Practice Briefing Note

Mendip House, March 2018

From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this briefing sheet. It is one way by which we are supporting multi-agency professionals working with adults at risk, or families to learn from practice.

This briefing sheet pulls together key messages arising from local case reviews.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults.

This document includes a feedback sheet to capture how you have used this learning.

The practice briefing will also be disseminated to training providers to ensure content is included within or informs safeguarding adults training.

What is a Safeguarding Adults Review?

The SSAB, as part of its Learning and Improvement Policy, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

Mendip House Safeguarding Adults Review

A SAR was commissioned following a whole service safeguarding enquiry into allegations of the mistreatment of residents living at Mendip House, a care home for adults with autism near Highbridge run by the National Autistic Society. None of the people living at Mendip House were Somerset residents; however, the review findings and recommendations include important learning for all about the commissioning and monitoring of out-of-area placements.

How you can make a difference

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

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

Carrying out effective reviews and visits with providers

- Ensure that the person has a voice and that it is heard.
- Maintain your professional curiosity throughout.
- Reviews should be part of the overall monitoring and safeguarding process which goes towards checking people are receiving good quality, safe services.
- For people with complex needs and histories a review should be a process, rather than a one-off meeting sitting in a manager's office. If a service attempts to get you to conduct a review in this way make your expectations clear.
- The aim should be to gather and consider all relevant information needed for that particular moment. Reviews should be proportionate, and for some people's circumstances - particularly where they have difficulty advocating for themselves or lack capacity - this requires more enquiry and consultation with others who know them well.
- A face to face visit with the person you are reviewing is an essential requirement of the review process, even if you have to do more than one visit to enable this to happen. If you arrive to find that you are not able to meet the person arrange to visit again, establishing a clear expectation that you wish to see them.
- Families are an under-used source of information. They know their son or daughter, mother or father best and may have the most contact with the service. Sometimes families have had concerns, but have not formulated them or spoken with anyone outside of the service provider. It is good practice to offer families a chance to speak to you privately, in person or via a phone call.
- Try to foster positive, though objective, relationships with staff – they can be good sources of information and may want someone to talk to if they have concerns. A review visit by an enquiring professional can sometimes trigger a staff member to whistle-blow about the concerns they have.
- When visiting services that describe themselves as 'specialist' ensure you gain evidence that care is effective, high quality and evidence based - don't assume everything is alright without seeing the evidence for it. Never assume that a service is providing specialist care because of the way it describes itself.
- The emphasis should always be on assuring yourself that the care is good and the environment is safe by considering **all** the evidence, not just believing what you are told or reviewing written information only. Never accept explanations that attribute concerns that you may have identified to a person's behaviour on face value.
- When reviewing someone with complex care needs ensure you view copies of their Support Plan, Behavioural Support Plan, Communication Profile, Epilepsy Profile, Health Action Plan, risk assessments as relevant. Are you assured that they reflect the person's needs? Are they up to date? Are they regularly reviewed? Or are the records haphazard, containing conflicting, out-of-date, information?
- Questions to consider throughout the review process: Does the service feel right? Are people well supported and safe? Does the person have a voice in their care? Ask questions, and ask for the evidence to back up and support what you are being told (e.g. if they say someone has 1:1 for 12 hours a day, ask to see the staff rota). Are the staff experienced? What is the rate of agency staff use? Where are night staff located, will they hear/be able to be alerted if something happens in the night?
- Reasons to invest additional time to the review process – e.g. Where someone's review is overdue; the person lacks capacity; there is no allocated worker; and/or the person is placed outside of the local authority area.

Useful further reading:
https://www.thinklocalactpersonal.org.uk/Latest/Outcome-focused-reviews-A-practical-guide/

Ensuring effective practice: recommendations

Individual / family

- See the person, and spend time with them in their environment
- Meet / speak with families separately as part of the review process
- Include advocates as needed, even if family members are involved; advocates support the family too
- Ensure the person that is the subject of the review has a voice **and is heard**
- Look for evidence of how people spend their time, rather than just accepting a care plan or timetable

Provider

- Discussions need to be honest and open in terms of quality, expectations, market needs and their position
- Providers and commissioners should work together to problem solve, support, share information and establish links across the market
- Building positive working relationships with providers is essential, as well as monitoring. It encourages better incident reporting and earlier intervention

Operational social care teams

- Ensure adequate preparation for reviews – this should include checking safeguarding concerns, reviewing the case notes and incident reports. Reviewing is a process, not one form, one visit, one conversation. Seek to be inquisitive.
- Reviews can take different forms and need to be proportionate
- Do not take information at face value – check, cross-reference. Ensure decisions about continuing placements are based on evidence, such as what is being achieved with and on behalf of individual residents
- Health input is critical – consider opportunities to undertake joint, holistic reviews of health and social care needs where feasible
- Observations are critical: spend time with the person and monitor the environment and staff interactions
- The 'family test'- would you be happy walking away if your mother, father, sister, brother or other family member was living there?
- Establish eligibility and mental capacity in relation to decisions relating to care provision / care planning
- Ensure your documentation is proportionate and accessible.

Commissioners of services

- Be clear about what's needed in the provider market, and what is available
- The commissioning task is more than that of place-hunting: commissioners are stewards of the public purse and the agents of people they support; examine how fees are being spent on their behalf. Are providers delivering what has been purchased? Are specialist services delivering specialist support?
- Notify host authorities of prospective placements in their area

Quality / Contract monitoring

- Check the latest Care Quality Commission reports before reviewing
- Ensure frequency of Quality Assurance monitoring and a consistent approach to contract monitoring
- Be clear of monitoring processes and approaches for both local and out-of-area placements – can these be enhanced?
- Aggregate information and intelligence about provider services, pool this with the host authority's safeguarding referrals and engage closely with the Care Quality Commission

With special thanks to Jane Stroud and the Somerset Reviewing to Improve Lives team

SOMERSET SAFEGUARDING ADULTS BOARD

Service Monitoring: Potential indicators of concern

The following areas of care ***may*** highlight that care is neglectful and could be harmful to residents

LEADERSHIP & MANAGEMENT	STAFF BEHAVIOUR & ATTITUDES	BEHAVIOURS & INTERACTIONS OF RESIDENTS
• The manager doesn't provide appropriate leadership or direct staff to do their job properly • The manager is often unavailable • There are insufficient staff to meet the needs of residents • There are high levels of staff turnover • There is a high reliance on agency staff • The service accepts residents whose needs they cannot meet • The manager does not inform commissioners when they are unable to meet the needs of specific residents • Policies and procedures are not readily available, accessible or do not appear to be being followed • Problems are not proactively recognised or responded to by the management of the service • Safeguarding alerts in relation to the service are unusually high/ low • Complaints in relation to the service are unusually high/low • Internal incident reporting (e.g. hospital admissions, pressure areas, instances of choking) is unusually high/ low • External incident reporting/communication not completed appropriately – e.g. CQC, Police, Commissioners	• Staff appear to lack knowledge of the individual needs of the people they are supporting (e.g. specific behaviours, individual interests or communication needs) • Members of staff use judgemental language about the people they support • Members of staff are controlling and there is little or no choice available • Communication across the staff team is poor, either written or verbal • Risks arising from abusive behaviour between residents is not recognise, adequately addressed or managed • Staff fail to treat service users with dignity or respect • There is a lack of documentation to demonstrate that Best Interests decisions are being made and adequately documented • Staff are not working to the principles of The Mental Capacity Act	• Residents' behaviours change without rationale or explanation about how this has been achieved • Residents' skills change – for example they become less independent, self-care or continence management deteriorates. • Residents appear distressed in the presence of certain members of staff or other residents • Residents behave differently in different environments (e.g. Day Centre) • Residents who appear distressed are either ignored or experience unacceptable delays in having their emotional support needs met • Residents who require it are not supported to eat their meals / drinks • Residents may appear hungry or thirsty and show signs of dehydration • Residents express a desire to move to a new placement
ISOLATION & LACK OF OPENNESS	**SERVICE DESIGN, DELIVERY & MAKE UP**	**ENVIRONMENT & BASICS OF CARE**
• There is little input from outsiders/professionals • Individuals have little contact with family or people who are not staff • Appointments are repeatedly cancelled • Members of staff do not maintain links between individuals and people outside the service • There is little contact with outside professional mainstream services • Appropriate referrals are not made (e.g. Speech & Language Therapy; GP; Dietician; CPN) • Management and/or staff demonstrate hostile or negative attitudes to visitors, questions or criticisms • It is difficult to meet residents privately • It is difficult to see the resident's bedroom • Family contact is supervised • The service is defensive and does not respond effectively to complaints • People who complaint experience reprisal or are unwilling to complain because they fear reprisal for their loved one	• Residents' needs are not being met as agreed and identified in care plans • Care plans are of poor quality and do not represent an accurate record of the care needs of the individual • Care plans and risk assessments are not reviewed / updated to reflect increased needs or changed risks • Agreed staffing levels are not being provided • Staff do not carry out actions recommended by professionals • The service is 'unsuitable' but no better option is available • The resident group appears to be incompatible • The diversity of support needs of the group is very great. This may lead to physical assaults on residents which should be reported to appropriate agencies and families • Safeguarding policies and procedures are not present or applied • Limited or no evidence of The Mental Capacity Act being applied	• Residents' rooms are not personalised • There is a lack of care of personal possessions • Personal possessions are lost or stolen • Support for residents to maintain personal hygiene is poor • Residents appear unkempt • There are insufficient bathroom facilities to meet the personal care needs of residents • Essential records are not kept effectively • The environment is dirty/smelly or of a poor quality with potential hazards (e.g. trip hazards) • There are few activities or things to do • Residents' dignity and privacy is not being promoted or supported • Residents are dressed in the wrong clothes • Resident independence and skills are not promoted. • Medication is not properly provided or recorded

Learning Lessons - Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

Your name	
Agency	
Date	

This briefing was cascaded to: (e.g. all district nurses; duty social workers etc.)
This briefing was used in: (e.g. supervision with X number of staff; team meeting; development event etc.)
Action taken as a result of the learning:
Other feedback / discussion points