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How Can Care Providers Learn From Safeguarding Adult Reviews?

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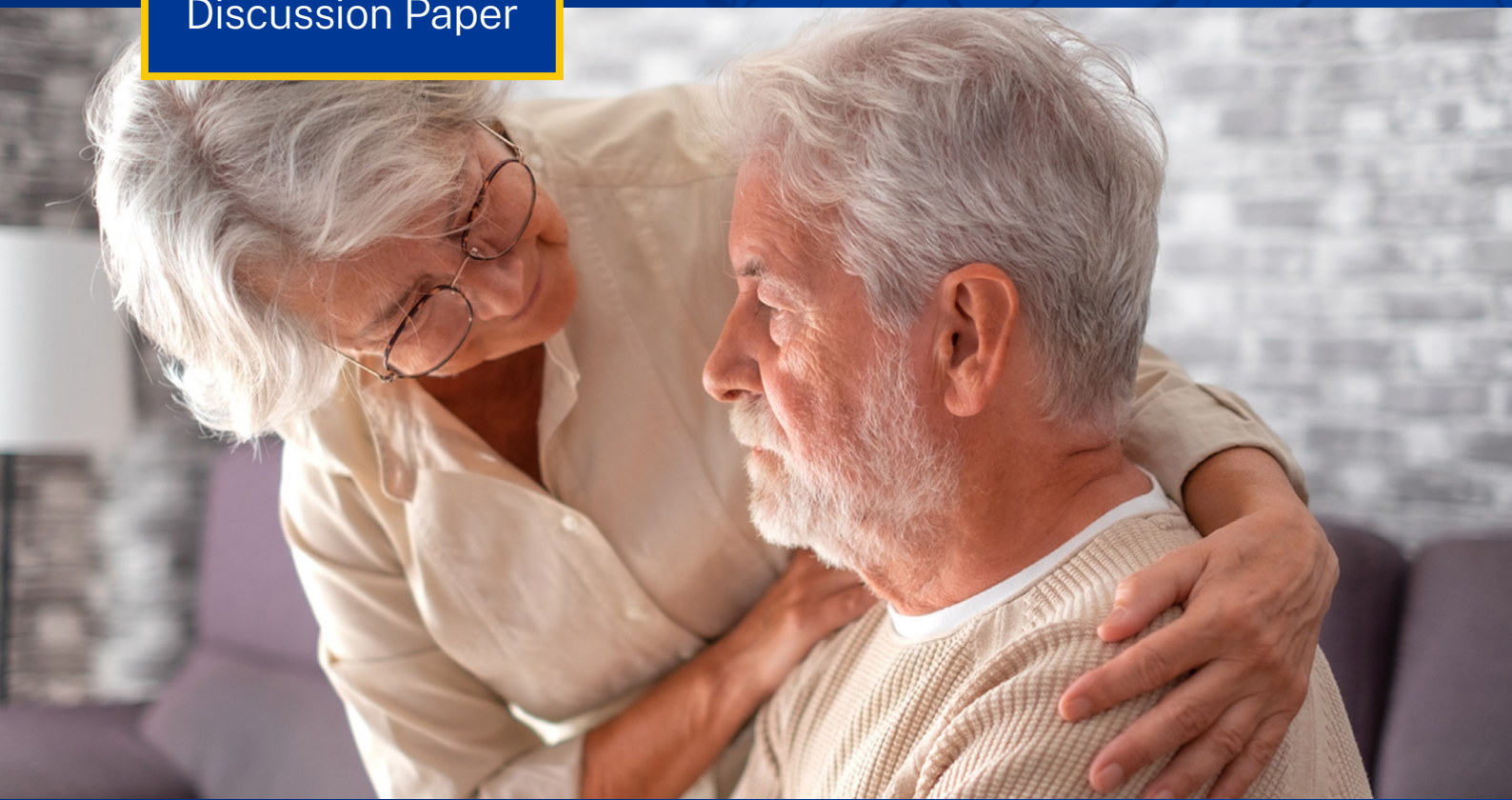
Discussion Paper



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1. Introduction

Safeguarding Adult Reviews (SARs) are commissioned by local Safeguarding Adults Boards (SABs) when there has been serious abuse or neglect, most often when an adult has died, and there is concern that partner agencies could have worked more effectively to safeguard the adult.

The aim of the SAR is not to attribute blame, but for organisations to work together to learn from what has happened. The Care Act statutory guidance (14.167) says that there should be:

> *"... a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice."*

This emphasis on reflective learning and improvement is also evident in a guide for care homes published by NICE and SCIE in 2021, which is applicable to other adult social care services. Creating a safeguarding culture, a quick guide for registered managers of care homes, encourages care services to be aware of and learn from SARs. However, we are not aware of any mechanism to identify and share relevant learning from SARs with care providers.

There are many issues relevant to care providers identified in SARs. SABs often reach out proactively to care providers in their area when there is relevant learning from a SAR in that area, and some SABs have established regular links with local care associations. While these actions are to be welcomed, the question remains:

> How would a care provider be expected to know about and learn from the findings of SARs from other parts of the country?

We have written this paper to prompt discussion as to whether there should be a national mechanism to identify and share with care providers the most relevant learning from SARs.

1.1 What did we do?

We undertook a small scale, informal review of easily accessible SARs published in 2022. As at February 2023, there were 60 SARs (or summaries of SARs) published on the website www.nationalnetwork.org.uk dated during the calendar year 2022. Of the 60 SARs, 37 concerned adults who had received a care service at some point during the review period. The most common services being received were care homes and homecare. Other people had received support from respite, supported living or day services. One person had directly employed personal assistants.

2. Issues identified in Safeguarding Adult Reviews

2.1 Self-neglect

The most common concern was self neglect (33 out of 60 SARs and 18 of the 37 SARs where the adult had received a care service). In particular, self-neglect was an issue for 14 of the 22 people who had received a homecare service, for 4 of the 12 people who had lived in a care home, and for the one person who employed personal assistants.

Two SARs concerned people with a complex combination of physical and mental health issues who were living in care homes. These two SARs discuss important and challenging issues around supporting people who may be living in a care home but who are declining care and treatment. These discussions, and the associated discussions around capacity, would be as relevant for care services and their managers as for local authority and NHS practitioners.

Both SARs suggest that the care homes could have done more to themselves escalate concerns and prompt the multi-disciplinary risk management that was needed. A key reference in the Ben SAR is to the need for the care home to have had greater confidence in pressing for a safeguarding response. We suggest that, in many cases, care services don't have a great deal of confidence in relation to safeguarding, and that this would merit wider discussion.

There were 14 SARs where self-neglect was an issue and the adult had received a homecare service at some point during the review period. However, we identified only one SAR that discussed the homecare service in any detail.

Considering how many SARs concerned people for whom self-neglect was an issue and who had received a homecare service, it is perhaps surprising that we identified so little detailed discussion of this. While this is arguably positive and reassuring, equally it could mean that it may underplay the role that homecare workers play in people's lives.

Of the people and services around the adult, it will often be the homecare workers who see the adult most often and who may well know them best. The 'Anna' SAR went as far as to say that, in the context of someone with whom professionals sometimes found it difficult to engage "... her developing relationship with one of the carers evidenced her willingness to be friends with someone."

The role ascribed to homecare workers by local policies on self-neglect is often focused on identification and reporting onwards. Perhaps this underestimates the role that homecare workers play in practice.

2.2 Capacity

We identified capacity as an issue in just over half of the SARs we reviewed (32 out of 60 SARs and 19 of the 37 SARs where the adult had received a care service). By this we mean that learning points were identified around whether, when or how capacity had been assessed, and/or actions arising from an assessment of capacity, rather than that the adult didn't have capacity for relevant decisions.

Capacity was an issue in many of the SARs where the main concern was self-neglect. SARs repeatedly highlighted situations where it would have been good practice to have assessed capacity but where an assessment was not undertaken, or not recorded. Many SARs also questioned the conclusion of those involved that the adult had capacity to make what was sometimes viewed at the time as a "lifestyle choice." SARs also highlighted situations where it would have been good practice to involve the Court of Protection, with a fairly common concern about a lack of legal literacy.

A common theme was the need for greater awareness of the concept of executive capacity, which is the ability to carry out a decision. Enfield Council's Executive capacity 7-minute briefing says:

> *"Executive capacity is about the ability to use or weigh information. The [Mental Capacity Act 2005] Code of Practice (para 4.21) notes: 'For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision.' ... A person may appear to be able to weigh facts while sitting in an interview setting but if they do not transfer those facts to real life situations in everyday life (executing the plan) they may lack mental capacity."*

There are various recommendations in the SARs in relation to capacity, for example:

- "Professionals should consider executive functioning when assessing capacity under the MCA."
- "The SAB should remind all local agencies of the importance of recording mental capacity assessments/best interest decisions on all occasions."

There is surprisingly little commentary on the assessment of capacity by care services, and few if any recommendations about capacity specifically directed to a care service. However, care services must undertake their own assessments of capacity, and they support many people with the kinds of complex needs that are evidently proving a challenge in relation to capacity for statutory sector professionals.

It is likely that some of the more nuanced discussions around capacity found in these SARs, for example in relation to executive capacity, would be new to many care services. The discussions within some of the SARs reviewed would form an excellent basis for awareness raising and learning materials.

2.3 Poor standard of care

One SAR concerned a care home where there had been failures in relation to the care of pressure ulcers. Another concerned a homecare service where there was found to have been neglect by an individual care worker which was not identified by the managers of the service.

2.4 Handovers between services

We identified several SARs where harm had occurred because of shortfalls in handovers between services. Two SARs concerned situations where the adult had moved from one care home to another. Two concerned situations where there had been a lack of communication between a hospital and a care service around discharge.

2.5 Cancelled services

We identified six SARs where a care service had been cancelled by the adult or by members of the adult's family on the adult's behalf. Covid-19 was noted by two families as the reason for cancelling their family member's service, suggesting that in other periods the number might be slightly smaller, but there would still be a significant number.

There are clear patterns across these SARs, including questions around capacity and, in some SARs, the possibility of coercion. The point at which the adult stopped receiving a care service was often seen with hindsight as a missed opportunity for further investigation or a fuller multi-agency response.

People stop and start care services all of the time. It would be unrealistic to ask a care service to undertake proactive investigations each time that happens. However, the number of SARs in this section could suggest that some awareness raising around the possibility of a safeguarding implication would be beneficial.

2.6 Police investigations

One SAR (adam-sar-v10) describes a complex series of events including abuse by a number of members of staff in a learning disabilities service. One of many issues considered by this SAR was that of information sharing in a situation in which the Section 42 enquiry was on hold pending a Police investigation. To summarise a complex situation, there was a lengthy investigation of alleged abuse, during which details don't appear to have been shared with the care provider. The SAR (p9) says that:

> *"The decision not to involve the care provider more fully in the safeguarding response meant that they were prevented from understanding what was happening to Adam and were unable to address the underlying cause of their staff's behaviour. It allowed the abuse to continue, even when new staff were employed to work with Adam."*

The SAR recommended that the SAB should "develop a new information sharing protocol for use in complex multi-agency enquiries." The situation described is, however, probably not unique to arrangements in this particular SAB area. This would, at first sight, appear to be an issue that could benefit from wider national policy discussion.

3. Conclusion

The SARs we reviewed may not represent all of those completed during 2022. However, they form a large enough sample to highlight some interesting and useful observations. We have done our best to summarise often complex and distressing circumstances into a small number of words. We hope that the benefits of seeking patterns and learning outweigh the risk of over-simplification.

There were few SARs where the central concern was the care service itself. Perhaps because of this, most discussion and recommendations focus on the actions of the statutory agencies, and local partnership working.

SARs often include recommendations for "professionals" or for "practitioners." It is often impossible to know whether the SAR author saw care workers as part of those groups. Although from the context we suspect often they may not have done, in our view many of those recommendations could be equally relevant for care workers.

We have listed in the appendix the SAR recommendations that were specifically directed to or about care services. We have added brief comments, highlighting some recommendations that could have wider relevance beyond the individual service or SAB area from which they arose. Overall, it is evident that SARs are making significant numbers of recommendations that it would be relevant to share with care services nationally, and not just in the area of the SAB which commissioned the review.

Our aim in writing this paper was to prompt discussion as to whether it would be a good idea to establish a national mechanism to identify and share with care services the most relevant learning from SARs across the country. The number of issues identified in this short and informal piece of work suggests that it would be.

In thinking about what this could look like in practice, we refer the reader to a recent bulletin from the Local Government and Social Care Ombudsman called Good Record Keeping. The bulletin has been written to share with care providers the learning from some recent investigations where poor record keeping was an issue. This example of making the learning more easily accessible to care providers is one that we would applaud.

Alongside the specific issues noted in this paper, many SARs describe safeguarding adults' processes that have not been well managed. A key point for care providers to recognise is that the statutory adult safeguarding response cannot necessarily be relied upon. There may be situations where a care service needs to take more of a lead to push things forward. Care services being proactive and confident in seeking a safeguarding response is a key issue, particularly for smaller care providers. This is one reason why we suggest a wider discussion about how the statutory agencies and care providers work together around safeguarding.

We recommend that policy makers and local partners should consider how they can support and encourage care providers, and the wider care provider sector, to take on a more proactive leadership role in relation to adult safeguarding.

Appendix

SAR recommendations specifically directed to or about care services

SAR Recommendation	IPC Comment
To consider a shared multi-agency care record in residents' rooms, to enhance communications.	This arose from a situation where various professionals were involved, and it was felt overall coordination could have been improved.
To develop a scheme of safeguarding champions across health and social care teams, aligned to raising awareness in staff meetings.	In the case above, family concerns about care were found to have been considered defensively. Champions as suggested here could be one of many ways of supporting a positive safeguarding culture.
To develop poster and leaflet displays, particularly in care and nursing home reception areas, on how to raise safeguarding adults and quality concerns.	This is one of several similar recommendations. It is something that care providers should have in place. The fact that a number of SARs raised it suggests that a reminder could be beneficial.
… Nursing Home to provide assurance of improved procedures and practice concerning escalation of care and safeguarding concerns and recording	This arose from a situation where the home was described as having been attentive, but to have been insufficiently proactive in raising concerns where meeting the adult's needs was proving to be challenging. This is a recommendation that could well have wider application.
The … SAB is to seek assurance that commissioners, care agencies and hospitals agree and document their role in ensuring that there is continuance of care in circumstances where an adult with care and support needs is discharged from A&E particularly as an out of area patient (i.e. not admitted to hospital).	The care agency assumed that the adult would be admitted to hospital and suspended care visits, but in fact the adult retuned home on the same day. In another SAR, the adult had been in hospital and was discharged without their homecare agency being told. This is an area of activity that would merit wider discussion.
An SAR noted that a subsequent improvement by the homecare agency was improved QA processes of service users' files and care workers' file.	This SAR didn't provide recommendations but noted subsequent improvements. From a care services perspective, a key issue from the SAR was that one homecare worker had undertaken all of the adult's care visits (3 a day) over a five week period, with no one else seeing the adult during that period. This left the adult vulnerable to neglect by the care worker. There could be benefit in highlighting more widely the risks of such an arrangement.

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... SAB should consider a) writing to every care home in the County reminding them of their duties and responsibilities in respect of the appropriate use of deprivation of liberty safeguards within those settings; b) conducting an audit of selected cases to ensure that deprivation of liberty safeguards are being used appropriately in care settings.	This arose from events in 2018/19 where one of the issues identified was an apparent lack of understanding by the care home in relation to the deprivation of liberty safeguards. Our question would be, if this recommendation is relevant for the SAB that commissioned the SAR, could it also be relevant in other local authority areas?
... SAB should seek assurance and evidence from commissioners and service providers that all staff who support people with a learning disability must be able to identify when an advocate is required and how to refer to one.	It is likely that the need for greater awareness as to when an advocate is needed applies beyond the area of this particular SAB.
Care staff must recognise the difference between a sexual offence and ISB [inappropriate sexual behaviour] caused by a medical condition. Care staff must be aware of the potential change dementia, as it progresses, might make on ISB.	This report concerned a situation in which a care home resident with a history of sexual offending sexually assaulted a fellow resident. Only a brief summary is published so far. However, it does seem reasonable to suggest that there could be benefit in wider awareness raising of this issue among care providers. Although CQC has recently published information about a case where it prosecuted a care home provider following a sexual assault, it is not known how widely care services are accessing that part of the CQC website.
The published practice briefing asked readers to consider a number of questions including "Does my organisation have robust policies and medication and transfers between care homes?"	The adult had experienced a significant deterioration in her health that was linked to her not receiving a prescribed medication following the transfer between two care homes. She sadly died some months later. The briefing provides a series of reminders about ensuring transfers are well planned and safe. We suggest these reminders could well be relevant to care providers in other local authority areas.

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