Torbay Safeguarding Adults Board

Serious Case Review

Concerning

Western Rise Residential Home

Overview report

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Contents

1. Executive Summary

This is the report of a Serious Case Review examining events that took place in the Western Rise care home. These events came to light in June 2014 and revealed the serious neglect of a number of residents. The neglect was uncovered during a full home review, with some residents requiring medical care and some being removed from the home and accommodated elsewhere.

There was a police investigation into allegations of neglect at the home, but following Crown Prosecution Service advice no charges were laid.

The purpose of this Serious Case Review (SCR) was to find out whether there were lessons to be learned about the way that professionals and agencies worked together to safeguard adults in the period from March 2012 to June 2014.

The main organisations relevant to this situation were represented at senior level on the Review Panel, which was chaired by an independent person. Each organisation carried out a review of its involvement, and those reviews were the basis for the review panel's discussions and recommendations.

The review has four main elements after the introductory sections:

- good practice that was noted
- lessons that have been learnt
- changes in policy and practice that have been made since the events
- recommendations for action to improve adult safeguarding further

The passage of time since the events means that many improvements have already been implemented by the agencies involved and these are referred to both in the report and in the action plan.

The review concludes that there were significant misinterpretations of the nature of safeguarding, quality of care and whistleblowing across a wide range of health and social care staff who visited the home. It discusses how residents were left in a home with service levels that, at the time, were not fit to take care of them. Many professional staff visited the premises but most did not see anything that, in their opinion, merited a safeguarding alert, yet when such an alert was triggered in May 2014, very significant and widespread failings were found. Some part of the overall failings was known by individual staff who had visited the home, but the overall pattern was not identified, and no individual or agency put together the whole picture until there was evidence of serious neglect and a Whole Home Investigation was triggered.

The key issue is a widespread culture of acceptance; accepting the situation in a home without probing further or challenging. That acceptance occurred within the staff employed within the home and within healthcare staff that visited. Policies, procedures and regulatory systems should identify incompetence, poor practice and poor management; however when the system is under pressure, when staff feel that there is nowhere else to place "difficult" residents, then issues that might in another context trigger an alert, may not do so. When staff of all kinds see others accepting poor

standards, then their own willingness to challenge can be blunted. Standards can deteriorate until someone calls a halt.

This review suggests that standards need to be objective, not subjective, there must be absolute standards for protecting the most vulnerable people, for ensuring their safety and dignity, not based on what is perceived to be appropriate in that area or at that time, but based on a recognised and communicated standard. It is also proposed that whenever possible visits be multi-disciplinary allowing for standards to be discussed and challenged.

While it is clear that lessons have been learnt by the organisations involved, both through this SCR process, and through their own responses to the events at the time, there are still significant problems with this care home. The focus groups that provided the views of some of the practitioners who had attended the premises were consistent in reporting that their members were fully aware of the whistle blowing and safeguarding procedures, but didn't feel they were called for at the home. Many of these visits had occurred in the period prior to the June 2014 Whole Home Investigation, which revealed systemic neglect to a level that required medical attention for some residents and the rehousing of others. The findings of the Whole Home Investigation are set out in detail. This describes what was occurring in the care home at a time when it was being visited by health care, and other, professionals and considered broadly acceptable.

During the course of this review, meetings were held with family members of residents in January 2016. These meetings revealed further reports of poor standards and many of the same factors that had been evident before the Whole Home Inspection of 2014. These events led to considerations regarding the commissioning of services from the home. Western Rise has now ceased to trade.

The report makes recommendations for action that the review panel believes can further improve the safeguarding of adults and the action plan sets out each agency's responses to all the recommendations.

2. Introduction

2.1. This report has been commissioned by Torbay Safeguarding Adults Board under its procedure for conducting Serious Case Reviews. The procedure requires that "a Serious Case Review (SCR) should be undertaken when:

- A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to have contributed to their death. In these circumstances the Safeguarding Adults Board should always carry out a review about the way agencies and professionals worked with the vulnerable adult.
- A vulnerable adult has suffered:
  - A possible life-threatening injury through abuse or neglect
  - Serious sexual abuse
  - Persistent, serious and permanent damage to health or development through abuse or neglect and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard vulnerable adults
  - Serious abuse takes place in an institution or when a number of abusers are involved."

2.2. The purpose of a Serious Case Review as stated in the procedure is as follows: "…. not to investigate, or to blame. It is to find out whether there are lessons to be learned about the way that professionals and agencies work together to safeguard vulnerable adults by:

- Making sure the procedures of all agencies work well
- Improving the way agencies work together
- Developing new and better ways of working
- Producing an Overview Report which brings together all the agency reports and suggests ways of doing things better."

2.3. This report deals with the care of residents at Western Rise residential home in Torquay, Devon. The Torbay Safeguarding Adults Board decided to establish a Serious Case Review following a "Whole Home Investigation" report and a Care Quality Commission (CQC) investigation in June 2014, both of which revealed evidence of neglect of residents in the home. A police investigation was mounted into elements of this neglect, but after consultation with the Crown Prosecution Service in August 2015 it was decided that no prosecution should follow.

2.4. The circumstances of the neglect within the home and the failure by many health care professionals who had visited the premises to identify the nature of the home as a safeguarding issue was the basis for this Serious Case Review. The Review Panel started its work in February 2015. The Terms of Reference for the review are attached at Annex 1.

3. The Serious Case Review Process and the Organisations Involved

3.1. Western Rise is a residential home in Torquay run by the Dr Pepper Care Corporation Limited. It was registered on 30 July 2010 under the Health and Social Care Act 2008. It was registered for 37 people with specialisms recorded as: accommodation for persons who require nursing or personal care, dementia, eating disorders, learning disabilities, mental health conditions, physical disabilities, sensory impairments and caring for adults over 65 years. Conditions were added to the registration specifying that the care home must not provide nursing care, must only accommodate a maximum of 37 service users at Western Rise, and must ensure that the regulated activity is managed by an individual who is registered as a manager.

3.2. The primary customer of the home was Torbay and Southern Devon Health and Care NHS Trust (TSDCT). Since 1 October 2015 this has been called the Torbay and South Devon NHS Foundation Trust (the Trust). Devon County Council and the Devon Partnership NHS Trust also place residents in the home. Residents can also be self-funded.

3.3. On 27 May 2014 a nurse from the Chadwell Older Persons Mental Health Team visited a resident in the home. She was so concerned about what she saw that she informed her team, who carried out a further visit on 29 May 2014. This visit identified further serious concerns, to the extent that the resident they were visiting was immediately removed from the home. The CQC were contacted and carried out an unannounced visit on 2 June 2014 and returned to complete the inspection on 4 June. A multi-agency Whole Home Investigation was started on 10 June. This Serious Case Review (SCR) was commissioned in response to the serious failings found by the CQC and within the Whole Home Investigation.

3.4. The Whole Home Investigation led to nine separate safeguarding adults' investigations and findings of a wide range of safety, quality and neglect issues. Some of these findings would not have been evident to a visiting professional seeing a single client, but many would have been if a wider view had been taken. On 22 October 2014 the lead of the Whole Home Investigation Report made a recommendation that a Serious Case Review be established.

3.5. The nature and conduct of the home has already been examined by the CQC and by the Whole Home Group. Detailed reviews have taken place which have identified the significant risks posed by the home. Steps have been taken to ensure the safety and safeguarding of residents. Subsequent CQC inspections revealed the dramatic improvements made in the home since these incidents. This SCR does not seek to re-examine what was found then, but rather to consider how such a situation developed and how processes for reporting concerns worked. This SCR focuses on the roles of agencies which allowed the home to operate in this manner.

3.6. On 17 March 2012 an unrelated fatal choking incident had occurred which led to a complete review of the health and social care provision to all the residents then in the home. There was a series of review meetings and a health and social care review of each resident then in the home. That review provides a baseline for the quality of care then being delivered. This SCR focuses on the period between that health and social care

review in March 2012 through to the findings of the CQC and Whole Home Investigations of June 2014.

3.7. Once the Safeguarding Board had decided that a Serious Case Review (SCR) should be undertaken, an independent Chair was identified to lead the process. The review was carried out by a multi-agency panel of senior representatives from all the organisations involved in the case. The panel agreed the Terms of Reference for the SCR and the process for completing Individual Management Reviews (IMRs).

3.8. Individual Management Reports were submitted from:

- Torbay and Southern Devon Health and Care NHS Trust
- Torbay Council
- General Practitioners
- Care Quality Commission
- Devon County Council
- Devon Partnership NHS Trust (DPT)

3.9. Information to support the work of the review was supplied by Devon and Cornwall Police. The police investigation into allegations of neglect reported to the CPS in July 2015 and in August a decision was made that no prosecution should follow.

3.10. The health care agencies brought a sample of staff that had visited the premises together into a group session. These group sessions became the basis for the agency reports and were the basis for discussion within the panel, to identify the lessons that can be learnt and agree the actions needed to improve ways of working. The CQC carried out an audit of its regulatory activity but did not interview staff.

4. Key events

4.1. The details below are drawn from the records of the CQC and the Community Business Support and Quality Team. Numerous other visits were carried out by professional staff of many kinds, to see patients and to meet staff. The experience of these staff is captured in Section 6.

4.2. On 16 March 2012 a resident with dementia who was in short term respite suffered from asphyxia and choking at the home and subsequently died. The resident had an obsessive compulsive eating disorder and had died as a consequence of quickly eating food from a sandwich trolley whilst staff attended to other residents. The incident resulted in a coordinated response to undertake full multi-disciplinary health and social care reviews for all 25 residents then living within Western Rise.

4.3. A range of recommendations arose from this wide ranging review. These included improvements in care planning and recording, management responsibility, risk assessments, referrals, the management of incontinence and the pervasive smell of urine and the need for improved cleanliness. It was noted that overall, residents reported that they were satisfied with the quality of care provided. The primary contact for the review was the then manager, and there was little or no contact with the home's owner.

4.4. **First CQC Inspection:** Following the chocking incident on 16 March 2012, the CQC was notified by the local safeguarding team. On 26 March, in response to this information, the CQC inspected Western Rise, this was the first inspection of the home under the provisions of the Health and Social Care Act 2008 (HSCA). The inspection was carried out against eight of the 28 essential standards which applied at the time. These were:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Safety, availability and suitability of equipment
- Supporting workers
- Assessing and monitoring the quality of service provision
- Notifications of death of a person who uses services
- Notifications of other incidents

4.5. Of the 8 essential standards inspected, improvements were needed in relation to three standards and 3 'compliance actions' were issued in relation to:

- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Assessing and monitoring the quality of service provision

4.6. Dr Pepper Care Corporation Limited was meeting the remaining 5 essential standards. However, to maintain this, CQC suggested that improvements were made in relation to:

- Supporting workers
- Notifications of death of a person who uses services
- Notifications of other incidents

4.7. **Events between the First and Second Inspections**. On 18 April 2012, an action plan was received by CQC, setting out what actions the care home was going to take to achieve compliance and to bring about the suggested improvements. The care home submitted timescales by which compliance would be achieved. (Action plans were requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.)

4.8. Between the time of the first inspection (26 March 2012) and the date of the next inspection (4 December 2012), CQC was notified by Dr Pepper Care Corporation Limited of four deaths of people living at Western Rise. The notifications included the history of GP and hospital involvement.

4.9. On 1 May 2012, a concern was received by CQC from a social worker about one person living at Western Rise. This related to the management of falls and general care. The social worker was made aware of the most recent inspection report and of the ongoing safeguarding concern. An action was recorded to follow this up at the next inspection.

4.10. Before 2014 the team that would later be called the Community Business Support and Quality Team (CBSQT) of the Torbay and Southern Devon Health and Care NHS Trust was called the Contracts Team. On 22 May 2012 members of this team visited Western Rise. They spoke with the proprietor and the manager. The outcome of this visit indicated a score commensurate requiring a medium level of monitoring. This was mainly due to the outcome of the previous CQC inspection. A Contracts Action Plan was drawn up and

agreed. This incorporated the actions required from the CQC report from 26 March 2012 and action required relating to a safeguarding case and quality assurance within the home.

4.11. On 19 June 2012 the safeguarding case mentioned above was closed. A visit was carried out by a nurse from the Torbay and Southern Devon Health and Care NHS Trust to meet with the proprietor and manager. The home was then put under the scrutiny of what was known as a Task Group. The Contracts Action Plan was closed on 9 July 2012

4.12. On 27 June 2012, a concern was received by CQC from a relative of a service user who had died prior to the first inspection on 26 March 2012. The relative said they had unanswered questions about the circumstances of their relative's death. The caller was due to meet with the police two days later and was advised to raise these questions then and to identify a point of contact with the safeguarding team.

4.13. On 10 October 2012, a call was received by CQC from a relative of a person living at Western Rise. The caller said their previous concerns about care which they had shared with the local safeguarding team were being addressed by the home and they did not want further action to be taken by the safeguarding team. This was passed to the local authority safeguarding team "in case they have any other concerns about other residents or general concerns about Western Rise". A note was made that the concerns raised should be followed up at the next inspection.

4.14. On 24 October 2012, CQC received from a social worker details of the concerns relating to 10 October 2012. These highlighted concerns about one person who had diabetes and had apparently been declining personal care. This resident had a fungal infection, a red and sore patch under their arm, dirty feet and had declined to see the chiropodist. Their nearest relative had not been informed of this. Records stated the person was aggressive, but in the social worker notes there was no plan in place to identify the cause or to manage this. They also noted that families were not invited to annual reviews. It is also reported this person's ensuite bathroom "smelt", the light bulb in the ensuite was exposed and there was a hole in the wall of this person's bedroom measuring approximately 2 feet by 1 foot.

4.15. On 19 November 2012 there was a follow up by the social worker who reported that action had been taken in response to the concerns. The outstanding issues were that care plans were not up to date, incident forms had not been completed and there were issues with medicines. The inspector recorded that these issues, together with the environmental issues, should be followed up at the next inspection, planned in the next month. On 22 November 2012, CQC received an invitation to a safeguarding meeting relating to the resident to be held on that day. Due to the short notice, the inspector was unable to attend and requested further information. These concerns relating to the resident falling frequently, skin and continence care, poor recording and reporting of incidents, lack of stimulation and supervision for this person and poor liaison with the health and social care professionals. The inspector recorded that these issues had been raised by the social worker with the manager of Western Rise and recommended actions to be taken.

4.16. On 28 November 2012, CQC received further concerns from the social worker about the same resident at Western Rise who had lost a significant amount of weight in the

previous six months. This person had fallen repeatedly. The falls had not been reported to the social worker and no action had been taken to reduce the risk of falls. A decision was made to move this person to a nursing home. The social worker expressed concerns about the manager's capability. The inspector was aware that an inspection was being planned for 4 December 2012.

4.17. **Second Inspection: 4 December 2012.** This was a planned inspection to check that essential standards of quality and safety were being met. The inspection looked at the following 8 of the 28 essential standards. These encompassed the majority of concerns raised with CQC, excluding medicines and environmental issues.

- Respecting and involving people who use services
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Safety, availability and suitability of equipment
- Supporting workers
- Assessing and monitoring the quality of service provision
- Notifications of death of a person who uses services
- Notifications of other incidents

4.18. Of those 8 essential standards, one standard, "Supporting workers" was not being met. The inspection report recorded that the areas highlighted in the concerns received by CQC were inspected. The report recorded that the care home might wish to note that record keeping could be improved.

4.19. **Events between the Second and Third Inspections.** On 9 January 2013, an action plan was received by CQC, setting out what actions the care home was going to take to achieve compliance with the essential standards. The care home provided timescales by which compliance with the essential standard of "Supporting workers" would be achieved.

4.20. On 29 January 2013 the CQC was notified by Western Rise of an outbreak of influenza. Between 7 February 2013 and 8 May 2013, CQC was notified of six deaths. Three were recorded as being due to influenza, two were recorded as being due to bronchopneumonia and one was recorded as being due to old age.

4.21. On 8 May 2013, CQC received a complaint about Western Rise. The detail of this is not available as the CQC policy for this type of correspondence is that it be retained for one month only. The inspector was advised they could request a hard copy of the scanned image, but there is no record this was requested.

4.22. On 17 May 2013, a CQC inspector responded to the complainant saying that while CQC did not investigate complaints about health and social care services they welcomed information which was provided, as it would be added to the information CQC already held about the service, and would help the CQC to target the focus and timing of its inspection activity. There is no record of what the concerns were. The inspector recorded they would consider the information at the next inspection planned for 2013/2014.

4.23. **Third Inspection: 7 June 2013.** This inspection was undertaken to check that action had been taken to meet the essential standard, "Supporting workers". It was found that this essential standard was not being met and this was judged to have a moderate impact on people that used the services. A repeat compliance action was issued. There is no record explaining why this repeat compliance action was issued, although the CQC enforcement policy in place at the time required such a record. There is no record in the report that the concerns received on 8 May 2013 had been followed up at this inspection.

4.24. **Events between the Third and Fourth Inspections.** On 9 November 2013, an action plan was received by the CQC, setting out what actions the care home was going to take to achieve compliance with the essential standard of "Supporting workers". The care home provided timescales by which compliance would be achieved.

4.25. **Fourth Inspection: 4 December 2013.** This was a scheduled inspection to check that essential standards of quality and safety were being met. The inspection looked at five essential standards:

- Consent to care and treatment
- Care and welfare of people who use services
- Safety and suitability of premises
- Supporting workers
- Records

Of those essential standards, one "Consent to care and treatment" was not being met. It was judged that this was having a moderate impact on people and a compliance action was issued.

4.26. **Events between the Fourth and Fifth Inspections.** An action plan was not received as to what actions the care home was going to take to achieve compliance with the essential standard of "Consent to care and treatment". There is no record of the inspector following this up with the care home. Between 14 January and 1 April 2014, CQC were notified of three deaths.

4.27. In February 2014 the local environmental health services visited Western Rise and instructed the home to undertake a deep clean of their kitchen. At the point of the beginning of the subsequent Whole Home Investigation this had not been actioned by Western Rise or followed through by local environmental health services.

4.28. **Notification of Serious Concern.** On 29 May 2014 a duty visit by Chadwell Older Persons Mental Health Team was undertaken to see a resident with advanced dementia at Western Rise following a concern raised by a CPN two days earlier. During the visit records for the resident within the home were found to be inconsistent and virtually non-existent. There were no thorough risk assessments. The resident was placed in the home in February of 2013 when her weight was recorded as approximately 58kg. By December that year she had lost 10kg, there was no record of her weight at the time of the visit. There were no food or fluid charts in place. When she was visited the two attending professionals found her locked in her room. It is unlikely that she would have had the capacity or ability to be able to open her door herself. Her room was filthy, with food apparently having been thrown on the walls and her bedding on the floor, the ensuite bathroom was filthy, with several piles of faeces on the bathroom floor. These

had been noted by the original alerter two days earlier. The resident was found not to have any underwear in her room and only one pair of slippers and a pair of boots. At the time of the visit, she was wearing one slipper and had one bare foot. The soles of her feet and slipper were covered in ingrained filth, which the CPN believed to be faeces.

4.29. Immediate action was taken to remove this resident to alternative care and the CQC were notified. In response the CQC undertook an unannounced visit on 2 June 2014 and identified significant concerns about other residents.

4.30. Due to immediate fire safety concerns CQC made an urgent referral to Devon and Somerset Fire Service as a number of residents were being locked in their rooms and had no keys or capacity to get to safety if there was a fire. The Fire Service subsequently ensured that corrective work was undertaken on that same day, which if not completed, would have resulted in an immediate closure of the home. The fire service also confirmed no evacuation plans were in place and further enforcement notice would be served. The fire risk assessment was noted as being 5 years out of date.

4.31. A new manager had been appointed for the home and her first working days were during the CQC inspections at the start of June. She began recovery plans with the various inspectors and reviewers that then came to the home.

4.32. **Fifth Inspection: 2 and 4 June 2014.** The fifth inspection of Western Rise was undertaken in response to the above concerns. 5 essential standards were looked at and none were met. All were judged to have a major impact on people living at Western Rise.

- Consent to care and treatment
- Care and welfare of people who use services
- Cleanliness and infection control
- Staffing
- Assessing and monitoring the quality of service provision

4.33. **Whole Home Investigation – June 2014.** Due to the severity of the issues a multi-agency safeguarding adult whole home large scale investigation was agreed on 9 June 2014 although action was already being undertaken within the home to assess risk and take action to safeguard vulnerable adults. This included Trust staff daily monitoring visits which by the time of 9 June had also highlighted a number of issues including:

- Strong smell of urine (environment and individual)
- Culture of care
- Manual handling concern
- Unkempt appearances
- Cold food given to residents
- Fluid not accessible to residents
- Slip hazard
- Managing challenging behaviour
- Infection control
- Basement stair lift not working limiting access to building for one resident
- Concerns relating to care and practices raised by resident CC

4.34. By 9 June each resident had received an initial immediate risk assessment and welfare check. It was noted in the meeting of 9 June that a head count of residents living within the home had to be undertaken because the care home and CQC were unable to confirm how many residents were living on the premises.

4.35. The investigation commenced on 10 June 2014 and staff from the following professions were involved:

- District nurses
- Occupational Therapists (OT's)
- Physiotherapist (physio)
- Dietician
- Social Workers (SW)
- Speech and language therapist (SALT)
- Community Psychiatric Nurse (CPN)
- Crisis Response Team (CRT)
- Emergency Duty Team (EDT)
- Environmental Health Department –Torbay Council
- Adult Community Mental Health Team
- Medicines management
- Police
- Fire Service
- IMCA
- Relevant GP's
- Independent care provider
- Infection control (who provided advice)

4.36. Each resident's care notes were reviewed and residents were assessed or interviewed. Family or next of kin were involved as appropriate. Mental capacity assessments were completed when appropriate and Depravation of Liberty Safeguards (DOLS) urgent referrals completed on behalf of the home where appropriate. These were left with the manager to date and send to the DOLS team. All residents were screened for Continuing Healthcare Checklist (CHC) eligibility

4.37. Assessments were carried out by a mix of professionals with key workers involved where necessary and where they were known. The Review Team was supplied with copies of weekly menus, which were analysed by dieticians. Staff training records were supplied and examined. District nursing files held by the care home were looked at. Medication Administration Record Sheets (MARS) were made available. Print outs of GP interventions was accessed and health and social records were reviewed.

4.38. The investigation leads collected information and feedback from the investigation team throughout each day. Feedback was given at the end of each day to the manager or owner of the care home regarding actions taken and concerns raised by the investigating team. Any equipment required was ordered on a daily basis by the OT's and physiotherapists. Staff inspected residents' rooms, the dispensary, the bathrooms, the kitchen and food storage areas. Residents were observed in communal rooms.

4.39. Manual handling equipment and stair lifts were checked. The review team were supplied with information on residents' personal expenditure by the Dr Pepper Care

Corporation. Information was supplied by TSDCT's finance team on those residents for whom TSDCT managed money.

4.40. The Whole Home Investigation identified a number of immediate concerns that led to a total of nine Individual safeguarding adult investigations. As an example of subsequent intervention issues it was noted that one female resident had thrush in her mouth, there was concern regarding her tissue viability and she only weighed 29.29kg. Investigators were advised that she did not use eating utensils and scooped food with her finger. Investigators subsequently witnessed cold bland porridge being given to her with no support which just ran off the finger due to its consistency. After the investigation she was given specialist utensils and has gained weight. Scales used in the home were found to be over calibrated. There was concern regarding dehydration; her skin was dry and she presented as thirsty when supported to drink. The Sudocrem by her bed was 4 years out of date. There was evidence of unsafe manual handling.

4.41. The investigation identified the following key themes:

- Inadequate care planning
- Inadequate knowledge of physical care needs/activities of daily living
- Inadequate knowledge of the mental capacity act and DOLS
- Issues regarding personal allowance and personal effects
- Inadequate risk assessments
- Poor monitoring of weight and evidence of weight loss in many residents
- Poor record keeping in the home
- Poor standards of infection control
- Issues pertaining to medicines management
- Concerns about the knowledge base of the homes care staff with regard to the residents' needs
- Homes overall inadequate monitoring of food and fluids
- Inadequate maintenance of the building and contents
- Inadequate housekeeping and hygiene monitoring
- Equipment not maintained or replaced where needed
- Poor management of challenging behaviour

4.42. **Events between the Fifth and Sixth CQC Inspections.** On 12 June 2014 a CQC Management Review Meeting (MRM) was held. The meeting decided that a warning notice would be issued in relation to each of these 5 standards:

- Consent to care and treatment
- Care and welfare of people who use services
- Cleanliness and infection control
- Staffing
- Assessing and monitoring the quality of service provision

4.43. On 18 June 2014 the Community Business Support and Quality Team, previously called the Contracts Team, carried out a visit to Western Rise to undertake a Business Care Home Quality Assessment. This meeting had previously been cancelled by the care home manager on three occasions. A Support and Improvement Plan was put in place.

4.44. **Sixth Inspection: 2 July 2014**. This inspection was undertaken in response to concerns. One essential standard was looked at and the care home was found to be non-compliant with moderate impact, that of "Management of medicines"

4.45. **Events between the Sixth and Seventh Inspections.** On 17 July 2014, the then registered manager of Western Rise applied to cancel his registration. This application was accepted and the manager's registration was cancelled and a new certificate was issued for the care home on 31 July 2014.

4.46. **Seventh Inspection: 5 August 2014.** This inspection was to follow up on the Warning Notices. Improvements had been made to all 5 essential standards. The Warning Notices were downgraded to compliance actions:

- Consent to care and treatment
- Care and welfare of people who use services
- Cleanliness and infection control
- Staffing
- Assessing and monitoring the quality of service provision

No CQC MRM was held to agree this regulatory action.

4.47. **Events between the Seventh and Eighth Inspections.** On 13 August 2014, an action plan was received by CQC, setting out how the care home was going to achieve compliance with the essential standard of "Management of medicines" following the (sixth) inspection on 2 July 2014.

4.48. **Eighth Inspection: 4 September 2014**. This inspection was carried out to examine the non-compliance with "Management of medicines". The inspection found improvements had been made and that the care home was compliant with this essential standard.

4.49. **Events between the Eighth and Ninth Inspections.** On 29 September 2014, an action plan was received by CQC as to what actions the care home was going to take to achieve compliance with the 5 essential standards following the (seventh) inspection on 5 August 2014. An application to register a new registered manager at Western Rise was received on 2 October 2014. This was approved and a certificate of registration was issued to the manager on 6 November 2014.

4.50. On 30 September 2014 the Community Business Support and Quality Team carried out a follow up visit regarding the Business Care Home Quality Assessment and the Support and Improvement Plan.

4.51. On 29 October 2014 the Safeguarding Adult Whole Home Investigation ceased. A key action was to continue with a 'Provider of Concern Process' led by the Community Business Support and Quality Team. The primary aim of the provider of concern process was to maintain service improvement monitoring to minimise risk to quality of care and service users.

4.52. **Ninth Inspection: 9 January 2015**. This inspection took place using CQC's new methodology. The home was rated as good against all the 'key questions', assessing whether the service was safe, effective, caring, responsive and well led. Overall, Western Rise was rated as good.

5. The Whole Home Investigation – commenced 10 June 2014

The following key themes were identified as a result of the investigation:

5.1. **Inadequate care planning**

Care plans were not personalised; information received from families was not put into residents' care notes. There was no evidence of recording of resident's likes and dislikes or of their life stories. There was a lack of evidence of care planning to meet specific medical needs e.g. epilepsy and diabetes. There was a lack of management plans around challenging behaviour, continence management, communication needs and special diets. The care plans that were inspected did not reflect the current needs of residents. There was little evidence in care plans regarding activities and for those that did exist there was little evidence that activities had taken place. There was a lack of care planning on how to support people who believed they were self-caring. There was evidence from a resident who was thought to be self-caring by the staff who was told she could "do it herself" when she has asked for help; in fact this resident required assistance with her personal care. There were no up to date manual handling plans. There was no involvement of residents who had mental capacity in their care planning or of engagement with representatives for those who lacked mental capacity. There was a lack of awareness of the need for monitoring and managing residents' bowels.

There was evidence that daily recording was repetitive and sporadic and the home's notes were disorganised and difficult to follow. There were no care plans which demonstrated escalation to appropriate professionals.

5.2. **Inadequate knowledge of physical care needs/activities of daily living**

Some residents were found with poor oral hygiene and some with oral thrush. Residents were found with red pressure areas and there was no appropriate equipment to manage their pressure needs.

Flannels and soap were found to be dry, indicating they were not being used. There was no evidence of towels, toilet paper and toothbrushes in some resident's rooms. It was noticed that some residents had been wearing the same clothes for several days. Residents' clothes were observed to be dirty and stained. Some residents were observed wearing others clothes. Hearing aids were not being worn and some had dead batteries. Residents were not shaved and there was evidence of some residents sharing a shaving appliance. A resident was observed not to have a fork at lunch time. It was noted that staff were not engaging with residents during half hourly checks, they were not giving drinks, talking to residents or checking continence.

There was evidence of staff not answering residents' bells, and push buttons that were placed out of residents' reach or broken. It was noticed that drinks were placed out of clients' reach. Some residents were in need of chiropody. Families were not being informed when residents were unwell.

5.3. **Inadequate knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS)**

There was clear evidence that the home staff did not understand the difference between the Mental Capacity Act and Human Rights Act in terms of how to manage the needs of residents who lacked capacity in areas such as personal care and diet. There was concern over the home owner's understanding of Mental Capacity and the Mental

Health Acts. There was a poor understanding of Deprivation of Liberty Safeguards (DOLS) throughout the staff group and no DOLS applications had been made.

5.4. **Issues regarding personal allowance and personal effects**

There was evidence that residents' personal allowances were mostly used for hairdressing, cigarettes or chiropody payments. There was limited evidence over the previous 6 months that residents had had new clothing, toiletries or treats. There was evidence that residents' clothes were not cared for, residents' clothes were found in other residents' rooms and not replaced or there were no clean clothes available. It was noticed that some of the men in particular had clothes which were too big for them. One resident's shaver had gone missing and not been replaced. There were no toothbrushes for some residents. There was evidence that one resident only drank cider; she was being charged for this from her personal allowance. It could be questioned why, as there was no evidence that the home was providing her with any additional or alternative non-alcoholic liquids. There were concerns that this demonstrated poor equity across residents, poor care planning and poor nutrition.

5.5. **Inadequate risk assessments**

There was no evidence of risks being managed through care planning within the home records. Care plans were non-existent for the risks of: smoking in bedrooms, hoarding, challenging behaviour, sexual relationships, skin integrity, manual handling. Fire doors and extinguishers were blocked by a hoist.

5.6. **Poor monitoring of weight and evidence of weight loss in many residents**

Residents' weights were not being checked regularly and consistently. Scales in the home were not calibrated and were over weighing. Some residents were severely underweight and malnourished. Many residents did not have food and fluid charts, some residents were malnourished and others were at high risk of becoming malnourished. Where the charts were present home staff were not consistently completing them. There was evidence of residents losing body mass, including one resident who had lost 6.3% of their body mass in 12 months. There was a lack of follow up and referring on to appropriate professionals for residents who were losing weight. There was a lack of knowledge by the home staff and cook on how to fortify food. Dieticians on the investigation noted low fat or diet yoghurts and poor quality menus that did not provide enough calories i.e. no added sugar squash. Fortified food, for example Complan, was observed to be incorrectly made; it was given during mealtimes when it should have been given between meals. Whole meals were pureed together rather than individual elements pureed separately. There was no separate puree menu, all meals were pureed with liquid added e.g. pizza and sausages (dieticians advise that sausages can't be pureed).

5.7. **Poor record keeping in the home**

There were gaps in daily recording and no reports written by night staff. Where there were care plans they were frequently ineligible in parts.

5.8. **Poor standards of infection control**

There were no personal waste, clinical or laundry bins in residents' rooms nor on each floor. Wet incontinence pads were not disposed of appropriately. There was a lack of hand gel, paper towels and toilet rolls in the bathrooms and a lack of hand gel in corridors. Home staff's understanding of infection control was poor; they were observed

using the same personal protective equipment (PPE) for all residents. Staff were seen answering the main front door wearing PPE and on one occasion a staff member was seen answering the front door with a pad in their hand. Staff on the Whole Home Investigation witnessed home staff using a "kitchen" cloth to clean faeces from the arm of a chair in the dining room. Toilet brushes were left standing in water contaminated with faeces. Sinks and toilets in some bathrooms and ensuites were dirty and with evidence of faecal matter on them. Not all home staff were aware that a particular resident had a bacterial bowel infection and that PPE should be used at all times. The kitchen was seen to be dirty and the freezer smelt. A meal was left uncovered in the kitchen and the cook was noted to be putting plates of food directly on the floor. There was no evidence that residents had personal identifiable manual handling equipment. Hoist slings were left hanging in a communal bathroom. The floor in a ground floor bathroom was sticky with wasps present. There was evidence that a resident's artificial eye had not been cared for.

5.9. **Medicines management**

The dispensary room was very hot and temperature within it was not monitored. The fridge in the dispensary was not locked. A new fridge had a spill in it. The medicines cupboard and dispensary room were dirty. While it was understood that home staff may not understand the medication they were giving, it was evident that they did not escalate questions over medication to the appropriate prescriber when residents questioned what medication they were taking.

5.10. **The knowledge base of the homes care staff with regard to the residents' needs**

There were concerns about medical needs e.g. not calling the GP when someone required a physical intervention following a head injury caused by another resident. There were concerns about the knowledge of manual handling, handling of food and pureed diets, safeguarding adults, the Mental Capacity Act, DOLS and medication.

A Resident who always ate with her fingers was given porridge that was too thin to stick to fingers. A district nurse on the investigation team sent this back and asked for more to be made. This happened on another day during the investigation. There was no equipment offered to support eating needs.

5.11. **Monitoring of food and fluids**

There was a lack of knowledge of soft diets and necessary calorie intake. There were no fluids in some bedrooms and it was generally observed that residents did not have free access to drinks. Residents informed the inspectors that they did not like the food. One resident, who was diabetic, was buying her own glucose tablets as she was hungry. There was a lack of food and fluid charts. It was noticed that cake and ice cream was being given inappropriately to diabetics. There was a lack of supervision of mealtimes, where there was a chaotic environment, with some residents wandering off without eating and others not being aware that it was mealtime. Other residents were observed helping themselves to food off others plates. There was a lack of evidence that fluids had been increased or offered in hot weather. There was a lack of choice to the main meals and there was no encouragement for residents to sit down and eat. Many drinks and foods were low calorie or low fat e.g. yogurts. Food and fluid charts were not being filled out. Mouldy bread was found in the kitchen by the dieticians. There was a lack of choice on the provision of night time drinks for example only white tea given and no

alternatives or sugar offered. Home staff had no knowledge or understanding of the impact that only drinking cider would have on calorific intake and alcohol dependency.

5.12. **Inadequate maintenance of the building and contents**

There was poor ventilation despite there being recent hot weather. The heating was still on in some rooms, some of which had no valves on the radiators. There were no restrictors on some windows on the ground floor. A resident's call bell was not working and a toilet seat was cracked. A bedroom ceiling needed repairing. There was broken equipment around the building which had not been repaired, including a stair lift. Equipment in the home, including stair lifts, bath lifts and scales, had not been annually tested. There were missing light bulbs and poor lighting, which highlighted the homes' lack of awareness of dementia care, visual impairment, physical disability and falls risks.

There were holes in carpets. Mattresses needed replacing and springs could be felt through them. A fire door and an extinguisher were blocked by a hoist. Windows throughout were in poor repair and dirty inside and out. A bannister leading to the second floor was loose and needed fixing. Taps were not working in a resident's room. There was an open electrical flex hanging from the wall in the dispensary. There was a lack of appropriate maintenance of the homes' pressure relieving equipment.

5.13. **Inadequate housekeeping and hygiene monitoring**

The home smelt strongly of urine, the carpet was stained and smelt of urine. The windows were dirty inside and out. The inspectors saw dirty wet bedding and floors. They saw dirty bathrooms with faeces on the toilets. Cups and plates were observed to be left in the hallways outside residents' rooms. Cantilever tables were sticky and dirty. Environmental health reported that they advised the care home to carry out a high level clean in February 2014 which had not happened.

5.14. **Equipment maintenance and or replacement**

There was a lack of appropriate equipment for residents with dementia and physical health issues for example cutlery, cups and plates, pressure cushions and mattresses. Call bells were not working, not plugged in, broken or not accessible to residents.

5.15. **Poor management of challenging behaviour**

There was evidence of poor care planning and understanding of how to manage challenging behaviour. There was a lack of appropriate referrals to outside agencies to aid management of challenging behaviour.

6. The work of the agencies

6.1. The main agencies who attended the home between 2012 and 2014 were:

- Care Quality Commission (CQC)
- Devon Partnership NHS Trust (DPT)
- Devon & Cornwall Police
- Devon & Somerset Fire & Rescue Authority
- Devon County Council
- General Practitioners
- Torbay and Southern Devon Health and Care NHS Trust
- Torbay Council

A series of focus groups were held with staff, facilitated by members of the review panel, these included district nurses, social workers, care co-ordinators, GPs, Review Officers and staff involved in a range of quality and finance support functions. The comments in the following sections were compiled from those focus groups with some material obtained from written reports.

6.2. **How was it to visit the premises?**

6.2.1. The home was well known to health and social care practitioners working in the Torbay area, it provided a number of placements to people with challenging behaviour. Most residents had been known to the agencies for many years and had been the subject of various assessments prior to living at the home. It was widely recognised amongst the visiting professionals who were spoken to that the home's fabric was in a poor state, which had been slowly declining over several years. They felt that the low fees charged at the home was a decision-making factor for placing people, alongside the home agreeing to take 'difficult to place' individuals.

6.2.2. DPT care co-ordinators described the environment as a 'rough and tumble' home that would take people who were difficult to place at low fees. The outside of the home was as poorly maintained as the interior. Care co-ordinators felt it was widely known that the home environment needed improvement, but that the home fulfilled a role by accommodating 'difficult to place' people. The case records provided evidence that many residents moved to the home following placement breakdowns in other homes in the area. The home had some very difficult and challenging residents. The home's staff sometimes attended residents along with care co-ordinators as they could be 'tricky'.

6.2.3. District nurses reported that the premises were smelly, tatty, battered, but that they were not seen as a safeguarding issue, the standards of the premises were not perceived as uniquely poor. They thought the home's staff were welcoming and kind and that the cleaners worked hard. They were generally escorted into the bedrooms of the residents then escorted out again, they did not get to look more widely around the home. The care home staff usually hovered to deal with any challenging residents. Although the District nurses reported feeling safe, one said that she once had coffee thrown over herself and another said that her hair had been cut by a resident.

6.2.4. Torquay Social Care staff reported that the premises were shabby, smelly and were not a good environment. They felt disappointed with the manager who they felt was covering up the reality of the premises. They reported that the place felt like a 'doss house'; beds were not made; residents were kept in their rooms. Residents had nothing to do. It felt chaotic and it was difficult to find staff to talk to, it felt unduly busy.

6.2.5. GP's visiting the home normally visited residents in their rooms. They were normally accompanied by the home manager, who seemed to be good and gave them a sense of confidence. On the occasions when residents' rooms were locked they understood this was through the residents' choice or for the resident's safety. Locks at the home were on the outside of doors so if they were locked residents would not be able to get out. Home staff would open the residents' room door and introduce the GP. There was a smell of urine throughout the place but the GP's felt that such a smell is not uncommon in residential and nursing homes in Torbay. An example was given of a resident with mental health problems who displayed very difficult behavior regarding their personal

care. The resident would not allow staff to tidy her room; it was a mess and the resident smelt unwashed.

6.3. **What did they see?**

6.3.1. Following the March 2012 fatality, safeguarding reviews of the residents were carried out. This included social workers meeting residents and checking over the premises. On entering the home, it was reported that there was a strong smell of urine and the odour of faeces on the ground floor. The manager explained that this was because two residents, both on the ground floor, were faecally incontinent and one of them had smeared faeces around his room. Other parts of the home did not suffer from the same smells. It was observed that the home was generally satisfactory in terms of environment and care, having then been through a period of refurbishment, although some parts of it looked like it needed updating. The manager was considered to have a relevant understanding and insight into the needs of the residents, and was able to talk at length about their care, which reflected the descriptions in the care plan. It was felt that the care home was able to meet the residents' needs at that time. It was reported "the care home is not the gold standard service we would all like for our residents, however the care is adequate and meeting (his) needs at the present time".

6.3.2. A social worker reported that bedrooms were generally personalised to residents' needs and lifestyle, with different décor, pictures and photographs, furniture. This was in contrast to the bedroom of the resident he had come to see, which was sparse, smelt strongly of faeces and did not feel personalised to his needs on first observation. The social worker observed chair scales and mini hoist, both appeared in good condition and well maintained. Medication trolley was locked and secured to the wall.

6.3.3. The residents care plan was updated regularly and there was an inventory of his clothes on file on admission into the home. The care plan discussed what needed to be done for the resident, and how to manage his behaviour patterns such as "try different approaches and return after five minutes when he has calmed down a bit and report to person in charge". The care plan did state clearly that one of his main behaviour traits was that he "will urinate in his sink and smear faeces in his room, carers to ensure room is checked regularly and cleaned as needed".

6.3.4. Details of the reviews were fed back to a planning meeting, were provided to the care home and were put into action as necessary.

6.3.5. A DPT Care Co-ordinator reflected that if there were any issues to raise care home staff would ask the manager or assistant manager to deal with them; they were always responsive, but on occasions appeared overwhelmed and ineffective. Staff always looked busy; at times there were very few of them present. Care home staff were not proactive in providing information and care co-ordinators would have to request information and chase up requests. There was little communication from the home staff to care co-ordinators. If a resident missed an appointment with the GP or other professional care co-ordinators were not routinely informed, and might not get to know for several weeks. Residents were routinely seen in their own bedroom; care co-ordinators did not get a 'feel' for other parts of the building.

6.3.6. A care co-ordinator described how he had agreed a covert medication policy with the care home staff in relation to one resident, but this was not used when the resident refused medication and it eventually led to the resident missing their medication for two weeks, resulting in deterioration of mental health. Staff subsequently stated that they were unaware of the covert medication policy. The resident was eventually sectioned.

6.3.7. The home had some very difficult and challenging residents. Home staff often visited residents with the district nurses as residents could be difficult. The staff would pre-empt behaviour of residents and act accordingly, often with food or distractions. It was felt that staff treated residents as individuals.

6.3.8. Torquay Social Care Workers reported that when they went to the home, while they would look around, they were focused on their current resident and did not really see other areas. They thought that residents were very challenging and confused and that it was hard to engage with them. The Social Care staff saw residents who were not stimulated and were not given anything to do. They formed the impression that some things that the care home staff did, were put on for the benefit of them as visitors, for example providing tea and cake. Some residents were well cared for but others had to be moved as they were not cared for appropriately. The home did not seem able to cope well with more complex residents.

6.3.9. The social care staff thought that staff at the home were not well trained or managed in respect of care plans or risk assessments, in fact they thought that overall the home was a shambles. On the surface it may have looked adequate, but while care seemed reasonable, the overall appearance was shabby and smelly. Several residents lost weight, one lady couldn't feed herself and food was just left in front of her. Social Care staff thought that they would not place anyone there through choice. The home took "hard to place" residents, for example, smokers were placed there. They felt that it was distressing to find people not being cared for and they felt uncomfortable in the premises. There was no 'one to one' attention; the home had lost the personal touch. Some residents had not been washed and looked disheveled. Social Care staff could not always tell who staff were and who residents were. They thought that residents weren't stimulated and weren't given anything to do.

6.3.10. A GP felt that the premises were "shabby to say the least". One boiler was broken so there was no hot water in places and there was mouldy bread in kitchens. The GP felt that it was generally a situation you would not want to put your relative in.

6.3.11. The perception of the GPs overall was that the dilapidated state of the premises was similar to quite a few local care homes at the time. It could do with money being invested in it but was not hazardous to health or urgently needing to be done. The GPs would not choose to go there but it seemed appropriate to them for the needs of the residents who were placed there. Many residents were suffering from self neglect; others were severely mentally disturbed. Originally some of these residents had been in other places where they were totally institutionalised, many were highly complex and several had been moved from other homes as those premises could not cope. With this resident population, the GPs felt that the home was doing as good a job as could be expected. They noticed that the residents had very few visitors. They felt that in other homes there would be more relatives giving opinions about the quality of care. When the GPs had interacted with relatives, they did not have any complaints.

6.3.12. The GPs felt that calls to them from the home seemed appropriate; these were mostly for chest infections, coughs, rashes, high temperature or confusion, out of character behaviour or the identification of infections. The manager seemed to know the residents well and care about them, which they felt was not always the case in other homes. The manager knew what medication the residents were on, which gave the GPs confidence. At some other care homes, staff did not know residents and had no information regarding them.

6.3.13. The GPs were only in the home for 5-10 minutes so they did not always notice things that were going on**.** They were not sure if residents were helped with eating their food**.** The care home made sure that residents were already in their room ready to be seen, whereas others didn't do this. There was nothing about the home that jumped out as a particular concern, indeed staff seemed to go over and beyond action that might have been expected in similar circumstances.

6.3.14. There were records of particular concerns, a social worker reported, "Old building, smelt of urine, no sign of individual stimulation or communication with people, environment un-stimulating - people sitting around walls, no interactions, not in sight of TV, food left next to people, if not eaten no indication that support was being offered, food appeared to be low quality, people in smoking area, unsupervised, some with ash all over clothes, residents going in and out of the kitchen, many people appearing to have significant dementia and unable to communicate their own needs". One resident was reported as falling multiple times, which was not reflected in a risk assessment or in management plans. When this was reported to the manager he did not portray any sense of concern or follow instructions or advice given. These incidents and falls were not reported by the home to the commissioning authority. Personal care was not attended to adequately, one resident was found wet on more than one occasion, reporting that he had redness around his groin and bottom. The resident had inadequate clothing and was cold. This was not addressed even after it was raised with the manager. The social worker gave verbal feedback and clear guidance to the home manager on each visit and this is recorded. On one occasion feedback was also given to the Home owner. The social worker described both as very laid back and seemingly un-concerned. The social worker reported back, on the same day, to her practice manager and expressed serious concern. She was clear about the poor standards observed, her concerns, advice given and action taken. The social worker understood that her concerns were fed back by the practice manager to the relevant local authority.

6.4. **How were staff and management coping in the premises?**

6.4.1. Torquay Social Care staff felt that the manager seemed overwhelmed, depressed and unsupported. He seemed a good follower and worker but not a leader. He was very quiet and 'laid back'; he wasn't coping. Residents were very challenging and confused.

6.4.2. DPT professionals felt there was little understanding of the Mental Capacity Act by staff in the home, including the proprietor.

6.4.3. One practitioner noted that many staff in the care home did not have English as their first language and some had a poor grasp of English, particularly some medical terms and names of drugs. Because of this, DPT professionals felt some care home staff were

not always able to recognise some of the cultural needs of people, or the needs of people with mental illness or learning disability. This lack of understanding often led to an inappropriate tone of voice or facial expressions, which are important tools in talking to residents.

6.4.4. If they had any questions, DPT professionals were directed to the manager or assistant manager. If they were not available messages were taken and they would get back to them, this on occasions, led to a poor ongoing dialogue between the home and DPT, as only the most important issues were raised. Staff pointed out that this is the same for other homes in the area and is a cause of concern.

6.4.5. The district nurses felt that staff in the premises were trying their best under difficult circumstances. Staff seemed to know them well and care seemed resident centered. The care home seemed to retain their staff, more so than other homes. Some of the staff were from other countries, notably the Philippines, and they were all very helpful.

6.4.6. The care home staff knew the district nurses were going at the same time every day and would mention anything they were worried about. They didn't seem to be hiding anything. The district nurses didn't go at mealtimes as this was protected time. This lack of seeing residents interacting with staff at meal times left a gap in their understanding of the regime of the home, but from what they saw residents seemed to have whatever food they wanted or needed. The care home staff carried out weekly weight checks and kept a fluid chart and they knew about diet and care.

6.4.7. The district nurses often asked the home's staff to check pressure areas if any resident was easily upset. The district nurses felt that the home staff were always very careful and that residents were looked after well considering the challenges in caring for them. Some of the residents had huge challenges yet the staff did not seem to get upset or shout.

6.4.8. The care home did not routinely contact the DPT care co-ordinators to share information, and the care co-ordinators would only be made aware when they visited their resident or made telephone contact with the home.

6.4.9. Care plans were difficult to access. They were kept locked away which made it difficult sometimes, but because of the complex residents, the district nurses did not blame the home for having poor systems.

6.4.10. Staff from the Torbay and Southern Devon Health and Care NHS Trust Business and Quality Assurance Team did visit the premises for a variety of reasons linked to their roles and responsibilities including quality review and multi-disciplinary meetings in respect of individual residents. It would appear that on most of these occasions access to the home was limited to the office or garden. Four members of the group had not seen residents on site stating "we only go in for the business side". Staff did offer to show Trust staff around and general feedback on the home environment included: "Run down, tatty, smelly, tatty furniture, there didn't appear to be any investment; the garden was good." In relation to social interactions experienced, the group reported "the staff were lovely but it appeared to be struggling financially"; "the service users seemed ok" and "difficult service users". The group identified that "the original registered manager did not appear to have the management skills, he might have been a

good carer but didn't have, or was not supported with the relevant management skills." No action was taken to raise this internally or with TSDCT management/teams.

6.4.11. For the Finance and Benefits (FAB) and Court of Protection (CoP) officers it appears that there may have been missed opportunities to meet with residents, however briefly, to gain assurance as to their health and wellbeing. Concerns regarding the condition of the environment were not communicated within TSDCT or to wider partner agencies. The sense that these were "difficult" residents, rather than individuals with a range of complex needs, may have unwittingly reinforced the acceptance of the poor state of the accommodation.

6.4.12. There were three attempts to engage the home in the new Quality Assurance process in the 5 months leading to the 2014 alert. The manager turned the Quality Officer away on one occasion, and cancelled the visit on another. This has been identified as a risk by the Quality Assurance team and practice has since changed.

6.4.13. One social worker who visited the home to see residents felt that staff were courteous and friendly and took time to answer questions. There seemed to be appropriate levels of staff during visits. The social worker was given time to sit in the office to look at notes and talk to staff. This social worker saw his residents in the lounge and garden and in their rooms. All the rooms that he saw were clean and tidy. The residents reported that they were happy with the care, support and food and had no complaints. Both residents were smartly and appropriately dressed. Domestic staff came into the resident's room during one of the social worker's visits to empty bins, they seemed to have a good relationship with the resident, with a friendly approach. It was noted that there was a locked door policy.

6.4.14. Western Rise was well known as a home able to cope with residents with illnesses linked to alcohol based dementia especially in younger adults (under 65). A social worker felt there was always a relaxed, calm atmosphere in the home. The manager was willing to take residents with more challenging behaviour than other homes would and was persistent with trying to cope with residents where other homes would have given notice. The manager appeared competent, not easily phased. The social worker felt the home were always willing to try and resolve issues around residents' behaviour with support from the local mental health team. The manager always gave visiting social workers extra time to provide details about how the resident had been. The manager would telephone the social worker appropriately if any issues arose. The social worker found that note keeping was not up to date but felt that staff were knowledgeable about their residents and how to cope with behaviours.

6.5. **Were staff aware of process for recording and reporting concerns?**

6.5.1. The district nurses were aware of the needs of the residents they were caring for. They do a lot of monitoring and assessing and use care plans to assist in this. They all knew about potential indicators of abuse and neglect and what to do if they had concerns about any vulnerable adults. They knew where policies and procedures regarding Safeguarding Adults were kept and how to raise their concerns. They were all "alerters" and regularly had update sessions. They maintained records of any concerns and ensured they were recorded on the Paris electronic record system.

6.5.2. The district nurses had daily meetings at which they could raise any concerns, however before June 2014 the meetings were not well structured and morale amongst the district nurses was low. While they saw vulnerable residents every day they did not feel that their opinions were sought.

6.5.3. Torquay Social Care staff knew about potential indicators of abuse or neglect. They also knew what to do if they had concerns about a vulnerable adult. They were all aware of the relevant safeguarding policies; they were updated and knew how to access them. They said that they would always flag up vulnerable residents. Any concerns were discussed every morning in the team meetings and records were made.

6.5.4. DPT professionals are required to complete various levels of safeguarding training. The care co-ordinators spoken to were experienced in recognising indicators of abuse and neglect and had been involved in previous safeguarding processes. They had knowledge of the safeguarding adult policy; and the need to manage differing levels of risk. Care co-ordinators felt in some scenarios it was about managing the 'least risky option' when all the options are risky. Staff said they routinely looked at individual care plans for people on their caseloads and would raise concerns with the home manager if required. They were not aware of any system which could recognise and collate several individual professional concerns to build a picture of the care provided in the home.

6.5.5. Visiting nurses made assessments and used care plans. They all knew about the potential indicators of abuse and neglect and what to do if they had concerns. The Health Care Assistants, although not carrying out assessments, knew what to do if they had concerns. They had all received updates and knew where safeguarding policies could be found. They were aware of the needs of the vulnerable adults they were working with, through carrying out assessments and talking to families.

6.5.6. The Torbay and Southern Devon Health and Care NHS Trust finance and quality support staff were aware of vulnerable adults and knew about potential indicators of abuse or neglect. The group were unanimous in stating they knew what to do if they had concerns about a vulnerable adult. Of note is the fact that in this focus group they commented "we don't see service users". As this is the main focus of Financial Assessments and Benefits (FAB) and Court of Protection Finance Team (CoP) interventions this is an unexpected outcome.

6.6. **What was the senior manager or other agency support regime?**

6.6.1. DPT care co-ordinators were not aware of any strategic agreement to support the home to manage people with difficult and challenging behaviour above and beyond individual care co-ordinators visiting people on their caseloads. DPT staff felt that there was not a collective approach to supporting the home from multi-agency professionals working with individuals in the home.

6.6.2. DPT senior managers in Older People's Mental Health services and the wider Trust were aware of the home following the death of a resident in March 2012, which initiated the review of all residents' health and care provision. First line managers were also aware and had been in conversations with other professionals.

6.6.3. Within Torquay Social Care, the nurses and HCAs did not know about involvement of any senior managers or other professionals; there was no indication from the other agencies and they were never asked their opinion or involved in any discussions. The nurses were surprised and frustrated that they had not been involved and no other agency or professional raised any concerns with them.

6.6.4. There was little senior management involvement with the district nurses; they were not involved in any decision making, but were not sure about any other managers. They were not represented at any meetings.

6.6.5. It is current practice in the Quality Assurance team of Torbay and Southern Devon Health and Care NHS Trust for officers to escalate concerns to the managers in the event that they are experiencing difficulties undertaking a quality review. Unannounced visits to confirm future meetings may also take place where telephone contact has failed. TSDCT's Provider of Concern process may also be invoked for a home where there are persistent concerns, complaints or quality assurance failures which do not however meet the threshold for Whole Home Safeguarding. This may be a formal or informal process.

6.6.6. GPs have annual online learning updates on safeguarding adults.

6.7. **Did anyone consider reporting the premises?**

6.7.1. The district nurses felt that there was never any reason to report anything at the home; they saw nothing that they would consider a safeguarding issue. They noted that the staff were very kind and caring, despite the challenging behavior of the residents. An example was given of one resident who wouldn't let the district nurses do a dressing so they let the care assistant do it under their supervision. The resident was fine with that and they healed the wound. The district nurses reported that they never felt threatened or unsafe. There were care plans, but mostly to do with concerns about nutrition and fluids, these were always documented. If they did have any issues to raise then they would use the care plans.

6.7.2. The district nurses reported any concerns and referred on to agencies such as the CPNs, but as far as the district nurses were aware nothing was done. The district nurses had their priorities but if there were concerns they would always refer them on. They have a safeguarding nurse but they believed that they were not allowed to go into the office to talk to them. They believed that they had to send an email. The district nurses looked out for concerns and discussed them but they do not get involved in safeguarding often. The district nurses do not get involved in the Safeguarding process, it is separate and they do not hear what's going on.

6.7.3. One of the Torquay Social Care workers did report to their line manager and recorded it on several occasions. One Social Care worker also reported challenging the home manager about the smell and some manual handling practices. Another social care worker reported to their line manager and the resident's family.

6.7.4. The Torquay Social Care workers thought that assessments and decisions appear to have been reached in an informed and professional way. They did not see a need for identifying a safeguarding issue.

6.7.5. Torbay and Southern Devon Health and Care NHS Trust Business Support staff felt that there were no financial concerns relating to individual residents which required action at that time.

6.7.6. GPs did not feel that the environment in a care home was a role for them, unless things were obviously extreme, for example if they were treading over faeces. If a GP had been into a bathroom and seen faeces they would see it as being appropriate to report. The GP's would report a home if it was a detriment to residents. If a home was a bit grubby they would not consider that a GP should report, however, if for example there was a rat in the kitchen it would be appropriate to report. They would not worry about untidiness. They felt that was more a role for the CQC. One GP did say that he had visited much worse premises around that time.

6.7.7. The CPN who made the final alert did so because what she saw was clear cut evidence of mismanagement and neglect. However, some weeks earlier she had seen evidence of a less clear nature, she had raised what she had seen at a staff meeting. Her concerns were around the quality and smell of the home. The feeling of the meeting was that those were minor issues compared to the difficult residents the home was dealing with and the issues raised were not recorded or referred on.

6.8. **How did workers take the wishes or feelings of residents into account?**

6.8.1. DPT staff record residents wishes and feelings as part of the assessment and in the review of care plans. Whilst reviewing TSDCT electronic case records it was noted that if an individual exercised their right to refuse treatment or medication, the care co-ordinator was not immediately informed, and on occasions, not made aware for several weeks.

6.8.2. Torquay district nurses did not feel that residents' wishes or feelings were ascertained. Torquay Social Care staff asked residents about their wishes and these were taken into account wherever possible and recorded. Family members were consulted and residents and families were seen individually.

6.8.3. Residents and their representatives are given the choice as to the manner and location of their FAB assessment. The CoP officers take an active role in Best Interest assessment and decision making as required by the individual's circumstances**.** This is recorded by the multi-professional teams and held on the resident's personal record.

7. Care Home Staff Views

7.1. A perspective from within the care home was obtained by interviewing the new manager, who was unconnected with incidents prior to the 2014 Alert and a Team Leader who had been a member of staff in both the old regime and the new one since 2014. Prior to her appointment the new manager had been briefly shown Western Rise by the manager of the linked Plymouth care home. During this tour the new manager was shown the communal areas of the home, but not people in their rooms nor care being given. She found the home to be untidy and dirty, but based on what she saw did not immediately see it as a safeguarding issue. When she returned, following the CQC inspection and could see the entire premises, she was horrified at what she saw.

Residents seemed to have given up, to have shut themselves off. There were basic things wrong, such as the absence of incontinence pads. Care plans did not reflect anything of use, or were missing, there were hardly any background details on the residents. Residents seemed scared to speak up for themselves. Some would not leave their rooms. Staff did not seem to care and were just keen to do the minimum and get home.

7.2. The new, current, manager arrived at the home just prior to the June 2014 CQC inspection and started work afterwards. She described the premises as the worst care home environment that she had seen. She found residents records incomplete, many medicines out of date and not issued and a general sense of neglect.

7.3. There was a strong smell of urine in the premises. The new manager felt that visiting professionals on a short visit, seeing only one resident, may not have realised how bad conditions were in the home. District nurses and other visiting professionals keep their own records so may not have realised the care records in the home were so poor. The previous manager seemed able to talk well about what was happening in the home, but was entirely wrong in his assessment of the quality of care being delivered.

7.4. The new manager was aware of the financial pressures on the home but was only willing to provide care where it could be effectively and safely done. This led to the movement out of the home of several residents that the home could not provide quality care for. Previously there was almost no relationship between care home staff and visiting professionals. There is now a very positive and helpful relationship with frequent telephone and personal contact.

7.5. Under the previous regime there was a vicious circle of patients apparently declining medication or treatment, not being encouraged to take it, then declining further, this included incontinence products, leading to soreness and the pervasive smell of urine.

7.6. There were challenges for the home including the low fees paid for residents in Torbay and the shortage of Mental Health inpatient services in the area.

7.7. The new manager would have declared a safeguarding alert about many of the issues found in the home if the CQC and Whole Home Investigation had not just done so.

7.8. The regime before 2014 was one of neglect, systems and process were largely absent. The manager was often absent from the premises. He would attend when there were due to be professional visits but otherwise was not on the premises.

7.9. Most of the staff were of long standing and were left to manage as they saw fit. Records were often not completed. New members of staff joining the premises were not formally inducted or trained but were left to make of the premises what they would. For a staff member spoken to, this was her first care home role, she arrived in 2013 as a carer. She found the home smelly and dirty, but she did not know what else to expect. She joined a team who seemed to accept that is how it was and so while she felt uncomfortable about it, she got on with her work. There was no organisational structure, there was no apparent hierarchy, other than the manager, who was often absent. There were no instructions about who to turn to in the event of an emergency or for any kind of advice.

7.10. The home was shabby, uncared for and had an uncaring approach. The only route open to staff to raise any concerns was via the manager, who seemed disinterested. There was little or no communication with healthcare professionals outside of the home.

7.11. Residents were not stimulated and were not treated as individuals. The atmosphere in the home was chaotic, stressful and not conducive to good care.

8. Identification of good practice

8.1. In any review process it is as important to identify good practice that needs to be maintained and developed as it is to identify shortcomings to be corrected. In this case there were a number of particular examples to note where individuals took responsible professional action in response to what they had observed or been told.

8.2. The action of the CPN who made the May 2014 safeguarding alert was clear and decisive, this was followed up quickly by her team. Their safeguarding alert led to the Whole Home Investigation which was again decisive, quick and comprehensive. The Whole Home Investigation worked over several days, with multiple agencies, to gain a complete picture of the safety and wellbeing of the residents and the state of the care home. The Whole Home Investigation process was locally developed and is available to be deployed when required.

8.3. Individual workers and teams have carried out effective reviews of residents in the home. There were significant notices of concern submitted by several social workers, not only referring to their current residents, but to the wider establishment.

8.4. The Older People's Mental Health Team have established their own comprehensive "Support Plan Review" for recording the status of residents.

8.5. A Single Point of Contact for adult safeguarding has been established at Torbay Police Station, this is a joint team including the police and the Trust. There is a plan to combine this arrangement with existing child safeguarding arrangements to create a single Multi Agency Safeguarding Hub (MASH) for adults and children. The current arrangements allow for triaging of reported concerns and combination of data sets.

8.6. The Trust holds the lead for Adult Safeguarding for both themselves and Torbay Council, they have clear safeguarding reporting mechanisms and has promoted the message, "Safeguarding is everyone's business".

8.7. Following the 2014 safeguarding alert safeguarding officers from the Trust delivered safeguarding training to staff within the home.

8.8. The Trust sent in a team to review the care home on 10 June 2014 and subsequently arranged for staff to remain in situ to support the care home staff until quality and safety was assured.

8.9. The relationship between the Trust and the CQC is positive and professional. This relationship has been improved further by the establishment in 2015 of regular CQC led Quality Assurance liaison meetings.

8.10. The newly appointed manager of the premises has made a significant difference already. In March 2015 the premises were inspected by the CQC and found to be “good” in all 5 areas inspected and good overall, with no areas for improvement identified.

8.11. DPT staff reported that following the June 2014 CQC and Whole Home Investigation inspections, the outside of the home has been improved and on-going work inside the home is happening. There is a notable difference in communication with the appointment of the current home manager.

8.12. The Trust has a system, called Datix, which allows for staff members to record low level concerns regarding any safeguarding issues. This system appears well known by staff and able to aggregate data, where no full alert exists.

8.13. The Business Support Quality Assurance team have developed a Quality Assurance tool which is used for contract management purposes with care home providers.

8.14. The Trust has a mystery shopper process which can give an indication about quality issues.

9. Lessons learnt

9.1. Lessons have been learnt by all the organisations involved, both through this SCR process, but also more immediately from their own responses after the events at Western Rise. This should be clear in what follows below and in the recommendations and actions that are proposed in response to that learning. The learning is set out under a number of key themes that are then carried through into the recommendations and action plan.

9.2. The events in Winterbourne View were reported by BBC’s Panorama in May 2011 and were subject of a Serious Case Review in 2012. A wide range of national policies and training processes have been developed since, but it must be of concern that in 2014 Western Rise could be operating in the ways found by the Whole Home Investigation, at a time when many professional staff were visiting.

9.3. The information that was finally revealed through the Whole Home Investigation in June 2014 was not hidden previously. It was triggered by one whistle blower and a follow up visit. Once the Whole Home Investigation was underway, all those involved became clear about the level of systemic poor standards of care. It is not possible to be certain that the situation that was seen in June 2014 would have been evident at any earlier point, but the general condition of the home appears to have been seen by those visiting from 2012 onwards. There were exceptions, but most visiting staff appear to have seen it as poor but acceptable.

9.4. Up until the 2014 alerts and the significant change of management and ethos, there was a culture within the home that allowed very poor standards to exist. That culture was perpetuated by weak management and a lack of attention to basic standards. Staff became part of that culture. Residents became affected by that culture, left unattended and displaying difficult behaviour. Visiting professional staff were not in the premises long enough to understand what was driving that culture and frequently did not probe

deep enough to discover what was going wrong. Once the gross neglect seen in May 2014 triggered the Whole Investigation and the June 2014 CQC inspection a full picture was established. Normal management action, staff communication and raising concerns should have revealed what was going on much sooner.

9.5. Staff who visited the premises on behalf of various agencies have been spoken with as part of this process, they were generally supportive of the home's staff and the challenges they faced. Individually they only visited the premises for brief periods and did not obtain a full picture of the quality of care being delivered. There was a lack of aspiration for quality of care, both from within the home and expressed by many who visited. Following the Whole Home Investigation and CQC inspection in June 2014, there has been a change in approach, both within the home and from visiting professionals. The smell of urine is now taken as evidence of things going wrong and is dealt with, residents individual needs are seen as a priority. The atmosphere in the home now is generally calm and orderly, with high standards from both staff and residents being expected and encouraged. Budgets have not changed and the resident group is largely similar; what has changed is the sense of leadership from key managers involved.

9.6. This review examined what happened rather than the underlying psychology of visiting staff that allowed it to happen. There are many useful research papers that explore biases in decision making and specifically in a social care context. NHS research in 2014 sets out some of the biases and influences on social workers working in the field of child protection[1]. Amongst others it discusses the risks of "confirmation bias" in which people have a tendency to maintain their intuitive beliefs even in light of evidence that challenges them. The report also discusses "groupthink" a bias that occurs when a group's desire to avoid conflict and achieve unanimity drives the decision-making process and subsequently results in bad decisions being made. Loyalty to the group often leads to ideas not being critically evaluated and alternative solutions not being raised.

Checks and Balances in Systems and Professional Relationships

9.7. This case revolves around the acceptance of poor care in a poor environment by a large range of staff from a wide range of professions. There seems to have been a general sense that conditions were not good, indeed were not good enough, but that there was no other better premises that could take the residents on. Visiting professionals thought that the care home staff were doing a reasonable job, in demanding circumstances.

9.8. Viewed with hindsight, the conditions at the home, certainly by May 2014, were not suitable for the residents that were cared for there. The range of issues exposed during the Whole Home Investigation and the June CQC visits, indicate conditions that should have caused real concern. There is no evidence that conditions were being concealed from visiting staff, nor that the state of the home had significantly deteriorated just prior to the end of May 2015 when the safeguarding alert was made, rather it seems like there was a general malaise, a general acceptance of the condition of the home. It is not clear why the safeguarding issues in the home were not identified before, either by any

[1] Clinical Judgement and Decision-Making in Children's Social Work: An analysis of the 'front door' system. Department for Education Research report April 2014 Elspeth Kirkman and Karen Melrose – The Behavioural Insights Team.

of the professionals visiting or identified with sufficient seriousness during the previous CQC inspections.

9.9. The significance of the "Whole Home Investigation" in June 2014, is that it was a review of everything in the home, by a large multi-disciplinary group, with collated findings. This allowed all the professionals to understand the entire situation, rather than just elements of it.

9.10. Visiting staff were influenced by the belief that other premises were as bad or worse and the perception that budgets allowed by those commissioning care was insufficient to buy better. The home manager was thought to be either out of his depth or unduly relaxed about the conditions of the home, the proprietor was rarely seen and staff, although friendly, were unduly busy. The home was generally supported by the visiting staff. The pressure upon the staff working in the home was recognised, and there was a perception that the home was under significant pressure. The home was scrutinised by frequent CQC inspections, but not sufficiently challenged otherwise by visiting staff, nor the Trust's QA team.

9.11. There were a large number of visits by various professionals to the premises over the relevant period, but other than in 2012 and during the Whole Home Investigation, no coordination of their overall sense of the home. There were reports compiled by social workers and others but these did not find their way to the Datix system or other shared database that may have allowed a wider view to have been formed. Reports were forwarded to the CQC and did inform inspections that were carried out, but did not lead to a multi-agency discussion.

9.12. In the report of the Victoria Climbié Inquiry, Lord Laming made the following comment: "…..The concept of "respectful uncertainty" should lie at the heart of the relationship between the social worker and the family. It does not require social workers constantly to interrogate their residents, but it does involve the critical evaluation of information that they are given... social workers must keep an open mind." 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.

9.13. There is nothing to suggest that the status of the care home owner as a GP played a part in the decision making of staff attending the premises. Almost all engagement of visiting and inspecting staff came through the manager. The previous experience of the proprietor played neither a positive nor a negative role in the situation.

9.14. It does not appear that home staff were frightened or intimidated to report neglect or poor standards. While many staff were foreign workers, whose jobs were dependent upon the home, they did not appear to be concealing the situation. The lack of management oversight in the premises allowed them to have an easy working life, unencumbered by having to carry out too many caring duties. The professionals that visited the home generally indicated that staff knew residents individually and were better than others in other homes. Nothing appears to have been intentionally hidden from visiting professionals. Staff in the home did not know any "whistle blowing"

systems. Staff in the home were only aware of their in house line management route to raise any concerns. They were not aware of any route to the CQC, the Trust's safeguarding procedures or any other. It appears that home staff did not raise concerns to their manager, as the culture was of complacency and neglect, led by the manager.

9.15. The staff in the home did seem poorly trained, with little knowledge about the Mental Capacity Act, effective safeguarding or the provision of care with dignity. When the Trust gave them training after the 2014 alert, they seemed genuinely shocked by the standards that were required of them.

CQC Inspections and Decision Making

9.16. With the exception of the third inspection on 7 June 2013, CQC's inspections of Western Rise were informed, and triggered, by information received. Information which related to individuals was used to inform evidence gathering and reporting. It is unclear whether the inspection on 7 June 2013 looked at the concerns received as there is no evidence that the information was requested before it was destroyed in accordance with CQC policy.

9.17. CQC Inspections were unannounced, thorough and mostly followed CQC methodology. However, where warning notices were downgraded to compliance actions as in August 2014 a CQC Management Review Meeting (MRM) was not held to show the rationale for this decision, which was contrary to CQC methodology. Reports were clear and, with the exception of the third inspection on 7 June 2013, took the views of people using the service into consideration. With the exception of the period following the June 2013 third inspection, actions plans were received from the provider, which included timescales.

CQC Decision Making

9.18. Following the inspection on 7 June 2013, a repeat compliance action was issued. An MRM was not held to record the rationale for this decision and the reasoning for the decision to downgrade the warning notices, served following the fifth inspection on 2 and 4 June 2014, to compliance actions cannot be established. This was a deviation from the enforcement policy in place at that time.

9.19. When an MRM was held on 12 June 2014, the rationale behind the decision to issue five warning notices was recorded. Other options considered and the rationale for not taking more significant enforcement action were recorded. The decision to issue warning notices was made in accordance with the CQC Scheme of Delegation in place at the time.

9.20. An additional MRM should have been held and recorded to review evidence of compliance with the warning notices. It is recorded on the MRM held on the 12 June that this should happen. An additional MRM should have been held when concerns were received by CQC about the management of medicines, which resulted in a further inspection on 2 July 2014, with resulting non-compliance.

9.21. In October 2014, CQC changed the inspection methodology; in April 2015, it introduced a revised enforcement and associated decision making policy. The decision making

framework would have resulted in CQC considering action that would affect the registration of Western Rise. This would have included consideration of cancellation, suspension or imposition of more significant conditions. The fitness of the registered manager to remain registered would also have been considered.

9.22. As an added level of quality assurance, decisions regarding enforcement action of a high or extreme nature are made in an MRM, in consultation with the inspection manager and not by the inspection manager. Scrutiny is provided by inspection manager peers, legal representatives and where necessary, and in accordance with the scheme of delegation, enforcement actions are agreed by Head of Inspection.

Training and Policy Implementation

9.23. This review reveals a number of training and policy issues. While all those involved claimed to be fully aware of their agencies safeguarding and whistleblowing policies, it was not clear was that they were sufficiently aware of risks and policies about abuse of vulnerable adults and their specific responsibilities within those policies. With some exceptions safeguarding does not seem to have been the context for considering the residents' needs or the quality of care that was being provided. There is a need for training to be delivered to set out the standards expected within care home environments and the trigger for creating safeguarding alerts. The issue appears to be that of thresholds rather than absolutes.

9.24. While the Whole Home Investigation was a very positive exercise, most other reviews involve only one discipline. It would be very useful in any review being conducted within a care home environment to have another profession adding to the review process. The Trust is an integrated health and social care body and where possible should be examining resident needs from both perspectives.

9.25. The Trust required annual resident reviews to be carried out face to face in the home, but an examination of ten reviews carried out for this SCR revealed that other than those residents with complex needs, those for residents receiving adult social care appeared scant in detail and lacking in independent input.

9.26. Various review tools have been established with different formats for different team's needs. It would be useful to have a unified format, even if different teams used different aspects of the tool.

9.27. Prior to the 2014 safeguarding alert district nurses appraisals were not being completed on time, paperwork was often poor and moral was low. This situation has been turned around by active and clear management.

Availability, Use and Sharing of Information

9.28. It became clear during this review that information was in the possession of many different people, not all of it clear facts, rather opinions, feelings and impressions, but there was no simple opportunity to discuss this with other professionals. Each visiting health or care professional carried out their functional role, seldom seeing other professionals, it was not until the situation was gross, as seen by members of the Chadwell Older person's team, that action was taken to coordinate information.

9.29. Datix is an intranet system that allows any member of staff within the Trust to record any safeguarding concerns, it is simple and clear and can record even minor data. Behind the system the data is received by the Business Support Quality Assurance team, where is can be used for contract monitoring or if aggregated amount to a safeguarding alert. The system is widely known to staff and well designed.

9.30. In this case, the system was in existence, but did not appear to be used in the way that it was intended. Staff spoken to within this review process indicated that they found the premises to be smelly, tatty, with a manager who was out of his depth and the Whole Home Investigation revealed issues that amounted to significant safeguarding incidents, yet in the 2014 before the safeguarding alert, there were only two entries on Datix. These incidents were an overdue catheter fitting and a pressure sore issue. There appears to be a disconnect between what people were seeing and their understanding of the Datix reporting system. In a different, unrelated care home case in the area, there were some 19 Datix reports, leading to action. The question remains why in Western Rise reports were not submitted. Datix is only available to staff in the Trust; data can be shared with other staff via the Single Point of Contact.

9.31. Discussions with staff indicates that the home had a reputation for taking on difficult residents and that this reputation had left visiting staff unwilling to challenge the standards of the home.

9.32. The Care Act 2014 and previous legislation since 2009 establishes a legal requirement for the provision of Independent Mental Health Advocates, who are professionally qualified to support people to fully participate in decisions about their care and treatment and explain their rights and options under the Mental Health Act. For residents within the Western Rise Care home, this service does not appear to have been offered.

9.33. At the time of the 2014 safeguarding alert the district nurses did not hold effective safety meetings, they were in two teams, North and South, and held their own separate meetings. Both teams had residents in the care home but did not regularly share their views. Since July 2014 there have been regular integrated team safety meetings, for all district nurses on duty. Standards and clear escalation processes are explicit. Evidence of neglect is now discussed regularly. Smell is an important factor, the smell of urine is not accepted and is considered as evidence of neglect. Understanding of what makes acceptable and unacceptable standard is discussed in the meeting but also in 1:1 meetings held with all staff.

Raising Concerns (Whistle Blowing) and Inspection

9.34. This case demonstrates the risk of conditioning of staff, over a period of time, to accept standards that are inappropriate. This can happen when they know or believe that there are no realistic options, or that others are aware and accept the conditions. There should be absolute, rather than comparative standards. There should not be a standard that is acceptable for one resident or group that would not be acceptable for others.

9.35. During the course of the review it emerged that staff in various agencies were confident about the whistle blowing process and about their various safeguarding schemes, but

they did not feel it was called for in this situation. It seems that opinions about care in the home had been calibrated downwards, so that the widely accepted view was; it is not what I would want for myself, but it is just about acceptable. Persistent neglect is more difficult to spot and report about than any gross activity.

9.36. Between 2012 and 2014 many professional staff from many different agencies visited the premises, these included GP's, district nurses, Social Care workers, quality assurance staff and CQC inspectors. There were also reports, notably from the CQC indicating that standards were not being met. Each visit pointed out systemic failings to a greater or lesser degree, each inspection was followed by an action plan. Focus groups held with all the main agencies whose staff attended reveals that overall they had a degree of sympathy for the staff in the home, an understanding of the challenges they were facing and an appreciation of the support that the home staff gave to the visiting professionals. The professionals appeared to have a single case focus, focussing their attention on the resident who they were there to see. There was a general acceptance that this was the home of last resort, if staff complained then where would residents go to? They did not believe that this was the worst of such homes at the time.

9.37. There is an effective whistle blowing system in place in Torbay, but that would not appear to be the issue here. All of the staff spoken to were clear they understood the safeguarding and whistle blowing systems but none felt it was required. The Datix alerting process is clear, but had only been used for two minor issues prior to the 2014 safeguarding alert.

9.38. The CPN who made the final alert did so because what she saw was clear cut evidence of mismanagement and neglect. However, some weeks earlier she had seen evidence of a less clear nature, she had raised what she had seen at a staff meeting. Her concerns were around the quality and smell of the home and the overall treatment of residents. The feeling of the meeting was that those were minor issues compared to the difficult residents the home was dealing with and the meeting did not pursue the information until the final alert was made.

Organisational Change

9.39. Over recent years the requirement to reduce expenditure within the NHS has been challenging and this has been coupled with the increasingly complex nature of the care required by individuals and the demographic age profile. The frontline workforce is fundamental to delivering safe care but have been required to meet the financial savings required. All the agencies involved in this situation have been through several years of cost cutting, not only feeling it themselves, but being conscious of it in other areas through colleagues and seeing news reports. A widely held view was that there was not enough funding and few choices. There was no evidence to suggest that budgets or cuts were in fact a driving force in this situation, indeed with a change of manager in 2014, there was an immediate and dramatic improvement leading to the CQC finding no areas of concern in the March 2015 inspection.

Safeguarding

9.40. Many of the residents in Western Rise had few, if any, visitors, therefore there was no advocate to speak up for them about general welfare issues. The services of

Independent Mental Capacity Advocates are available to support residents, but only for specific decisions, not for general advocacy.

9.41. Visiting staff who were spoken to gave accounts of a premises that were smelly, tatty, and shabby, with a manager who was over worked and apparently out of his depth. Visiting staff also talk of care home staff who were friendly and resident centred. Staff had an understanding that these premises were at the least, not adequate, yet they also had an understanding of the financial regime that both the local statutory agencies and therefore the home were working under. Several staff indicated that though they thought the home was inadequate, it was by no means the worst in the area and other homes had for various reasons sent difficult residents there. There was a general acceptance that this home was doing what it could do in difficult circumstances. The broad mind set appeared to be that this was just how it was. It was only when the Whole Home Investigation was carried out in June 2014 that the true nature and extent of the neglect in the home was revealed.

9.42. There were complaints before the May 2014 safeguarding alert, the CQC had received several, from visiting staff and from relatives, but not sufficient to cause an overall concern or to trigger an intervention as dramatic as the June 2014 Whole Home Investigation.

9.43. If residents are complex or challenging and need to be moved, they are likely to need a higher level of support, scrutiny and care rather than less.

9.44. During discussions with GPs, weight loss of residents with dementia was considered to be a normal occurrence and not necessarily problematic. Since the 2014 safeguarding alert monitoring of resident weight and the identification of weight loss as an indicator of concern has been established. District nurses note weights recorded by care home staff, but are also able to check weights themselves.

Pre admission assessment, allocation and contract management

9.45. Processes for allocation of residents to care homes should be based on a clear process of resident choice, however when residents are unable to exercise that choice, it does not appear that independent advocacy is utilised. This can lead to residents being placed in a home without due scrutiny or oversight. There is a joint responsibility between the care home proprietor and the funding body to ensure that the home is right for the resident.

9.46. In a judgement in December 2014 the High Court heard the Judicial Review brought by the Torbay Quality Care Forum, representing 28 of the 108 care home operators in Torbay. The court concluded that some elements of the model that determines fees was unlawful. This will affect calculations for the 2014/15 funding year. The council have made some amendments to the model, but is appealing the outcome of the Judicial Review, with the matter to be heard in November 2016.

9.47. Since the incident the home has completed a pre-admission assessment for each new resident entering the home. This is gradually being rolled out across other providers where there have been identifiable concerns. The home manager has negotiated an agreed fee based on the individual's needs where they are more complex than the current fee structure would accommodate.

9.48. Funding levels must be a factor in the provision of care. However they are only one factor, much less important than management ability and effective systems. The movement of Western Rise from failing all CQC inspection areas to passing them is not a product of new funding, but of more effective management.

10. Changes in policy and practice since the events

10.1. The passage of time since the original events means that there have been changes in national policy and practice that are relevant to the themes identified above and have already strengthened systems and standards. Local policy and practice has also, in many cases, already been reviewed and revised. These changes are summarised here to supplement the issues raised in the recommendations.

Checks and Balances in Systems and Professional Relationships

10.2. At the end of 2013 the Trust developed a "Provider of Concern" process. This allows consideration of any care home through three tiers, initially Contract Action Planning, then "Provider of Concern" notification, and then the "Whole Home Investigation". This tiered process allows for escalation and de-escalation of concerns with consultation with the proprietor of the home concerned. This has been reviewed again recently in order to make the system simpler and more effective.

10.3. Changes in local policy mean that annual reviews of care home residents may now be carried out by telephone, rather than in person, this contains risks, which will require mitigation.

10.4. At the time of the 2014 safeguarding alert, intelligence was available, but unknown to the Torbay Quality Assurance and Business Support team, with regard to a sister home in Plymouth which had experienced similar issues. Since this case, checks are made on any care homes or businesses associated with a home about which there are quality concerns to ensure there is oversight on key issues such as leadership/management; care planning and record keeping; communication and staff training; and medication management amongst others.

10.5. Since October 2014 under the new approach by the CQC, services are assessed and a rating awarded against five key questions – Is the service caring? Is the service safe? Is the service responsive? Is the service effective? Is the service well led? If a service is rated as inadequate for any of the key questions, a follow up inspection will be undertaken within 6 months. If at the inspection the service is rated for that or any other key question as inadequate the service will be placed in special measures. Special measures is a framework to prevent services failing to maintain at least good across all five questions.

Training and Policy Implementation

10.6. Level 4 safeguarding investigator training now uses the imagery from the 2014 safeguarding alert in Western Rise to illustrate the issues.

10.7. As part of an introduction to the Care Act the initial learning has been shared in forums across Torbay and Devon and in the joint Devon and Torbay SAB operational leads subgroup.

10.8. Work is underway to streamline protocols across Devon and Torbay local authorities and clinical commissioning groups to ensure equitable approaches to suspending placements in care homes that are the focus of whole home safeguarding processes.

10.9. There is a clear direction from the Devon and Torbay Safeguarding Adults Board chair for maxim possible alignment of policies across Devon and Torbay.

10.10. Current Level 3 safeguarding training for GP's explores concepts of responsibility for action.

10.11. Over the period the Trust has focussed on ensuring that all staff in the organisation are competent to the required level of safeguarding adults training for their role. This has resulted in significantly higher levels of compliance across the levels 1-6 which by December 2015 will achieve 90% across all levels (Level 2 is e learning and in July 2015 was at 78%). Monthly reports are now sent to all line managers setting out compliance with the required safeguarding training.

10.12. CQC inspectors and inspection managers have been reminded of the role and purpose of the management review meeting and the triggers for holding a management review meeting. This is contained within the guidance "How to carry out a management review".

10.13. CQC inspectors and inspection managers have been reminded that where new information of concern is received an MRM must be held and recorded to look at all the issues relevant to the location and the safety and welfare of service users.

Availability, Use and Sharing of Information

10.14. Quarterly coordination meetings are now held between the CQC, local authorities, healthcare providers and the Clinical Commissioning Group. These CQC and Commissioners Quality Monitoring meetings allow for regular co-ordination, the sharing of good practice and raising of concerns. Coordination and relationships have improved in the past 18 months both informally and formally.

Raising Concerns (Whistle blowing) and Inspection

10.15. The Quality Assurance Framework has been enhanced following this safeguarding review. There has been a greater focus on care alongside the business aspects of the team.

10.16. Officers are pro-active in supporting homes particularly where there have been complaints or whistle blowers raising moderate concerns.

Organisational Change

10.17. District nurses are now in one team rather than two. All district nurses on duty on each day take part in a safety meeting in which cases and homes are discussed. Standards are explicitly discussed and cases are escalated quickly. Liaison is quickly established with GPs or with internal management as necessary.

10.18. Since the 2014 safeguarding alert monitoring of resident weight and the identification of weight loss as an indicator of concern has been established. District nurses note weights recorded by care home staff, but are also able to check weights themselves.

10.19. Since this incident the home has completed a pre-admission assessment for each new resident entering the home. This is gradually being rolled out across other providers where there have been identifiable concerns. The home manager has negotiated an agreed fee based on the individual's needs where they are more complex than the current fee structure would accommodate.

Safeguarding

10.20. Training has been provided for staff within Western Rise itself. Safeguarding has become a key agenda item on the daily safety meeting of the district nurses.

11. Events Following Family Meetings

11.1. The body of this report was concluded on 29 October 2015. At that time the incumbent manager of the care home appeared to be running a good regime, there had been a positive CQC inspection and local agencies appeared to be content with progress.

11.2. On 27 and 28 January 2016 meetings were held to allow for members of the Torbay Safeguarding Adults Board to brief family members of residents of the home about the findings of this review. Over the two days five family members were able to attend. Without prompting, they begun to disclose concerning issues about the current conditions for their relatives in the home and the accounts they gave indicated that conditions in the home had deteriorated once again.

11.3. The manager of the premises had resigned from her position within the previous weeks; not all relatives who were met with were aware of these events. There was a concern from families that there had not been sustained significant improvement to the standard of care following the departure of the previous home manager in 2014 and the commencement of the new manager, who had in any event now also moved on. The home owner has made temporary arrangements for the registered manager from another of his homes to provide some management cover and to support the deputy manager of the home.

11.4. Family members' feedback included comments regarding the atmosphere in the home not being pleasant and that there was a strong smell of urine. Malodour is an indicator of neglect and had been considered to be a key sign of poor standards during the Whole Home Inspection in 2014. The conservatory smelt of smoke and was unpleasant to sit in when visiting. There were adverse comments about the lack of communication from the home to the family; next-of-kin were not informed when a resident was poorly or

regarding any changes to medication or health. Relatives were not aware of care plans, not invited to attend nor participate in the care plan review. Relatives expressed concerns about staffing, they reported that there were sometimes few staff, and often no one around to ask questions of, with some staff unable to communicate in English. None of the family members had phone numbers or details of GP or other professionals working with their relative. Family members were not aware that they could view the care plan or participate in the reviews. On a wide range of issues families were concerned about the level of care provided.

11.5. Following the family meetings, the Chair of the Serious Adult Review panel commissioned immediate additional checks. These included asking the "Experts by Experience" Group of the Torbay Health & Social Care NHS Trust to undertake a mystery shopping exercise which took place on 2 February. The overall feedback from this exercise was negative and confirmed some of the concerns raised the previous week.

11.6. The Experts by Experience Group conducted their mystery shopping work by posing as people looking to place a relative in the home. (This is part of an on-going quality assurance programme commissioned by the Torbay Safeguarding Adults Board (TSAB). When they attended, they simply pressed the door bell and were let in, no one asked them who they were or why they wanted to visit. When they entered the entrance hall they saw about six people with their dressing gowns on, one with nothing on their feet. It appeared to be disorganised chaos, with people wandering around. A woman with crutches eventually spoke up and said she was the manager and the other person present was a resident, before this it had been hard to distinguish who were staff and who were residents.

11.7. The mystery shoppers asked to be shown around as no further communication was offered by the manager. The 'manager' said she enjoyed working with residents in her words "mental issues" and seeing the improvement her interaction with them made. Residents seemed to be being treated with dignity by other staff but not by the manager, who was observed speaking to a resident in stern terms.

11.8. The home smelt strongly of urine which was very over powering. Continence was reported to be dealt with "on a rota system" which was not explained in any detail.

11.9. The mystery shoppers were left with a poor impression of the care given to the residents and their possessions. They had concerns about food choices, interaction with residents, staffing levels and training. Overall the mystery shoppers felt that they would not recommend this home, in fact they thought it seemed out of control. They reported that they came out of the home feeling like they needed a bath and wanting to change clothes, largely because of the overpowering smell of urine.

11.10. On 3 February 2016 members of the Quality and Business Support Team of the Trust visited the premises. They also noted the overpowering smell of stale urine in the main reception hall and main lounge. They saw that there were lots of staff around, some in uniform, others not, which was confusing and made the home feel chaotic. There were lots of people milling around in the hallway but they did not witness any care home staff interacting with residents.

11.11. Residents were sitting in the home with their coats on. The digital thermometer in the TV lounge was showing 18 degrees centigrade which seemed a little cold for a care home. One elderly female was seen sleeping in chair in the lounge. There were two large plastic jugs of juice on the mantelpiece in the main room, but there were no cups in sight. One resident was seen in night clothes descending stairs independently, retrieving a drink and returning upstairs independently. A care plan examined by the member of staff appeared to be minimal in content.

11.12. Due to all of these concerns an immediate suspension of placements was agreed on 3 February 2016 and the home owner was advised of this.

11.13. On 4 February four CQC Inspectors carried out an unannounced inspection of the home. They found that the home then had 27 residents. The youngest was 32 years old and had a psychosis. There were a number of other people with mental health issues, living alongside older people with dementia. The staff had been working with little direction, training or supervision. The staff demonstrated kindness, and appeared well intentioned. However, it was clear they did not have the skills needed to support people with complex mental health needs, beyond meeting their basic physical needs. Residents were kept warm, had food and drinks, had their benefits, and had a room of their own. People told the inspectors that they were grateful to be at the home, and clearly had low expectations. However, they also said that it was “a dead end” and “not somewhere you would choose if you had a choice”.

11.14. The CQC inspectors did not see evidence that people were at risk of malnutrition, dehydration, pressure damage or choking, because for the most part, those risks were being managed. However, the care was not personalised, as it was very task oriented. Medicines were generally well managed.

11.15. The immediate risk identified by the CQC was in relation to fire. There was at least one person who was described as an arsonist living at the home. Some residents smoked in their bedrooms and risk assessments were not in place. One person was meant to be supervised at all times when smoking but was not. No staff members were carrying out routine fire checks because there was confusion about who should be doing them. The CQC asked the proprietor to take immediate action and shared their concerns with the fire service.

11.16. There was a lot of activity in the hall at certain times of the day, and some people choose to wear night clothes, or clothes and dressing gowns. This could be considered as a positive, as people were not forced to conform, and were supported to dress as they choose and to move around that part of the home as they pleased. CQC inspectors were not certain that residents had meaningful activities, that attended to their feelings and were useful and valued. The inspectors questioned why, if they did have, they would need to wait around the hall near the kitchen and the office where staff were likely to be.

11.17. The home smelt strongly of urine. It was perceived as “tatty” with stained carpets and scuffed and marked walls. Some decoration had taken place, apparently by the staff, who were happy to do the work. Areas of the home were not in use, this included the downstairs sitting room and the attached conservatory. The conservatory was particularly uninviting. Other areas of the home were well used, although they looked

worn. Some new chairs had been purchased. These were higher than other chairs or settees, and therefore suitable for people with mobility needs. Some chairs did appear to be damp, and it was not clear if this was with urine or spilt drinks. Some rooms lacked curtains or blinds in the windows.

11.18. All through the home there were many different key pads restricting movement around the home. Staff still did not have a good understanding of the Mental Capacity Act and were risk aversive. Some Deprivation of Liberty Safeguards (DoLS) authorisations were in place, but staff were unaware of these, or of their significance.

11.19. The home proprietor indicated that he had started a training programme and was addressing the issues. He acknowledged that the governance systems had not identified the issues as they should have done. The training that had been planned did not include caring for people with dementia or supporting people with mental health needs.

11.20. The CQC inspectors gave immediate feedback to the proprietor and his team. The home was then due to be rerated by the CQC.

11.21. Plans are now in place via Torbay Council to decommission the home.

11.22. Four safeguarding incidents regarding the home had been reported since October 2015, two had been from nurses regarding pressure sores, one regarding medication, one had been a sexual matter, reported by the then manager and one regarding dermatitis on the face of a resident.

11.23. This review was commenced in order to understand why health and social care staff who visited the premises had not reported the adverse conditions when the visited them. Lessons had been learnt during the review and apparent improvements had been made. Following the meeting with relatives yet more concerns arose, concerns that were in many respects the same as those that had triggered the 2014 Whole Home Inspection. Once again many staff had visited and had not felt the premises merited a quality or incident report via the Datix system.

11.24. The overriding issue appears to be that of acceptance and tolerance of poor standards, by those delivering care and by those witnessing the care giving. This is not because people are inherently uncaring, rather an appreciation that care home standards are to some degree at least dependent upon funding. The budget for each resident per week, unless negotiated up by the care home manager is £375 per week. This sum has to cover seven days a week, twenty-four hours a day, the provision of food, accommodation and basic care, for a resident population who are for a variety of reasons vulnerable, frail and challenging. Cost is not the only and possibly not the primary, factor in the standard of care provided, but it is a major factor that significantly influences the ability of management and staff to provide a quality service. Cost also affects the willingness of visiting staff to “whistleblow”; staff know broadly the budget and what it can be expected to provide. Staff have a view that it is not good, not what I would want for myself of my family, but it is better than being homeless. They also know that if they seek to move residents out, there is not a great deal of choice within the budget available. What may at first seem like an issue for font line staff is in fact an issue for those that commission services; front line staff become acclimatised to the conditions that budget and market conditions make available.

12. Recommendations

Checks and Balances in Systems and Professional Relationships

12.1. Ensure that intelligence regarding care home quality issues is shared with partner agencies. In March 2013 the Local Government Association produced Advice and Guidance to Directors of Adult Social Services on Safeguarding Adults, which should be adopted. "Although Safeguarding Adults Boards do not commission services they do bring together commissioners and providers, set standards and influence commissioning decisions in both social care and health sectors. Effective Boards gather and share market intelligence from a wealth of sources - the more diverse and active its members the better. The data will be both formal (alerts, referrals and trends) and informal (generalised concerns, unresolved allegations, users' complaints and expressions of dissatisfaction). When gathered together into a database, patterns will emerge which can prompt further enquiries or a watching brief. Open to all members, it will shift the Board from reactive to proactive - preventing harm before bad practice can build up"

12.2. Maintain and develop the regular co-ordinating meetings with key partners and Care Quality Commission (CQC) to share good practice and raise concerns.

12.3. Use current feedback mechanisms to capture soft intelligence on care home provision. This includes the care home feedback via the Datix process. This should be used each time any Trust employee has visited accommodation and believes the environment may be symptomatic of poor standards of care or neglect. Staff need to be trained in the existence and use of the system. One harmonised system should be developed, covering both the acute and community elements of the Trust.

12.4. There should be a greater role for care home registered owners. Staff with concerns should be able to speak to them, not just to managers. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 enforces a duty of candour on care home proprietors. This should be part of contractual arrangements.

12.5. When staff request GP to visit, the home should ensure that staff are available to accompany the GP and that they have care home record and management plans with them.

Training and Policy Implementation

12.6. Safeguarding training should stress to all professionals their duty to be alert to risks to vulnerable adults in all settings including residential homes and to discuss concerns with their organisation's safeguarding lead.

12.7. Action plans following CQC enforcement action are required by law. These should be checked to ensure they address the breaches of regulations. Where they do not, the inspection should follow this up with the provider.

Availability, Use and Sharing of Information

12.8. Each resident has a "Plan of Care" recording personal and care issues, when healthcare professionals visit a care home to see a patient, they should check the "Plan of Care" and make a brief entry on it. Consideration should be given to developing standardised recording tools and providing good examples to providers.

12.9. The CQC will consider its policy in relation to the retention of information received. The Knowledge and Information Management policy states that scanned images should be destroyed within one month of receipt. It is recommended that all evidence received by CQC is available until the next comprehensive inspection.

Raising Concerns (Whistle blowing) and Inspection

12.10. Clear and simple standards about how a care home should look, feel and smell, should be produced, so that visiting staff, residents and families know what to expect. A guide for staff including "What does good look like". This should be supported by the development of harmonised quality assurance tools for the different professionals who carry out reviews within home reviews.

12.11. Add Care Homes to GPs locality meeting agenda to consider any safety and quality issues and integrate GPs into quality assurance data sharing regimes.

12.12. Ensure additional quality assurance measures for care homes that accommodate people who are considered "difficult to place".

12.13. Ensure additional scrutiny for care homes with a workforce who may not have English as their first language. The ability for effective communication between residents and staff should be brought into the contracting process. Evidence of use of the new care certificate should be incorporated into commissioning arrangements?

12.14. Ensure that all staff working in care homes are aware of safeguarding alerting procedures. This should be part of the contracted induction process for new staff and be included in update training. This is a regulatory responsibility and care homes should have a safeguarding adult's policy and ensure that all staff undertake training as part of induction.

12.15. Dignity in Care training should be introduced as part of commissioning arrangements. Care homes could have a nominated dignity in care champion.

Organisational Change

12.16. Clearly identify budgets and banding for care home provision, both for the overall provision of care across the authority and within individual care homes.

12.17. Changes in local policy mean that annual reviews of care home residents may now be carried out by telephone, rather than in person, this contains risks, which will require mitigation which should be considered in the light of this case.

Safeguarding

12.18. Details of safeguarding specialists for each agency should be prominently displayed for staff and access to them for advice should be simple and quick.

12.19. Ensure all staff in care homes understand the meaning of safeguarding under the terms of the Care Act 2014.

12.20. Ensure that relevant Trust staff are aware of the environment in which care is provided to residents of every age, ability and disability.

12.21. Establish a multi-disciplinary team, as part of the Business Support and Quality Assurance Team, to allow for support to be given to care homes and targeted visits. This team to give an operational ability to the Business Support team. This team could consist of a nurse, social worker and occupational therapist and act as trouble shooters for homes of concern. This team would be a primary means for the effective support to and supervision of care home standards.

12.22. There appears to have been missed opportunities for quality and finance support staff visiting care homes to be alert to the environment and to note the "softer intelligence" available e.g. appearance of staff and residents, call bell responsiveness, staffing ratios, menu choices, hygiene etc. The emphasis of the visits to the home as "business only" requires a refocus on putting the resident at the centre of interactions.

12.23. Resident trend data, including weight should be checked by visiting GPs and district nurses and any concerns raised.

Pre admission assessment, allocation and contract management

12.24. A process should be developed to oversee the complexity of residents and establish whether a home is capable of serving the needs of the total home population.

12.25. Compliance with Quality Assurance Framework to be embedded in all new overarching contract specifications for both residential and domiciliary care. Action following failure to comply to be clearly stated and adhered to.

12.26. Where a resident has been placed in a home, but does not have an effective advocate through a relative, an independent advocate should be identified.

13. Implementation

The Safeguarding Board is asked to accept this report and its accompanying action plan as the basis for implementing the further changes the review identified as necessary.

Annex 1 SCR Terms of Reference

Introduction

1) This Adult Serious Case Review (SCR) is commissioned by the Torbay Safeguarding Adults Board in response to serious failings within a care home for adults. This was identified during a duty visit by Chadwell Older Persons Mental Health Team on 29 May 2014. This visit had been triggered following a concern raised by a CPN. The duty visit identified such serious concerns that the resident they were visiting was immediately removed from the home. The CQC were contacted and carried out an unannounced visit on 2 June 2014 with a more comprehensive assessment on 4 June.

2) The concerns identified were so serious that the CQC issued enforcement actions in five key areas, namely, consent to care and treatment, care and welfare of people who use services, cleanliness and infection control, staffing and assessing and monitoring the quality of service provision. A Whole Home Investigation team consisting of staff from a wide range of professions entered the home on 10 June 2014. This team confirmed the findings of the CQC and identified further serious issues.

3) A Serious Case Review (SCR) is a process for all partner agencies to identify the lessons that can be learned from particularly complex or serious safeguarding adults cases, where an adult in vulnerable circumstances has died or been seriously injured and abuse or neglect has been suspected. As a result of such a review, the board will be given recommendations for changes to improve practice and services in the light of lessons identified.

4) The aim of the process is to learn lessons and make improvements, rather than blaming individual people or organisations. It relies on a spirit of openness to learning about what went well, as well as what could be improved. The process is based on national guidelines and has been agreed by all agencies who are members of the Torbay Safeguarding Adults Board. The SCR Panel is chaired by, and all serious case reviews are overseen by, the Independent Chair of the Safeguarding Adults Board.

5) In line with the process agreed by TSAB for such reviews, on 22 October 2014 the SCR sub group received a referral report from the lead of the Whole Home Investigation Group. Following receipt of the report and discussion at the sub group, the chair of the SCR sub group recommended that the Independent Chair of the TSAB convene an SCR.

Purpose of the Review

6) The nature and conduct of the home has been examined by the CQC and by the Whole Home Investigation Group. This SCR will not seek to re-examine these fact, rather examine how such a situation developed and how processes for reporting concerns worked. The review will have the following specific themes:

- Understand why a number of different agencies, and health and social care staff failed to recognise or act on observations relating to the poor environment and

poor quality of care provided within the home. Seeking to understand why these issues not picked up sooner.

- Understand how the CPN who made the initial alert, felt motivated to do so, when others had not.
- What was the challenge and scrutiny with regard to the homes ability to manage people's needs, particularly for those residents with complex needs, apparently far beyond the homes ability to manage them?
- What was the process of pre admission assessment that allowed individuals to be admitted into the care home? Was there proper consideration of individual needs and the homes ability to meet them?
- Were there any factors affecting the ability to place residents in appropriate locations elsewhere, leading to inappropriate placements to this home?
- Did the Torbay Local Authorities base fee structure result in a lack of adequate funding to keep people safe and enable the home to properly manage people's needs?
- Did the professional status of the legal owner of the home, as a GP, lead to inappropriate perceptions and any lack of scrutiny? (refer to Parkfield SCR)
- Did the employment or immigration status of staff at the home have any impact on their ability to receive appropriate training or raise concerns or alerts?
- Invite the involvement of family and, where appropriate, advocates of residents of the home.
- Consider whether, under the circumstances, agency intervention could have, or would not have, prevented the home's unsafe operations, given the information that comes to light through the review.
- Provide a report which summarises the chronology of events, analyses and comments on the actions of the agencies involved, and makes any required recommendations for improving the way agencies, singly and together, respond to domestic abuse.
- Identify how and within what timescales any recommendations will be acted on, and what is expected to change as a result.

Review Panel and process

7) It will be for the SCR Chair and Independent Report Writer with support from the Serious Case Review Sub Group (Adults) to establish a suitable Review Panel to deliver the SCR.

8) Subject to confirmation by their agencies, other panel members should include:

- CQC
- Health & Social Care
- GP
- Devon County Council
- Police
- Others – to be determined

When the panel membership has been formed their details should be communicated to TSAB and added to this Terms of Reference. Representatives from other organisations

may be asked to contribute to the review on an ad hoc basis. These may include representatives of voluntary agencies that may have had contact with the home.

9) The Review Panel will meet as required and may also confer by other means, including secure email. The panel will determine more fully the scope of the Individual Management Reviews (IMRs) that may be required, and agree which aspects of the agency contact with this home reports should cover.

10) Due to the sensitive nature of correspondence content, any information issued electronically to Review Panel Members will be sent to secure email addresses. It will be the responsibility of recipients to ensure that data is stored and processed when received in accordance with their own agency data protection policies and in accordance with relevant legislation.

11) The following agencies are expected to provide Internal Management Review reports (IMRs) in line with Adult SCR guidance and taking account of these terms of reference. Other agencies will be identified as the review progresses:
    a) Devon Partnership NHS Trust (DPT)
    b) Torbay Council
    c) Devon & Cornwall Police
    d) Devon & Somerset Fire & Rescue Authority
    e) Torbay and South Devon NHS Foundation Trust (the Trust)
    f) The Care Quality Commission Inspection reports and Whole Home Investigation reports will be taken as key source documents from those agencies.

12) The timetable and detailed scope for the IMRs should be set by each agency in consultation with the Independent Chair. Reports will be needed promptly. Undertaking preliminary work without delay also avoids the risk of loss of information through staff turnover or agency restructuring. The Review Panel may invite responses from any other relevant agencies or individual identified through the process of the review.

13) The Review Panel will report through an overview report which draws on the IMRs and other evidence collected, and responds sensitively to any concerns of the residents and their families. The report will be accompanied by an executive summary and an action plan. The Independent Chair will oversee preparation of these documents, and the Review Panel will check that contributors are satisfied that their information is correctly represented.

14) The action plan which must be communicated to TSAB will set out who will do what, by when, with what intended outcome, and how progress will be checked. Review Panel members will ensure actions are agreed by senior managers of their agencies.

Scope of the review

15) Detailed reviews have taken place which have identified the significant and dangerous risks posed by the home. Steps have been taken to ensure the safety and safeguarding of residents. This SCR will focus on the roles of individuals and agencies which allowed the home to operate in this unsafe manner.

16) A fatal choking incident occurred on the 17th of March 2012. This led to a health and social care review of all the residents then in the home. Although no SCR was triggered there were a series of review meetings. This should provide a baseline for the quality of care then being delivered and was a period of intervention by Health and Social Care agencies. The home was last inspected by CQC on the 4 December 2013, it was inspected again on 2 June 2014. The SCR can focus on the period from March 2012 through to June 2014. Any relevant other incidents, before or after, will be considered to establish if this focus should be extended, this will be discussed with the panel. IMR's should focus on events since March 2012, but mention any significant incidents prior to that.

17) In their contribution to the review, agencies should consider in particular how they support and encourage staff to raise safeguarding alerts.

18) The Review Panel as a whole will also seek to:

- Identify which agencies and professionals should be asked to submit reports or otherwise contribute to the review including, where appropriate, agencies that have not come into contact with the home but might have been expected to do so.
- Establish whether there is any evidence that agencies knew or should have known about the unsafe and unsatisfactory operations of the home. If there is, to examine whether the information was shared with others and/or whether it was acted upon in accordance with recognised best professional practice.
- Establish if any of the agencies or professionals involved considered that their concerns (if communicated) were not taken sufficiently seriously or not acted on appropriately by the other parties involved.
- Establish if the operation of the home indicates that there have been failings in one or more aspects of the local operation of commissioning, placing or supervision of residents into care homes in Torbay and South Devon.
- Identify what appear to be the most important issues to address in identifying the learning from this situation and how the relevant information can best be obtained and analysed.
- Establish how friends, family members, advocates and residents can contribute to the review, and who should be responsible for facilitating their involvement.
- Establish how matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for the relevant sharing of information without incurring significant delay in the review process.
- Clarify how the review process can take account of previous lessons learned i.e. from research and previous SCRs.

Responsibilities

19) The Review Panel is responsible to the Independent Chair of TSAB and any unresolved issues will be addressed to via the Independent Chair.

20) The role of the Independent Chair is to ensure that the right questions are asked and to oversee the development of the Overview Report. An Overview Report Writer will be commissioned by TSAB for this SCR. The recommendations and the report will be from the whole Review Panel.

21) The report agreed by the Review Panel will be issued for 'sign off' by TSAB through its Chair. The TSAB will make arrangements to issue the draft Overview Report, Executive Summary, Action Plan and any other relevant documents. TSAB will arrange publication, including appropriate briefings of media, staff and stakeholders. Partner agencies will support this through their communication teams as required.

22) The Review Panel is expected to operate collaboratively and reach agreed conclusions. Individual panel members are responsible for liaison with their agency during the review, briefing senior managers and individual staff as appropriate, and ensuring any IMR is delivered, maintaining confidentiality in line with Home Office guidance.

23) All agencies involved in the review will bear the salary and expense costs of their own staff, meeting rooms etc. External expenditure necessarily incurred by the review, including payment of the Independent Chair and Overview Report Writer, will be met by the TSAB unless commissioned directly by another agency. Such expenditure will be agreed in advance between the Independent Chair and the TSAB SCR Chair.

24) All agencies contributing information to the review have a responsibility to share evidence with any appointed police disclosure officer, if there are any criminal proceedings. Devon and Cornwall police will explain arrangements through their representative on the review panel if required.

Methodology

25) The Independent Chair of TSAB will consult with Devon and Cornwall Police to establish the status of any criminal investigation. If such an investigation is planned or is in progress, negotiation will occur to ensure effective disclosure and prevention of any conflict.

26) The review will be provided with IMR's from those agencies involved in commissioning places within the home, managing care or visiting residents. The Independent Chair will ensure that the right questions are asked and to oversee the development of the Overview Report. The overview report writer will be commissioned by TSAB for this SCR.

27) A scoping exercise will be conducted to identify key practitioners who can assist with the review themes. A number of these practitioners will be invited to take part in 1:1 or group discussions

Annex 2 Table of Recommendations

No	Recommendation	Actions Agreed	Lead Responsibilities	Timescale
1	Ensure that intelligence regarding care home quality issues is shared with partner agencies.	Continue developments in promoting the use of Datix and data sharing within and between agencies.	Torbay and South Devon NHS Foundation Trust	February 2017
2	Maintain and develop the regular co-ordinating meetings with key partners and Care Quality Commission (CQC) to share good practice and raise concerns.	Business Support Quality Assurance Team.	Torbay and South Devon NHS Foundation Trust	Action Completed
3	Use current feedback mechanisms to capture soft intelligence on care home provision. This includes the care home feedback via the Datix process. This should be used each time any Trust employee has visited accommodation and believes the environment may be symptomatic of poor standards of care or neglect. Staff need to be trained in the existence and use of the system. One harmonised system should be developed, covering both the acute and community elements of the Trust.	Message to all staff of importance of using Datix.	Torbay and South Devon NHS Foundation Trust	February 2017

4	There should be a greater role for care home registered owners. Staff with concerns should be able to speak to them, not just to managers. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 enforces a duty of candour on care home proprietors. This should be part of contractual arrangements.	Commissioning Teams to build in the role of registered owner and duty of candour into contractual arrangements. To ensure that Care Act Statutory guidance (14.74) relating to open culture of Safeguarding, working in partnership is central and evidenced in all regulated care contractual arrangements.	Torbay Council Commissioning Team (Torbay Local Authority) Devon County Council Commissioning Team (Devon Local Authority)	February 2017
5	When staff request GP to visit, the home should ensure that staff are available to accompany the GP and that they have care home record and management plans with them.	Commissioning Team to build record management into contractual arrangements.	Torbay Council Commissioning Team in Partnership with Torbay and South Devon NHS Foundation Trust and South Devon and Torbay Clinical Commissioning Group	February 2017
6	Safeguarding training should stress to all professionals their duty to be alert to risks to adults at risk in all settings including residential homes and to discuss concerns with their organisation's safeguarding lead.	Consider whether the use of E learning is sufficient. Work with Torbay Safeguarding Adult Team to ensure lessons from this review are promulgated.	Torbay and South Devon NHS Foundation Trust	February 2017

7	Action plans following CQC enforcement action are required by law. These should be checked to ensure they address the breaches of regulations. Where they do not, the inspection should follow this up with the provider.	Ensure action plans following CQC enforcement action are completed and followed up.	Care Quality Commission	February 2017
8	Each resident has a "Plan of Care" recording personal and care issues, when healthcare professionals visit a care home to see a patient, they should check the "Plan of Care" and make a brief entry on it. Consideration should be given to developing standardised recording tools and providing good examples to providers.	Ensure that when healthcare professionals visit care homes an entry is made into the Plan of Care. A cross reference should be made on electronic records also.	Torbay and South Devon NHS Foundation Trust in partnership with Devon and Torbay Council Commissioning Teams This action should include care home forum representatives prior to being finalised	February 2017
9	The CQC will consider its policy in relation to the retention of information received. The Knowledge and Information Management policy states that scanned images should be destroyed within one month of receipt. It is recommended that all evidence received by CQC is available until the next comprehensive inspection.	CQC to review retention of information policy.	Care Quality Commission	February 2017

10	Clear and simple standards about how a care home should look, feel and smell, should be produced, so that visiting staff, residents and families know what to expect. A guide for staff including "What does good look like". This should be supported by the development of harmonised quality assurance tools for the different professionals who carry out reviews in care homes.	Develop objective adult care home quality standards, with checklists.	Torbay Council and Devon County Council Commissioning Teams	February 2017
11	Add care homes to GPs locality meeting agenda to consider any safety and quality issues and integrate GPs into quality assurance data sharing regimes.	Arrange via GP lead.	South Devon and Torbay Clinical Commissioning Group in partnership with Torbay and South Devon NHS Foundation Trust	February 2017
12	Ensure additional quality assurance measures for care homes that accommodate people who are considered "difficult to place".	Ensure there is effective scrutiny of planned placements and reviews to ensure that placements are appropriate to people's needs and wishes.	Torbay Council Commissioning Team in partnership with Torbay and South Devon NHS Foundation Trust	February 2017
13	Ensure additional scrutiny for care homes with a workforce who may not have English as their first language. The ability for effective communication between residents and staff should be brought into the contracting process. Evidence of use of the new care certificate should be incorporated into commissioning arrangements.	Develop within QAF contracting process.	Torbay Council and Devon County Council Commissioning Teams	February 2017

14	Ensure that all staff working in care homes are aware of safeguarding alerting procedures. This should be part of the contracted induction process for new staff and be included in update training. This is a regulatory responsibility and care homes should have a safeguarding adult's policy and ensure that all staff undertake training as part of induction.	complete within new QAF Staff training audit tool.	Torbay Council Commissioning Team	February 2017
15	Dignity in Care training should be introduced as part of commissioning arrangements. Care homes could have a nominated dignity in care champion.	Business Support Quality Assurance Team to build in the role of dignity in care into contractual arrangements.	Torbay Council Commissioning Team	February 2017
16	Clearly identify budgets and banding for care home provision, both for the overall provision of care across the authority and within individual care homes.	Torbay Council/CCG responsibility pending Judicial Review Appeal.	Torbay Council Commissioning Team and South Devon and Torbay Clinical Commissioning Group	February 2017
17	Changes in local policy mean that annual reviews of care home residents may now be carried out by telephone, rather than in person, this contains risks, which will require mitigation which should be considered in the light of this case.	TSFDT Operational Directorate to monitor effectiveness.	Torbay and South Devon NHS Foundation Trust	February 2017

18	Details of safeguarding specialists for each agency should be prominently displayed for staff and access to them for advice should be simple and quick.	Establish effective display and communications.	Torbay and Devon Safeguarding Adults Board Executive Group Members	November 2016
19	Ensure all staff in care homes understand the meaning of safeguarding under the terms of the Care Act 2014.	Ensure effective training and standards. Link to section 14.74 of Care Act Statutory Guidance i.e. commissioners should encourage an open culture of safeguarding.	Torbay Council Commissioning Team	February 2017
20	Ensure that senior Trust staff are aware of the environment in which care is provided to residents of every age, ability and disability and the quality of it.	Establish quality data and communication approach.	Torbay and South Devon NHS Foundation Trust in partnership with Devon Partnership Trust and local commissioning teams	February 2017
21	Establish a multi-disciplinary team, as part of the Business Support and Quality Assurance Team, to allow for support to be given to care homes and targeted visits. This team to give an operational ability to the Business Support team. This team could consist of a nurse, social worker and occupational therapist and act as trouble shooters for homes of concern. This team would be a primary means for the effective support to and supervision of care home standards.	Prepare a decision paper for the Trust board to propose such a team.	Torbay and South Devon NHS Foundation Trust in partnership with Torbay Council Commissioning Team	February 2017

22	There appears to have been missed opportunities for quality and finance support staff visiting care homes to be alert to the environment and to note the "softer intelligence" available e.g. appearance of staff and residents, call bell responsiveness, staffing ratios, menu choices, hygiene etc. The emphasis of the visits to the home as "business only" requires a refocus on putting the resident at the centre of interactions.	Team training to be tailored to meet this requirement.	Torbay and South Devon NHS Foundation Trust	February 2017
23	Resident trend data, including weight should be checked by visiting GPs and district nurses and any concerns raised.	Ensure that visiting staff are aware of the importance of weight measurement, on entry and exit from care homes and periodically throughout the stay.	Torbay and South Devon NHS Foundation Trust in partnership with South Devon and Torbay Clinical Commissioning Group	February 2017
24	A process should be developed to oversee the complexity of residents and establish whether a home is capable of serving the needs of the total home population.	Quality Assurance and Operational reviewing systems.	Torbay Council Commissioning Team in partnership with Torbay and South Devon NHS Foundation Trust and South Devon and Torbay Clinical Commissioning Group	February 2017
25	Compliance with Quality Assurance Framework to be embedded in all new overarching contract specifications for both residential and domiciliary care. Action following failure to comply to be clearly stated and adhered to.	Commissioning Team and quality assurance systems.	Torbay Council Commissioning Team	February 2017

26	Where a resident has been placed in a home, but does not have an effective advocate through a relative or carer, an independent advocate should be identified.	Establish effective advocacy systems for all people living in care provider settings.	Torbay and South Devon NHS Foundation Trust in partnership with Torbay Healthwatch	