Safeguarding Adult Review (SAR):
AB Nursing Home /Adult A:
Learning brief

Bracknell Forest
SAFEGUARDING BOARD

Background:

The nursing home was located in a large old building and had been the subject of ongoing monitoring and support from the local authority over several years due to concerns about the quality of care. The improvements required were rarely sustained, and the home was frequently red flagged with actions set to improve standards before new residents could be placed there. However, the home was a popular choice, being very conveniently placed for families in Bracknell. Following a CQC inspection in 2015 (due to the death of Adult A) the home was found to be inadequate and several warning notices were issued. The home finally closed in 2016, and it has since been demolished.

Reason for the review:

Adult A was a 93 year old woman who had dementia. In Feb 2015 she was living in AB nursing home and her death followed a scalding injury that subsequently transpired to be the result of a senior carer failing to check the water temperature. Due to her dementia, Adult A was not able to communicate her pain and subsequently sustained burns across 12% of her body and she died three days later in hospital. Although a SAR was commissioned shortly after her death, due to the ongoing police investigation, the focus of the review at that time only considered the overall functioning of the nursing home.
Following a successful prosecution in 2021, the parent company was fined £1.04m for the offence of corporate manslaughter and staff directly involved received suspended prison sentences.
Crucial details unearthed during the police investigation enabled BFSB to commission a subsequent multi-agency review in 2022 that also considered the victim impact statement made by Adult A's daughter. An addendum to the review was added to the original report which can be found on the Board's website.

Good practice:

- The SAR highlighted examples of good communication and information sharing between professionals
- Despite the resistance presented by the care home BFC & CQC made extensive efforts to improve standards of care
- Following the death of Adult A, services worked to secure good relationships with residents and families and ensured the successful move of vulnerable elderly residents from the care home
- Those engaged in the police investigation were tenacious and, despite lengthy delays, secured a successful prosecution.

Key learning:

1. Opportunities for professionals/organisations to ensure quality and safety when commissioning and monitoring care providers

- Care governance processes provide an effective method of monitoring and the 'flag' system should operate as an effective tool to alert staff to current risk levels, inform decision-making and promote change in the care home
- Contracts with care providers (including those operated by the NHS) should be clear about areas for improvement which, if not resolved, would be regarded as a breach of contract then requiring actions to be taken.

2. The importance of professionals/organisations understanding their roles and responsibilities

- Care providers and their staff must understand what is expected of them and have arrangements in place to ensure adequate care that includes addressing issues of risk without delay
- Care providers should operate transparently and communicate effectively with their staff and residents/ relatives about any concerns that are raised
- Where care providers do not fulfil their responsibilities, commissioning agencies should provide information to residents and their relatives
- Ensuring the quality of care and sharing information about potential risks is a responsibility shared between both commissioners and regulators
- Officers involved in complex police investigations can benefit from the support of a 'Vulnerabilities Steering Group' that supports best practice
- Inter-agency training can help ensure that all professionals are able to assertively raise any concerns that they have with staff in care homes and where necessary bring these to the attention of the local authority.
- Professionals should be aware of how to report safeguarding concerns and be familiar with the multi-agency BFSB Policy & Practice guidance

3. Information sharing and communication

- Where care providers are resistant to taking necessary actions to ensure adequate care, professionals should escalate their concerns in line with the BFSB Resolving Professional Disagreements about Safeguarding Adults (Escalation Policy)

4. People and their families should be well-informed about the quality of care and know how to raise their concerns

- Individuals'/family members' decision making needs to be supported by a clear understanding of their own or their relative's care and support needs. They can only exercise their rights and understand potential risks if they are well-informed and have information that is:
  - ◊ easily accessible in a variety of formats
  - ◊ brought to their attention at the right time
  - ◊ explicit about rights and informs their expectations of care providers and commissioners
- It is important that the 'general public' also understand what constitutes good care that enables them to make informed decisions
- On-line resources are a primary source of information for many people, but not so for all. It is important that information exists in formats that are accessible and is available in key locations
- Individuals and their families should have access to information about the work of the Care Governance Board. They should expect to be informed of their rights, what good provision looks like and understand their entitlement to raise concerns where provision falls short.
- Professionals should be aware that families may feel under pressure to find/agree a placement within the timescales imposed upon them.