Northamptonshire
SAFEGUARDING ADULTS

Serious Case Review

Executive Summary

Parkside House
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Northampton
NN2 7HE

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Acknowledgement

At the heart of this Serious Case Review are five people of advanced years who died while living in residential care. All those involved in this Review wish to express their regret that their end of life was marked by unnecessary suffering and avoidable physical neglect. We extend our sincere condolences to the families who have lost their relatives.

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1. Introduction to the Report

This report has been commissioned by the Northamptonshire Safeguarding Vulnerable Adults Board (SOVA Board) under its procedure for conducting Serious Case Reviews (SCRs).

Paragraph 4.8 of the procedure requires that *"a Serious Case Review will take place when a vulnerable adult dies (including death by suicide)* ***and*** *abuse or neglect is known or suspected to be a factor in the vulnerable adult's death".*

Work to protect vulnerable adults is governed by the Northamptonshire Inter-Agency Safeguarding Adults procedures which have been agreed by all partner members of the SOVA Board. Paragraph A2.7.1 identifies six forms of abuse that are covered by the procedures:

- Neglect and acts of omission
- Discriminatory abuse
- Financial and material abuse
- Physical abuse
- Psychological abuse
- Sexual abuse

In this case 5 elderly people who were resident at Parkside House died between the 22nd July 2009 and the 6th August 2009 from causes that were considered to be consistent with the effects of severe neglect. The circumstances of the case met the criteria for having a Serious Case Review and the Panel commenced its work in December 2009.

2. Summary of events

At the time of the incident that led to the inter-agency safeguarding procedures being implemented, Parkside House Nursing Home was a registered care home for up to 20 service users aged 65 and over suffering from dementia or long standing mental illness.

On the 21st July 2009 a female resident at Parkside House was admitted to Northampton General Hospital where she was found to be suffering from severe necrotic sores (grade 4). She was described as being unresponsive and dehydrated and her overall condition was considered by Hospital staff to be consistent with severe neglect. The inter-agency procedures were commenced on the 21st July but she died on the afternoon of the 22nd July.

Also on the 21st July another resident of Parkside House was identified as having similar severe pressure sores. He remained at Parkside House and received "End of Life" care from a District Nurse before dying on the 22nd July 2009.

A multi-agency assessment of all residents was put in place on the 24th July and Social Care and Health staff worked alongside staff in Parkside for the following 7 days to try to improve the safety and well being of residents. However it was judged that three residents needed to be moved without delay due to their condition. The first of these was moved to a community hospital where she died on the 28th July. The second resident was moved to another nursing home where she died on the 6th August. Another resident of Parkside House was also moved to another nursing home where she too died on the 4th August.

Work undertaken at Parkside House by Health and Social Care staff between 24th and 31st July highlighted grave concerns about the standard of care being provided and at the end of that week it was judged that there had been insufficient progress made to allow residents to safely remain at the home. All remaining residents were moved from Parkside House on or shortly after the 31st July.

No further residents were admitted to Parkside House and the Care Quality Commission subsequently commenced proceedings to cancel the home's registration.

3. Organisations submitting Individual Management Reviews and information to this Serious Case Review

Northamptonshire County Council (NCC)
NHS Northamptonshire
NHS Northamptonshire Provider Services
Northampton General Hospital (NGH)
Care Quality Commission (inspection reports and chronology)

4. Identification of good practice

The actions taken by staff at Northampton General Hospital were timely and appropriate, and in particular the Safeguarding of Vulnerable Adults lead person in quickly identifying that the pressures sores being suffered by the female resident admitted to NGH on the 21st July were the result of neglect.

While it is regrettable that by the time the first resident was admitted to hospital it was not possible to do more for her than to provide end of life care, the speed with which the alert was raised and the subsequent action taken almost certainly prevented at least some of the other residents from suffering the same level of neglect.

The response provided by all agencies following the Safeguarding of Vulnerable Adults notification was also a good model of inter-agency co-operation and collaboration. The minutes of the strategy meetings show that there was a measured and thorough assessment of residents and that there was a careful attempt to balance the safety and welfare of residents against the disruption of moving.

The holding of a debriefing meeting in October 2009 to consider what had happened and to take actions ahead of the Serious Case Review is good practice.

5. Lessons learnt from this Review

This section will be laid out under a number of **key themes**.

a) Inspection and contract monitoring

There were fairly clear signs from both the Care Quality Commission and the Northamptonshire County Council contract monitoring processes that standards were slipping at Parkside House and that this decline was linked to a lack of leadership and management control at the home. Homes that have strong

leadership pay attention to the details that are required to ensure that the physical and emotional health of residents is maintained. Without this there is a danger that standards and important key processes are not maintained. This can pose a real risk to residents as clearly happened at Parkside House.

The grading given to homes by the Care Quality Commission is influential in terms of the way those homes are regarded by commissioning organisations. Therefore where the quality of a home is judged to be marginal it would seem important to seek information from others involved with that home to help to clarify the judgement. While it cannot be said for sure that consulting the GP, District Nurses, Care Management or the Continuing Health Care/Residential Nursing Care Contribution assessors specifically about the possible downgrading would have altered the Care Quality Commission's judgement, it may have done so which might in turn have increased vigilance about the welfare of residents.

b) Individual review and assessment processes

Organisations that fund people to live in residential homes that they have approved as suitable to provide care have a responsibility to ensure that they are safe and well looked after. Carrying out regular and thorough reviews of those placed is a key means by which this responsibility is carried out. Very little was provided in any of the Individual Management Reviews about how reviews were expected to be conducted or how they dealt with safeguarding issues. While getting the initial decision about funding and placement right is important, this case highlights that the ongoing assessment and review process is of equal importance.

The needs of people living in care homes change over time and it is vital that in carrying out reviews these changes are picked up. In the case of Parkside House their Care Quality Commission registration was for people suffering from dementia and long standing mental illness. However by July 2009 it is clear that they were actually looking after people with those needs plus considerable physical and nutritional needs that they simply could not manage.

There is nothing in the Individual Management Reviews to suggest that any individual professional involved with Parkside House failed in their duty to carry out the tasks assigned to them. However organisations charged with inspection and contract monitoring, processes for review and assessment and a variety of professionals who visited the home in the run up to 21st July 2009 collectively did not identify what later became obvious when the statutory agencies moved in to the home.

c) Communication

There is very little evidence of communication between agencies about Parkside House in the pre-trigger period. Agencies and sections within agencies carried out their separate tasks with little or no reference to each other.

This is in marked contrast to what happened subsequently once the alert had been raised when senior managers became involved and co-operated to manage the situation. Since that time there have been positive signs that Health Services and Northamptonshire County Council have recognised the importance of taking a more holistic overview of care provision and the responsibilities that they share for those placed in homes.

d) Information

On its own information does not protect people living in care homes but it does provide an important tool for those charged with maintaining standards and ensuring that the needs of individuals are met as it provides the facility to bring together information from different sources to form a clear view of what is happening. This Serious Case Review highlights some significant failings - people being "unsure" whether Continuing Health Care reviews had taken place, systems that could not identify which clients are placed in which homes and data inaccuracy. Building into IT systems the capacity to identify all residents, their funding sources and the outcomes of their recent reviews is an integral part of developing an effective service that ensures needs are met and users safeguarded at all times.

e) Safeguarding intelligence

While the situation at Parkside House was starting to deteriorate during 2009 an inter-agency meeting had been set up to share safeguarding concerns. Even if Parkside had been identified as a risk it is unclear what the status of the meeting was and as such what it would have been able to do about it. Its existence is not mentioned in any other Individual Management Reviews apart from the one provided by the NHS Provider Services and there were no minutes of the meetings. The collection of sensitive information about possible concerns can be a useful tool in managing a large diverse sector such as residential care but it must have a means of translating that information into verifiable fact that can then be used to ensure increased vigilance by all agencies.

f) Procedures and policies

Overall the inter-agency procedures for the safeguarding of vulnerable adults seem to have worked reasonably well. The involvement of a number of senior managers in the strategy groups gave the situation a status that was probably warranted by the seriousness of what was discovered at Parkside House and the complexity of needing to move the residents. However the procedure (section A3.7.1- 3) does not include a requirement for senior management involvement and it is important that the process will work effectively without this and not be reliant on senior management input.

Trying to elicit an understanding of the policies and procedures governing the processes of contract monitoring and reviews of individuals funded by agencies proved difficult from the Individual Management Reviews because they contained little information about this. This makes it difficult to judge whether the system problems were related to issues with the procedures. It is a learning point for future Serious Case Reviews that agencies need to make available the policies and procedures they rely upon to carry out their work so that the Serious Case Review can form a view on whether these require amendment.

Having clear understandable policies and procedures does not ensure good practice and safety for service users but again it is an important tool in facilitating effective service. A number of actions and processes have been put in place since July 2009 but it is unclear to what extent these are embedded through joint policies and procedures. In considering whether actions can be regarded as "completed" it will be important for the Safeguarding Vulnerable Adults Board to be able to see that changes are fully in place and are therefore sustainable for the future.

g) Involvement of users and their families

Eliciting the views of service users and their relatives is an important part of the inspection and contract monitoring process. In homes such as Parkside House where many of the residents may not be able to articulate their views it is particularly important that relatives are specifically asked if they have any concerns or issues about the care being provided. This did not happen in the Northamptonshire County Council Health and Social Services contract monitoring process of October 2008. However there is nothing to suggest that sending out questionnaires to relatives as part of that process would have elicited concerns, indeed the Care Quality Commission inspection conducted a month later brought forward only three remarks from families when they were invited to comment, all of which were positive. Nonetheless obtaining the views of residents and their families is an integral part of the contract monitoring process which should not have been missed out. This point is acknowledged in the lessons learned section of the Health and Social Services report.

h) Dignity of service users

Overall those managing and working with the situation at Parkside House in the days following the trigger incident took considerable care to assess and act on the needs of each individual resident. However the Health and Social Services report acknowledges that the use of bin liners to carry personal belongings when the residents moved is poor practice and this point has been acted on by NCC. Issues of service user care and dignity should be central to considerations of any safeguarding process and need to be built in to this rather than an afterthought.

i) The role of the Coroner

It appears from the chronology that the verdict of the coroner in respect of three of the residents of Parkside House who died directly affected the decision in respect of legal action by the police. There are also discrepancies between the views of some professionals that this was a case of serious neglect and the verdict of the coroner. This may suggest that the relationship between the three processes- Safeguarding of Vulnerable Adults investigations, decisions about criminal proceedings and the role of the coroner requires clarification.

j) Safeguarding awareness and training

There is no evidence from the Individual Management Reviews of any specific links between what happened at Parkside House and the level of safeguarding awareness of any individual or group of staff although the debriefing meeting of the 12th October 2009 does identify training for GPs and NHS Provider staff as one of the actions to be taken. It is important that everyone involved in work with older people is able to recognise signs of actual or possible abuse and understands their responsibility to act on these concerns.

6. Recommendations from the Overview Report

This section follows the **key themes** identified in section 5 of this report.

a) Inspection and contract monitoring

A1 In any case where the contract monitoring process identifies concerns about the management and operation of a home and therefore its

suitability to care for service users, a process must take place that brings together information from all agencies that have placements in that home and the Care Quality Commission. This process will then ensure that it is safe for residents to remain in the home and that steps are taken to rectify the areas of concern.

A2 In any case where the Care Quality Commission believes that there may be grounds for downgrading a star rating of a home from adequate (one star) to poor (zero star) placing organisations must be made aware of this and a process take place that brings together information from all agencies who have placements in that home before a decision is reached.

b) Individual review and assessment processes

B1 All organisations involved in the contracting and placing of people in care homes must ensure that their processes for the ongoing monitoring, re-assessment and review of residents for whom they are responsible are effective. This means that reviews are carried out at least within the agreed timeframe; by a professional who has received training on safeguarding issues to a minimum of tier 2 level; that changes to the individual's circumstances and needs are assessed against the specification of the service provider; and that a clear record of the assessment and review process is made.

c) Communication

C1 All organisations involved in the contracting and placing of people in care homes must ensure that there are effective mechanisms for regular communication between and within their services that are not just dependent on the personal relationships of staff. This means developing a clear policy and procedural framework which includes information sharing protocols; fixed points for meetings; terms of reference for meetings; and accountabilities.

d) Information

D1 In line with recommendations 1-4 of its Individual Management Review, Northamptonshire County Council Health and Social Services must develop integrated information systems that bring together information about individual service users placed in care homes; the outcomes of their reviews; and the results of contract monitoring visits to form an overview of each home and the care home market as a whole.

D2 As part of the intention to establish a joint monitoring team Northamptonshire County Council Health and Social Services and local NHS services should extend the information base to include placements made under Continuing Health Care and Residential Nursing Care Contribution funding.

e) Safeguarding intelligence

E1 It is not recommended that a separate process is used to gather and share safeguarding intelligence. However protocols for information sharing and communication must include a clear statement about how staff in organisations report "unsubstantiated concerns" and the actions that will be taken by the key organisations to assess and monitor these.

f) Procedures and policies

F1 Although no significant difficulties appeared to occur with the Northamptonshire inter-agency safeguarding adult procedures in this case they are now nearly 3 years old. These procedures require a review and update to ensure that they remain relevant and effective and that any lesson learned from this or other Serious Case Reviews are taken into account.

F2 It is recommended that the processes for carrying out reviews of service users under Health and Social Services, Continuing Health Care and Residential Nursing Care Contribution funding are brought together under a single multi-agency procedure and paperwork that emphasises a holistic approach to the needs of individuals regardless of their funding source. The development and use of this integrated process should be supported by joint training.

F3 That each of the four key organisations involved in this case be asked to provide an update to the September 2010 meeting of the Safeguarding Vulnerable Adults Board on the actions they reported in their Individual Management Reviews including how these actions have been embedded through revised or new policies and procedures.

g) Involvement of users and their families

G1 The Northamptonshire County Council Health and Social Services contract monitoring process must be strengthened so that the requirement to seek the views of service users and their relatives is more central to the process and that no review of a service is "signed off" without these views having been sought.

G2 The proposed multi-agency procedure for the review of service users receiving Northamptonshire County Council Health and Social Services, Continuing Health Care and Residential Nursing Care Contribution funding (F2 above) must include the requirement to seek the views of service users and their relatives and must show how those views have been taken account of in the review process.

h) Dignity of service users

H1 In carrying out strategy meetings and planning actions for safeguarding older people the agenda must always include a specific section covering actions that are required to ensure that the dignity of service users is maintained at all times.

i) The role of the Coroner

I1 A meeting should be held with the Coroner involving senior managers from Health, Northamptonshire County Council Health and Social Services and the Police to consider the inter-relationship between Safeguarding of Vulnerable Adults investigations, the role of the coroner and criminal proceedings that arise from this case. The purpose of the meeting will be to consider whether any form of agreement or protocol is required for such situations in the future.

j) Safeguarding awareness and training

J1 All key partners involved in the Safeguarding Vulnerable Adults Board should agree a standard by which all staff involved in work with older people receive at least basic awareness (level 1) training on safeguarding and how to identify and act on cases of actual or possible abuse. This training needs to be updated at least every 3 years. The Safeguarding Vulnerable Adults Board must receive regular reports on the uptake of this training in organisations.

7. Governance arrangements for implementation of the action plan

An action plan from this Serious Case Review has been developed to take forward its recommendations. The Safeguarding Vulnerable Adults Board, through its Quality Assurance sub-committee will take responsibility for robustly monitoring the plan until such time as it is satisfied that the recommendations have been completed and there is evidence that they have been fully embedded into practice and tested to ensure compliance.

The plan includes timescales for implementation and all agencies have the responsibility to report to the Safeguarding Vulnerable Adults Board any obstacles that prevent the completion of the task within the agreed timeframe.

Marie Seaton
Chair of the Northamptonshire Safeguarding Vulnerable Adults Board
June 2010