Learning from Safeguarding Adults Reviews

Presentation to Peterborough Safeguarding Adults Board

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1a. A brief summary of the safeguarding adults reviews

1b A word about their methodology

SECTION 1 THE REVIEWS

1a. A brief summary of the safeguarding adults reviews

In all there were three separate reviews

- A involved poor clinical decision making and management of bowel care and diabetes*
- B involved a home where there had been serious breaches of professional behaviour in relation to residents, other staff members and the management of the home, these were examined alongiside reviews of clinical care in relation to
- a separate complaint about clinical leadership and decision-making in relation to end-of-life care* and 5 other clinical cases
- C involved a man who was allowed to become seriously dehydrated and unwell before being admitted to hospital, this is still ongoing

* In these two cases there was a significant delay in facilitating and addressing complaints by family members

1b A word about their methodology

- Individual Management Reviews were sought from key agencies
- These provide a chronology of the agency's contacts regarding this person or set of issues and their analysis of what went wrong and what could be put right

- A Panel is then convened from each of the main statutory agencies/ professional network to analyse the interactions between agencies and to make wider recommendations about change across all service settings

- An independent author is involved in these meetings and the Panel oversee the accuracy and analysis in the report and its recommendations …these are given back to each agency to turn into concrete and achievable changes in their practice

- The SAB takes charge of implementing these action plans and embedding change across the whole sector and the professional network.

2a Poor recording practice

2b Clinical decision-making

2c Managing diabetes

2d End-of –life care

SECTION 2 AREAS OF NURSING AND CARE PRACTICE HIGHLIGHTED IN THE REVIEWS

2a Recording practice

- The observations of staff and of the professional network suggests a staff team that were not uncaring in their interactions with service users but that lacked the resources, skills and perhaps the clinical leadership to maintain systems that could *support* and *enable* good care. It is not good enough just to show a caring attitude if a service user is suffering the discomfort of constipation, or if their haphazard eating puts them at risk of going into a diabetic coma, you also have to be responsibly informed and make clinically sound decisions. The paperwork in any service setting should function to structure the skilled input of nursing and care staff. Good records are kept not as a chore, or as a “back-covering” exercise, but because they are the means by which consistent individually tailored care can be delivered.

2b Clinical decision-making

- Records seen by the Panel in all these cases were inadequate, inconsistent and not fit for purpose
- Sharing clinical decision-making between GP's and nursing home staff did not always go smoothly
- Clear guidelines about particular conditions were needed, and/or should have been followed alongside specific and detailed care plans to manage individual needs, co-morbidities and emergencies
- End of life care was poor, not planned for, and tackled as a "crisis" because conversations had not been held in anticipation of a person's final illness
- Complaints had been discouraged, lost or not passed on
- Notes and records "went missing" impeding investigations

2c Managing diabetes and other co-morbidities

Nursing older people is complicated because they often have multiple, interacting conditions, for resident A these included

- Diabetes controlled by medication and diet
- Asthma and possibly Chronic Obstructive Pulmonary Disease (COPD)
- Diabetic retinopathy
- Suspected glaucoma
- Bilateral cataracts
- Diverticular disease and chronic diarrhoea
- Hypertension (that is high blood pressure)
- Osteopenia (that is the early signs of loss of bone density that can lead to osteoporosis)
- Pernicious anaemia
- Pressure ulcers
- Pulmonary embolism as diagnosed through a CT pulmonary angiography scan (CTPA) for which she was taking Warfarin which has to be closely monitored

"her GP again specifically asked for the home to monitor her blood sugar levels over a one-week period and they were measured the following day but then not again for a week and not again after that. The reason given for this failure to follow the GP's instructions was that there was a malfunction / error message on the machine. The home did not seem to have any contingency plans for dealing with this other than to keep trying, so no-one tried to replace the machine or get it re-calibrated or to find another machine that could be used in the interim. Given the crucial role that blood sugar testing had in the care of xxxxxx and has in relation to other residents with diabetes, including in acute episodes, this is an extraordinary omission and failure of decision-making".

Lack of expertise in dealing with consequences of eating difficulties, diarrhea and vomiting in relation to diabetes eg not calling an ambulance when BSL 1.4 even though it should be between 4 and 7

Conforms to national picture of poor care and coordination

"The initial findings from the first-ever England-wide Care Home Diabetes Audit have unfortunately revealed a lack of comprehensive assessment, monitoring and specialist care".

2d End-of –life care

- In these cases staff did not seem confident about managing end-of-life care
- Conversations about dying, advanced statements, DNAR either did not take place at all or took place in a rush at the end when they could have been calmly addressed when the person was first admitted

- In relation to A
- *her death was not expected and the signs that she was dying were not recognised by the staff in a timely way. It is as if the staff were on two pathways, one of which was to calmly watch over her while noticing that her vital signs were failing and the other was that they were in an "emergency" situation and that they were monitoring her to see when /whether they should call an ambulance. They could not do both, and in the event they ended up doing neither.*

3a Neglect

3b Abuse

3c The importance of skilled supervision

SECTION 3 MORE DELIBERATE ABUSE AND NEGLECT

3a Neglect

- Neglect is usually a product of ignoring needs or taking short cuts
- It thrives on confusion and a lack of clear standards
- It is often justified on the basis that there is too much to do and too few people to do it but this means that short term demands are met and longer term care needs are put on the back burner
- This leads to crises and crisis management as a way of operating all the time
- Instead services should prioritise
  - Accessing appropriate and timely health care for residents
  - Supporting staff to access appropriate CPD and developing professional consensus within the staff team by using external and evidence based guidelines
  - Having clear bench marks for example about when to call the GP or when to call an ambulance
  - Authorising staff to make these decisions on the spot and supporting them when they make difficult judgment calls
  - Having difficult discussions with residents and family members about how they want illnesses to be managed, and
  - planning for, rather than being derailed by, terminal illness and dying

What is meant by "neglect"?

- That an omission caused harm
- That it was "wilful" that is the person knew that by not doing something they would cause harm
- So we need benchmarks
- We need to be able to say "This is what good care looks like"
- We need to notice when guidance is not being followed
- We seek medical assistance when…. Why didn't you follow that rule….when you knew it would lead to xx going into a coma….

3b Abuse feels more deliberate and insidious

- Abuse in residential and nursing home settings is not just another “type” of abuse,- institutions **produce** circumstances and relational dynamics that make abuse more likely
- We ask people, often on low pay and without specialised knowledge, to care for people who can sometimes be difficult and challenging , without expert knowledge, support, insight, space for reflection or proper supervision and governance
- You have to work positively all the time to avoid these situations slipping into abuse
- In particular the hidden aspects of the work that include personal care and dealing with bodies and death, need to be addressed and contained so that they do not tip over into opportunities to tease, bully, humiliate or denigrate

Different pressures and motivations

- **Situational,** that is the environment causes the person to harm someone, for example if there aren't enough staff, or the person is out of their depth …*pressurised*
- **Opportunistic** , the person is tempted to abuse because the opportunity presents itself, for example they take something because it is left out on the table ….*tempted*
- **Deliberate**, planned and/or targetted, that is they identify the most vulnerable person and/or least likely to complain in order to abuse …*cruel*

- *These can be minimised by providing good support, equipment and guidance to staff, designing in safeguards to avoid temptation and careful recruitment and supervision*

There are lots of early warning signs but people don't notice or feel they can't act

- Lack of a tangible sense of what is wrong "niggly concerns" that accumulate ***over time***
- Lack of confidence that these concerns are reasonable or proportionate
- Lack of "evidence" to back up concerns
- Fear of immediate reprisals or long term detrimental consequences
- Fear that concern or complaint will not be handled well so that their intervention will be in vain
- Sometimes a feeling of being complicit in poor practice oneself

- Joyce,T. and Oakes,P.(2004) Protecting people with intellectual disabilities from abuse: Why does it take so long for someone to say something Journal of Intellectual Disability Research **48 p419**
- Marsland, D. Oakes, P. and White, C (2007) Abuse in Care: Early indicators of the abuse of people with learning disabilities in residential settings

And if you are someone with a remit to hold services to account

- "A significant feature of the early indicators …is that they are not complex or obscure entities. Instead they highlight tangible and often readily identifiable evidence of ***decaying and unsafe services. Such indicators are visible to external people who spend time in services*** as part of their professional roles or as a consequence of familial relationships. (Marsland et al 2007 p17)
- So be worried about too much staff change, agency staff, sickness, people saying they can't cope, the way staff talk to each other, the way they talk to and about clients, the way they talk to and about their managers, if they seem out of their depth, if they seem afraid of their managers or of any of their co-workers, if they don't want to work on particular shifts, if there is a sexualized atmosphere, if they are not welcoming to you, if they act towards you without respect **because these are not vague or unimportant things, they are the tangible signs that things are not working**
- If you can, name these things in a helpful way, if not escalate your concerns either within or outside your service

Taking some of these interacting factors seriously we see that …

- Policies that don't match resources have no credibility and this spells danger (Wardaugh and Wilding 19913)
- Staff teams or shifts who are left to manage themselves leave fertile ground for bullying, racism or intimidation and because they are unchecked (autonomous work groups) they develop their own way of doing things and cutting corners
- Punitive models creep in where challenging behaviour or difficult areas of care are not well understood, managed and contained
- People who have been harshly treated themselves tend to react harshly to others when cornered or faced with loss of control/competence unless they have information that empowers them to do something different by managing the situation calmly and with compassion, that is why effective training and monitoring of physical restraint is so important
- Management structures that fail to support good practice give licence to individual staff to cut corners or abuse

And individual staff use these arguments to justify their behaviour

- When faced with difficult choices or hard challenges we argue with ourselves about how to act
  - *I am usually such a good person*
  - *They are throwing it back in my face*
  - *I have worked so hard for this person*
  - *No-one will notice*
- I give myself a "**moral holiday**" (Tomita 1996)
- If I want to abuse, I overcome my own scruples, I evade consequences and I overcome or discount the victim's resistance (Finkelhor 1984)

So management and containment relies on

- Understanding service users and the complexity of their needs
- Creating positive roles for staff and giving them the requisite information and tools to do the job
- Explicit monitoring of key areas of practice to create accountability
- Careful recruitment and retention of staff
- Creating positive and helpful stories about the people we care for, who they are, why they do what they do, why they may have problems
- Modeling compassionate and containing uses of authority

3 c Supervision is needed because care work triggers uncomfortable feelings

- You have to contain your "usual' uncensored responses to another person and manage difficult emotional reactions such as irritation, disgust, embarrassment, boredom, and sometimes fear, aggression and loss of "the upper hand"
- You have to manage calmly and by controlling situations not people, making clear decisions and assigning staff time and input fairly
- You need to put on hold your own physical and emotional needs throughout the day
- Caring for others sometimes when you are not feeling cared for yourself, which is very difficult

What does "skilled" supervision look like ?

- Supervision is not the same as "instruction" or "telling someone how to carry out certain procedures" although these might be part of a good supervisor's role
- It involves containing staff in an ethical framework that keeps their work safe and "good –enough" by continually affirming and reaffirming the humanity of the people who need our services
- It requires managers to constantly restate appropriate explanations of difficult behaviour or personality traits and anchor these in the cognitive impairments or health conditions of people needing care so that blaming, teasing and humiliation have no part in day-to-day care
- It requires a delicate balance between acknowledging how difficult the work is, and the painful emotions and defences that grow up around it, while holding to this line
- Lead by example, that is show staff how to work with difficult individuals and always talk respectfully about residents in front of staff thereby keeping a boundary

Why is supervision difficult?

- Its easy if you come in from “outside” and bring a fresh pair of eyes
- It is easy if you go home at night and do not have to be part of the staff group every day but it is difficult where
  - You rely on the good will of staff to fill your roster and show flexibility and commitment
  - You live locally and are part of the community to which the staff you supervise also belong
  - You feel intimidated on the grounds of gender, ethnicity or religion
  - You are working with people who seek to evade challenge or containment
  - You feel somewhat implicated in having “gone along with” less than optimal practice in the past
- **When these factors are in play, even the most skilled supervisor needs to get help and support to back them up**

4a Documentation
4b Prosecution of wrong-doing
4c Holding clinicians to account
4d Using the Disclosure and barring service

Section 4 Difficulties in investigation

4a Documentation: why bother with notes?

- The care plan and clinical notes are there to be “used”
- There should be evidence of the fact that they inform decision-making and shape the care that is being given so for example bowel charts are there to ensure the comfort and safety of residents when they cannot retain this information for themselves, they are not designed to be an additional chore to be made up after the event
- One example of the need for careful note-keeping was where someone with diabetes became ill as a result of diarrhoea but their fluid intake, bowel chart and blood sugar levels were not being accurately recorded so that they could not be at the heart of decision-making and the standards ie the level at which an ambulance should have been called was not clear in the notes,- this led to failure
  - To call an ambulance until it was too late
  - To inform relatives that the resident was extremely unwell
- Completing records and care plans as a batch and in retrospect is not helpful, they should be brief, useful, contemporaneous and accessible
- In Case A there was an additional problem in that key statutory agencies had also failed to complete their own paperwork. There were important omissions and the supervisory systems that allowed the discharge to go ahead without this minimal sharing of information also need to be rectified. Quality assurance should be on-going and systematic.

4b Prosecution of wrong-doing

- Lack of documentation not only impedes consistent clinical care and care practice but it gets in the way of review and investigation
- Destroying or “losing” records breaches “Duty of Candour” and is potentially a criminal act, as it involves obstructing the police and/or the coroner in the course of their duties and can carry a prison sentence if one is convicted
- Senior staff in residential and nursing homes should, on first indications that an enquiry needs to take place, secure all documents safely
- Failure to do so allows poor practice to go unchecked and /or abusive staff to continue working in this sector and this in turn throws doubt on the integrity of a home and its management

4c Holding clinicians to account

- Clinicians are bound to make mistakes sometimes, this does not mean that they are evil people, but that in a busy environment mistakes are always possible
- Responsible clinicians/professionals agree to be held accountable for their work, to learn from any mistakes and to be open about any problems such as addictions or convictions
- Their professional bodies provide a structure within which clinicians are challenged about any mistakes or routine poor practice, asked to complete additional training and/or to work under tighter supervision by having “conditions to practice” applied to their employment and/or
- Where the matter is very serious or negligent they are banned from working in a professional role; they are thereby held to the highest of standards and are accredited to work as independent professionals in future
- These mechanisms are essential if the quality of care in nursing and residential homes is to be maintained

4d Using the Disclosure and Barring Service

- The DBS is a broader service, not limited to one profession, that exists to prevent abusive or neglectful staff from working with adults or children who are vulnerable or at risk
- It means that a person cannot simply resign and go to work in another home without being held to account
- It means that seriously abusive staff are kept out of the social care workforce across all sectors
- This is very important especially where cruelty, theft, sexual abuse and exploitation, boundary violations, wilful failure to work to clinical guidelines or care plans has taken place.
- It augments references and qualifications as a way of ensuring appointments to these jobs are safe and considered
- You are letting down other employers as well as vulnerable people if you fail to refer to this service when breaches of standards occur

These will be turned into action plans in each service that will be monitored by the SAB

SECTION 5 SUMMARY OF RECOMMENDATIONS

Recommendations across all the reviews address

- End of life care, including sensitive discussions with residents and their families about DNAR's, hospital admissions and pain relief
- Best interests decision-making using the MCA to address refusal of medication and other matters
- Improving accessibility and coordination between homes and emergency services and coordination between homes and hospital admissions and discharge teams; clarification of information that should accompany a person when they go into hospital and better discharge information when they return home
- Improved clinical care in relation to pressure areas, diabetes, and other co-morbid conditions
- Better liaison between clinicians and home owners/managers in relation to Safeguarding Enquiries, including passing on complaints promptly, securing documentation, communicating with professional bodies, assisting criminal prosecutions and safer recruitment
- More skilled supervision, appraisal and management of disciplinary procedures and reports to professional bodies including support from proprietors and senior managers or company directors and improved governance of provider agencies
- Safeguarding training that focuses on neglect as well as overt abuse, on complex cases, proper recording, clinical decision-making, appropriate sanctions and support for both whistleblowers and first line managers

Working with services at risk of neglecting or abusing their clients

SECTION 6 ACTING ON LESSONS LEARNED

Across all sectors we need to share

- An accurate understanding of
  - Early indicators of poor practice
  - Consensus about good practice and professional support for difficult areas of the work
  - Necessary infrastructure and structures that can underpin acceptable care for example tools like the MUST and good practice guidance such as the Gold Standards Framework
  - Knowledge of how abusive dynamics arise in teams and how they can be contained and managed
  - A balance between specialist knowledge and ordinary humanity
- These need to be shared and embedded in the work of each home *and* in the wider professional and commissioning network

We need to balance support with scrutiny and, if need be, sanctions

- *When we are working with individual staff or with whole services that have fallen short of acceptable standards we need to work in an exploratory and collaborative way to start with but then reach a point of clarity about what is going to be tried, or done, or monitored or reported back*
- And then we need to capture this in a plan ***that is followed up***
- *So we use a graduated approach and at any time we are clear where we areand, even if we hand over to other staff we don't have to keep retracing our steps*

Protective

Proactive

be Preventative

Doing nothing is not an option, it is a passive way of permitting abuse of the most vulnerable people, you have to keep putting positives in place of negatives.