torbay safeguarding adults board

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# Executive Summary

# Safeguarding Adults Review

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# A Residential Home in Torquay

# 6 February 2019

**This executive summary was produced by Torbay Safeguarding Adults Board's Safeguarding Adult Review Subgroup. It is based on the Safeguarding Adults Review of a residential home in Torquay.**

## 1 The Safeguarding Adults Review

1.2 In January 2018 the Torbay Safeguarding Adults Board ("TSAB") commissioned a Safeguarding Adults Review ("SAR") of a residential home in Torquay, a 14-bed unit registered for adults under 65 years with mental health conditions and/or physical disabilities. During the time period reviewed by the SAR there were 14 residents in the home, operationally commissioned by Torbay and South Devon NHS Foundation Trust, Devon County Council and Northern, Eastern and Western (NEW) Devon Clinical Commissioning Groups ("CCG's").

1.3 The Care Act 2014 requires Safeguarding Adults Boards ("SAB's") to arrange a SAR in circumstances where an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect and there is concern that partner agencies could have worked together more effectively to protect the adult.

The Terms of Reference for this SAR were to:

- Review the care management responsibility for people with complex and challenging behaviour in the residential home.
- Review the impact of the commissioning arrangements where a number of organisations and local authorities are commissioning placements for people with complex and challenging needs.
- Review relevant aspects of the application of regulations around the residential home
- Review policy, procedure and practice in relation to the residential home.

## 2 Background

2.1 During 2017, Torbay and South Devon NHS Foundation Trust embarked on a *Whole Home/Large Scale Enquiry* into the residential home.

2.2 In July 2017, following concerns reported by Devon Partnership Trust's Intensive Assessment and Treatment Team to Torbay and South Devon NHS Foundation Trust (on behalf of Torbay Council under its delegated arrangements for social care), the Care Quality Commission ("CQC") inspected the residential home. Concerns were centred on the behaviour management ('traffic light') system in place in the residential home; care planning and the quality of life of the residents.

2.3 The CQC inspection found that the service was unsafe; that people were not protected from risks to their health, safety and wellbeing; people were exposed to abusive practices and physical aggression from others. In addition, staff were provided with insufficient information about people's care to enable them to support people safely. Where controlled measures were in place, these were not always adhered to. There were insufficient numbers of staff employed at the service to ensure people were safe.

The inspection also found that people could not be assured they would receive their medicines as prescribed and that changes to the fire safety precautions placed people at risk in the event of a fire.

The residential home was found to be 'inadequate' when rated by CQC on whether it was effective, caring, responsive and well-led. The inspection report comprehensively shows the mismatch between written statement of purpose and practice.

2.4 During the period reviewed by the SAR there had been 14 residents staying in the home at various times. The residents' needs were complex, and included young people under 18.

## 3 Learning Identified

3.1 The learning from this review, which applies to all the professional groups involved, is that cultivating an approach that includes an element of respectful uncertainty and of challenge, is a necessary foundation for effective safeguarding work with adults. The challenge goes beyond challenging the status quo in the home and extends to challenging the commissioning of services and the quality assurance processes in place.

3.2 The provider's attention to care plans was not of the standard necessary to guide and support care practitioners to meet the outcomes specified in assessments of need. Initially case managers assumed competence in a registered service. When concerns arose, professionals checking quality accepted the provider's assurance. The detrimental consequence of setting recognised care planning aside was only fully revealed in the CQC inspection and Whole Home Enquiry. Evidence of effective care planning should always be documented and verified with the service user, their family and key worker.

3.3 Commissioning agencies must be unequivocal about professionals who are entering into a contract for the provision of care, that their duties and responsibilities are understood, that they are familiar with the relevant law, procedure and guidance as well as being trained accordingly.

3.4 There is a need to have a lead commissioner, in certain circumstances, to provide a single channel of communication and to assist and support the provider in coordinating admissions, case management and review activities. Such an advisory role would help providers resist external pressures and be able to keep an overview of client compatibility, workload and skill mix in care homes.

3.5 Good practice found in multi-agency safeguarding adults whereby agencies prioritise engagement and information sharing should be replicated at an earlier point in preventative activity to improve outcomes and to support the quality of services that providers deliver.

3.6 Quality assurance systems must be clear of duplication and mixed messages. The placing organisation should check that the provider is competent to deliver against its statement of purpose.

3.7 Services for young people and adults with multiple and complex needs are hard to find and supply needs stimulating. The issue is acknowledged as a national one that is beyond this Review to address. Commissioners need to work together to stimulate and create local capacity to respond to local need

3.8 Contracts should be sufficiently detailed to enable clarity of understanding of the expectations of placing organisations, such that they can take enforcement action when these expectations are not being met.

3.9 The list of services and areas where the CQC authorise and regulate a service to operate should be adhered to by the provider, the commissioner and CQC unless there is express authorisation to do otherwise. If this involves children, then OFSTED must additionally authorise.

3.10 There is a need to consider the benefits that appropriate CCTV and other technology can bring to service users and to the support and supervision of staff.

3.11 Placing organisations have a responsibility to be transparent with people about the availability and location of suitable placements to enable them to contribute fully to placement decisions.

3.12 The quality assurance system and processes of the Local Authority in which the provision is based should be explicit.

3.13 Roles of organisations and messages about multi-agency adult safeguarding processes need to be continually reinforced across agencies and with service providers.

## 4 Next Steps

The Torbay Safeguarding Board will agree an action plan which will be implemented by all partners represented at Torbay Adults Safeguarding Board, including guidance for practice learning.