2020

Mornington Hall and Baker's Court Safeguarding Adults Review

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INDEPENDENT REVIEWER

HUNTERSJOY LIMITED

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EXECUTIVE SUMMARY

1. Introduction

1.1 The concerns that triggered this Safeguarding Adults Review was a number of deaths and hospital admissions from two care homes run by the same provider and the consequences surrounding each incident. Sadly, five of the six adults at the centre of this review died, and the Newham Safeguarding Adults Board wishes to send condolences to the families who lost loved ones. There was an identified theme of poor care provision by the Care Provider. The evidence considered as part of this SAR and the subsequent lessons learnt validates the SAB decision to commission a non-statutory SAR. The lessons will inform recommendations to improve practice and partnership working.

1.2 This SAR was commissioned on January 2020. The initial timescale for the SAR was March to July 2020. Due to the exceptional circumstances of the COVID 19 pandemic, the gathering of information from various partners was understandingly challenging with agencies focus being on responding to the pandemic, for example hospitals were not required to return information.

1.3 This SAR reviewed care provided to the adults between January 2018 to November 2019.

1.4 HC – One Oval Limited (HC-One) is one of the largest care providers across the United Kingdom with over 300 care homes. Mornington Hall and Baker's Court are two care homes based in the London Borough of Newham that are owned and operated by HC – One.

1.5 The individuals subject to this review share the following characteristics:

- They are all over the age of 65
- Mr. P, Ms. R and Mrs. S resided in Baker's Court, operated by HC - One
- Mrs. Q, Mr. T and Mr. U resided in Mornington Hall operated by HC – One
- Mr. P, Ms. R, Mrs. S, Mr. T, and Mr. U, all died whilst residing in a HC – One care home. Mrs. S and Mr. T both died at the care home. Mr. P, Ms. R and Mr. U died once admitted to hospital.
- The adults date of deaths occurred between 14 July 2018 and 24 November 2019

1.6 The Care Quality Commission (CQC) carried out an unannounced inspection in July 2019. The CQC rating for Mornington Hall is 'Inadequate' – report published 10 October 2019. At the time of writing this report, September 2020 there has not been an updated inspection report or rating published. The inadequate rating meant the home is in 'special measures'. This means CQC keep the service under review and, if they do not propose to cancel the provider's registration, the CQC will re-inspect within 6 months to check for significant improvements.

1.7 The CQC carried out an unannounced inspection for Baker's Court on 23 September 2019 – the report was published 21 November 2019 with a rating of 'Requires Improvement'. The previous rating for the service in January 2019 was 'Requires Improvement'

1.8 As a result of the CQC inspection outcomes, the care provider developed an improvement plan.

1.9 The families of the adults' subject to this review were invited to contribute their views. These are recorded in detail in the main body of the report.

2. Summary of Findings

HC – One Oval Limited (Care Provider)

2.1 The repeated incidence of care quality concerns, between 2018 and 2020, within both Mornington Hall and Baker's Court, raises the question of the effectiveness of the improvement plan. The plan focuses on implementation and consistent use of improved systems, policies/ procedures, data bases and staff competence but the repeated concerns evidence that there is limited or no evidence of lessons from previous safeguarding concerns, prevention of future deaths notices, being learnt. It is of concern that the improvement plans are not translating into improved care quality outcomes for the other adults.

2.2 Care staff are expected to possess the necessary skills and knowledge to demonstrate professional capability. They need to be confident, critically reflective and self-aware to analyse, review and evaluate their own skills, knowledge and professional practice. Practice must translate into records to meet statutory requirements. In the 6 cases subject to this review, the poor record keeping included; care plans not being updated, daily records not updated with consistency, weight and liquid charts not updated with consistency, risk assessments updated on occasion without evidence of actions to address increased risk. The gaps in the records contributed to the inconsistent and at times, poor quality of care being provided to the adults as there was no accurate record of sharing information.

2.3 Failure to implement the care provider's own policy and procedures such as falls policy and safety planning linked to identified risk, all contributed to the inconsistency in the care, negatively impacting the adults care, such as repeat falls, gaps in following through specialist advice, such as repositioning of the adult to manage wound care.

2.4 Limited evidence of the families' and residents' voice being considered to understand what their needs and wishes were impacted the care being provided to the adult both while alive and at end of life. No evidence of requests for an independent advocate to support residents who did not have any known family or friends.

2.5 Lack of consistent management in the homes; effective care home management was lacking in both Baker's Court and Mornington Hall. Evidence shows, in order for a home to be effective, stable management is a key factor. The lack of consistent stable management at operational level, with ineffective corporate level oversight, impacted the continuation of the improvement plans following the acquisition of the homes. The relationship with commissioners and the CQC was also compromised with a frequent change in HC – One operational home managers, causing delays in progressing with agreed improvements.

2.6 Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPRs) for residents were not considered as part of the end of life care planning. The care provider recorded two out of the six adults subject to this review, had a DNACPR whilst in hospital, but did not communicate with the adults GP, nor the family about what the adults' wishes were, when in the care home regarding end of life.

2.7 Delayed identification of medical deterioration or increased risk, delays in seeking specialist care, delays in following up specialist care referrals and on occasion delays in effectively implementing specialist advice, contributed to the circumstances that led to the poor quality of care in some instances subject to this review.

Adult Social Care

2.8 The Care Act 2014 places a duty on local authorities to make enquiries when; an adult has care and support needs, is at risk of abuse or neglect and unable to protect themselves from abuse or neglect as a result of their care and support needs. In some circumstances the enquiries are being conducted in line with Care Act statutory guidance for example Mr. P's case. However, the enquiries are not robust and lack evidence of professional curiosity in gathering enough evidence to understand the 'whole picture'. This should include professionals to identify: what lessons can be learnt from the enquiry and how to prevent future incidents of a similar nature. In all cases considered, the Care Act section 42 enquiry was prematurely closed without all facts being considered and all sources or information being considered.

2.9 Safeguarding enquiries coordinated by ASC must be multi agency, considering all the information. When there is a concern about a care provider, it is not sufficient to simply gather information from one source i.e. the care provider, but to consider all the agencies involved in the care of the individual, including the adult's view, their family or their representative.

2.10 Poor communication, a lack of accountability and professional curiosity, contributed to the delays in Mr. U not being moved to an appropriate mental health care of older people (MHCOP) bed. While the focus was on the funding, the adult was forgotten, with little to no evidence of how the risks of his needs not being met, in a non MHCOP bed, would be

managed, while the funding issue was resolved. The decision to move Mr. U and then agree funding was made 4 weeks after the initial request.

2.11 Stage one of the Newham's ASC contract provider concerns and escalation process was initiated for Mornington Hall on the 16 May 2018. Insufficient progress and lack of improvement resulted in Stage 5 being implemented on 14 June 2019. The 11-month progression was too long a timeframe considering the seriousness of the concerns in relation to the quality of care being provided. Although there was ongoing discussion with the care provider, neither the Contracts team or Safeguarding Governance team were given sufficient reassurance that the improvements were impacting the quality of care. The escalation process was too slow, a resolution to address the quality of care should have been sought with more urgency.

2.12 The escalation process, including the criteria for progressing to actions taken such as embargo of new placements, is not transparent and detailed in guidance. It is not clear why Mornington Hall was progressed to escalation but not Baker's Court. The spotlight of the ongoing quality improvement was on Mornington Hall, whereas from the evidence submitted to this review, it is clear that Baker's Court were experiencing similar concerns regarding the quality of care provided to residents.

2.13 The Newham contracts and commissioning escalation procedure and guidance does not include a clear pathway of communicating concerns to other funding authorities including Local Authorities and Clinical Commissioning Group (CCG).

2.14 While Newham ASC should work in partnership with the CQC and take into account the CQC inspection results, i.e. Mornington Hall 'Inadequate' and Baker's Court 'Requires Improvement', decisions for provider concerns escalation should be based on the evidence gathered by the Newham Quality Assurance Board and the Safeguarding Governance Team.

2.15 The operational teams, safeguarding governance, contracts and commissioning all had ongoing concerns about the care being provided in HC –One care homes, Baker's Court and Mornington Hall. The number of safeguarding concerns and complaints provided evidence that although HC One was presenting an improvement plan, it was not effective enough in translating into improved quality of care to the residents. A gap in the interface between commissioning and governance resulted in a situation where alternative care provision was not available. For this reason, escalating both Mornington Hall and Baker's Court to stage five of the escalation process i.e. suspension of contract was not a feasible option due to limited alternative placements.

ELFT Community Health

2.16 Safeguarding concerns identified by East London Foundation Trust (ELFT) community health services, must be raised within 24 hours to the Newham ASC.

Newham Safeguarding Adults Board (NSAB)

2.17 Quality Marker 7 SAR Quality Markers; The SAR is effectively managed. It runs smoothly, is concluded in a timely manner and within available resources. To ensure the most effective learning from a SARs, all IMR authors must undertake a briefing prior to commencing the work. IMR authors must possess the skills of recording, analysis, reflection and critical thinking to enable them to identify the key learning for their individual organisation.

3. Summary of Recommendations

Immediate Recommendation ASC and CCG

3.1 All existing residents to be invited to participate in a multi-disciplinary review of their needs and care provision. Reviews to include family, adults, the care provider, commissioners including ASC, instructed advocate if needed and the adults GP. Self-funded residents to be offered the opportunity to have a multi-agency care placement review. The recommendation must provide reassurance to the NSAB that all residents placements are safe and that residents are receiving good quality of care.

Newham Safeguarding Adults Board

3.2 Review Newham SAR procedure, including accountability, support and training to IMR authors when the NSAB uses the IMR methodology again. Consider quality marker guidance[1] of what type of SAR is proportionate, including when appropriate to apply the currently piloting Rapid Time SAR.

Adult Social Care

3.3 Annual safeguarding audit of practice and decision making. Audits should consider the 'beyond auditing' model which places an emphasis on practitioners developing their skills through participating in the audits of their active cases. The audits should focus on professional curiosity and multi-agency enquiries and decision making.

3.4 Newham ASC Contracts and Commissioning team to review the focus of provider monitoring visits to include themed visits, focusing on the customer experience and outcomes. Where appropriate i.e. specific health themed visits, the visits to be conducted jointly with the CCG. Any gaps in care delivery to be identified and for contacts and commissioning to support providers with specific targeted training and development. Consider whether this can be facilitated across different providers across Newham to ensure lessons learnt are shared and to improve outcomes for the Newham adults receiving care and support.

[1] Safeguarding Adults Review Quality Markers checklist SCIE & RiPfA June 2018

3.5 Newham ASC to review their contracts team quality improvement board, terms of reference, including accountability and information sharing with other teams within ASC. Consider how evidence gathered by the safeguarding governance team, through Care Act section 42 enquiries is shared and impacts the decisions of the contracts team. Providers to be briefed on the procedures, criteria for implementing and legislative framework to ensure there is an understanding of accountability, roles and responsibilities.

3.6 Review the provider concerns and escalation process to include practice guidance and procedure. The guidance must include transparent criteria for initiating the process, accountability for decision making and monitoring the progression of improvement, support and guidance to achieve the ultimate goal of de – escalation as the quality of care has improves.

3.7 Review mechanisms for sharing both hard and soft information about nursing and care homes that is informed by and in turn informs operational front line staff. Review the escalation process when information considers residents to be at risk or receiving poor quality care, what decisions need to be made to protect not only individuals but other residents. This should include communication with other placing authorities both health and social care.

Care Provider – HC – One Oval Limited

HC- One have implemented an improvement plan as a result of concerns raised and the CQC inspection reports. The improvement plan focused on embedding staff understanding and consistent implementation of the systems to improve care planning, risk assessment and monitoring of external referrals. In addition, there has been a focus on developing continuous staff competency through training, mentoring, induction and supervision. In both homes the management team has been recruited and is now considered to be a stable permanent team. With this in mind, the recommendations consider how the improvement plan can be achieved and used as a mechanism for ongoing further improvements in quality of care for residents.

3.8 HC – One to ensure that care planning meetings with new residents, and where appropriate their families, to take place within 14 days of admission to discuss the care planning. Review the care planning for existing residents and ensure appropriate care planning has taken place and if not ensure it is completed as a matter of urgency. The GP to be included in the care planning meeting to facilitate the discussion and authorize the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) if a DNACPR is appropriate.

3.9 Responsibility and accountability for implementing the agreed home improvement plan to include the local home management team from the onset. Home Management team to focus on building strong partnerships with all other professionals, including the Newham Quality Improvement Board. HC-One corporate team to monitor, support and provide advice and guidance to ensure positive trajectory.

3.10 Existing systems to be applied with consistency to 'hear' the residents and their families/ representatives voice. As part of the regular audit of care, residents and families should be given an ongoing opportunity to voice both their compliments and concerns. This includes being part of care planning, residents' surveys, resident meetings, family meetings and responding in a timely manner to formal complaints.

3.11 HC – One improvement plan to be continually reviewed and critically analysed for effectiveness through considering the experience of the current residents. Are new concerns similar in nature to previous concerns? Or have the changes improved the quality of care provided to the residents?

ELFT – Community Health

3.12 In cases where the administration of antipsychotic depot medication has been transferred to the GP practices, community nurses to ensure that the contractual agreement which includes a mechanism for review is followed in all cases prior to administering the medication.

3.13 Safeguarding training should stress to all professionals their duty of care and the need to be alert and vigilant to risks of abuse in all settings including care homes, ensuring that the local safeguarding procedure of reporting concerns is embedded in practice.

4. CONTEXT OF SAFEGUARDING REVIEWS

4.1 Under Section 44 of the Care Act 2014, Safeguarding Adults Boards (SAB) must arrange a Safeguarding Adults Review (SAR) if:

I. There is reasonable cause for concern about how the SAB, member of it or other persons with relevant functions worked together to safeguard the adult and the adult dies as a result of abuse or neglect, whether or not it was known or suspected before the adults dies (s44(2)) OR

II. If the adult is still alive and the SAB knows or suspects, that the adults has experienced serious abuse or neglect (44(3).

4.2 In addition, SABs are free to commission a SAR in any other situations where it is thought there is valuable learning for the partnership (s44(4)). It is on this basis that the Newham SAB commissioned this thematic SAR.

4.3 A key principle for completing a SAR, is to ensure there is a culture of continuous learning and improvement across the organisations that work together, and the approach taken to the reviews should be proportionate to the scale and the level of complexity of the issues examined.

4.4 Involvement of the people who are the subject of the reviews is recognised as an important aspect of the learning from the review. If the person who is the subject of the review is living, he or she will be approached to ascertain their wishes on involvement in the review and where indicated, assess capacity to consent to this.

4.5 The SAB commissioned an independent author to provide the SAR report. The author is an experienced safeguarding practitioner, consultant and trainer. She holds a professional background as a social worker, working across all service areas of safeguarding adults. The author is independent of the Newham SAB. The lead reviewer, Belinda Oates was commissioned to start the SAR in March 2020.

4.6 Belinda Oates is a qualified social worker registered with the Social Work England. She has over 25 years' experience of working in the field of social care. Belinda gained practice experience initially as a front-line social worker before progressing to management roles which included; multi-agency team manager and safeguarding adults operational and strategic manager. Belinda has been working independently for the last 14 years. Her work as a consultant and trainer has focused primarily on safeguarding adults as legislated by the Care Act 2014 and Mental Capacity in line with Mental Capacity Act 2005.

4.7 A SAR is not designed to hold individuals or organisations to account. Other processes exist for the purpose. The SAR enables all information from partner agencies to be reviewed in one place enabling the author to identify key areas for development and learning to support SAB partners to improve ongoing safeguarding practice.

4.8 The Care Act 2014 (s44(5)) states, each partner must cooperate and contribute to the review, identifying lessons to be learnt and to apply the lessons to future practice.

4.9 The Department of Health's six principles for adults safeguarding should be applied across all safeguarding activity.[2] The principles will be considered throughout the SAR as follows:

Empowerment	Understanding how service users were involved in their care; involving service users or their representatives in the review
Prevention	The learning will be used to consider how practice can be developed to prevent future harm to others
Proportionality	The learning of six cases will be more effective in the learning lessons and considering the themes
Protection	The learning will be used to protect others from harm
Partnership	Partners will co – operate with the review, considering how partners are working together to safeguard adults in Newham
Accountability	Agencies will be transparent in the review with the SAB holding individual agencies to account for agreed recommendations.

4.10 The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of people who have died or been seriously abused or neglected. The recommendations and action plans from a SAR need to be followed through by the SAB.[3]

5. TERMS OF REFERENCE

The 6 adults subject to this SAR, did not meet the statutory criteria for a SAR. The Newham SAB commissioned the SAR on the basis that there are valuable lessons to learn from how partner agencies provided support and care to the adults who live in care homes in Newham. The concerns that triggered this SAR was number of deaths and hospital admissions from the two care homes run by the same provider and the consequences surrounding each incident. There was an identified theme of poor care provision by the care provider. The evidence considered as part of this SAR and the subsequent lessons learnt, validates the SAB decision to commission a non-

[2] Department of Health (2016 Care and Support Statutory Guidance Issues under the Care Act 2014) s14.125

[3] Department of Health (2016) Care and Support Statutory Guidance issues under the Care Act 2014) s14.128

statutory SAR. The lessons will inform recommendations to improve practice and partnership working.

6. SCOPE

Exceptional Circumstances

This SAR was commissioned on January 2020. The initial timescale for the SAR was March to July 2020. Due to the exceptional circumstances of the COVID 19 pandemic, the gathering of information from various partners was understandingly challenging, with agencies focus being on responding to the pandemic.

The SAR subcommittee agreed that the hospitals involved in providing care for the adults would not contribute an IMR, but would view the draft report and contribute comments as appropriate.

This SAR covered both the care provider and other agencies interventions between January 2018 to November 2019

The Care Settings

6.1 HC – One Oval Limited is one of the largest care providers across the United Kingdom with over 300 care homes. Mornington Hall and Baker's Court are two care homes based in London Borough of Newham that are owned and operated by HC – One.

6.2 Mornington Hall and Baker's Court were acquired by HC – One Oval Limited from BUPA in December 2016.

6.3 Mornington Hall is a 120 bedded, nursing home comprising of 4 units; Hamfrith, Cornwell, Roding and Haywood. Baker's Court is 78 bedded, care home providing nursing and dementia care. The Roding unit was closed on in April 2020.

6.4 Mornington Hall has been subject to an organisation concerns enquiry led by Newham Safeguarding Governance team. Newham suspended any new placements in August 2019. At the time of the review Newham ASC continued to suspend new placements to Mornington Hall nursing home.

6.5 The care home residents at Mornington Hall were all registered with the E12 GP Surgery Church Road Practice and the residents at Baker Court with Lantern Health CIC – GP Church Road Practice.

Care Quality Commission Inspection Reports

6.6 The CQC carried out an unannounced inspection in July 2019. The CQC rating for Mornington Hall is 'Inadequate' – the report was published on the 10 October 2019. At the time of writing this report, September 2020, there has not been an updated inspection report or rating published. The 'Inadequate' rating means the home is in 'special measures'. This means that the CQC keep the service under review and, if they do not

propose to cancel the provider's registration, CQC will, in normal circumstances re-inspect within 6 months, to check for significant improvements.

6.7 The inspection identified breaches of regulations in relation to; person centered care, dignity and respect, consent, safe care and treatment, safeguarding, premises and equipment, staffing and governance.

6.8 CQC instructed the terms of the registration for Mornington Hall, as a result of the 'inadequate' rating as follows:

- 'The Registered Provider must not admit any new service user to Mornington Hall Care Home without the prior written agreement of the Care Quality Commission.
- The Registered Provider must ensure there is sufficient, suitably qualified, managerial capacity present at Mornington Hall Care Home to deliver effective governance and oversight.
- Upon the imposition of this condition, the Registered Provider must provide to the Care Quality Commission on the 28th day of each month (or nearest working day falling thereafter when 28 falls on a non-working day) monthly submissions in relation to the updates and actions completed on the Home Improvement Plan in place at Mornington Hall Care Home.'

6.9 The CQC carried out an unannounced inspection for Baker's Court on 23 September 2019 – the report was published on the 21 November 2019; with a rating of 'Requires improvement'. The previous rating for the service in January 2019 was 'Requires improvement'.

6.10 The inspection identified areas requiring improvement included resident's safety, staffing, people's care, treatment and support and leadership and management.

6.11 Due to COVID 19, the CQC had not at the time of this report, returned for a full or themed inspection. The CQC has implemented the Emergency Support framework (ESF) for all regulated services, during this unprecedented period of limited onsite inspections. The ESF provided structured conversation via telephone and or video link, with providers covering 4 key areas; safe care, staffing arrangements, protection from abuse and assurance processes, monitoring and risk management. The CQC are in the process of moving from ESF to a transitional regulatory framework which will join various methodologies of inspection including onsite visits to providers.

The 6 Adults

6.12 Five out of the six adults subject to this review are deceased. Mrs. Q moved from Mornington Hall to another care home not operated by HC – One in another London Borough.

6.13 The individuals subject to this review share the following characteristics:

- They are all over the age of 65.
- Mr. P, Ms. R and Mrs. S resided in Baker's Court, operated by HC – One.
- MS Q, Mr. T and Mr. U resided in Mornington Hall operated by HC – One.
- Mr. P, Ms. R, Mrs. S, Mr. T, and Mr. U, all died whilst residing in a HC – One care home. Mrs. S and Mr. T both died at the care home. Mr. P, Ms. R and Mr. U died once admitted to hospital.
- The adults date of deaths occurred between 14 July 2018 and 24 November 2019.

6.14

Adult	Pen Picture
Mr. P.	Mr. P. was an 88-year-old man who lived in Baker's Court care home from 26 January 2018 until his admission to the London Royal Hospital on 10 July 2018 and his subsequent death on 14 July 2018. Mr. P's placement was arranged and funded by the London Borough of Redbridge. Mr. P's cause of death is recorded as a subdural hemorrhage following a fall from his wheelchair in the care home on the 10 July 2018. The Coroner issued a Prevention of Future Deaths Report, 12 March 2019, requiring the Care provider HC – One to respond. The Coroner did not specify further actions after considering the reports from HC – One. A safeguarding concern was raised by Mr. P's son following his death raising concerns about the quality of care provided by HC – One to his Father.
Ms. R.	Ms. R was a 92-year-old White British woman, who was admitted to Baker's Court care home on the 12 September 2019 from the Royal London Hospital. The records contain no contact details of family or details of friends. At the time of admission, the care provider, Baker's Court record Ms. R as being immobile and requiring nursing in bed. Ms. R's placement was arranged and funded by London Borough of Tower Hamlets. Ms. R was funded by Newham CCG for the nursing care component (FNC) from the 13 September 2019. Ms. R sustained a right neck femur fracture following an unwitnessed fall at the care home on 28 October 2019. Initially Ms. R declined to be checked or have her observations taken. She did not complain of pain. On 29 October 2019, Ms. R again declined to have her body examined but was complaining of a pain in her right leg. Ms. R was admitted to hospital on 30 October 2019. She had sustained a fracture. She had surgery to repair the fracture. She died in hospital on the 12 November 2019. Coroner's inquest was held on 12 March 2020. The record of inquest 12 March 2020 recorded the conclusion of the Coroner as to the death of Ms. R as '*sustained a right neck of femur fracture following an unwitnessed fall at her care home on the 28 October 2019. She underwent a surgical procedure to address the fracture but sadly developed a lower respiratory infection post – operatively. The lower respiratory tract infection is likely to have been contributed to by the immobility following the fall.'*

Mrs. S.	Mrs. S was an 84-year-old African-Caribbean woman who lived at Baker's Court care home from the 29 May 2019 until she died on the 26 June 2019. Mrs. S moved to Baker's Court from hospital, prior to hospital she was residing in a different care home. She was moved from the previous care home at her family's request due to concerns of neglect. Mrs. S's placement was arranged and funded by London Borough of Newham. On pre admission to Baker's Court, Mrs. S was assessed as needing long term MHCOP nursing care. Mrs. S's pre – admission assessment, indicated that she communicated in English and could make her needs known but had comprehension difficulties. Mrs. S had a DNACPR in place in hospital. She had two children, a son and a daughter. On 26 June 2019, Mrs. S was visited by her daughter at approximately 13H00. Mrs. S's daughter found her mother non responsive and cold lying on her bed. The London Ambulance Service were called, however after a period of attempted resuscitation Mrs. S was pronounced dead. As this was an unexpected death the police were called.
Mrs. Q.	Mrs. Q was 89- years- old at the time of the incident, subject to this review. She is an Asian lady who moved as a private self-funder in to Mornington Hall on the 20 October 2017. Mrs. Q was originally from India. She moved to Manchester with her family in 1968. Mrs. Q has two sons who are joint lasting power of attorney for her finances, health and welfare. Mrs. Q moved from Manchester into the residential unit of Mornington Hall in 2017, to be closer to her sons. Mrs. Q was assessed on the 17 September 2018 as meeting the criteria for Funding Nursing Care (FNC), which is paid for by the CCG, though the care is overseen by the local authority. The FNC payment is a top up of £165.56 per week to the main care component, which Mrs. Q continued to fund privately. At this time Mrs. Q was moved from the residential unit to the nursing unit at Mornington Hall. Newham ASC records do not include any prior intervention with Mrs. Q's care at Mornington Hall, until a safeguarding concern was raised in December 2018, regarding the quality of care she was receiving at Mornington Hall. The time period under review is 1 November 2018 – 7 January 2019, at which time Mrs. Q was admitted to hospital. Additional concerns were raised by the hospital doctors and by her son, about the care that Mrs. Q received at the care home in relation to wound care. The hospital doctors attribute the poor care in the care home leading to her hospital admission. Hospital records indicate on admission Mrs. Q was diagnosed with a grade 4 pressure sore, sepsis and hypernatremia. Following her hospital stay, Mrs. Q's family moved her to an alternative care home not wishing for her to return to Mornington Hall due to the poor level of care that she had received.
Mr. T.	Mr. T was an 82-year-old man, born in Stratford. He was married and had two sons and a daughter with his first wife, who died over 18 years ago. Mr. T did not have regular contact with his children due to their work commitments. Mr. T worked in a meat house. He used to play squash and snooker and was a Tottenham football supporter. Mr. T moved to Mornington Hall in 2016, the exact date is not recorded. From the time he moved in, Mr. T said he wanted to move closer to his friend who lived out

	of borough. Mr. T's friend visited regularly. Newham ASC were involved with Mr. T, on and off throughout his stay in Mornington Hall until his death on 3 November 2019. Mr. T suffered a cardiac arrest on the 3 November 2019 at the care home. Concerns were raised that the staff members who were responding to Mr. T were not skilled in basic life support. The LAS reported on arrival, Mr. T was pale, no cardiac output and agonal breathing, indicating cardio pulmonary resuscitation (CPR) was required immediately, but this was not being recognised or performed by those staff present. Paramedics carried out three cycles of advanced life support but Mr. T. was pronounced dead at 15:28pm. Mr. T did not have Do Not Attempt Cardio Pulmonary Resuscitations (DNACPR) in place at the time of his death. Without a valid DNACPR, staff should have started CPR, commonly referred to as basic life support.
Mr. U	Mr. U was a 90-year-old white British man, who moved to Mornington Hall on the 8 June 2019 for a two-week period of respite. The respite period was extended and turned into a permanent placement as it was assessed to be in Mr. U's best interest to remain in the care home. Mr. U was previously living in the community with his wife. He was in receipt of four calls a day from one carer. On the 14 June 2019 ASC placed an embargo on the placing of any new residents funded by Newham ASC at Mornington Hall. When Mr. U moved into the care home, he moved into a residential bed. Mr. U required MHCOP residential. The care home was advised to request residential MHCOP nursing funding. The funding was agreed on the 14 June 2019 however, ASC Brokerage team, who have responsibility for identifying available care provision for ASC and communicating funding decisions with care providers, failed to communicate the funding decision to the care home. Mr. U's family visited on the 29 July 2019 and raised concerns about Mr. U's deterioration. He was admitted to hospital the same day. Mr. U was found to have a chest infection on admission and was treated with IV antibiotics and fluids. His condition did not improve. After consultation with Mr. U's wife and son, it was agreed to stop active treatment. Mr. U died on the 2 August 2019. Cause of death was recorded as bronchopneumonia and metastatic carcinoma of prostate.

7. METHODOLOGY

This review included two stages.

Stage 1

1. Independent Management Reviews and Chronologies

All agencies involved in the adults' cases in this review were invited to participate in contributing to the review. The table below indicates who contributed.

Families and representatives of the adults' subject to the review were invited to contribute their views to the review.

Adult	IMRs	Other Contribution
Mr. P	• HC -One – Baker's Court • East London Foundation Trust Community – East Ham Care Centre	• London Borough of Redbridge email correspondence with Newham Safeguarding Team • Coroners Regulation 28 report to prevent future Deaths – 12 March 2019 • GP Lantern Health Carpenters – Church Road Practice – GP report • Mr. P's son
Ms. R	• HC – One Baker's Court • London Borough of Newham ASC • East London Foundation Trust Community – East Ham Care Centre • London Borough of Tower Hamlets ASC	• Record of Coroner Inquest 12 March 2020 • GP Lantern Health Carpenters – Church Road Practice – GP report for Coroner
Mrs. S	• HC – One Baker's Court • London Borough of Newham ASC • East London Foundation Trust Community – East Ham Care Centre • GP Lantern Health Carpenters – Church Road Practice	• Mrs. S's daughter
Mrs. Q	• HC – One Mornington Hall	• Summary of safeguarding interventions from Newham Safeguarding Governance Team (ASC)

	• East London Foundation Trust Community – East Ham Care Centre • London Borough of Newham ASC	• GP Lantern Health Church Road Practice • Mrs. Q's two sons
Mr. T	• HC – One Mornington Hall • East London Foundation Trust Community – East Ham Care Centre • London Borough of Newham ASC	• Summary of ASC interventions from Safeguarding Governance Team • Email trail from HC – One care home manager and Safeguarding Governance Team regarding disciplinary actions. • Mr. T's friend
Mr. U	• HC – One Mornington Hall • East London Foundation Trust Community – East Ham Care Centre • London Borough of Newham ASC	• E 12 Surgery Church Road Health Care Centre Medical Records • Safeguarding Strategy Meeting Minutes 18 July 2019 • Mental Capacity Assessment 19 June 2019 • Mr. U's wife

In addition, the following documentation was reviewed:

- HC – One Oval Limited Baker's Court Care Home CQC inspection report – 23 September 2019
- HC – One Oval Limited Mornington Hall Care Home CQC inspection report – 22 July 2019
- London Borough of Newham Organisational Concerns Procedure – April 2019
- Newham Quality Improvement Board Meeting Minutes October 2018 – December 2019

The following agencies contributed to the review via telephone conferencing:

- The CQC National Safeguarding Advisor
- The CQC Inspection Manager covering North East London.
- London Borough of Newham Contract Team
- CCG Safeguarding Lead

Stage 2

The outcome of stage 1 of this review has been analysed and collated into a written report identifying themes and learning from all 6 cases.

Explanation of Key Terms used in the report narrative

- **Safeguarding Adults Section 42 Enquiry** – The Local Authority legal duty to conduct or ensure others conduct an enquiry when an adult who has care and support needs and is experiencing or at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from with risk of, or experience the abuse or neglect
- **CPR** – Cardio Pulmonary Resuscitation - the manual application of chest compressions and ventilations to patients in cardiac arrest, done in an effort to maintain viability until advanced help arrives. This procedure is an essential component of basic life support (BLS), basic cardiac life support (BCLS), and advanced cardiac life support (ACLS).
- **CHC -** Continuing healthcare funding, also known as CHC funding, is free healthcare provided by the NHS which can be received in any setting outside of hospital including at home, within a hospice or in a care home.
- **DNACPR -** Do Not Attempt Cardio-Pulmonary Resuscitation - It means that if a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or shouldn't be taken by a healthcare professional, including not performing CPR on the person.
- **DOLs** – Deprivation of Liberty safeguards - The DOLs under the Mental Capacity Act 2005 allows restraint and restrictions that amount to a deprivation of liberty to be used in hospitals and care homes – but only if they are in a person's best interests. To deprive a person of their liberty, care homes and hospitals must request standard authorisation from a local authority.
- **FNC -** NHS-funded nursing care is when the NHS pays for the nursing care component of nursing home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care.

8. THE SIX ADULTS

1. Mr. P

Mr. P. was an 88-year-old white British man who lived in Baker's Court care home from 26 January 2018 until his admission to the London Royal Hospital on the 10 July 2018 and his subsequent death on the 14 July 2018. Mr. P's placement was arranged and funded by the London Borough of Redbridge. Mr. P was moved from another care home, which closed down, to Baker's Court. Mr. P was born in London and attended a private school outside London. When he finished school, Mr. P served in the Royal Air Force as a radar operator as part of his national service. Mr. P was an avid reader and enjoyed reading; newspapers, books, and according to his son, 'anything he could get his hands on.' He regularly used the internet up until 6 months prior to his death. In Mr. P's son's words 'My Dad was a gentleman'. Mr. P put a lot of value on manners and courtesy. He could not abide bad manners. He would get frustrated and angry at discourteous behaviour.

Mr. P was assessed as having capacity to make his own decisions about all aspects of his life. He was an independent man who used a Wheelchair to mobilize. His mobility at the time of admission was recorded as 'being able to stand, but not walk.' Mr. P. preferred to stay in his wheelchair, which had a pressure relieving cushion. Mr. P was offered a pressure relieving mattress on his bed but he signed a statement refusing consent for the mattress. Mr. P had chronic bilateral leg ulcers, arterial fibrillation, pulmonary embolism and hypertension and deep vein thrombosis at the time of his placement in Baker's Court.

He liked to have his meals in his bedroom, where he had a small fridge for sweets and drinks. Mr. P had one son who was in regular contact with both Mr. P and the care provider. Mr. P.'s initial risk assessment on admission, identified a risk of falling when he reached for things. The plan was to encourage Mr. P to call for help by using his call bell, if he needed something out of his reach. Records from the care home indicate that Mr. P refused support with personal care and cleaning his room, however he took all his prescribed medication with the support of the care staff.

Mr. P had numerous pressure areas, and there was ongoing intervention from ELFT community services throughout his stay at Baker's Court. He was at times reluctant to accept help but with encouragement, agreed to the GP and Tissue Viability nurses' interventions. The records are conflicting in information, about what equipment he agreed to, and what equipment he was actually in receipt of.

Between 20 February 2018 and 10 July 2018, Mr. P was recorded to have had 12 falls. The circumstances around the falls were all similar in nature, in that Mr. P either slipped or fell from his wheelchair. Mr. P died on the 14 July 2018 in hospital being treated for a head injury, sustained in the last fall at the care home on the 10 July 2018.

2. Ms. R

Ms. R was a 92-year-old woman, who was admitted to Baker's Court care home on the 12 September 2019 from the Royal London Hospital. Ms. R's placement was arranged and funded by the London Borough of Tower Hamlets. Prior to Ms. R's hospital admission, she was living in the community with support from a care agency. At times Ms. R refused the care. Ms. R was known to Tower Hamlets ASC since 2003 according to the digital records, although it is believed she may have been known longer but the paper records were not accessed as part of the review. Ms. R had a lengthy history of hospital admissions. Ms. R's care plan recorded Ms. R was a Christian lady who was widowed. When living in the community she enjoyed listening to Christian music which her vicar brought to her weekly when he visited. The historical records made reference to a number of safeguarding incidents over the years including, a warden shouting at Ms. R, a buildup of belongings in her home and risks associated with Ms. R's use of a mobility scooter as she had seriously reduced vision.

The Tower Hamlets ASC assessments were started but not completed prior to admission, records indicated they were updated only after Ms. R died. There is a lack of clarity from the ASC records as to whether Ms. R consented to the placement at Baker's Court. No mental capacity assessment completed prior to admission. On admission, to Baker's Court, Ms. R's assessment by the care provider recorded that Ms. R was immobile and required support/ nursing in bed. Ms. R was assessed as being at risk of falls but no previous falls were recorded in the assessment. From the 13 September 2019, the nursing care component (FNC) of Ms. R care was funded by Newham CCG. On the 16 September 2019, the care provider made a request to Tower Hamlets ASC, for a Deprivation of Liberty safeguards (DOLs) assessment for Ms. R. The assessment was completed 18 September 2019 but was never processed through to authorisation by Tower Hamlets ASC as it was on a waiting list. The DOLs had not been authorized at the time of Ms. R death on the 12 November 2019. The DOLs under the Mental Capacity Act 2005 allows restraint and restrictions that amount to a deprivation of liberty to be used in hospitals and care homes – but only if they are in a person's best interests. To deprive a person of their liberty, care homes and hospitals must request standard authorisation from a local authority.

An Occupational Therapist from ELFT Community Services assessed Ms. R on 22 October 2019 and recommended that the bedrails be removed as Ms. R had started to climb over the bedrails and complained of being trapped 'like a caged animal'. A crash mat was put in place with the bed being set at the lowest height. Hourly checks were implemented by the care provider. On the 25 October 2019, the GP prescribed an anti – depressant for Ms. R.

On the night of the 27 October 2019, Ms. R declined to go to bed to sleep, preferring to sleep in the armchair. At 14H00 the following day, Ms. R was found on the floor attempting to move towards her bedroom door. Records indicate that Ms. R declined to be checked or have her observations taken, she was moving her arms and legs. She did not complain of any pain. There is no record of Ms. R's capacity to make the decisions about the risks or any consideration of her mental capacity at this point, or any other point in the care providers records. The records are

contradictory, as it states that the examination took place but Ms. R declined. It is not clear how the examination took place without consent.

On the 29 October 2019 at 07H10, Ms. R complained of pain in her leg. Ms. R consented to a physical examination. Bruising was observed but Ms. R declined to have her observations be taken. At 08H20, Ms. R complained of pain, 999 was called, but the care home staff were informed that they would need to wait two to four hours for the ambulance. Ms. R was seen by her GP during a routine visit who advised hospital admission. An ambulance arrived at 13H30. On admission, the hospital confirmed that Ms. R had a broken hip.

Ms. R had surgery to repair the hip on 30 October 2019.

Ms. R died on 12 November 2019. The Coroner recorded death as acute kidney failure, lower respiratory tract infection, right fractured neck of femur. The record of inquest 12 March 2020 recorded the conclusion of the Coroner as to the death of Ms. R as '*sustained a right neck of femur fracture following an unwitnessed fall at her care home on the 28 October 2019. She underwent a surgical procedure to address the fracture but sadly developed a lower respiratory infection post – operatively. The lower respiratory tract infection is likely to have been contributed to by the immobility following the fall.'*

3. Mrs. S

Mrs. S was an 84-year-old African-Caribbean woman, who lived at Baker's Court from 29 May 2019 until her death on 26 June 2019. Mrs. S was born in Jamaica, and moved to the UK in the 1960's. She had 6 children, 5 sons and a daughter. Mrs. S was described as a loving mother, who never wanted to get anyone into trouble. Mrs. S daughter explained that her mother did not like to complain about the care in the home. Mrs. S's daughter visited her in the care home regularly and often brought in food. Mrs. S's sons and families would visit Mrs. S.

Mrs. S was living in another care home prior to her admission to Newham Hospital. The family raised a safeguarding concern, regarding the poor level of care in the care home prior to Mrs. S's hospital admission. Mrs. S was initially treated for a urinary tract infection, which developed into urinary sepsis. Mrs. S's family requested she move to a different care home following concerns of neglect by the existing care provider. Newham ASC commissioned Mrs. S placement from hospital on the 29 May 2019. Mrs. S needs had changed and the previous care home were unable to meet her care needs. The preadmission assessment for Mrs. S records that she had a DNACPR in place at hospital. Mrs. S's preadmission record highlights that Mrs. S speaks English and is able to make her wishes known but that she has comprehension difficulties. She was immobile on admission and should be nursed in a bed on an airflow mattress and she had a grade 3 pressure sore on her sacrum.

Baker's Court applied for a DOLS, which was granted on the 20/06/2019. The request took 41 days, which makes Newham DOLS and safeguarding team in breach of 20 days. There is no evidence that this breach impacted on Mrs. S's care. Mrs. S was seen regularly during her stay at Baker's Court by both the community nurses and her GP. Mrs. S's GP, recommended that

Baker's Court arrange a care planning meeting with Mrs. S's family as she lacked capacity to participate and contribute to her care planning. The GP recommended the meeting discusses a DNACPR with the family as Mrs. S had one in hospital. This meeting was not arranged until the 14 June 2019, 12 days before Mrs. S died. The family did not attend the meeting and no DNACPR was agreed.

On the 30 May 2019, HC- One raised a safeguarding concern regarding a pressure sore that Mrs. S was admitted with following her stay in hospital. Mrs. S died, prior to the conclusion of the safeguarding enquiry.

Mrs. S's care plan included hourly observations. The recording of the observations is inconsistent.

Mrs. S's daughter visited frequently. On the 26 June 2019, she visited her mother at 13H00. On arrival she found her Mother lying in bed, non-responsive and cold to touch. At 13H05, a staff member went to offer Mrs. S some lunch and observed Mrs. S's daughter on the phone telling the person on the other end of the call that her mother had died. The staff member immediately informed the nurse, who called the emergency services and on their guidance started CPR. When the paramedics arrived, they continued CPR, but Mrs. S remained unresponsive and was pronounced dead.

The police attended the home. Mrs. S's daughter indicated that the home care staff gave the police an inconsistent account of when they last saw Mrs. S alive. The records state that the nurse saw Mrs. S at 12H20 and that she was okay. The daughter arrived at 13H00 and Mrs. S was unresponsive and cold to touch. The police found evidence that the records had been amended and were not clear. The author of the records and charts, was not the staff member who provided Mrs. S with her care, but another staff member who admitted to supporting her colleagues by completing the documents on their behalf.

Baker's Court sent a notification of an unexpected death to the CQC on 27 June 2019. Mrs. S's daughter notified Newham ASC of her mother's death and of the circumstances. A social worker visited the home on 27 June 2019, but there is no evidence of a Care Act 2014 section 42 enquiry being conducted.

4. Mrs. Q

Mrs. Q is an Asian woman, who lived in Mornington Hall from 20 October 2017 to 7 January 2019. She was admitted to hospital on the 7 January 2019 with sepsis, grade 4 pressure sore and hypernatremia. Following her admission to hospital, her family supported her to move to an alternative care home, due to concerns about the care she received while living at Mornington Hall. Mrs. Q's son is the registered Lasting Power of Attorney for both Mrs' Q's finances and health and welfare.

On the 23 November 2018, the care home identified that Mrs. Q had an abscess on her sacrum. A Tissue Viability Nurse (TVN) from ELFT Community Health Services visited 4 times during the

period, 3 December 2018 – 7 January 2019 and provided advice and support with a wound care plan for Mrs. Q, which included 2 hourly positional changes. On the visit on the 27 December 2019, the TVN referred to the sacral wound being a grade 4. There was delay of 6 days for the blood screening requested by the GP to be completed.

On admission to hospital on the 7 January 2019, Mrs. Q's son requested an assessment from a geriatrician consultant. Both Mrs. Q's son, who is a consultant microbiologist and the geriatrician consultant stated that the poor care that Mrs. Q had received at Mornington Hall had attributed to Mrs. Q's life threatening prognosis.

Mrs. Q's son made a formal complaint to the care provider, in December 2018. He regularly reminded the home manager of the need for a response, but the response was only received on 25 April 2019 from the Area Director of HC - One. The response included copies of the homes internal investigation, copies of the root cause analysis, datix information and safeguarding documentation. The family were not satisfied with the response. On the 17 May 2019, Mrs. Q's son received a second response to his complaint from head of Quality and Regulation at HC One, acknowledging the distress caused by the poor care provided to Mrs. Q. Mrs. Q's family have instructed solicitors and are taking legal action against HC-One regarding the poor care Mrs. Q received while residing in the nursing unit of Mornington Hall. Their concern is primarily around the fact that although they have attempted to get answers via the complaints procedure, to date they have not been sent any HC – One investigation report, root cause analysis or evidence from HC- One that, lessons have been learnt that can prevent other residents experiencing the same failures that their mother Mrs. Q experienced.

A safeguarding concern was raised by HC – One to Newham ASC on the 3 December 2019. This was subsequently closed. The family raised a concern about the outcome of the enquiry and ASC reopened the enquiry on the 21 January 2019. The outcome of the enquiry, once further investigation took place was that '*pressure sores were avoidable and were acquired whilst Mrs. Q was under the care of Mornington Hall*.'

Following Mrs. Q's admission to hospital, Mrs. Q's family raised concerns about the quality or care provided to Mrs. Q to the CCG, who were funding the nursing care component (FNC) of her placement. The responsibility for overseeing the quality of care provided to Mrs. Q was with Newham ASC.

5. Mr. T

Mr. T was an 81-year-old white British man, who had lived in Mornington Hall since 2016. Mr. T had three children who he did not see regularly. His first wife was deceased, but he had a friend who visited regularly, who he wished to move closer to. She lived in another Borough. Between 2016 and November 2019, there were numerous ASC interventions, in an attempt to find Mr. T an alternative placement closer to his friend. In April 2019, extra care placement funding was agreed by Newham ASC, however the identified provider refused to accept Mr. T

stating that he required residential care. Mr. T's health deteriorated between 10 July 2019 and until his death on the 3 November 2019.

On the 3 November 2019, the care staff found Mr. T in respiratory distress. The care home staff called the paramedics who attended at 14H11pm. Paramedics reported the resident was unresponsive, pale, no cardiac output and agonal breathing. Paramedics reported the staff present had not started CPR, nor recognised the signs that CPR was required. Paramedics commenced CPR as no DNACPR was in place. Three cycles of advanced life support were attempted but Mr. T was pronounced dead at 15H38.

6. Mr. U

Mr. U was a 90-year-old white British man, who moved to Mornington Hall on the 8 June 2019 for a two-week period of respite. The respite period was extended and subsequently the placement was made permanent. Mr. U required MHCOP residential care. The care home reported him displaying challenging behaviour linked to his dementia diagnosis. A request for increased funding was made on 13 June 2019 and agreed on the 14 June 2019. However, ASC Brokerage did not communicate the decision to the care home. Mr. U continued to be placed in an inappropriate bed, with the care home reporting not being able to meet his level of care in a non MHCOP bed. The home manager reported ongoing concerns to the safeguarding team on 4 July 2019, as to no decision being made regarding the funding. On the 10 July 2019, at a professionals meeting, the decision was made to confirm Mr. U's placement as permanent in an MHCOP nursing bed. On the 18 July 2019, the strategy meeting agreed that Mr. U must be moved and the funding can be agreed post moving.

On the 28 July 2019, Mr. U was admitted to hospital at the family request due to his deterioration in his health. On the 29 July 2019, the care home manager emailed ASC to inform them there was no MHCOP bed available. In consultation with Mr. U's family, active treatment for pneumonia was discontinued on the 2 August 2019 as Mr. U was not responding to the treatment. Mr. U died on the 2 August 2019. The cause of Mr. U's death was recorded as bronchopneumonia and metastatic carcinoma of prostate.

9. FAMILY AND REPRESENTATIVES VIEWS

9.1 Safeguarding Adults focus is on achieving outcomes for vulnerable adults. The Care and Support Statutory Guidance for SARs 14.167 states 'families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively'

9.2 5 out of the 6 adults subject to this review, are deceased. Mrs. Q's family moved her from the care home to another care setting. At the time of her being transferred to hospital, she was assessed as not having capacity to make decisions about her care needs. Her family made decisions for her. Mrs. Q sadly passed away in January 2021.

9.3 All the families or representatives of the adults' subject to this review were sent a letter on the 21 September 2020, from the NSAB chair inviting them to discuss their family members care with the independent reviewing officer. As a result, 5 family members had an individual conversation with the author, the independent reviewer. Mr. P's son, Mrs. Q's two sons, Mrs. S's daughter and Mr. U's wife. Mr. T's friend had a discussion on the telephone with the author. Ms. R's records did not have any family or friends' details, who could be invited to participate in the review. All the families had follow on meetings with the independent reviewer and the independent chair of Newham SAB in order to go through the report and were invited to send comments in where they wished to do so. No recommendations changed as a result of these comments.

9.4 Mr. P's son had an individual conversation with the Reviewer on the 25 September 2020. His views of the care that his Father, Mr. P, received at Baker's Court included:

a. When the family and Mr. P identified Baker's Court, they did their research and the care home was owned by BUPA. The last inspection was a good inspection. They had an expectation that when HC-One took over, as the staff were remaining in position under the new company, that the care would continue to be of a good standard. This however, was not the case.
b. The staff did regular risk assessments regarding Mr. P falling from his wheelchair but they did not act upon the identified risks. It was only on the last occasion that the home, at the insistence of his son, agreed, to refer Mr. P for a wheelchair review, but they still failed to do so. Mr. P's son believes that this negligence lead to his Father's untimely death. While he is realistic that his Father was not likely to have lived for much longer, it upsets him that he died in this manner due to failures by the care home.
c. At the time of his death, the London Borough of Redbridge had agreed the funding for Mr. P to be transferred to a care home closer to his son as Mr. P was not happy in Baker's Court. His family were concerned that they were regularly raising complaints to the staff at Baker's Court but that none of the issues were addressed. The family were in the process of finding a suitable, alternative home.
d. Mr. P was a well-read man, who had, when reading the papers about deaths and failures of care homes, always told his son he did not want to die that way. Mr. P's son says the manner in which his Father died now 'haunts him' knowing that he died in the one way, that he was clear he did not want to.
e. Mr. P often complained to his son about how discourteous the staff in the care home were. Mr. P used a plastic receptacle to urinate. He was able to maintain his independence and did not require the support of staff when using the receptacle. Mr. P complained to his son that often, when he was using the receptacle, the staff would just 'barge' into his room without knocking, which upset him. Mr. P. was a proud man and rightly wanted staff to respect his privacy and dignity.
f. Mr. P was an articulate man and enjoyed having discussions about current affairs and a chat with staff. When he was in the previous care home, this was one aspect

that Mr. P particularly enjoyed, the fact that staff took time out, to have a chat. In, Baker's Court Mr. P found the staff to be abrupt and to be simply doing their job with no compassion or care. They would often come and tell him that he has an appointment rather than discussing it with him. He mentioned to his son he did not feel like a human but 'a parcel simply being passed around.' He did not socialize with the other residents as many of them were unable to communicate due to cognitive impairment. For this reason, Mr. P stayed in his room for the majority of the time.

g. Mr. P's son was distressed to be told when in hospital following Mr. P's fall on the 10 July 2018, that his Father had been found to have necrotic areas of skin on his buttocks and legs, something the hospital raised as a prime concern. When he asked the care home about this, he was told that his Father often refused medication or treatment. Mr. P's son mentioned his Father often complained about pain on his buttocks and legs and although he could be challenging and at times angry with staff, if he was in pain he would not have refused medical intervention.
h. Mr. P's son is of the view, that the only positive aspect about the care that his Father received was that, his Father commented that the food was good.

9.5 Mrs. S's daughter had an individual conversation with the Reviewer on the 8 October 2020. She discussed the following views about the care Mrs. S received and the response from statutory agencies:

a. Mrs. S's daughter has been affected by her Mother's death and says that she has had a number of health issues since her Mother died. She constantly remembers her Mother and how she saw her the day she died. This causes her a great deal of distress. Ms. S expressed her frustration, distress and nightmares that she still has as a result of the poor care her mother received from the staff at the care home.
b. There were numerous concerns about the care that her Mother received from the care home. The families main concern was that the care was not provided with any love or compassion but that the staff, were just 'doing their job.' The family raised concern about the lack of safeguarding procedures in operation, resulting in Ms. S's wellbeing not being considered. Mrs. S's daughter expressed frustration at the fact that the staff did not treat everyone the way that, they would want their own family member treated if they needed care.
c. When Mrs. S first moved into the care home, her daughter was unable to use the ensuite toilet due to the poor hygiene, specifically the unpleasant odour.
d. Mrs. S's daughter would support her Mrs. S to have a wash when she visited, as whenever she visited, Mrs. S had food around her mouth and her face. Mrs. S would spit food out if she there were lumps in it, but staff did not always support Mrs. S by helping clean her face after meals.
e. Although the TVN visited and examined Mrs. S, stating that the pressure wounds were healed, Mrs. S would call out in pain and told her daughter that she was not

being repositioned by staff which was why she was uncomfortable. She did not want her daughter to make a complaint to staff.

f. On the 26 June 2019, the day Mrs. S's daughter found her Mother deceased on arrival in the care home, Mrs. S's daughter recounted that the staff asked her initially to leave the room. She went to a separate room and spoke to her sister in law and then returned to her Mothers bedroom. Mrs. S's daughter explained to the staff that her mother was deceased but the staff argued that Mrs. S was still breathing. Mrs. S's daughter listened to her Mothers chest and disagrees that her Mother was still breathing. She explained to the staff that it was just the liquid on her Mothers lungs not a breath. Mrs. S's daughter believes that if she had not re-entered the room, the staff would have covered up the true facts.
g. Mrs. S's daughter raised concern about the lack of written records of her mother's care. On the day of Mrs. S's death, amendments were made to the records. Carer staff statements to the police when interviewed were inconsistent in details including times and when they last saw Mrs. S.
h. Mrs. S's daughter expressed her frustration at the number of reviews that have taken place, with no evidence of lessons learnt as in her view there is no change in the care for residents. She explained that she had raised safeguarding concerns to Newham ASC on more than one occasion but has never been informed of the outcome of the investigations. She shared that she had spoken to a contact officer from Newham ASC when she was visiting on one occasion at Baker's Court care home. The contract officer listened to her concerns, but nothing changed. Mrs. S's daughter feels strongly that the care provider should be held responsible for the poor level of care that her Mother and other residents have received. Her hope is that this review will result in action being taken to address all the concerns and improve care for residents so that no other adults' nor their families have to experience what Mrs. S and her family experienced.

9.6 Mrs. Q's eldest son had an individual conversation with the Reviewer on the 9 October 2020. Mrs. Q's, second son, had an individual conversation with the Reviewer on the 12 October 2020. In addition to telephone conversations, Mrs. Q's family shared with the Reviewer, a letter of complaint sent to HC- One on the 15 April 2019 regarding their mothers care. The letter was sent to Newham Safeguarding Governance team in April 2019. To date, the family have not received satisfactory written answers from HC - One to the questions they raised about their mothers' care.

Mrs. Q's sons have joint lasting power of attorney for both Mrs. Q's finances and her health and welfare decisions. Mrs. Q does not have mental capacity to participate in the review.

The family's view, is that the staff at Mornington Hall grossly neglected to care for their mother and staff were by large, incompetent in fulfilling their duty of care, to Mrs. Q during her stay in the nursing unit. The family believe that there was no single error but a

whole system failure which included lack of specialist care. The catalogue of failures all contributed to Mrs. Q being admitted to hospital with life threatening septicaemia. These failures included:

a. Poor nutrition and hydration; Mrs. Q was previously assessed by the SALT. She was admitted to hospital in April 2018 with aspirational pneumonia. When discharged, the SALT provided advice to the care home about supporting Mrs. Q to eat slowly. Meals would take between 45 minutes and 1 hour. The care staff spent 10 – 15 minutes supporting Mrs. Q with meals. Family were often present to support with meal times but it was not possible to be present for all meal times. However, Mrs. Q was found to be dehydrated and malnourished when she had a blood test in 4 January 2019. When Mrs. Q was prescribed nutritional supplements in December 2018, there was a delay in administering them by the care home.
b. Pressure wound risk assessment; Mrs. Q's care records state that Mrs. Q had a history of pressure wounds. The family were not informed of any previous pressure wounds. There was no preventative action and monitoring to reduce the likelihood of a recurrence.
c. Failure to mobilise; Mrs. Q's care plan stipulated that she should be repositioned and mobilized to prevent pressure wounds. The care home staff failed in the consistency of repositioning or mobilising Mrs. Q in line the advice given by both her son, who is a medical doctor nor the specialist services, such as a TVN.
d. Failure to recognize and monitor for the development of the pressure sore; the care home failed to respond appropriately or seek specialist advice when it was identified that Mrs. Q had a pressure wound. As a result of the poor response the wound progressed from a grade 1 to grade 2 (with no record of body mapping observation for 6 weeks between these stages) and then ultimately a grade 4 pressure sore very rapidly.
e. Failure to prevent and monitor for signs of infection; Mrs. Q's family believe if the care home had ensured that the advice from the hospital consultant, for Mrs. Q, to have a blood test was not delayed by both the GP and the care home for 6 days, she could have been treated earlier appropriately in the care home or failing this, admitted to hospital sooner. The infection would more likely than not have been localized rather than developed into life threatening septicaemia. Once Mrs. Q had her blood test, there was a further delay of 3 days prior to action being taken, by which point Mrs. Q had developed a severe septicaemia requiring urgent ambulance transfer to hospital.
f. Mrs. Q's son, offered the home medical advice, support and requested that they communicate with him regarding his mother's medical care. The home did not communicate with him. Mrs. Q's family found the communication by the home, on a whole largely, lacking. On the day that Mrs. Q was moved from the residential unit to the nursing unit, the family were not informed, even though

they had requested to be notified of the specific time to enable them to be present to support Mrs. Q with the move.

g. Mrs. Q's family requested information about the home policy, procedures and clarity on how they were implementing the care wound policy. The home manager was unable to locate the procedure initially. When it was found, it was in a locked drawer, that staff did not have access to. The procedure was not an HC – One procedure but a BUPA procedure.
h. The family state there were failings by the home's registered GP, who was present with the hospital consultant when she recommended a blood test. The blood test was not carried out for 6 days. Mrs. Q family had previous conversation with the GP about Mrs. Q wound care, they found the GP response to be unsatisfactory with the family recalling the GP explaining, due to his large case load, he was not aware of all the specifics of each residents in the care home.
i. Mrs. Q's family moved Mrs. Q from Manchester, to be near her family. They feel guilty that after promising her good care, she was treated in the neglectful way that she was in Mornington Hall. It is their belief, that if it was not for the excellent medical treatment she received once being admitted to hospital, she would have died of the septicaemia which was caused by the poor nursing care at Mornington Hall.
j. Mrs. Q's family wish is that HC- One provide them with information, that is transparent and open to demonstrate that their mothers case has been thoroughly investigated and the lessons learnt. They hope to see evidence of improvements made to ensure that the current residents receive good quality medical and social care.

9.7 Mr. U's wife and main carer had a conversation with the Independent Reviewer on the 19 October 2020. She discussed the following views about the care Mr. U received and the response from statutory agencies;

a. Mr. U's wife expressed anger that Newham ASC had promised Mr. U and his family that they would commission a respite placement close to the family home. However, Mornington Hall was a £10 taxi fare each way, from the family home. The consequence of this was that Mrs. U's visits were limited to when her son was able to take her to visit Mr. U.
b. Mrs. U's view of the care provided to her late husband by the care provider, in her own words was 'disgusting'.
c. Mrs. U explained that Mr. U hated being left on his own. The room that he was in at the care home, was at the end of a long corridor and very isolated. Mr. U would often be shouting out in distress when she visited. She was concerned the staff did not hear him when he called out and would leave him without company for long periods of time.

d. Mr. U lost weight when in the care home, staff would put his food down but not assist him to eat. When they came to clear the food, it was not eaten but instead of prompting Mr. U to eat they would remove the food.
e. On the day Mr. U was admitted to hospital, it was the family who recognised he needed medical attention and the ambulance was only called at their insistence. The family were concerned at the lack of care and nursing by the staff. They question why the care home staff did not recognise the deterioration in Mr. U's health and call an ambulance earlier.
f. Mrs. U believes that if Mr. U had not been moved to the care home, but had been allowed to continue to live at home, with her providing his care, it is likely he would still be alive today.

9.8 Mr. T's friend has a telephone conversation with the NSAB independent chair and the author on the 18 March 2021. She discussed her views on the care Mr. T received:

a. Mr. T would often be asleep during meal times. When Mr. T's friend visited, he would say he was hungry and when staff were asked to fetch him a sandwich they responded by saying he had missed his meal as he was sleeping. Mr. T's friend regularly asked they wake Mr. T so that he did not miss meals but this was an ongoing concern.
b. Mr. T's friend's view was that the care was not as 'good as it should have been'. Mr. T would complain that the call bell in his room was not being answered, he never had a jug of water in his room although both herself and Mr. T made repeated requests for a jug of water.
c. On one occasion Mr. T attended hospital, the staff did not arrange transport but called Mr. T's friend and she was told that he was at hospital and needed support to return home. Mr. T's friend got a cab and went to collect him from the hospital. It is not clear from the records as to why the home or the hospital did not arrange the transport on this occasion.
d. When Mr. T moved into the care home, according to his friend, he felt that his independence was taken away from him. He often expressed frustration that he was not able to have his own money and spend it as he chose. Mr. T enjoyed going out for meals with his friend but was angered by the fact that his friend was always asked for receipts when they ate out. Mr. T's friend felt that when Mr. T moved to the care home, he started to 'give up' due to all the frustration he felt at his loss of independence and in his view his dignity. He felt he no longer had any control over his life.

10. THEMATIC LEARNING AND ANALYSIS

THE CARE PROVIDER

CQC, Newham Safeguarding Governance and Newham Quality Improvement Board raised ongoing incidents of concern with the care provider between 2018 and 2020. The incidents included among others, the 6 adults subject to this SAR. HC-One Oval Limited worked in partnership with all the agencies and developed and produced improvement plans to address the lessons learnt from the safeguarding enquiries and Coroners Section 28; Prevention of Future Death Report. Although this improvement plan has been shared with the various agencies, it has failed to address the core issues and ultimately improve the quality of care for residents. This is evident through the continued incidence of falls, wound care, absence of DNACPR, poor communication with families, lack of escalation of referrals to specialist care teams and complaints. Although efforts have been made to standardize corporate policy and procedures, recording data bases, training and mentoring, these improvements have yet to provide evidence that lessons have been learnt. There is limited evidence that the actions taken as part of the improvement plans are translating into an improved quality of care for the residents.

10.1 Record Keeping

10.1.1 In a care setting, the records are imperative to ensure that all staff have an understanding of the adults' needs and how best to meet all their needs. In Mr. P's case there was a lack of recorded information regarding the ongoing falls. The recording of the falls was inconsistent as was the response to the falls. In addition, although there is reference to referrals to ASC, and safeguarding, the records lack sufficient evidence as to what the outcome of the referrals were.

10.1.2 The records provided by Baker's Court for Ms. R are confusing in the style that they are recorded. Often they leave the reviewer asking questions of clarification. There are a number of contradictory statements, specifically regarding Ms. R declining consent for examinations and observations, but then an observation or an examination is recorded. Newham ASC safeguarding records Ms. R as lacking capacity on admission to the care home, but at no point in the care provider records is there any reference to Ms. R lacking capacity and a best interest decision being made.

10.1.3 Although, there was a detailed pre admission assessment completed and mandatory risk assessments completed in a timely manner for Mrs. S, her care plan was not completed within 7 days of admission. There was inaccurate information regarding her care needs, the care planning records state no history of urine tract infection. However, prior to admission to Baker's Court, Mrs. S had been in hospital with a urinary tract infection which later developed into urinary sepsis. Care plans showed that Mrs. S was on hourly observations. However, the records do not provide evidence of hourly observations. A staff member admitted to not providing the care to Mrs. S directly, but to completing the recording of the observation checks on behalf of colleagues.

10.1.4 Mrs. Q's records were inaccurate in basic details; such as date of birth. Mrs. Q had an agreed wound care plan which included two hourly positioning. The records were inaccurate, with information missing. There was a lack of recorded evidence that

specialist advice from both the GP and TVN was followed. In one instance, the care home record incorrectly recorded the diagnosis of the pressure wound.

10.1.5 The care provider's IMR report stated '*the home has been unable to provide an investigation report or the care files covering the time in respite care, in order to fully outline and establish all areas of care and support needs*'. This leaves the reviewer assuming the records are not completed, which raises questions about the record keeping of Mr. U's care.

10.2 Management Scrutiny and Oversight

10.2.1 From the recorded evidence, it is clear that Mr. P experienced at minimum 12 falls, over a 6-month period. All the falls were similar in nature, i.e. he fell from his wheelchair trying to reach for something or slipped. There is no evidence that the Home Manager critically analysed the records or had oversight, reassessed the risks of falling or took decisive action as to how to support Mr. P, to reduce the risk of injury, while still supporting him to maintain his independence.

10.2.2 Mrs. Q's son raised a complaint to the management at Mornington Hall about the care being provided to his mother in Dec 2018. He received the response in April 2019 after regularly chasing the home manager for a response. The complaint provided management with an opportunity to investigate the care that Mrs. Q was receiving and to address, not only the areas that needed improvement for Mrs. Q, but to improve the quality of care provided to all the residents. This took months, by which time Mrs. Q had moved out of the home.

10.2.3 A concern was raised by the London Ambulance Service (LAS) about the lack of intervention by the care home staff, when Mr. T required immediate CPR. The manager of the care home took immediate appropriate action to address the concern, removing the staff from direct contact with residents for the duration of the internal enquiry. In addition, immediate action was taken to train all relevant staff on basic life support.

10.3 Risk Management and Care Planning

10.3.1 Lack of consistent and competent risk assessments is a consistent factor in Safeguarding Adult Reviews. Risk assessments involve collating and sharing information through observation, communication and investigation. It is an ongoing process, that involves persistence and skill to assemble and manage relevant information in ways that are meaningful to all concerned.[4]

10.3.2 Mr. P experienced ongoing falls and slips from his wheelchair while he resided at Baker's Court. The response to these falls was inconsistent. On some occasions medical attention was sought and details recorded, while on other occasions the records indicate

[4] London Multi – Agency safeguarding policy and procedures April 2019

observations, but do not clarify how often and when they needed to be completed. Although the risk assessment was updated on occasion, the consequent care planning did not consider interventions that would support Mr. P to manage the risk of further injury.

10.3.3 There is a lack of evidence of who initially assessed and authorized Ms. R to have bed rails. The DOLS had not been authorized by Tower Hamlets at this stage. On the 22 October 2019, Ms. R was assessed by an Occupational Therapist from ELFT Community Health Services, who advised the bedrails be removed from Ms. R's bed. There is no recorded evidence of the risk assessment being updated at this stage, although intervention was put in place to reduce the risk of falls including the lowering of the bed and the use of a crash mattress. In addition, hourly checks were implemented, however, the records are not consistent as to when and what was observed hourly.

10.3.4 The care provider, Baker's Court had received the Coroners Section 28; Prevention of Future Death Report, for Mr. P on the 12 March 2019 prior to Ms. R's fall. A key recommendation was a risk assessment following a fall. The care provider had on this occasion completed the fall risk assessment following Ms. R's fall on the 28 October 2019. However, the fall took place on the 28 October 2019, the risk assessment was completed on the 29 October 2019. In order to manage the immediate risk this assessment should be immediate.

10.3.5 Mrs. S was admitted to Baker's Court from hospital following treatment with urinary sepsis. The care provider, care records are inaccurate and lack detail. There was no record of the risk assessment regarding bowel and bladder care. The Tissue Viability Nurse (TVN) from ELFT Community Services recommended on the 7 June 2019, that Mrs. S was to be provided with heel protectors to prevent pressure sores. There is no record to confirm that the risk was addressed and that the recommendation was acted upon.

10.3.6 In Mrs. Q's care, the initial wound was categorised incorrectly. The risk of deterioration was not identified, until Mrs. Q's skin integrity had deteriorated significantly. There were significant delays seeking and following specialist advice, such as blood screening (6-day delay). The nutritional supplements prescribed were out of stock, but there is no evidence of further specialist advice being sought for an alternative. As a result, Mrs. Q was prescribed supplements on the 14 December 2018, she received them until 28 December 2018, but then there was a gap until they commenced again on the 5 January 2019.

10.3.7 LAS paramedics reported that Mr. T was pale, with no cardiac output and agonal breathing, when they arrived indicating immediate Cardio Pulmonary Resuscitation (CPR) was required. The care home staff in attendance did not recognize the need for immediate CPR nor took appropriate action to respond while waiting for the arrival of the paramedics.

10.3.8 Mr. U was visited by the GP on 25 July 2019 due to his health deterioration. Advice was provided to the care home staff. On the 29 July 2019, his family visited and raised

concern of his deterioration which prompted the hospital admission. No recorded 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR)

10.4 Specialist Care referrals and advice

10.4.1 One of the key principles of the Care Act 2014 is accountability. What this means in practice, is that an adult must be supported to understand who and which agency is responsible for their care and support. Agencies have different statutory duties and have the duty to support on different aspects of a person's wellbeing. With this in mind, the Care Act 2014 includes the principle of partnership working. Partnership working relies on good communication and information sharing between agencies to ensure positive outcomes for Adults.

10.4.2 Mr. P experienced at least 12 falls/ slips from his wheelchair in the period February 2018 to July 2018. However, the care provider failed to make a referral to the wheelchair provider for a reassessment until July 2018. As Mr. P, died on the 14 July 2018, his wheelchair was never assessed as to whether changes could have prevented him from falling.

10.4.3 The care provider's records indicate that there was a request for a review of Mr. P's placement on the 4 April 2018. The Care Provider reported being unable to provide the right level of care for Mr. P, due to his reluctance to accept support. The referral was never followed up by the care provider and Redbridge ASC have no recorded evidence of the reassessment request. Redbridge ASC have no record of being notified of the 12 falls that Mr. P experienced prior to his death.

10.4.4 The care provider has recognised, that where referrals were made to external health professionals, such as the OT, that they were not routinely followed up to achieve a positive outcome for Ms. R. The GP recommended that the care home, arrange a care planning meeting to discuss Ms. R's DNACPR, however this was not progressed. As Ms. R had not family or friends listed on her records, an advocate should have been instructed to support Ms. R.

10.4.5 The care provider staff were proactive in seeking a GP review for Mrs. S on the 14 June 2019 and the 16 June 2019, when she was observed as being unwell. The new wounds on the hip and hand were reviewed by the GP in a timely manner at the request of the care staff.

10.4.6 There was a 6 - day delay from the date, the care home staff identified Mrs. Q's sacral wound and when they made a referral to the Tissue Viability Nurse (TVN) from ELFT Community Services for specialist advice. There was a 6-day delay from the date the GP recommended a blood screening and the date the blood screening was completed.

10.5 Self-determination versus the need to protect

10.5.1 Strengths based approaches are not prescriptive: there is no one size fits all model. Approaches recognize that the individual is aware of their situation and of the care and support they require. they also aim to ensure that the individual is always at the heart of any intervention, is supported to share their views about their family, friends and are able to contribute. In strengths-based practice the individual is empowered to have as much choice and control as possible and encouraged to propose options and solutions to enable them to have the life they want.[5]

10.5.2 In Mr. P's care records, there is a lack of evidence that Mr. P was supported in giving his views on how he wanted his care to be provided. He refused, support but the question that one asks is 'Did anyone offer him an opportunity to express what he wants and how the risks of falling could be managed in a manner, which was acceptable to him?' The records indicate that he was encouraged to call for help, but what was his view on asking for help and what was his reluctance to accept support? As Mr. P engaged with his GP, it may have been preferable for him to have a dialogue with his GP about the falls and how best these could be managed.

10.5.3. A care staff member documented on the care home records that Ms. R stated that, she feels like a 'caged animal' with the bed rails. Ms. R's views are not referred to in any other records in terms of how her care should be provided. There is a reference to her not consenting to a physical examination and observations following her fall. But it is not clear whether she had capacity to understand the risk of injury and what support she was given, to help and encourage her to understand the importance of the examination.

10.6 Dignity in care and death

10.6.1 Mr. P's records state that he had capacity. However, the records do not specify what specific decision Mr. P has capacity to make. This is contradicted by an application for a DOLS on the 6/02/2018. There is no evidence of ASC completing a mental capacity assessment. The GP records clearly record; that Mr. P has capacity to make his own decisions about his care. This raises questions about the care home staff understanding of the Mental Capacity Act 2005 and DOLS criteria.

10.6.2 Ms. R's records from Newham ASC and Tower Hamlets ASC state she lacked capacity to make decisions about her care planning. Records from the care provider do not reference her capacity or best interest decisions, at any stage of her stay at Baker's Court care home. The care provider referred Ms. R for a DOLs assessment to Tower Hamlets on the 16 September 2019, the assessment was completed on the 18 September 2019 but was never authorized by Tower Hamlets ASC as it was on a 'waiting list' awaiting approval. The care provider has a legal responsibility to make a referral for a DOLs assessment to

[5] Department of health and Social Care: Strengths Based approach: practice framework and handbook February 2019

be completed by the LA, if they are concerned that the adult requires 24-hour supervision and is prevented from leaving, this is commonly called the 'acid test'. No evidence in the care provider records of the authorization been followed up.

10.6.3 Mrs. S had a 'Do Not Attempt Cardio-pulmonary Resuscitation' (DNACPR) when she was in hospital. A DNACPR order helps ensure that a patient's death is dignified and peaceful. It should have been considered as previously Mrs. S expressed a clear wish not to be given CPR. At the time of Mrs. S admission to the care home, the existence of a previous DNACPR was shared by the hospital and family with the care home. The home was requested by the GP, to arrange a meeting for the GP and home with Mrs. S's family, as she was assessed as not to have capacity about her care plan nor end of life care. The meeting was not progressed by the care provider. On the day of Mrs. S's death, her daughter found her and did not start CPR. When the care staff called the emergency services, they stated that Mrs. S did not have a DNACPR, so they started CPR. When the paramedics arrived they continued CPR.

10.6.4 The care home records include the information that Mr. T had a DNACPR while in hospital, but that he did not have one at the home. While it is recognised that the GP would lead this discussion with the adult, the care home has a duty of care and should be recognizing the absence of the DNACPR and communicate with health, to ensure this is facilitated.

10.6.5 Mr. U was initially admitted for 2 weeks' respite which was then agreed as a permanent placement on the 10 July 2019. At time of admission, Mr. U had a diagnosis of dementia. There is no evidence from the records available for this review that the family were included in Mr. U's care planning. A DNACPR was discussed with the GP for a clinical decision or family members.

Lessons Learnt – HC – One Oval Limited
1. The repeated incidence of care quality concerns, between 2018 and 2020, within both Mornington Hall and Baker's Court, raises the question of the effectiveness of the improvement plan. The plan focuses on implementation and consistent use of improved systems, policies/ procedures, data bases and staff competence but the repeated concerns evidence that there is limited or no evidence of lessons from previous safeguarding concerns, prevention of future deaths notices, being learnt. It is of concern that the improvement plans are not translating into improved care quality outcomes for the other adults.
2. Care staff are expected to possess the necessary skills and knowledge to demonstrate professional capability. They need to be confident, critically reflective and self-aware to analyse, review and evaluate their own skills, knowledge and professional practice. Practice must translate into records to meet statutory requirements. In the 6 cases subject to this review, the poor record keeping included; care plans not being updated, daily records not updated with consistency, weight and liquid charts not updated with consistency, risk assessments updated on occasion without evidence of actions to address increased risk. The gaps in the records contributed to the inconsistent and at

times, poor quality of care being provided to the adults as there was no accurate record of sharing information.

3. Failure to implement the care provider's own policy and procedures such as falls policy and safety planning linked to identified risk, all contributed to the inconsistency in the care, negatively impacting the adults care, such as repeat falls, gaps in following through specialist advice, such as repositioning of the adult to manage wound care.

4. Limited evidence of the families' and residents' voice being considered to understand what their needs and wishes were impacted the care being provided to the adult both while alive and at end of life. No evidence of requests for an independent advocate to support residents who did not have any known family or friends.

5. Lack of consistent management in the homes; effective care home management was lacking in both Baker's Court and Mornington Hall. Evidence shows, in order for a home to be effective, stable management is a key factor. The lack of consistent stable management at operational level, and ineffective oversight at corporate level, impacted the continuation of the improvement plans following the acquisition of the homes. The relationship with commissioners and the CQC was also compromised with a frequent change in HC – One operational home managers, causing delays in progressing with agreed improvements.

6. Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPRs) for residents were not considered as part of the end of life care planning. The care provider recorded two out of the six adults subject to this review, had a DNACPR whilst in hospital, but did not communicate with the adults GP, nor the family about what the adults' wishes were, when in the care home regarding end of life.

7. Delayed identification of medical deterioration or increased risk, delays in seeking specialist care, delays in following up specialist care referrals and on occasion delays in effectively implementing specialist advice, contributed to the circumstances that led to the poor quality of care in some instances subject to this review. The repeated incidence of care quality concerns, between 2018 and 2020, within both Mornington Hall and Baker's Court, raises the question of the effectiveness of the improvement plan. The plan focuses on implementation and consistent use of improved systems, policies/ procedures, data bases and staff competence but the repeated concerns evidence that there is limited or no evidence of lessons from previous safeguarding concerns, prevention of future deaths notices, being learnt. It is of concern that the improvement plans are not translating into improved care quality outcomes for the other adults.

LONDON BOROUGH OF NEWHAM ADULT SOCIAL CARE

10.7.1 Mr. P's son raised a safeguarding concern about the circumstances of his father's death and the care he received during his stay at Baker's Court. The Care Act section 42 enquiry was undertaken by Newham ASC. The Care Act section 42 enquiry was

completed on the 8 January 2019. While there is evidence that the family were included in the enquiry, the enquiry lacked any evidence of professional curiosity. The enquiry focused on whether Mr. P had the capacity to agree to refuse care. There is no evidence, that the risk assessments were viewed or that any consideration of how Mr. P could be better supported to prevent future falls, such as, for example, a referral to the wheelchair service. The enquiry outcome is recorded as '*the circumstances of the injury could have been as the consequence of an accident by tripping over the wheelchair and hitting his head on the floor. So it is difficult to say one way or another where any deliberate injury has been caused by Baker's Court staff in this case.'* The enquiry does not address all the concerns raised by Mr. P's son regarding the necrotic skin and pressure care management, nor the wheelchair referral or the fact that the extension of the wheelchair belt to support Mr. P, was found in his belongings not accessible to him.

10.7.2 The Care Act 2014 section 42 places a statutory duty on LA's to conduct an enquiry, or make sure others do, if an adult has care and support needs, is at risk of abuse or neglect and is unable to protect themselves from the risk of abuse or neglect due to their care and support needs. A concern was raised and a Care Act section 42 enquiry, was initiated for Mrs. S in relation to a grade 3 pressure wound. Mrs. S died prior to the conclusion of the enquiry. At the time of her death, the enquiry was closed with no further investigation or outcome. The enquiry should have been concluded and while the lessons learnt would unfortunately, not have changed the outcome for Mrs. S, if there were gaps in her care, these lessons could have been learnt and prevented them being repeated when caring for other residents.

10.7.3 Newham ASC were informed of Mrs. S's death and the circumstances surrounding her death. A safeguarding section 42 enquiry, should have been undertaken to understand the facts surrounding her death. In Mrs. S's case, while there was an internal investigation by HC- One – it is Newham ASC duty to conduct a multi-agency enquiry. This should have been completed prior to Mrs. S's case being submitted for a SAR.

10.7.4 The care provider raised a safeguarding concern to Newham ASC, regarding Mrs. Q's wound care in December 2018. The subsequent enquiry and outcome decisions were based on the information provided by the care provider. The enquiry was closed. Mrs. Q's son and the geriatrician consultant who examined Mrs. Q on her admission to hospital challenged the outcome of the enquiry and as a result Newham ASC reopened the enquiry. The second enquiry considered the multi-agency views and sought specialist advice. The outcome of the second enquiry was '*pressure sores were avoidable and were acquired whilst Mrs. Q was under the care of Mornington Hall*.'

10.7.5 The care provider raised a safeguarding concern about the circumstances surrounding Mr. T's death and the lack of response from their care staff. Newham ASC requested an internal enquiry from the care home. On the evidence from the internal enquiry, the decision was to progress to the SAR. The Care Act section 42 enquiry did not explore information from other agencies involved, such as LAS, GP, nor included the views of Mr. T's family or representative.

10.7.6 Mr. T was consistent with his expressed wish of moving from Mornington Hall from when he moved in, from 2016 up and until his death in December 2019, a period of 3 years. Although there was a number of interventions from ASC, including agreed funding to move to an extra care placement in April 2019, the move never took place and he died in the care home. One of the assessments started in February 2018, but did not end until February 2019. The records provided to the author do not detail all the delays, but leave the reader questioning why the adults' views were not acted upon in a timelier manner. Mr. T is recorded as having capacity to decide where he lived.

10.7.7 Mr. U's funding for an MHCOP placement was agreed on the 14 June 2019 by ASC, however, Newham Brokerage only informed the care provider on the 26 July 2019. During this period the care provider had numerous dialogues with the social worker and the ASC safeguarding team about the delay in the decision regarding funding. The safeguarding team made a recommendation that a safeguarding concern be raised against Newham for the delay in their decision making. This illustrates a lack of communication between different teams within ASC. Before advising of action, either the safeguarding team or the social worker should have communicated with brokerage regarding the decision. By the time the decision was communicated to the care provider, there was no longer an MHCOP bed available.

London Borough of Newham Contracts and Commissioning

10.7.8 The Contracts and commissioning team worked in partnership with Safeguarding Governance team, to address ongoing concerns in both Mornington Hall and Baker's Court from May 2018 through to current date.

10.7.9 A letter of concern in relation to Mornington Hall was sent to HC-One on the 16 May 2018, in line with stage one of Contracts team - Provider Concerns and Escalation Process. On the 4 June 2018 stage two, was implemented and stage five was implemented on the 14 June 2019.

10.7.10 Stage five of the Provider concerns escalation is a notification letter to the provider of a suspension. At the time of the SAR, Mornington Hall continued to be under suspension of new placements by Newham ASC.

10.7.11 Both safeguarding organisation concerns and the Quality Improvement Board minutes provided for the review consistently focus on the same concerns in Mornington Hall. A summary of these include:

a. Inconsistent and unstable management team
b. Staffing levels
c. Staffing competency
d. Safeguarding concerns regarding unexplained injuries
e. Falls and risk assessments
f. Poor and inconsistent record keeping
g. Lack of referral for specialist advice and follow up
h. Response to safeguarding concerns

10.7.12 Baker's Court was discussed at the Quality Improvement Board and serious organisational concerns meetings repeatedly between May 2018 and current date, but the escalation process was never initiated.

LONDON BOROUGH OF TOWER HAMLETS ASC

10.7.14 There is a lack of clarity on the assessment of Ms. R's needs and her mental capacity assessments by the hospital social work team in in relation to Ms. R's discharge into a respite bed as written assessments were not completed and recording is not detailed of clear. There is evidence of a social worker requesting on the 12 November 2019, the care provider place Ms. R on a waiting list for a permanent bed. However, there is no supporting assessment. Ms. R died on the 13 November 2019. The DOLS assessments while completed were not activated due to being 'placed on a waiting list' for authorisation.

Lessons Learnt – Newham ASC

1. The Care Act 2014 places a duty on local authorities to make enquiries when; an adult has care and support needs, is at risk of abuse or neglect and unable to protect themselves from abuse or neglect as a result of their care and support needs. In some circumstances the enquiries are being conducted in line with Care Act statutory guidance for example Mr. P's case. However, the enquiries are not robust and lack evidence of professional curiosity in gathering enough evidence to understand the 'whole picture'. This should include professionals to identify: what lessons can be learnt from the enquiry and how to prevent future incidents of a similar nature. In all cases considered, the Care Act section 42 enquiry was prematurely closed without all facts being considered and all sources or information being considered.

2. Safeguarding enquiries coordinated by ASC must be multi agency, considering all the information. When there is a concern about a care provider, it is not sufficient to simply gather information from one source i.e. the care provider, but to consider all the

agencies involved in the care of the individual, including the adult's view, their family or their representative.

3. Poor communication, a lack of accountability and professional curiosity, contributed to the delays in Mr. U not being moved to an appropriate mental health care of older people (MHCOP) bed. While the focus was on the funding, the adult was forgotten, with little to no evidence of how the risks of his needs not being met, in a non MHCOP bed, would be managed, while the funding issue was resolved. The decision to move Mr. U and then agree funding was made 4 weeks after the initial request.

4. Stage one of the Newham's ASC contract provider concerns and escalation process was initiated for Mornington Hall on the 16 May 2018. Insufficient progress and lack of improvement resulted in Stage 5 being implemented on 14 June 2019. The 11-month progression was too long a timeframe considering the seriousness of the concerns in relation to the quality of care being provided. Although there was ongoing discussion with the care provider, neither the Contracts team or Safeguarding Governance team were given sufficient reassurance that the improvements were impacting the quality of care. The escalation process was too slow, a resolution to address the quality of care should have been sought with more urgency.

5. The escalation process, including the criteria for progressing to actions taken such as embargo of new placements, is not transparent and detailed in guidance. It is not clear why Mornington Hall was progressed to escalation but not Baker's Court. The spotlight of the ongoing quality improvement was on Mornington Hall, whereas from the evidence submitted to this review, it is clear that Baker's Court were experiencing similar concerns regarding the quality of care provided to residents.

6. The Newham contracts and commissioning escalation procedure and guidance does not include a clear pathway of communicating concerns to other funding authorities including Local Authorities and Clinical Commissioning Groups (CCG).

7. While Newham ASC should work in partnership with the CQC and take into account the CQC inspection results, i.e. Mornington Hall 'Inadequate' and Baker's Court 'Requires Improvement', decisions for provider concerns escalation should be based on the evidence gathered by the Newham Quality Assurance Board and the Safeguarding Governance Team.

8. The operational teams, safeguarding governance, contracts and commissioning all had ongoing concerns about the care being provided in HC –One care homes, Baker's Court and Mornington Hall. The number of safeguarding concerns and complaints provided evidence that although HC One was presenting an improvement plan, it was not effective enough in translating into improved quality of care to the residents. A gap in the interface between commissioning and governance resulted in a situation where alternative care provision was not available. For this reason, escalating both Mornington Hall and Baker's Court to stage five of the escalation process i.e. suspension of contract was not a feasible option due to limited alternative placements.

EAST LONDON FOUNDATION TRUST COMMUNITY HEALTH

10.7.13 Mr. P was seen on three occasions during his stay at Baker's Court, by the Community Tissue Viability Nurse (TVN). He agreed to the TVN examining the pressure areas on his legs, but refused to transfer from the chair to the bed for further examination. The TVN provided a treatment plan for Mr. P to the staff at the care home but the care home staff are recorded as stating that Mr. P does not comply to the treatment, he keeps moving the dressing at his own will. Mr. P is assessed as having capacity, but the records do not indicate whether there was a discussion with Mr. P, regarding why he keeps removing the dressing, or what an alternative treatment plan may be available.

10.7.14 The community nurses were visiting Mrs. S at Baker's Court to administer medication including antipsychotic depot medication. There is no evidence that the depot medication was reviewed. Depot medication should not be administered by community nurses without regular reviews.

10.7.15 Mrs. S was seen by the community tissue viability nurse on the 10 June 2019, the notes indicate that Ms. S had a pressure sore on her sacrum, but that the wound was almost healed and that Mrs. S was to be discharged from TVN case load.

10.7.16 On the 31 October 2019, Mr. T was assessed by the rapid response nurse. She notes 'bruises all over Mr. T's body.' She recorded that Mr. T was uncooperative with assessment and declined nursing care. No safeguarding concern was raised or action taken to address the concern of the 'bruises all over Mr. T's body'.

Lessons Learnt – ELFT Community
1. Safeguarding concerns of unexplained bruising must be raised within 24 hours to the Newham ASC.

NEWHAM SAFEGUARDING ADULTS BOARD

10.7.17 The reviewer analysed records from various agencies. The limited quality of the IMRs provided by statutory agencies was an ongoing challenge in enabling the reviewer to form a complete picture of the events that led to the incidents under review. The challenges included inaccurate information, contradictory information and gaps in information. SAR are an opportunity for agencies to reflect on practice and learn through critical analysis of their agencies interventions. One of the key roles of the SAB is to support IMR authors from all agencies, this is most frequently done via an appointed SAR panel. Due to the pandemic, the NSAB made the pragmatic decision, not to appoint a SAR panel. The panel would no doubt

have improved the support to the IMR authors which consequently would have strengthened the quality of the IMRs.

Lessons Learnt - NSAB
1. Quality Marker 7 SAR Quality Markers; The SAR is effectively managed. It runs smoothly, is concluded in a timely manner and within available resources[6]. To ensure the most effective learning from a SAR's, all IMR authors must undertake a briefing prior to commencing the work. IMR authors must possess the skills of recording, analysis, reflection and critical thinking to enable them to identify the key learning for their individual organisation.

[6] Safeguarding Adult Review Quality Markers checklist SCIE & RiPfA June 2018

11. THE CARE PROVIDER IMPROVEMENT PLANS

INITIATIVES IMPLEMENTED

HC – One Oval Limited actively participated in this SAR. The following are initiatives which each home reported to have been agreed as part of the homes improvement plans and are at various stages of implementation.

Mornington Hall and Baker's Court Initiatives

11.1 Review of incident reporting and investigation/ root cause analysis and process to ensure all staff follow HC – One policy and procedure and are clear of roles and responsibilities.

11.2 Review the process of follow up of any referrals to external professionals/ agencies. Ensure all staff are clear regarding their role and responsibilities. Designated staff to undertake this responsibility and ensure all contacts are recorded within care records.

11.3 Review of governance arrangements at the home and operational level to ensure policies and procedures are clearly understood and applied in practice. Particularly linked to review of weight loss, food and fluid recording, medicine management, falls management and oversight and review of daily records, information sharing and implementation of specialist guidance within care planning.

11.4 Home Manager to ensure systematic review of training and staff competencies to ensure competency and consistency of practice in:

a. Skin care
b. Diabetes
c. Duty of candour
d. Falls management
e. Continence care
f. Care planning
g. Medicine management
h. Investigation and reporting of incidents.
i. Recording

Baker's Court Initiatives

11.5 Review of Information sharing and communication with staff and involved external professionals. Implement a process to facilitate a robust interagency communication process to ensure a seamless admission process and to ensure that all key information is shared and reviewed post hospital discharge.

11.6 Implement a joint protocol with the GP to ensure clear role and responsibilities for the planning of family meetings and facilitation of discussion regarding residents' DNACPR.

11.7 Review risk management with staff to ensure knowledge regarding available assistive technology to support falls prevention.

11.8 Review mental capacity assessments to ensure colleagues are clear how to assess and constantly review where there is a question about a person's capacity.

11.9 Implement a protocol for staff to follow to ensure timely engagement with external professionals, when there is a lack of clarity around capacity and complexity of care and support.

11.10 Residents who experience frequent falls will receive a multi – disciplinary review of their care and treatment. Including input from the GP, funding authority, local falls service, occupational therapist and wheelchair services. This will enable a multi- disciplinary approach to risk management and care planning.

11.11 Review of recording to support consistency with care and support to ensure prompting, encouraging and remind residents to use mobility aids and equipment, such as wheelchair lap straps.

11.12 Incident investigations and root cause analysis are completed in accordance with HC – One policy to ensure senior staff have oversight of falls and therefore have the opportunity to undertake trend analysis and seek further external support and guidance in a timely manner.

11.13 Local learning to be implemented through daily flash meetings, shift handover, staff meetings, staff supervisions and case study scenarios, training and coaching sessions.

Mornington Hall Initiatives

11.14 Review governance process to ensure evaluation of care records and supplementary records in relation to care and support is shared and communicated effectively and in line with HC – One policy requirements through daily flash meetings, handover arrangements and care reviews.

11.15 Review of assessment of skin/ wound care assessment process with staff to ensure HC – One policy and procedure is known, understood and consistent in practice.

11.16 Ensure wound care plans are implemented, detailed and include supportive guidance and specialist practice requirements from involved health care professionals.

11.17 Review archiving process locally to ensure policy and procedure is followed and data is stored correctly and accessible when required.

11.18 Review of leadership performance and inclusion within internal reporting to consistently ensure robust governance and leadership. Continuous and consistent use of the home improvement plan to demonstrate required areas for action, performance trajectory and sustainability.

11.19 Liaise with external heath care professionals to develop communication and information pathways to support safe and effective hospital discharge.

11.20 Review of hospital discharge assessment/ reassessment process to ensure all changes in care and support arrangements are known, and detailed and translated swiftly into care

planning. This must include changes to DNACPR and end of life care, support and preferences.

HC – One Oval Limited Organisational Initiatives

11.21 Recruitment of Home Management, which has been achieved and HC – One reported stable management team in both care homes.

11.22 Coaching and development of area management staff in effective completion of home visits reports and cornerstone audits, analysis of risk and following up actions to measure outcomes.

11.23 Digitisation of the home improvement plan has allowed organisational visibility and oversight of the progression of improvements.

11.24 Emeds and Ecare are being rolled out across the organisation to reduce risk associated with human errors in medicines management and care planning documentation completion.

11.25 Measurement via monthly home improvement plan submission cover actions regarding:

a. Written systems to ensure competency of all staff, through the digitised supervision and appraisal procedure.

11.26 Training sessions have been undertaken for all relevant staff in how to supervise and appraise effective managers and staff.

11.27 Consistency of care records and risk assessments reflecting current needs is completed through HC-One's care planning procedure and completion of cornerstone. All staff are supported with care planning and audits are completed and monitored via Cornerstone and the electronic home improvement plan.

11.28 All falls policies and procedures have been summarized onto one page documents called 'Here's how to…'. This will enable easy access for all care staff. These will be reviewed twice a year for updates.

HC – Ones view of Improvements

11.29 HC – One were given the opportunity to contribute information reflecting what changes have been made to learn lessons and improve the quality of care to residents. The following information was shared:

11.30 **Mornington Hall**

- Recruitment of key roles, (an experienced clinical General Manager, Clinical Lead, Wellbeing colleagues, Head Chef, Home Manager)
- Improved practice regarding 1:1 supervisions and observations

- Training compliance has improved and continues to be reviewed to ensure improved and consistently, positive trajectory – 94.1%
- Monthly Governance meeting – chaired by the Home Manager.
- More effective and robust joint working arrangements with the GP's. – close working relationship with the clinical lead. Virtual meeting and direct contact with the Home Manager. Monthly Multi – Disciplinary Team meetings. The GP has fed back that he trusts the judgment and decision of the Home Manager. The GP has confidence in the Home Manager.
- Lesson learnt shared at Heads of Department meetings and with care colleagues to ensure reflective practice and shared learning opportunities
- Capability / performance management of identified nursing staff
- Elimination of care/nurse agencies and the care home is running with all permanent carers and nurses.
- Care plan audits led by the Home Manager
- Care plan training session facilitated by the Clinical Director
- Care plan coaching by the Home Manager
- Remembering together booklets completed with Residents/ Relatives involvement
- Zoom calls facilitated to support residents talking and seeing relatives.
- Environmental changes to the home, include a Bar, Cinema, refresh of the hairdressing salon.
- Recent annual relative survey undertaken we are awaiting the outcome.
- Monthly newsletter for residents and relatives.
- Relatives meeting booked for 17 November 2020, this will need to be a virtual meeting due to the November 2020 national lockdown.

11.31 **Baker's Court**

- Permanent home manager recruited to the post and had commenced their position.
- Implementation of Clinical Service Manager role – new candidate recruited and waiting for DBS clearance prior to starting.
- Good working with the local GP, communication have increased from the Home to the GP and therefore the GP have acknowledged the Homes proactive approach which enables the GP to be more responsive to each Resident Care needs.
- Monthly multi-disciplinary team meetings.
- Lesson learnt shared at Heads of Department meetings and with care colleagues to ensure reflective practice and shared learning opportunities.
- Monthly joint nurses and carers meeting to enable effective information sharing about service delivery, practice changes, residents care and support.
- A new deputy system has been implemented which allows easier communication with all colleagues.
- A clinical manager has been assigned to the care home to offer support.
- Group supervisions to nurses lead by the assigned clinical manager.
- More proactive working with professionals and asking for help and clarity.
- More open and transparent working relationship with Newham safeguarding team
- Residents meetings

- Ongoing work with the quality assessor to improve well-being activities.
- Training compliance for mandatory training is 92.6%
- Supporting residents to speak to families via zoom calls.
- Newsletter
- Weekly quality calls hosted by the Regional Quality Director and the Area Quality Director to discuss quality improvements and trajectory and ensure planned developments are consistent in practice.

Reviewer's Analysis

11.32 The care provider has provided evidence that there are improvements in staffing, mentoring, training and quality assurance systems. There are improvements in the environment for the residents. There are increased opportunities for residents to engage in social activities and crucially at this difficult time, with limited access for families and friends, support to engage with families and friends via virtual meetings.

11.33 The care provider must actively engage in an individual multi-agency review of each resident arranged and chaired by their placing authorities including the CCG, Newham ASC and other placing LA's. This will provide the residents an additional opportunity to 'voice' their wishes and feelings about their care. The reviews should seek to provide reassurance to all agencies and families that lessons have been learnt and that all the initiatives introduced and implemented have ultimately translated into improved quality of care for all residents.

12. RECOMMENDATIONS

Recommendations made by the thematic review are listed below. It should be noted that the period of the thematic review has taken some time to complete and so, some of the practice has developed over that time. The effectiveness of the recommendations should be monitored through the planned multi-agency dashboard and audit programme, with a focus on improved outcomes for Adults.

Immediate Recommendation ASC and CCG

12.1 All existing residents to be invited to participate in a multi-disciplinary review of their needs and care provision. Reviews to include family, adults, the care provider, commissioners including ASC, instructed advocate if needed and the adults GP. Self-funded residents to be offered the opportunity to have a multi-agency care placement review. The recommendation must provide reassurance to the NSAB that all residents placements are safe and that residents are receiving good quality of care.

Newham Safeguarding Adults Board

12.2 Review Newham SAR procedure, including accountability, support and training to IMR authors when the NSAB uses the IMR methodology again. Consider quality marker checklist guidance[7] of what type of SAR is proportionate, including when appropriate to apply the currently piloting Rapid Time SAR.

Adult Social Care

12.3 Annual safeguarding audit of practice and decision making. Audits should consider the 'beyond auditing' model which places an emphasis on practitioners developing their skills through participating in the audits of their active cases. The audits should focus on professional curiosity and multi-agency enquiries and decision making.

12.4 Newham ASC Contracts and Commissioning team to review the focus of provider monitoring visits to include themed visits, focusing on the customer experience and outcomes. Where appropriate i.e. specific health themed visits, the visits to be conducted jointly with the CCG. Any gaps in care delivery to be identified and for contacts and commissioning to support providers with specific targeted training and development. Consider whether this can be facilitated across different providers across Newham to ensure lessons learnt are shared and to improve outcomes for the Newham adults receiving care and support.

12.5 Newham ASC to review their contracts team quality improvement board, terms of reference, including accountability and information sharing with other teams within ASC. Consider how evidence gathered by the safeguarding governance team, through Care Act

[7] Safeguarding Adult Review Quality Markers checklist SCIE & RiPfA June 2018

section 42 enquiries is shared and impacts the decisions of the contracts team. Providers to be briefed on the procedures, criteria for implementing and legislative framework to ensure there is an understanding of accountability, roles and responsibilities.

12.6 Review the provider concerns and escalation process to include practice guidance and procedure. The guidance must include transparent criteria for initiating the process, accountability for decision making and monitoring the progression of improvement, support and guidance to achieve the ultimate goal of de – escalation as the quality of care has improves.

12.7 Review mechanisms for sharing both hard and soft information about nursing and care homes that is informed by and in turn informs operational front line staff. Review the escalation process when information considers residents to be at risk or receiving poor quality care, what decisions need to be made to protect not only individuals but other residents. This should include communication with other placing authorities both health and social care.

Care Provider – HC – One Oval Limited

HC- One have implemented an improvement plan as a result of concerns raised and the CQC inspection reports. The improvement plan focused on embedding staff understanding and consistent implementation of the systems to improve care planning, risk assessment and monitoring of external referrals. In addition, there has been a focus on developing continuous staff competency through training, mentoring, induction and supervision. In both homes the management team has been recruited and is now considered to be a stable permanent team. With this in mind, the recommendations consider how the improvement plan can be achieved and used as a mechanism for ongoing further improvements in quality of care for residents.

12.8 HC – One to ensure that care planning meetings with new residents, and where appropriate their families, to take place within 14 days of admission to discuss the care planning. Review the care planning for existing residents and ensure appropriate care planning has taken place and if not ensure it is completed as a matter of urgency. The GP to be included in the care planning meeting to facilitate the discussion and authorize the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) if a DNACPR is appropriate.

12.9 Responsibility and accountability for implementing the agreed home improvement plan to include the local home management team from the onset. Home Management team to focus on building strong partnerships with all other professionals, including the Newham Quality Improvement Board. HC-One corporate team to monitor, support and provide advice and guidance to ensure positive trajectory.

12.10 Existing systems to be applied with consistency to ‘hear’ the residents and their families/ representatives voice. As part of the regular audit of care, residents and families should be given an ongoing opportunity to voice both their compliments and concerns. This

includes being part of care planning, residents' surveys, resident meetings, family meetings and responding in a timely manner to formal complaints.

12.11 HC – One improvement plan to be continually reviewed and critically analysed for effectiveness through considering the experience of the current residents. Are new concerns similar in nature to previous concerns? Or have the changes improved the quality of care provided to the residents?

ELFT – Community Health

12.12 In cases where the administration of antipsychotic depot medication has been transferred to the GP practices, community nurses to ensure that the contractual agreement which includes a mechanism for review is followed in all cases prior to administering the medication.

12.13 Safeguarding training should stress to all professionals their duty of care and the need to be alert and vigilant to risks of abuse in all settings including care homes, ensuring that the local safeguarding procedure of reporting concerns is embedded in practice.

13. GLOSSARY

ASC – Adult Social Care

CPR – Cardio Pulmonary Resuscitation

CCG – Clinical Commissioning Group

CHC - Continuing healthcare funding, also known as CHC funding, is free healthcare provided by the NHS which can be received in any setting outside of hospital including at home, within a hospice or in a care home.

CQC – Care Quality Commission

DNACPR - Do Not Attempt Cardio-Pulmonary Resuscitation

DOLs – Deprivation of Liberty safeguards - The DOLs under the Mental Capacity Act 2005 allows restraint and restrictions that amount to a deprivation of liberty to be used in hospitals and care homes – but only if they are in a person's best interests. To deprive a person of their liberty, care homes and hospitals must request standard authorisation from a local authority.

ELFT – East London Foundation Trust

FNC - NHS-funded nursing care is when the NHS pays for the nursing care component of nursing home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care.

IMCA – Independent Mental Capacity Advocate

IMR – Independent Management Review

LAS – London Ambulance Service

MCA – Mental Capacity Act 2005

MHCOP – Mental Health Care of Older People

NQIB – Newham Quality Improvement Board

NSAB – Newham Safeguarding Adults Board

SAB – Safeguarding Adults Board

SALT – Speech and Language Therapy

TVN – Tissue Viability Nurse

OT – Occupational Therapist

Safeguarding Adults Section 42 Enquiry – The Local Authority legal duty to conduct or ensure others conduct an enquiry when an adult who has care and support needs and is experiencing or at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from with risk of, or experience the abuse or neglect

SAR – Safeguarding Adults Review

Vital Interest – a term used in the Data Protection Act 2018 to permit sharing of information where it is critical to prevent serious harm or distress, or in life threating situations

14. REFERENCES

1. Department of Health (2016 Care and Support Statutory Guidance Issues under the Care Act 2014)
2. Department of Health & Social Care; Strengths-based approach: Practice Framework and Practice Handbook February 2019
3. London Multi – Agency Adult safeguarding policy and procedures April 2019
4. Learning from SAR: A report for the London Safeguarding Adults Board Suzy Braye and Michael Preston – Shoot July 2017
5. SCIE: (2015) Adult Safeguarding Sharing Information
6. Safeguarding Adult Review Quality Markers checklist SCIE & RiPfA June 2018