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Highlighting Lessons from a Safeguarding Adults Review Where There Were Multiple Abusers in One Care Setting (Care Home A)

(extract from the Executive Summary)

This Safeguarding Adults Review (SAR) considered the serious failures in care in relation to older people within a residential and nursing home, and explored how a sub-culture of cruelty and disrespect arose that led to the prosecution of 5 individual members of staff and the dismissal of another two. The review focused on an on-going pattern of verbal abuse and psychological cruelty that either went unnoticed, and/or was allowed to continue unchecked throughout 2013.

This review also considered another significant safeguarding concern in relation to perceived failures in obtaining timely medical care for a specific resident of the same home who died in March 2013. This particular case demonstrated how the home failed to have adequate care plans in place, and it provided further evidence of the extreme vulnerability of the residents, some of whom had very complex needs or who were particularly challenging, at the time of the abuse.

As the independent author said *"poor care does not arise in a vacuum. It grows where staff are under pressure and do not have the appropriate knowledge or skills, and where there are home managers who don't deal with this properly, or are not supported to do so. Serious bullying undermines the judgement of colleagues and cuts across appropriate accountability and supervision".*

The Concerns

During 2013 there were a number of difficulties in providing clinical care to the very vulnerable adults living in the home and this was made worse by the fact that a small group of staff, including one particular member who showed a level of gender based bullying, had formed a clique, acting without respect for clients, taunting them and handling them without using proper equipment or care. This sustained cruelty crossed a line of decency and humanity.

These concerns were raised in October 2013 by an anonymous whistle-blower

There had been earlier incidents concerning some of the same staff which should have been recognised and dealt with under more rigorous disciplinary procedures.

The investigation

Some of the victims lacked capacity and therefore came within the remit of the 2005 Mental Capacity Act, and specifically of Section 44 that made it **an offence for a person to mistreat, or to wilfully neglect, a person who lacks capacity in their care.**

The allegations were investigated internally and under the guidance of the Adult Social Care's safeguarding procedures *and* a criminal investigation which resulted in charges brought under Section 44 of the 2005 Mental Capacity Act. Seven members of staff were dismissed on the grounds that they had been guilty of gross misconduct. All seven were referred to the Disclosure and Barring Service (DBS) and should not be able to work in this sector again. Five of the seven were prosecuted, four were convicted and custodial sentences were given.

Learning from the Review

- Earlier incidents of abuse had not been dealt with adequately or recognised as gross misconduct
- Safer recruitment policies were not followed
- A group of staff, working without scrutiny or accountability, were able to form a clique, enabling each other's abusive behaviours, particularly on night shifts

- Regional management did not provide sufficient support to the Home Manager to enable her to deal with issues of bullying, intimidation or to follow their own zero-tolerance commitment to abusive behaviour
- Care plans were inadequate - particularly for those with more challenging needs
- End of life care and planning was inadequate
- Daily management of clinical conditions was poorly managed
- The Mental Capacity Act and best interest decisions were not considered when medication and other care was refused.

Implications for Practice:

(taken from the review recommendations)

- **Care homes must implement and follow safer recruitment procedures**, including checking references, waiting for DBS checks, questioning previous employment history and gaps in employment. Once employed there must be regular meaningful and documented supervision and a system for appraisal.
- **Home Managers should not miss opportunities to take disciplinary** action, or involve the police, for matters which may be an indication that further abuse is likely to occur. Proper recording of incidents and disciplinary meetings would support this.
- **Managers of care homes should regularly drop by unannounced** during night shifts and weekends to monitor standards and provide support.

- **Home Managers and other senior staff should be supported to deal with serious issues** including abuse of residents, and bullying and intimidation of colleagues, and be given the skills to know when disciplinary procedures should be instigated and properly applied.
- **Accurate and effective care records must be completed by care home staff and all homes should have a secure system for their storage.**
- **Clinical conditions such as Diabetes, Epilepsy, cardio vascular conditions and infections** are not unusual in older people and **should be managed smoothly by the home in partnership with healthcare professionals,** this should include sharing of information in the event that they do have to be admitted to hospital and proper discharge planning when they need to return to their home.
- **Adult at risk meetings should always consider referring matters of clinical negligence or mistreatment to the Nursing and Midwifery Council** (NMC) when registered nurses are involved. Other disciplines should also be referred to the relevant professional body in the event of neglect or abuse.
- **Police should always consider a prosecution under section 44 of the 205 Mental Capacity Act when a** person mistreats, or to wilfully neglects, a person who lacks capacity in their care.

The full executive summary of this review can be found at: www.peterborough.gov.uk/safeguardingadults