that training and employment checks are undertaken and in place. Should concerns arise, they are escalated and shared with the CQC.

The CQC has developed best practice guidance with regards to learning from safety incidents. https://www.cqc.org.uk/guidance-providers/learning-safety-incidents

Recommendations

1. Adult Social Care to develop a robust system for ensuring keeping in touch conversations (formerly known as reviews) are carried out at least every 12

months to ensure needs are being met appropriately and safely and the person is living a good life. An escalation process should be incorporated into the system to address outstanding keeping in touch conversations.

2. Consideration should be given by care homes, for Residents who privately fund their own care, to be offered an annual review of their care and support. This offer should be made in conjunction with the Resident and their family where appropriate, and involve relevant professionals

3. All agencies involved in the CQC Information Sharing meetings should ensure that they disseminate any causes for concern raised in the meetings about individual care homes to operational staff within their agencies. This will increase the ability of staff to be vigilant to potential issues/concerns

4. The Board should ensure that there is an escalation process for the sharing of key information between the various quality assurance bodies, over and above the use of the CQC Information Sharing meetings

5. All the agencies responsible for monitoring standards within care homes should clearly record their response to any requests for information or opinion on decisions as to further action. Agencies should regularly review and audit their processes for undertaking this

6. The Board should request that the Quality and Performance Committee consider how they might undertake a quality assurance audit of care homes

7. The Board should seek assurance from agencies that they are able to identify falls risks, undertake appropriate risk assessment and act to manage identified risk

8. The Board should seek assurance that current training for all residential and nursing homes fully covers:

a) The circumstances in which safeguarding referrals should be raised and the process and procedures by which that is done in relation to guidance on when falls should be reported
b) The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
c) The Care Act 2014